Fact Sheets

Details for: FY 2008 INPATIENT PROSPECTIVE PAYMENT SYSTEM FINAL RULE

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FY 2008 INPATIENT PROSPECTIVE PAYMENT SYSTEM FINAL RULE
IMPROVING THE QUALITY OF HOSPITAL CARE

On August 1, 2007, the Centers for Medicare & Medicaid Services (CMS) issued a final rule to update the hospital inpatient prospective payment system (IPPS) for fiscal year (FY) 2008. The final reforms in this rule continue the Agency's commitment to health care quality and to making health care more affordable and accessible for Medicare beneficiaries.

The Reporting Hospital Quality Data for Annual Payment Update Program

Background

Section 5001(a) of the Deficit Reduction Act of 2005 (DRA) set out new requirements for the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. The DRA provides that, beginning with the payment update for FY 2007 and each subsequent fiscal year, the annual percentage increase amount will be reduced by 2.0 percentage points for any "subsection (d) hospital" that does not submit certain quality data in a form and manner, and at a time, specified by the Secretary. In addition, the DRA requires that CMS begin to expand the "starter set" of 10 quality measures that have been used since 2003.

Quality Measure Set for FY 2008

In the FY 2007 IPPS and calendar year (CY) 2007 hospital outpatient prospective payment system (OPPS) final rules, CMS proposed to add new measures to the RHQDAPU program to bring the total to 27 measures for FY 2008. (See chart on the next page.)

To receive the full update for FY 2008, hospitals will be required to report the following 27 measures:

QUALITY MEASURES
Heart Attack (Acute Myocardial Infarction)

	• Aspirin at arrival *
	• Aspirin prescribed at discharge *
	• ACE inhibitor (ACE-I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction *
	• Beta blocker at arrival *
	• Beta blocker prescribed at discharge *
	• Thrombolytic agent received within 30 minutes of hospital arrival **
	• Percutaneous Coronary Intervention (PCI) received within 120 minutes of hospital arrival **
	• Adult smoking cessation advice/counseling **
Heart Failure (HF)	
	• Left ventricular function assessment *
	• ACE inhibitor (ACE-I) or Angiotensin Receptor Blocker (ARBs) for left ventricular systolic dysfunction *
	• Discharge instructions **
	• Adult smoking cessation advice/counseling **
Pneumonia (PNE)	
	• Initial antibiotic received within 4 hours of hospital arrival *
	• Oxygenation assessment *
	• 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) – named SIP for discharges prior to July 2006	
	• 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 patient ***
	• SCIP-VTE 2: VTE prophylaxis within 24 hours pre/post surgery ***
	• SCIP Infection 2: Prophylactic antibiotic selection for surgical patients ***
Mortality Measures	
	• Acute Myocardial Infarction 30-day mortality (Medicare patients) ***
	• Heart Failure 30-day mortality (Medicare patients) ***
Patients' Experience of Care	
	• HCAHPS Patient Survey ***

* Measure included in 10 measure starter set

** Measure included in 21 measure expanded set for FY 2007

*** Measure included in 27 measure expanded set for FY 2008

Expansion of Measure Set for FY 2009

Continued expansion of the quality measure set is consistent with the letter and spirit of the DRA. The Secretary is required to expand the set of measures determined to be appropriate for the measurement of the quality of care furnished by hospitals in inpatient settings, beginning with FY 2007. In the FY 2008 IPPS final rule, CMS is moving quickly to add new measures for the FY 2009 annual payment update determination. For FY 2009, the set of measures for the RHQDAPU program will consist of the 27 measures identified for FY 2008 and the following additional measure:

- Pneumonia 30-day Mortality (Medicare patients)

CMS plans to finalize the set of measures for the RHQDAPU for the FY 2009 annual payment update in the CY 2008 Outpatient Prospective Payment System (OPPS) final rule to be published in November 2007. CMS plans to announce the final RHQDAPU inclusion status for the following additional three measures:

- SCIP Infection 4: Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose
- SCIP Infection 6: Surgery Patients with Appropriate Hair Removal
- SCIP Cardiovascular 2: Surgical Patients on Beta Blocker Therapy Prior to Admission Who Received a Beta Blocker During the Perioperative Period

These measures have been put forth by the Hospital Quality Alliance (HQA) for inclusion in its public reporting set, contingent upon endorsement by the National Quality Forum (NQF). The measures are also fully specified and included in the CMS-Joint Commission *Specifications Manual for National Hospital Quality Measures*. The measures offer important additions to our understanding of patient outcomes (mortality) and patient safety efforts, and could help encourage additional systems change in hospitals in the areas of pneumonia care and surgical services. These measures have been endorsed, or are currently under endorsement review by the NQF and will be added to the measure set, contingent on their receiving NQF endorsement by publication of the OPPS CY 2008 final rule in November 2007. Data collection for these measures for purposes of RHQDAPU will begin in CY 2008.

CMS solicited comments on whether and how to add other measures to the RHQDAPU measure set for payments beginning in FY 2009 and future years. Based on the measures identified in the rule, CMS solicited input from a broad set of stakeholders concerning: (1) priority for implementation of measures or topics in FY 2009 and beyond, (2) challenges/potential benefits posed by identified measures or topics, and (3) identification of gaps in topics or conditions (including process and outcomes).

Based on comments received, no consensus emerged from the commenters to prioritize the covered topics and measures for FY 2009 and future years. A number of commenters mentioned that the costs of data collection and submission for abstraction-based measures were challenging to hospitals. In addition, some commenters urged CMS to be cautious with

these measures and measure sets, and asked about details of implementation that have not yet been addressed. CMS will continue to monitor these measures and measure sets in terms of both feasibility and acceptability, and consider them for future inclusion in the RHQDAPU program. CMS continues to be committed to the use of NQF-endorsed and HQA-adopted measures in the RHQDAPU program.

Data Submission

For purposes of the FY 2008 payment determination, CMS is requiring hospitals to submit aggregate population and sample size counts for Medicare and non-Medicare discharges for the four topic areas (AMI, HF, PNE, and SCIP) on a quarterly basis. Improved data quality will allow CMS to assess the completeness of hospital submitted data for all payors.

Public Display Identifying Hospitals that Share a Common Medicare Provider Number

In response to concerns raised by providers, CMS is increasing transparency in public reporting and improve the usefulness of the Hospital Compare website by identifying IPPS hospitals that share a common Medicare Provider Number (MPN) and noting on the *Hospital Compare* website where publicly reported measures combine the experience of two or more hospitals. Currently, hospitals that share the same MPN must combine data collection and submission (for both clinical measures and for HCAHPS). These measures are then publicly reported as if they represented a single hospital. CMS estimates that approximately 5 to 10 percent of the hospitals reported on Hospital Compare share their MPN with other hospitals.

CMS is currently revising the Annual Payment Update (APU) pledge for hospital participation in the RHQDAPU program. To identify shared MPNs, the APU pledge would be amended to require the name and address of each hospital that shares the same MPN. This will produce a full enumeration of individual APU hospitals and will only be used for public reporting purposes; billing, claims and other processes would not be affected.

Hospital-Acquired Conditions

Section 5001(c) of the DRA requires hospitals to begin reporting on October 1, 2007 the secondary diagnoses that are present on the admission (POA) of patients. By October 1, 2007, the Secretary must select at least two conditions that are: (1) high cost or high volume or both; (2) assigned to a higher paying DRG when present as a secondary diagnosis; and (3) reasonably preventable through application of evidence-based guidelines. Beginning October 1, 2008, cases with these conditions would not be assigned to a higher paying DRG unless they were present on admission.

In the proposed rule, CMS considered 13 and proposed to select 6 conditions that would be subject to the provision. While there were some public comments that said CMS should only select serious preventable events (Object left in surgery, blood incompatibility and air embolism), CMS believes there is a significant public health interest in selecting more. Based on public comments, CMS decided not to select 1 of the original six conditions (septicemia) but added an additional 2 (falls and mediastinitis—a preventable surgical site infection that follows heart surgery). In addition, CMS selected catheter associated urinary tract infections, pressure ulcers and vascular catheter associated infections. CMS also indicated that it will work to create a code to identify ventilator associated pneumonia as well as determine when septicemia and deep vein thrombosis are not present on admission and preventable in the hospital so that these conditions may be included in the future.

Value-Based Purchasing

Section 5001(b) of the DRA requires CMS to develop a plan to implement a Value-Based Purchasing (VBP) Program for payments under the Medicare program for subsection (d) hospitals beginning with FY 2009. Congress specified that the plan include consideration of the following issues:

- The ongoing development, selection, and modification process for measures of quality and efficiency in hospital inpatient settings;
- The reporting, collection, and validation of quality data;
- The structure of value-based payment adjustments, including the determination of thresholds or improvements in quality that would substantiate a payment adjustment, the size of such payments, and the sources of funding for the value-based payments; and
- The disclosure of information on hospital performance.

CMS has created an internal Hospital VBP Workgroup to develop the mandated plan. The Workgroup hosted two public "Listening Sessions" in early 2007 to solicit comments from relevant affected parties on outstanding questions associated with plan development.

Recalled/No Cost/Partial Credit Devices

In the CY 2007 OPPS final rule, a policy was adopted to pay a hospital less when a device is provided to them at no cost. In the FY 2008 IPPS rule, CMS expanded this policy to the IPPS.

When a medical device is recalled or replaced under warranty, hospitals will often receive a replacement at low or no cost. Currently, there is no differential in payment to the hospital under the IPPS based on whether the hospital received a full or partial credit. Since a manufacturer will often provide a credit or partial credit for the recalled device rather than a free replacement, CMS proposed to apply the policy when the hospital received a credit equal to 20 percent or more of the cost of the device. However, based on public comments, we raised the threshold to 50 percent and are making other administrative changes to ensure that there are no delays in payments to the hospital from this policy. Under the rule, hospitals will be required to identify when they receive a replacement device and CMS will reduce the DRG payment to reflect the hospital's lower cost. CMS believes that the routine identification of Medicare claims for certain device implantation procedures in situations where a payment adjustment is appropriate may enhance the medical community's recognition of device – related problems, potentially leading to more timely improvements in medical device technologies.

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