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# Quality-Related Proposals in the FY 2016 IPPS Proposed Regulations

+Insights

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The proposed rule, released by the Centers for Medicare & Medicaid Services on April 17, 2015, includes changes to several key quality-related initiatives affecting acute care hospitals and long-term care hospitals.

On April 17, 2015, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that would update payment policies and rates for services furnished under the Medicare Hospital Inpatient Prospective Payment Systems (IPPS) and Long-Term Care Hospital (LTCH) Prospective Payment System (PPS). 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, 2015.

The rule includes a number of changes to various quality-related initiatives. Proposed changes affect the following programs:

- Hospital Readmissions Reduction Program
- Hospital Value-Based Purchasing (VBP) Program
- Hospital Acquired Condition Reduction (HAC) Program
- Hospital Inpatient Quality Reporting (IQR) Program

**Hospital Readmissions Reduction Program**

In October 2012, CMS began reducing Medicare payments for IPPS hospitals with excess readmissions, pursuant to the Hospital Readmissions Reduction Program. Excess readmissions are measured by a ratio: a hospital's number of "predicted" 30-day readmissions for heart attack, heart failure, pneumonia, hip/knee replacement and chronic obstructive pulmonary disease (COPD) divided by the number that would be "expected," based on an average hospital with similar patients. A ratio greater than 1 indicates excess readmissions. In previous rulemaking, CMS expanded the readmissions measures for FY 2017 and future years by adding a measure for patients readmitted following coronary artery bypass graft surgery.

*Proposal – Refinement to the Pneumonia Readmissions Measure*

CMS proposes a refinement to the 30-day Pneumonia Readmission Measure (NQF #0506) that would expand the measure cohort for the FY 2017 payment determination and subsequent years. A cohort refers to the index readmissions included in a measure. (Fig. 1)

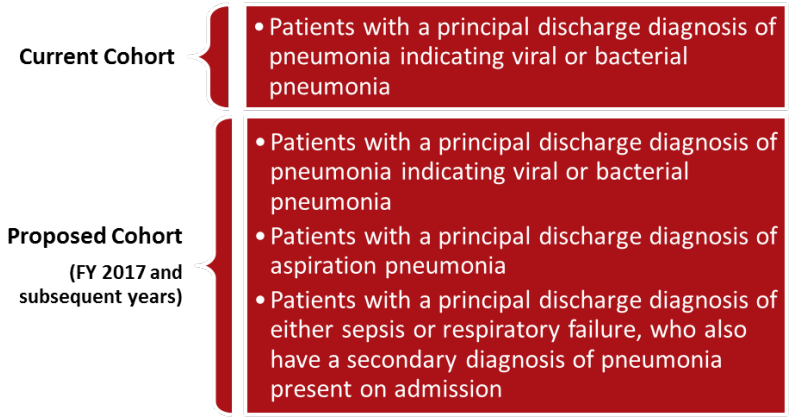


**Figure 1**

CMS believes expanding the cohort would better represent a hospital's complete population of patients who are receiving clinical management and treatment for pneumonia, and would ensure the measure includes more complete and comparable populations across hospitals. CMS also believes the use of comparable populations would reduce measurement bias resulting from different coding practices seen across hospitals.

*Proposal – Extraordinary Circumstances Exception Policy*
CMS proposes an extraordinary circumstances exception policy that would align with existing policies. The proposed policy would allow hospitals that experience an extraordinary circumstance, such as a hurricane or flood, to request a waiver for use of data from the affected time period.

More information on the Hospital Readmission Reductions Program is available on the CMS website.

**Hospital Value-Based Purchasing Program**
The Hospital VBP Program adjusts payments (up and down) to hospitals for inpatient services based on measure performance. A hospital's value-based incentive payment percentage is based on its Total Performance Score (TPS), which is derived from its performance against measures that are divided into four domains: Safety, Clinical Care, Efficiency and Cost Reduction, and Patient and Caregiver-Centered Experience of Care/Care Coordination.

The base operating DRG percent reduction was 1 percent for FY 2013 and 1.25 percent for FY 2014. It increased to 1.5 percent for FY 2015, and will rise again to 1.75 percent for FY 2016 and 2 percent for FY 2017 and subsequent years.

| Previously Adopted Measures for the FY 2018 Hospital VBP Program | |
|---|---|
| ***Patient and Caregiver-Centered Experience of Care/Care Coordination Domain*** | |
| HCAHPS | Hospital Consumer Assessment of Healthcare Providers and Systems Survey |
| CTM-3* | 3-Item Care Transitions Measure |
| ***Clinical Care Domain*** | |
| MORT-30-AMI | Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Myocardial Infarction Hospitalization |
| MORT-30-HF | Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Heart Failure Hospitalization |
| MORT-30-PN | Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Pneumonia Hospitalization |
| ***Safety Domain*** | |
| CAUTI | National Healthcare Safety Network Catheter-Associated Urinary Tract Infection (CAUTI) Outcome Measure |
| CLABSI | National Healthcare Safety Network Central Line-Associated Bloodstream Infection (CLABSI) Outcome Measure |
| Colon and Abdominal Hysterectomy SSI | Centers for Disease Control and Prevention Harmonized Procedure Specific Surgical Site Infection Outcome Measure (Colon, Abdominal Hysterectomy) |
| MRSA Bacteremia | National Healthcare Safety Network Facility-Wide Inpatient Hospital-Onset Methicillin-Resistant *Staphylococcus aureus* (MRSA) Bacteremia Outcome Measure |
| CDI | National Healthcare Safety Network Facility-Wide Inpatient Hospital-Onset *Clostridium difficile* Infection (CDI) Outcome Measure |
| PSI-90 | Patient Safety for Selected Indicators (Composite) |
| PC-01** | Elective Delivery |
| ***Efficiency and Cost Reduction Domain*** | |
| MSPB-1 | Payment-Standardized Medicare Spending Per Beneficiary |

*Proposed new measure
**Proposed to be moved from the Clinical Care – Process subdomain to the Safety domain

*Proposal – Removal of Two Measures for the FY 2018 Program*

CMS proposes to remove the IMM-2 Influenza Immunization measure from the Hospital VBP Program because the agency believes the measure is topped out, meaning there are high levels of performance with little variation and, therefore, little room for further improvement. CMS believes this measure should continue to be part of the Hospital IQR Program measure set, however, because it is the only measure that addresses the Best Practices to Enable Healthy Living goal in the CMS Quality Strategy and the priority of the same name in the National Quality Strategy.

CMS also proposes to remove the AMI-7a Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival measure. Data indicates that AMI-7a is not widely reported by hospitals, and that many hospitals have fewer than the minimum number of cases required for reporting because most acute myocardial infarction patients receive percutaneous coronary intervention instead of fibrinolytic therapy. CMS also proposes to remove this measure under the Hospital IQR Program.

*Proposal – New Measure for the FY 2018 Program Year*

CMS proposes to add a 3-Item Care Transition measure (CTM-3) (NQF #0228) to the FY 2018 Hospital VBP Program. This measure adds three queries to the Hospital Consumer Assessment of Healthcare Providers and Systems Survey:

- During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left (strongly disagree, disagree, agree, strongly agree).
- When I left the hospital, I had a good understanding of the things I was responsible for in managing my health (strongly disagree, disagree, agree, strongly agree).
- When I left the hospital, I clearly understood the purpose for taking each of my medications (strongly disagree, disagree, agree, strongly agree).

The inclusion of this measure in the Hospital VBP Program is supported by the Measure Application Partnership (MAP), a public-private partnership convened by the National Quality Forum (NQF) for the purpose of providing input to CMS on the selection of certain quality and efficiency measures. Other evidence in support of adding this measure includes its previous adoption in the Hospital IQR Program and the fact that CMS posted data on the measure on Hospital Compare for at least one year before the beginning of the proposed performance period for it in the Hospital VBP Program.

*Proposal – Domain Reassignment for the FY 2018 Program and Domain Re-Weighting*

The Clinical Process of Care domain is made up of two subdomains: Clinical Care – Outcome and Clinical Care – Process. If CMS finalizes the removal of the IMM-2 and AMI-7a measures, it proposes to move PC-01 (the only measure left in the Clinical Care – Process subdomain) to the Safety domain and to remove the Clinical Care – Process subdomain beginning with the FY 2018 program year. CMS also proposes to revise the weighting of the domains based on these changes.

| **Domain Weights for the FY 2017 Program Year for Hospitals Receiving a Score on All Domains** | | **Proposed Domain Weights for the FY 2018 Program Year for Hospitals Receiving a Score on All Domains** | |
|---|---|---|---|
| **Domain** | **Weight** | **Domain** | **Weight** |
| Safety | 20% | Safety | 25% |
| Clinical Care<br>• Outcomes<br>• Process | 30%<br>25%<br>5% | Clinical Care | 25% |
| Efficiency and Cost Reduction | 25% | Efficiency and Cost Reduction | 25% |
| Patient/Caregiver Experience | 25% | Patient/Caregiver Experience | 25% |

*Proposal: Domain Weighting for the FY 2018 Program Year for Hospitals Receiving Scores on Fewer than Four Domains*
In the FY 2015 IPPS final rule, CMS adopted a policy that, for the FY 2017 program year and subsequent years, hospitals must receive domain scores on at least three quality domains in order to receive a TPS. CMS believes this policy allows as many hospitals as possible to participate in the program while ensuring reliable TPSs.

Because CMS proposes to remove the Clinical Care – Process subdomain from the Hospital VBP Program effective with the FY 2018 program year, the agency considered whether it should revisit the requirement that hospitals receive scores on at least three domains in order to receive a TPS. CMS decided not to propose a change at this time, but it invites comment on whether it should consider adopting a different policy on this topic.

*Proposal: Integration of CDC's New Standard Population Data*
For the Hospital VBP Program, CMS uses the Centers for Disease Control and Prevention's (CDC's) standard population data to compare measure performance between the baseline and performance period. In the proposed rule, this CDC data is referred to as "current standard population data." Beginning in 2015, the CDC is making changes to the calculation of this data. This new version of the data is referred to in the proposed rule as "new standard population data."

For technical reasons, CMS does not believe it can use the new data right away. CMS intends to continue to use the current standard population data to calculate performance standards and to calculate and publicly report measure scores. Beginning with the FY 2019 program year and subsequent years, the Hospital VBP Program will use the new standard population data.

*Proposal: FY 2019, FY 2021 and Subsequent Program Years*
Because of the time necessary to adopt measures, CMS often adopts policies for the Hospital VBP Program well in advance of the program year for which the policies will be applicable.

In one such instance, CMS intends to propose to include the selected ward (non-intensive-care-unit (ICU)) locations in the CAUTI and CLABSI measures beginning with the FY 2019 program year in future rulemaking. The agency intends to propose to adopt a baseline period of January 1, 2015, through December 31, 2015, and a performance period of January 1, 2017, through December 31, 2017, for these measures. This proposed policy change, which is consistent with a recent NQF re-endorsement update, will expand data collection related to this measure.

Another instance is the Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate following COPD Hospitalization (NQF #1893) (MORT-30-COPD), which is a risk-adjusted, NQF-endorsed mortality measure monitoring mortality rates following COPD hospitalizations. CMS proposes its adoption for FY 2021 and subsequent program years.

*Summary: Previously Adopted and Newly Proposed Measures for FY 2019, FY 2021 and Subsequent Program Years*
In the proposed rule, CMS provided a summary of the previously adopted and newly proposed measures for the FY 2019, FY 2021 and subsequent program years.

| **FY 2019 Previously Adopted Measures** | |
|---|---|
| ***Clinical Care Domain*** | |
| THA/TKA | THA/TKA Hospital-Level Risk-Standardized Complication Rate Following Elective Primary Total Hip Arthroplasty/Total Knee Arthroplasty |
| ***Safety Domain*** | |
| PSI-90 | Patient Safety for Selected Indicators (Composite) |

| FY 2021 Newly Proposed Measure | |
|---|---|
| ***Clinical Care Domain*** | |
| MORT-30-COPD | Hospital 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Chronic Obstructive Pulmonary Disease Hospitalization |

*Miscellaneous Proposals*
CMS also seeks comment on measures that could potentially be used to expand the Efficiency and Cost Reduction domain in the future.

The care provided by hospitals is measured during a performance period and is then compared against performance during a baseline period. CMS proposed baseline and performance periods for the FY 2018 and future program years.

CMS is required to establish performance standards for the measures selected under the Hospital VBP Program. The performance standards must include levels of achievement and improvement. CMS proposed performance standards for FY 2018 and future program years.

More information on the Hospital VBP Program is available on the CMS website.

**Hospital Acquired Condition Reduction Program**
HACs are a group of conditions that, in CMS's view, are reasonably preventable and that patients did not have upon admission to the hospital, but which developed during the hospital stay. Effective October 1, 2014, CMS implemented the HAC Reduction Program, which uses a combination of public reporting and financial incentives to encourage hospitals to reduce HACs. Hospital performance under the HAC Reduction Program is determined based on a hospital's Total HAC Score, which can range from 1 to 10. The higher a hospital's Total HAC Score, the worse the hospital performed under the HAC Reduction Program. Effective FY 2015, the law requires a payment reduction of 1 percent for all discharges for hospitals that rank in the quartile of hospitals with the highest Total HAC Score. (Fig. 2)

*Proposal – Changes for Implementation of the HAC Reduction Program for FY 2017*
CMS proposes three changes for the FY 2017 HAC Reduction Program:

- Previous regulations codified that there will be a two-year applicable time period to collect data used to calculate the Total HAC Score. CMS proposes to continue similar two-year time periods:
  - AHRQ PSI-90 composite measure – July 1, 2013, through June 30, 2015
  - CLABSI, CAUTI, Colon and Abdominal Hysterectomy SSI, MRSA Bacteremia and CDI – CYs 2014 and 2015

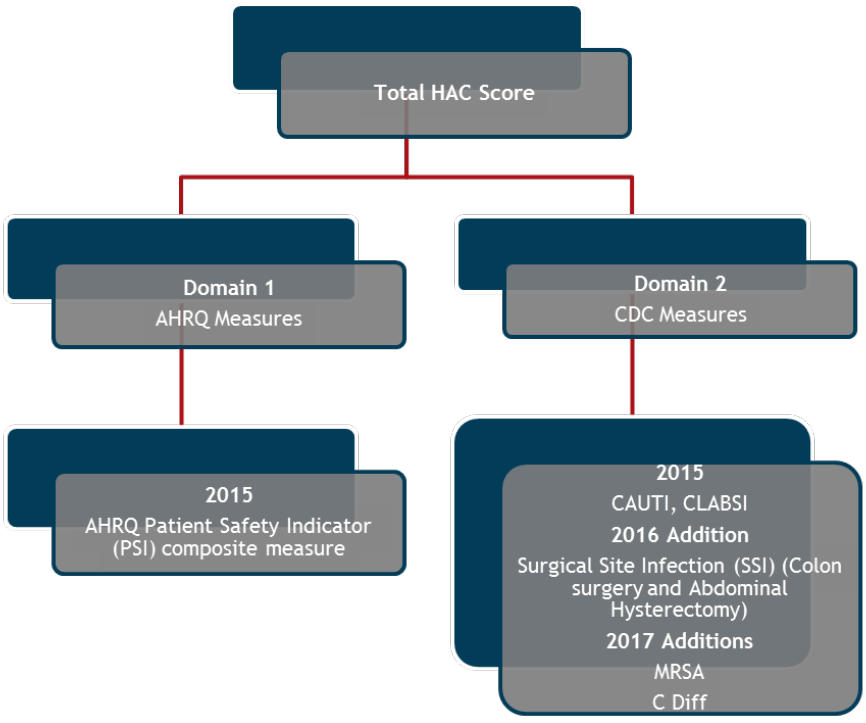


**Figure 2**

- CMS proposes technical changes to the method for calculating the HAC score when data is missing.
- For FY 2017, CMS proposes to reduce the weight assigned to domain 1. CMS is proposing this change to reflect the additional measures recently added to domain 2. Additionally, the Medicare Payment Advisory Commission and other stakeholders have indicated in comments that domain 2 should be weighted more than domain 1 because they consider the CDC chart-abstracted measures to be more reliable and actionable than claims-based measures.

| Program Year | Domain 1 AHRQ Patient Safety Indicators | Domain 2 CDC National Health Safety Network Measures |
|---|---|---|
| FY 2016 | 25 percent | 75 percent |
| FY 2017 (proposed) | 15 percent | 85 percent |

*Proposal: Measure Modification for FY 2018*
CMS adopted the CLABSI and CAUTI measures inclusive of pediatric and adult patients in ICUs for the FY 2015 HAC Reduction Program. CMS proposes an expansion to the population covered by these measures beginning in FY 2018. Specifically, CMS proposes to include data from pediatric and adult medical ward, surgical ward and medical/surgical ward locations in addition to data from ICU locations. CMS believes this refinement more accurately captures hospital-wide performance and will allow hospitals that do not have ICUs to report this measure.

*Proposal: ICD-10 Issues*
In preparation for the October 1, 2015, implementation of ICD-10, CMS proposes that the ICD-10-CM/PCS Version 33 HAC list replace the ICD-9-CM Version 32 HAC list. CMS solicits public comments on the new list, which is located in Appendix I of the ICD-10-CM/PCS MS-DRG Version 32 Definitions Manual.

HAC Score Calculation*

FY 2015: (Domain 1 Score x 35%) + (Domain 2 Score x 65%) = Total HAC Score

FY 2016: (Domain 1 Score x 25%) + (Domain 2 Score x 75%) = Total HAC Score

*Hospitals reporting measures in two domains

*Proposal: Extraordinary Circumstances Exception Policy*
CMS proposes an extraordinary circumstances exception policy for the HAC Reduction Program that would align with existing policies. This policy would allow hospitals that experience an extraordinary circumstance (such as a hurricane or flood) to request a waiver for use of data from the affected time period.

More information on the Medicare HAC Reduction Program is available on the CMS website.

**Hospital Inpatient Quality Reporting Program**
In order to receive the full annual percentage increase in payments, hospitals are required to report data on measures selected by CMS for the Hospital IQR Program. Additionally, CMS is required by law to make measure data publicly available. This data is posted on the Hospital Compare website.

*Proposal: Measure-Related Changes*
CMS proposes a number of measure-related changes to the Hospital IQR Program. CMS estimates that these proposed changes will result

in total hospital costs of $169 million across approximately 3,300 IPPS hospitals.

- CMS proposes to remove nine measures for the FY 2018 payment determination and subsequent years:
  - STK-01: Venous Thromboembolism (VTE) Prophylaxis (NQF #0434)
  - STK-06: Discharged on Statin Medication (NQF #0439)
  - STK-08: Stroke Education (NQF endorsement removed)
  - VTE-1: Venous Thromboembolism Prophylaxis (NQF #0371)
  - VTE-2: Intensive Care Unit Venous Thromboembolism Prophylaxis (NQF #0372)
  - VTE-3: Venous Thromboembolism Patients with Anticoagulation Overlap Therapy (NQF #0373)
  - IMM-1: Pneumococcal Immunization (NQF #1653)
  - AMI-7a: Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival (NQF #0164)
  - SCIP-Inf-4: Cardiac Surgery Patients with Controlled Postoperative Blood Glucose (NQF #0300)
- CMS proposes to add eight measures to the Hospital IQR Program for the FY 2018 payment determination and subsequent years:
  - Hospital Survey on Patient Safety Culture
  - Kidney/UTI Clinical Episode-Based Payment Measure
  - Cellulitis Clinical Episode-Based Payment Measure
  - Gastrointestinal Hemorrhage Clinical Episode-Based Payment Measure
  - Lumbar Spine Fusion/Re-Fusion Clinical Episode-Based Payment Measure
  - Hospital-Level, Risk-Standardized Payment Associated with an Episode-of-Care for Primary Elective THA/TKA
  - Excess Days in Acute Care After Hospitalization for Acute Myocardial Infarction
  - Excess Days in Acute Care After Hospitalization for Heart Failure
- CMS proposes to require hospitals to report 16 of the 28 Hospital IQR Program electronic clinical quality measures that align with the Medicare Electronic Health Record (EHR) Incentive Program and span three different NQS domains.

CMS also proposes to implement in the Hospital IQR Program the measure refinement of the 30-day Pneumonia Readmission Measure (NQF #0506) discussed previously.

*Proposal: Electronic Core Data Elements*
CMS has identified 21 clinical variables also referred to as core clinical data elements. These data elements are routinely collected on hospitalized adults and can potentially be extracted from hospital EHRs. CMS seeks public comment on the concept of collecting these data elements. Specifically, it seeks comment on the following issues:

- The use of the core clinical data elements derived from EHRs in risk adjustment of outcome measures, as well as other types of measures
- The collection of additional administrative linkage variables to link a patient's episode of care from EHR data with his or her administrative claim data
- The use of content exchange standards for reporting these data elements

CMS also proposes several policies related to technical and timing issues associated with data submission.

More information on the Hospital IQR Program is available on the CMS website.

**Other Quality Efforts**

These hospital inpatient programs are not the only areas in which CMS has recently made announcements regarding its quality efforts. As CMS leadership indicated in a recent blog post, CMS is responding on numerous fronts to Secretary Burwell's January 2015 announcement of a new vision for the Medicare program: the goal of shifting Medicare payments from volume to value. Recent efforts include a request for comments on the potential expansion of the Bundled Payments for Care Improvement Initiative. Additionally, in the FY 2016 proposed rule for Skilled Nursing Facilities (SNFs) that was released on April 20, 2015, CMS introduced the concept of value-based purchasing for SNFs. A value-based purchasing program for SNFs was authorized by the Protecting Access to Medicare Act of 2014.

In other recently released regulations, CMS has begun implementing provisions of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, which was enacted on October 6, 2014. The IMPACT Act requires CMS to collect standardized patient assessment data and data on quality, resource use and other measures from four types of post-acute care providers: home health agencies, inpatient rehabilitation facilities, SNFs and LTCHs. It also requires the reporting of quality measures and resource use measures in specific domains. In the recently published rules, CMS proposed to adopt the following cross-cutting quality measures for three of these four settings: (1) new or worsening pressure ulcers, (2) falls with major injury, and (3) an admission and discharge functional assessment with a care plan that addresses function.

Finally, on April 23, 2015, CMS released the 2013 PQRS Experience Report, which summarizes the historical reporting experience of eligible professionals in the eRx Incentive and the Physician Quality Reporting System (PQRS) programs through program year 2013, as well as preliminary PQRS data for the 2014 program year. Highlights from this report were discussed in a recent +Insights article.

More information on the CMS quality strategy is available online.

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