FACT SHEET

FOR IMMEDIATE RELEASE  Contact: CMS Media Relations Group
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CMS makes changes to improve quality of care during hospital inpatient stays

OVERVIEW: On August 1, 2012, the Centers for Medicare & Medicaid Services (CMS) issued a rule that will update Medicare payment policies and rates for inpatient stays in acute-care hospitals under the Inpatient Prospective Payment System (IPPS) and hospitals paid under the Long-Term Care Hospitals (LTCH) Prospective Payment System (PPS) in Fiscal Year (FY) 2013.

The rule also finalizes the payment update that will be used to calculate FY 2013 target amounts for certain hospitals excluded from the IPPS, such as cancer and children’s hospitals, and religious nonmedical health care institutions. The rule, which applies to approximately 3,400 acute-care hospitals and approximately 440 LTCHs, will generally be effective for discharges occurring on or after October 1, 2012.

In addition to promoting accurate payment for inpatient services to Medicare beneficiaries, the rule will strengthen the Hospital Inpatient Quality Reporting (IQR) Program, finalize new policies and measures for the Hospital Value-Based Purchasing (VBP) Program, and establish the framework for two new quality reporting programs that will apply to PPS-Exempt Cancer Hospitals and psychiatric hospitals and psychiatric units paid under the Inpatient Psychiatric Facilities (IPF) PPS. It also establishes requirements for the Ambulatory Surgical Center Quality Reporting (ASCQR) Program, most of which are effective for the Calendar Year (CY) 2014 payment determination, the first payment determination under the ASCQR Program.

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

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

BACKGROUND: The Hospital Value-Based Purchasing (VBP) Program utilizes measures that have been adopted for the Hospital IQR Program. The Hospital VBP Program 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 Hospital IQR Program grew out of the Hospital Quality Initiative developed by CMS in consultation with hospital groups. Participation in the program is voluntary, but the Medicare law now requires CMS to adjust payments to hospitals that do not participate successfully by reducing their applicable percentage increase by 2.0 percentage points. Since the implementation of the financial penalty, hospital participation has increased to well over 99 percent of Medicare-participating hospitals that are reimbursed under the IPPS.

Measures reported under the IQR Program are published on the Hospital Compare Web site (http://www.hospitalcompare.hhs.gov/), and may later be adopted for use in the Hospital VBP Program that was created by the Affordable Care Act and that will affect payment rates to hospitals beginning in FY 2013.

**CHANGES TO THE HOSPITAL IQR PROGRAM:**

The Hospital IQR Program measure set has grown from a starter set of 10 quality measures in 2004 to the current set of 72 quality measures. These measures include chart-abstracted measures (e.g., heart attack, heart failure, pneumonia, surgical care improvement), claims-based measures (e.g., mortality and readmissions measures for heart attack, heart failure, pneumonia); AHRQ Patient Safety Indicators and Inpatient Quality Indicators; healthcare-associated infection measures; one survey-based measure (e.g., patient experience of care), immunization measures, and structural measures.

*Changes to the measures to be reported:* The finalized measure set for the Hospital IQR Program is intended to reduce burden on hospitals, create a more streamlined measure set, and improve care through increased focus on perinatal care, surgical complications for hip and knee replacement procedures, readmissions, and care transitions.

The final rule reduces the number of measures in the IQR program from 72 to 59 for the FY 2015 payment determination, and 60 for the FY 2016 payment determination. Specifically, CMS removes one chart-abstracted measure and 16 claims-based measures. CMS also adopts three claims-based measures, one chart-abstracted measure on perinatal care, one structural measure, and adds care transition measure items to the existing “patient experience of care” survey. See Appendix A for a complete list of the Hospital IQR measures.

*Program Requirements for the FY 2014 Update:* In the final rule, CMS reduces burden and simplifies the validation requirements for the IQR program measures. Because more than 99 percent of sampled hospitals were validated as reporting accurate data in the most recent year, CMS is reducing the annual random sample from 800 hospitals to 400 hospitals. CMS is also reducing the targeted sample to up to 200 hospitals by using specific targeting criteria. The targeted sample would include, for example, hospitals meeting CMS reporting requirements but with abnormal or conflicting data patterns, and hospitals with large increases in their scores on quality measures.

These policies will help ensure that accurate quality data are used on the Hospital Compare website and in the Hospital VBP Program.
**LTCH Quality Reporting Program:** In this rule, CMS finalizes updates to measures that will be used in the FY 2014 and FY 2015 quality reporting program for LTCHs. In addition, CMS adds two new quality measures for the FY 2016 payment determination year. These new measures are: Percent of Residents or Patients Who Were Assessed and Appropriately Given the Seasonal Influenza Vaccine (Short-Stay), and Influenza Vaccination Coverage Among Healthcare Personnel.

The LTCH Quality Reporting Program ties a portion of an LTCH’s payment to its participation in the Program. LTCHs that do not comply with the LTCH quality reporting program will see their yearly Federal update payments reduced by two percentage points beginning in FY 2014.

**NEW QUALITY REPORTING PROGRAMS:**

Sections 3005 and 10322 of the Affordable Care Act called for CMS to create new quality reporting programs for two types of hospitals that are exempt from payment under the IPPS. These include IPFs as well as 11 hospitals that have been exempted from the IPPS as cancer hospitals. This final rule would implement both of those programs.

Specifically, CMS finalizes an initial set of five quality measures and program requirements for reporting in FY 2013 by IPPS-Exempt Cancer Hospitals. The measures include two healthcare-associated infection (HAI) measures developed by the Centers for Disease Control and Prevention (CDC) — Central Line Associated Blood Stream Infection and Catheter Associated Urinary Tract Infection — along with three cancer “process of care” measures on chemotherapy and hormone therapy developed by the American College of Surgeons.

CMS also finalizes a new quality data reporting program for IPFs that would reduce the IPF PPS annual payment update by 2.0 percentage points for IPFs that do not comply with the quality data submission requirements. For this program, CMS is finalizing an initial set of six “process of care” quality measures for reporting in FY 2013 for the FY 2014 payment update.

The six measures focus on administration of multiple antipsychotic medications, use of physical restraints, hours of patient seclusion, creation of post-discharge continuing care plans, and transmission of those plans to subsequent care providers after discharge. These measures were developed by the Joint Commission.

**ASCQR PROGRAM**

CMS is also finalizing several requirements for the ASCQR Program relating to the measures that were finalized for the CYs 2014, 2015, and 2016 payment determinations in the CY 2012 Outpatient Prospective Payment System/ASC final rule with comment period that appeared in the November 30, 2011 *Federal Register.*

Specifically, CMS finalizes new administrative, data completeness, and extraordinary circumstance waivers or extension request requirements, as well as a reconsideration process. ASCs that fail to report quality data or to comply with these requirements will incur a 2.0
percentage point reduction in their annual payment update for that payment determination year, beginning with the CY 2014 payment determination. Data collection for the claims-based measures for the CY 2014 payment determination will begin with services furnished on October 1, 2012.

**UPDATES TO THE HACs LIST:**

The HACs payment policy, which was mandated by the Deficit Reduction Act of 2005, prevents hospitals from being paid at the higher MS-DRG rate for patients with complications or major complications if the sole reason for the higher payment is the occurrence, during the beneficiary’s hospital stay, of one of the conditions on the HACs list. We are adding Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED) and Iatrogenic Pneumothorax with Venous Catheterization to the HAC payment provision for FY 2013. Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED) procedures will be added as a sub-category under the broader, “Surgical Site Infections” HAC category.

More than 500,000 CIEDs are implanted each year in the United States, and 70 percent of CIED recipients are age 65 or older. CIED therapy reduces morbidity and mortality in selected patients with cardiac rhythm disturbances. However, the benefit of CIED therapy is somewhat reduced by complications following device placement, including infections. Patients can present with early or late infections because of CIED placement.

Pneumothorax is defined as the presence of air or gas in the space between the tissue of the lung and parietal pleura, or surface lining of the lung (the pleural cavity). The presence of air in this space partially or completely collapses the lung and is life threatening. Air can enter the intrapleural space through the chest wall. Iatrogenic pneumothorax is a type of traumatic pneumothorax that results from infiltration into the pleural space during the course of a diagnostic or therapeutic medical intervention, such as needle placement for central line catheter guidance.

CMS is also adding two codes, 999.32 (Bloodstream infection due to central catheter) and 999.33 (Local infection due to central venous catheter) to the existing Vascular Catheter-Associated Infection HAC Category.

See Appendix C for the complete list of HACs.

**CHANGES TO THE HOSPITAL VALUE-BASED PURCHASING PROGRAM:**

The final rule includes a number of policies related to the Hospital Value-Based Purchasing (VBP) Program. These policies are intended to support the CMS three-part aim of better health care, better health in the entire population, and lower costs through improvement.

**Program Requirements for FY 2013:**

CMS finalized important operational details for Fiscal Year (FY) 2013—the first year in which value-based incentive payments will be made under the Hospital VBP Program. The final rule establishes:
• When hospitals will receive Total Performance Scores.
• The application of the one percent reduction to base-operating Diagnosis-Related Group (DRG) amounts for FY 2013 discharges.
• That value-based incentive payments will be made begin in January 2013 with respect to discharges occurring in FY 2013.

CMS also finalized a review and corrections process that will allow hospitals to correct their performance data before that data is made public on the Hospital Compare website. The agency also finalized an administrative appeals process that will give hospitals an opportunity to appeal the calculation of the performance assessment for their total performance score.

VBP Program Requirements for FY 2015:

CMS finalized several policies for the FY 2015 Hospital VBP Program, including:

• Grouping and scoring measures in four domains: Clinical Process of Care, Patient Experience of Care, Outcome, and Efficiency

• New measures, including:
  o Two new Outcome measures – Central Line-Associated Blood Stream Infection (CLABSI) measure and the Patient Safety Indicator (PSI-90) composite measure
  o One new Efficiency measure – Medicare Spending per Beneficiary (MSPB-1)

• Applicable minimum numbers of cases and measures for the expanded Outcome domain and the new Efficiency domain

• Finalized performance standards, including achievement thresholds and benchmarks for all measures as well as “floors” for all eight Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) dimensions

• Domain weighting for hospitals’ FY 2015 Performance Scores

See Appendix A for a table of finalized measures for the FY 2015 program as well as some of the measures finalized for the FY 2016 Hospital VBP Program. CMS expects to propose additional measures for the FY 2016 program in future rulemaking.

The finalized domains, domain weighting, baseline periods, and performance periods for all finalized FY 2015 measures can be found in Appendix B.

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

The final rule will appear in the August 31, 2012 Federal Register and can be downloaded at: http://www.ofr.gov/inspection.aspx?AspxAutoDetectCookieSupport=1

It will take effect October 1, 2012.

###
Finalized Quality Measures Hospital Value-Based Purchasing (VBP) Program

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinical Process of Care Measures</strong></td>
<td></td>
</tr>
<tr>
<td>AMI-7a</td>
<td>Fibrinolytic Therapy Received within 30 Minutes of Hospital Arrival</td>
</tr>
<tr>
<td>AMI-8a</td>
<td>Primary Percutaneous Coronary Intervention (PCI) Received within 90 Minutes of Hospital Arrival</td>
</tr>
<tr>
<td>HF-1</td>
<td>Discharge Instructions</td>
</tr>
<tr>
<td>PN-3b</td>
<td>Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital</td>
</tr>
<tr>
<td>PN-6</td>
<td>Initial Antibiotic Selection for Community-Acquired Pneumonia (CAP) in Immunocompetent Patient</td>
</tr>
<tr>
<td>SCIP-Inf-1</td>
<td>Prophylactic Antibiotic Received within One Hour Prior to Surgical Incision</td>
</tr>
<tr>
<td>SCIP-Inf-2</td>
<td>Prophylactic Antibiotic Selection for Surgical Patients</td>
</tr>
<tr>
<td>SCIP-Inf-3</td>
<td>Prophylactic Antibiotics Discontinued within 24 Hours After Surgery End Time</td>
</tr>
<tr>
<td>SCIP-Inf-4</td>
<td>Cardiac Surgery Patients with Controlled 6 a.m. Postoperative Serum Glucose</td>
</tr>
<tr>
<td>SCIP-Inf-9</td>
<td>Urinary Catheter Removed on Postoperative Day 1 or Postoperative Day 2</td>
</tr>
<tr>
<td>SCIP-Card-2</td>
<td>Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period</td>
</tr>
<tr>
<td>SCIP-VTE-2</td>
<td>Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxes within 24 Hours Prior to Surgery to 24 Hours After Surgery</td>
</tr>
<tr>
<td><strong>Patient Experience Measures</strong></td>
<td></td>
</tr>
<tr>
<td>HCAHPS*</td>
<td>Hospital Consumer Assessment of Healthcare Providers and Systems Survey</td>
</tr>
<tr>
<td><strong>Outcome Measures</strong></td>
<td></td>
</tr>
<tr>
<td>AHRQ (PSI-90)</td>
<td>Complication/patient safety for selected indicators (composite)**</td>
</tr>
<tr>
<td>CLABSI</td>
<td>Central Line-Associated Blood Stream Infection**</td>
</tr>
<tr>
<td>MORT-30-AMI</td>
<td>Acute Myocardial Infarction (AMI) 30-day mortality rate</td>
</tr>
<tr>
<td>MORT-30-HF</td>
<td>Heart Failure (HF) 30-day mortality rate</td>
</tr>
<tr>
<td>MORT-30-PN</td>
<td>Pneumonia (PN) 30-day mortality rate</td>
</tr>
<tr>
<td><strong>Efficiency Measures</strong></td>
<td></td>
</tr>
<tr>
<td>MSPB-1</td>
<td>Medicare spending per beneficiary**</td>
</tr>
</tbody>
</table>

* Finalized dimensions of HCAHPS in the FY 2015 Hospital VBP Program are Communication with Nurses, Communication with Doctors, Responsiveness of Hospital Staff, Pain Management, Communication about Medicines, Cleanliness and Quietness of Hospital Environment, Discharge Information, and Overall Rating of Hospital.
CMS finalized these as new measures for the FY 2015 Program for Hospital VBP.

CMS also finalized the following FY 2016 measures:

<table>
<thead>
<tr>
<th>Measure ID</th>
<th>Description</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHRQ PSI Composite</td>
<td>Complication/patient safety for selected indicators (composite)</td>
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<tr>
<td>MORT-30-AMI</td>
<td>Acute Myocardial Infarction (AMI) 30-day mortality rate</td>
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</tr>
<tr>
<td>MORT-30-HF</td>
<td>Heart Failure (HF) 30-day mortality rate</td>
<td></td>
</tr>
<tr>
<td>MORT-30-PN</td>
<td>Pneumonia (PN) 30-day mortality rate</td>
<td></td>
</tr>
</tbody>
</table>
Finalized domains, weights, performance and baseline periods for all FY 2015 measures

<table>
<thead>
<tr>
<th>Domain</th>
<th>Weight</th>
<th>Baseline Period</th>
<th>Performance Period</th>
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<tbody>
<tr>
<td>Outcome:</td>
<td>30%</td>
<td></td>
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</tbody>
</table>
### APPENDIX C

## HACS ADOPTED IN PREVIOUS RULEMAKING AND ADDITIONS FOR FY 2013

<table>
<thead>
<tr>
<th>HAC</th>
<th>CC/MCC (ICD-9-CM Codes)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HACS ADOPTED IN PREVIOUS RULEMAKING</strong></td>
<td></td>
</tr>
<tr>
<td>Foreign Object Retained After Surgery</td>
<td>998.4 (CC)</td>
</tr>
<tr>
<td></td>
<td>998.7 (CC)</td>
</tr>
<tr>
<td>Air Embolism</td>
<td>999.1 (MCC)</td>
</tr>
<tr>
<td>Blood Incompatibility</td>
<td></td>
</tr>
<tr>
<td>ABO incompatibility reaction, unspecified</td>
<td>999.60 (CC)</td>
</tr>
<tr>
<td>ABO incompatibility with hemolytic transfusion reaction not specified as acute or delayed</td>
<td>999.61 (CC)</td>
</tr>
<tr>
<td>ABO incompatibility with acute hemolytic transfusion reaction</td>
<td>999.62 (CC)</td>
</tr>
<tr>
<td>ABO incompatibility with delayed hemolytic transfusion reaction</td>
<td>999.63 (CC)</td>
</tr>
<tr>
<td>Other ABO incompatibility reaction</td>
<td>999.69 (CC)</td>
</tr>
<tr>
<td>Pressure Ulcer Stages III &amp; IV</td>
<td>707.23 (MCC)</td>
</tr>
<tr>
<td></td>
<td>707.24 (MCC)</td>
</tr>
<tr>
<td>Falls and Trauma:</td>
<td>Codes within these ranges on the CC/MCC list:</td>
</tr>
<tr>
<td>- Fracture</td>
<td>800-829</td>
</tr>
<tr>
<td>- Dislocation</td>
<td>830-839</td>
</tr>
<tr>
<td>- Intracranial Injury</td>
<td>850-854</td>
</tr>
<tr>
<td>- Crushing Injury</td>
<td>925-929</td>
</tr>
<tr>
<td>- Burn</td>
<td>940-949</td>
</tr>
<tr>
<td>- Other Injuries</td>
<td>991-994</td>
</tr>
<tr>
<td>HAC</td>
<td>CC/MCC (ICD-9-CM Codes)</td>
</tr>
<tr>
<td>---------------------------------------------------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Catheter-Associated Urinary Tract Infection (UTI)</td>
<td>996.64 (CC)</td>
</tr>
<tr>
<td></td>
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<tr>
<td>Also excludes the following from acting as a CC/MCC:</td>
<td></td>
</tr>
<tr>
<td>112.2 (CC)</td>
<td></td>
</tr>
<tr>
<td>590.10 (CC)</td>
<td></td>
</tr>
<tr>
<td>590.11 (MCC)</td>
<td></td>
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<tr>
<td>590.2 (MCC)</td>
<td></td>
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<tr>
<td>590.3 (CC)</td>
<td></td>
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<tr>
<td>590.80 (CC)</td>
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<td>590.81 (CC)</td>
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<td>595.0 (CC)</td>
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<td>599.0 (CC)</td>
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<tr>
<td>Vascular Catheter-Associated Infection</td>
<td>999.31 (CC)</td>
</tr>
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<td></td>
<td>999.32 (CC)</td>
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<tr>
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<td>999.33 (CC)</td>
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<tr>
<td>Manifestations of Poor Glycemic Control</td>
<td>250.10-250.13 (MCC)</td>
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<td>250.20-250.23 (MCC)</td>
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<td>251.0 (CC)</td>
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<td>249.10-249.11 (MCC)</td>
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<td></td>
<td>249.20-249.21 (MCC)</td>
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<tr>
<td>Surgical Site Infection, Mediastinitis, Following Coronary Artery Bypass Graft (CABG)</td>
<td>519.2 (MCC) And one of the following procedure codes: 36.10–36.19</td>
</tr>
<tr>
<td>Surgical Site Infection Following Certain Orthopedic Procedures</td>
<td>996.61 (CC)</td>
</tr>
<tr>
<td></td>
<td>998.59 (CC)</td>
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<tr>
<td></td>
<td>And one of the following procedure codes: 81.01-81.08, 81.23, 81.24, 81.31-81.38, 81.83, 81.85</td>
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<tr>
<td>HAC</td>
<td>CC/MCC (ICD-9-CM Codes)</td>
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<td>----------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Surgical Site Infection Following Bariatric Surgery for Obesity</td>
<td>Principal Diagnosis – 278.01</td>
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<tr>
<td></td>
<td>539.01 (CC)</td>
</tr>
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<td>539.81 (CC)</td>
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<tr>
<td></td>
<td>998.59 (CC)</td>
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<tr>
<td></td>
<td>And one of the following procedure codes: 44.38, 44.39, or 44.95</td>
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<tr>
<td>Deep Vein Thrombosis and Pulmonary Embolism Following Certain Orthopedic Procedures</td>
<td>415.11 (MCC)</td>
</tr>
<tr>
<td></td>
<td>415.13 (MCC)</td>
</tr>
<tr>
<td></td>
<td>415.19 (MCC)</td>
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<td></td>
<td>453.40-453.42 (CC)</td>
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<td></td>
<td>And one of the following procedure codes: 00.85-00.87, 81.51-81.52, or 81.54</td>
</tr>
<tr>
<td><strong>ADDITIONAL HACS FINALIZED FOR FY 2013</strong></td>
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<tr>
<td>Surgical Site Infection Following Cardiac Implantable Electronic Device (CIED)</td>
<td>996.61 (CC)</td>
</tr>
<tr>
<td></td>
<td>998.59 (CC)</td>
</tr>
<tr>
<td></td>
<td>And one of the following procedure codes: 00.50,00.51,00.52,00.53,00.54, 37.80,37.81,37.82, 37.83,37.85, 37.86, 37.87, 37.94, 37.96,37.98, 37.74, 37.75, 37.76, 37.77, 37.79, 37.89</td>
</tr>
<tr>
<td>Iatrogenic Pneumothorax with Venous Catheterization</td>
<td>512.1 (CC) (Iatrogenic pneumothorax) in combination with the associated procedure code 38.93 (Venous Catheterization)</td>
</tr>
</tbody>
</table>