The Measurement Spiral: The Ongoing Dance of Chaos and Order

Vicky Mahn-DiNicola RN, MS, CPHQ
Vice President, Midas+ Solution Strategy

22nd Annual Midas+ User Symposium
The more things change…
• “The costs of healthcare are spiraling upwards. Ideas for reforming the healthcare systems are hotly debated. The promise of medicine has never been brighter. This future, however, has never been more uncertain.”

• “Our highest priority initiative is to discover the best organization for healthcare delivery to offer the most efficient production of service”

American Medical Association
Committee on Cost of Medical Care

1927
Then again…

some things DO change!
Review of Proposed IPPS Rule for FY 2014
CMS-1599-P
Posted April 26, 2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services
42 CFR Parts 412, 482, 485, and 489
[CMS-1599-P]
RIN 0938-AR53
Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute
Care Hospitals and the Long-Term Care Hospital Prospective Payment System and
Proposed Fiscal Year 2014 Rates; Quality Reporting Requirements for Specific
Providers; Hospital Conditions of Participation
AGENCY: Centers for Medicare and Medicaid Services (CMS), HHS.
ACTION: Proposed rule.
SUMMARY: We are proposing to revise the Medicare hospital inpatient prospective
payment systems (IPPS) for operating and capital-related costs of acute care hospitals to
implement changes arising from our continuing experience with these systems. Some of
the proposed changes implement certain statutory provisions contained in the Patient

Healthcare Quality is Personal

- Sleep deprivation
- Skin integrity
- Oral Care
- IV Management
- Lab draw technique
- Variation in process

“It’s not about the numbers.”
Comment Period Ends
June 25, 2013 5 p.m. EDT

Submit electronic comments to http://www.regulations.gov
Or Mail to: Department of Health and Human Services,
Attention: CMS-1599-P,
P.O. Box 8011,
Baltimore, MD 21244-1850.
Hospital Inpatient Quality Reporting Program

Readmission Reduction

Inpatient Quality

Hospital Acquired Conditions

Value Based Purchasing

Inpatient Psychiatric Quality

Resources
Proposed Removal of 8 Measures
for FY 2016 Payment Determination

Acute Myocardial Infarction
• AMI-2 Aspirin prescribed at discharge
• AMI-10 Statin prescribed at discharge

Pneumonia
• PN-3b: Blood Culture Performed in ED prior to First Antibiotic Received in Hospital

Heart Failure
• HF-1 Discharge Instructions
• HF-3 ACEI or ARB for LVSD

Surgical Care Improvement
• SCIP-Inf-10 Surgery patients with perioperative temperature management

Immunization
• IMM-1: Immunization for Pneumonia

Structural Measure
• Systematic Clinical Database Registry for Stroke Care
Four Measures Still in Suspension

- AMI-1 Aspirin at Arrival
- AMI-3 ACEI/ARB for LVSD
- AMI-5 Beta-blockers at discharge
- SCIP Inf-6 Appropriate Hair Removal

CMS reserves the right to reactive these with a 3 month notice prior to resuming data collection if and when they have evidence that performance is declining....
Summary of 29 Chart Abstracted Measures to be collected January 1\textsuperscript{st} to December 31\textsuperscript{st} 2014 for FY 2016 Payment

No new chart abstracted measures proposed (SCIP Inf-4 modifications)

<table>
<thead>
<tr>
<th>Hospital Inpatient Quality Reporting</th>
<th>Hospital Inpatient Quality Reporting</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute MI</strong></td>
<td><strong>VTE</strong></td>
</tr>
<tr>
<td>• AMI-7a Fibrinolytic agent 30 minutes of arrival</td>
<td>• VTE-1 VTE Prophylaxis</td>
</tr>
<tr>
<td>• AMI-8a Timing of PCI Intervention</td>
<td>• VTE-2 ICU VTE Prophylaxis</td>
</tr>
<tr>
<td><strong>Heart Failure</strong></td>
<td>• VTE-3 VTE anticoagulation overlap therapy</td>
</tr>
<tr>
<td>• HF-2 Evaluation of LVSF</td>
<td>• VTE-4 Unfractionated heparin monitored by protocol</td>
</tr>
<tr>
<td><strong>Pneumonia</strong></td>
<td>• VTE-5 VTE discharge instructions</td>
</tr>
<tr>
<td>• PN-6 Appropriate initial antibiotic selection</td>
<td>• VTE-6 Incidence of potentially preventable VTE</td>
</tr>
<tr>
<td><strong>Stroke</strong></td>
<td><strong>Surgical Care Improvement Project (SCIP)</strong></td>
</tr>
<tr>
<td>• STK-1 VTE Prophylaxis</td>
<td>• SCIP Inf-1 Antibiotic 1 hour prior to incision</td>
</tr>
<tr>
<td>• STK-2 Antithrombotic therapy</td>
<td>• SCIP Inf-2 Prophylactic antibiotic selection</td>
</tr>
<tr>
<td>• STK-3 Anticoagulation for Afib/flutter</td>
<td>• SCIP Inf-3 Antibiotics discontinued 24 hrs postop</td>
</tr>
<tr>
<td>• STK-4 Thrombolytic therapy</td>
<td>• SCIP Inf-4 Cardiac surgery with controlled glucose</td>
</tr>
<tr>
<td>• STK-5 Antithrombotic therapy hospital day 2</td>
<td>• SCIP Inf-9 Postop urinary catheter removed postop day 1 or 2</td>
</tr>
<tr>
<td>• STK-6 Discharged on Statin</td>
<td>• SCIP- Card-2 Surgery patients on beta-blocker prior to surgery receive during periop period</td>
</tr>
<tr>
<td>• STK-8 Stroke education</td>
<td>• SCIP-VTE-2 Appropriate VTE prophylaxis within 24 hours pre/post surgery</td>
</tr>
<tr>
<td>• STK-10 Assessed for Rehab</td>
<td><strong>Emergency Department Throughput</strong></td>
</tr>
<tr>
<td><strong>Perinatal Care</strong></td>
<td>• ED-1 Median time from arrival to departure</td>
</tr>
<tr>
<td>• PC-01 Elective delivery prior to 39 completed weeks of gestation</td>
<td>• ED-2 Median time from admit decision to departure</td>
</tr>
<tr>
<td><strong>Global Immunization Measures</strong></td>
<td><strong>Emergency Department Throughput</strong></td>
</tr>
<tr>
<td>• IMM-2 Immunization for Influenza</td>
<td>• ED-1 Median time from arrival to departure</td>
</tr>
</tbody>
</table>

2013 Midas+ User Symposium
Proposed Measure Refinements

Beginning January 1, 2014

• Changing SCIP-Inf-4 Controlled 6am Glucose for Cardiac Surgery Patients to “controlled glucose 18-24 hours post cardiac surgery”

• Must demonstrate that a corrective action was taken for patients with a glucose > 180 mg/dl) in order to pass the measure
# Healthcare Associated Infections Measures

## Hospital Quality Reporting Program for FY 2016

### Healthcare Associated Infections

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
</table>
| Central Line Associated Bloodstream Infection| • ICU  
• Medical (proposed beginning 1-1-2014)  
• Surgical (proposed beginning 1-1-2014)                                                             |
| Catheter- Associated Urinary Tract Infection  | • ICU  
• Medical (proposed beginning 1-1-2014)  
• Surgical (proposed beginning 1-1-2014)                                                             |
| Surgical Site Infection                       | (combined total of 10 or more per CY)  
• SSI following Colon Surgery  
• SSI following Abdominal Hysterectomy                                                                |
| MRSA Bacteremia                                |                                                                                                   |
| Clostridium difficile (C. difficile)           |                                                                                                   |
| Healthcare Personnel Influenza Vaccinations    | (Provided October 1st through March 31st)  
(proposed date of collection May 15th)                                                                  |

No new measures proposed to be added except for additional stratification groups in CLABSI and CAUTI and New date for reporting Healthcare Personnel Influenza Vaccination.
Proposed Changes to HAI Validation
Starting with November 2013 Events

- Half the hospitals report on:
  - SSI (2 records)
  - MRSA (5 records)
  - C. Difficile (5 records)

- Half the hospitals report on:
  - SSI (2 records)
  - CLABSI (5 records)
  - CAUTI (5 records)

Hospitals to submit only parts of the Medical record relevant to these infections
CMS proposing that hospitals do not alter format of downloadable Validation Template
Proposal for Mandatory Submission of HIC Numbers for all Healthcare Associated Infection Events

• Proposed rule to require hospitals to report the Medicare Beneficiary ID numbers (HIC Numbers) to NHSN for all HAI events reported for Medicare Beneficiaries (currently this is voluntary)

• This will allow CMS to match medical records to NHSN data as part of validation
Option to Submit CQM eMeasures instead of paper-based “core measures” FY 2016 Payment Determination

- Submit at least one quarter of data for encounters discharged in FY 2014 (October 1, 2013 through September 30, 2014) for the 16 eMeasures defined by Meaningful Use Specifications for Stroke, VTE, ED and Perinatal Care instead of paper-based “core measures” for these same topics only

- Must continue submission of other paper-based topics

- No data validation and no public reporting for the initial year

- CMS estimates a savings of 800 hours per year in data abstraction for hospitals electing this option

- Estimates 2.66 hours required for reporting! *(read for yourself on page 1397)*
Option to Submit CQM eMeasures instead of paper-based “core measures” FY 2016 Payment Determination

- May elect to use this data for the EMR Incentive Program Clinical Quality Measure Reporting Requirement (Meaningful Use) in addition to Hospital Inpatient Quality Reporting requirement

- May elect to use this data ONLY for Hospital Inpatient Quality Reporting requirement

- Either option requires submission via QNET using HL7 Quality Reporting Document Architecture Category I Revision 2 standards extracted from certified EHR technology
Timelines for Electronic Submission

For Example: If a hospital elects to submit data for both MU and HIQR for CY Q3 2014 it would need to submit data by November 30, 2014 NOT February 15, 2015.

Submission for Both EMR and HIQR

<table>
<thead>
<tr>
<th>Reporting Periods</th>
<th>Submission Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>For eligible hospitals in 1st year of MU Attestation – Any 90 consecutive days in FY 2014 prior to July 1, 2014</td>
<td>July 1, 2014</td>
</tr>
<tr>
<td>For eligible hospitals that are beyond their first year of MU program, any FY 2014 quarter or the entire FY 2014 (October 1, 2013 to September 30, 2014)</td>
<td>Nov 30, 2014</td>
</tr>
</tbody>
</table>

Submission for ONLY HIQR Program

<table>
<thead>
<tr>
<th>Discharge Period</th>
<th>Submission Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 2014</td>
<td>August 15, 2014</td>
</tr>
<tr>
<td>Q2 2014</td>
<td>November 15, 2014</td>
</tr>
<tr>
<td>Q3 2014</td>
<td>February 15, 2015</td>
</tr>
<tr>
<td>Q4 2014</td>
<td>May 15, 2015</td>
</tr>
</tbody>
</table>
Live Clients

You must be a Midas+ Live client for us to submit eMeasure data for you

• **Stage 1:** Hospitals that want to use their data for BOTH HIQR and MU Stage 1, should report data electronically, rather than through attestation. If you use attestation, it does not fulfill the HIQR requirements. The deadline for submission for TWO BIRDS WITH ONE STONE is **July 1, 2014**.

• **Stage 2:** Hospitals that want to use their data for BOTH HIQR and MU Stage 2, will have a modified data submission of 1 or more quarters of data (Q4 2013 through Q 3 2014 discharges) by **November 30, 2014** (as opposed to the Q3 2014 HIQR deadline of February 15, 2015)

*For clients that have other vendors for MU Clinical Quality Measures but use Midas+ CPMS or DataVision for paper core measures you will have to let us know not to submit your paper based measures for Stroke, VTE, ED and Perinatal Care. Details on how to register for these measure submission processes will be released in future client communications.*
Is CMS Moving Too Fast?

- Expect to see a proposal in FY 2015 rule to make electronic reporting of selected quality measures mandatory for HIQR
- Rumors that CMS will propose that CQM eMeasures to be used for VBP by 2017
- Five new electronic measures proposed for “future” years
  - Severe sepsis and septic shock management bundle
  - Cesarean Section
  - Exclusive breast milk feeding
  - Healthy term newborn
  - Hearing screening prior to hospital discharge
### Claims Based Outcome Measures FY 2016

#### Mortality Measures (Medicare Patients Only)
- Acute MI 30-day mortality rate
- Heart Failure 30-day mortality rate
- Pneumonia 30-day mortality rate
- Stroke 30-day mortality rate
- COPD 30-day mortality rate

### Readmission Measures (Medicare Patients Only)
- Acute MI 30-day Readmission Rate
- Heart Failure 30-day Readmission Rate
- Pneumonia 30-day Readmission Rate
- Total Hip/Knee Arthroplasty 30-day Readmission Rate
- Hospital-wide All Cause Unplanned Readmission
- Stroke 30-day Readmission Rate
- COPD 30-day Readmission Rate

### AHRQ Patient Safety Indicators
- PSI-90 Complication patient safety composite **
- PSI-4 Death among surgical inpatients with serious treatable complications (Nursing Sensitive Care)

### Surgical Complications
- Hip/Knee Complication Rate following Elective Primary Total Joint Arthroplasty

Four new measures proposed for FY 2016 Payment Determination….
Additional Claims Based Measures Proposed

FY 2016 Payment Determination

Stroke
- 30-day risk standardized Ischemic Stroke Readmission Rate
- 30-day risk standardized Ischemic Stroke Mortality Rate
  ✓ Hemorrhagic strokes and TIAs are excluded
  ✓ Both measures not yet endorsed by NQF

COPD
- 30-day risk standardized COPD Readmission Rate
- 30-day risk standardized COPD Mortality Rate
  ✓ COPD as a principal diagnosis
  ✓ Respiratory Failure as principal diagnosis with a secondary diagnosis of COPD
  ✓ Patients transferred from another acute care facility excluded
  ✓ Patients enrolled in Medicare Hospice Program any time in 12 months prior to index hospitalization are excluded from measure population
Healthcare Quality is Personal

- Family involvement
- Advanced directives
- Pain Management
- Fear of hospitalization

“Why do I care what a hospital’s COPD Mortality Rate is? I know perfectly well its going to kill me…..why don’t you measure the things that matter?”
HCAHPS Patient Experience Survey Domains

No Measure Modifications Proposed for FY 2016 HIQR Program

<table>
<thead>
<tr>
<th>Dimensions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with Nurses</td>
</tr>
<tr>
<td>Communication with Doctors</td>
</tr>
<tr>
<td>Responsiveness of Hospital Staff</td>
</tr>
<tr>
<td>Pain Management</td>
</tr>
<tr>
<td>Communication about Medicines</td>
</tr>
<tr>
<td>Cleanliness and Quietness of Environment</td>
</tr>
<tr>
<td>Discharge Information</td>
</tr>
<tr>
<td>Overall Rating of Hospital</td>
</tr>
</tbody>
</table>

- Adult (18+)
- Medical, surgical or maternity care
- Overnight stay or longer
- Alive at discharge
- Excludes hospice discharge, prisoner, foreign address, “no-publicity patients, patients excluded due to state regulations, patients discharged to nursing homes or SNF
AHRQ Patient Safety Measures

Previous FY 2013 Rule

- AHRQ PSI-90 Composite Measure is published on Hospital Compare and will be included in Value-based Purchasing Program beginning with FY 2015 discharges
- **Remove** the individual measures making up the composite measures from Hospital Compare (removed in the FY 2013 final rule)

FY 2014 Proposed Rule

- **Restore** the individual measures that make up the PSI-90 Composite Measure in Hospital Compare
  - PSI 03 Adult pressure ulcer per 1000
  - PSI 06 Adult iatrogenic pneumothorax per 1000
  - PSI 07 Adult CV BSIs per 1000
  - PSI 08 Adult postoperative hip fracture per 1000
  - PSI 12 Adult postoperative PE or DVT per 1000
  - PSI 13 Adult postoperative sepsis per 1000
  - PSI 14 Adult postop wound dehiscence per 1000
  - PSI 15 Adult accidental puncture or laceration per 1000
Proposed Changes to Structure of Care Measures and Reporting Timelines for HIQ Reporting Program

<table>
<thead>
<tr>
<th>Structural Measures FY 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation in a Systematic Database for Cardiac Surgery</td>
</tr>
<tr>
<td>Participation in a Systematic Database Registry for Nursing Sensitive Care</td>
</tr>
<tr>
<td>Participation in a Systematic Database Registry for General Surgery</td>
</tr>
<tr>
<td>Safe Surgery Checklist Use (previously adopted in prior rule making but effective for the first time with the FY 2016 Payment Determination)</td>
</tr>
<tr>
<td>Participation in a Systematic Clinical Database Registry for Stroke Care *</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CMS Fiscal Year</th>
<th>QNEt Reporting Deadlines</th>
<th>Applicable Time Periods</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2014</td>
<td>April 1 to May 15, 2013</td>
<td>January 1 to December 31, 2012</td>
</tr>
<tr>
<td>FY 2015</td>
<td>January 1 to February 15, 2014</td>
<td>January 1 to December 31, 2013</td>
</tr>
<tr>
<td>FY 2016</td>
<td>January 1 to February 15, 2015</td>
<td>January 1, 2014 to December 31, 2014</td>
</tr>
</tbody>
</table>

* Proposed for Removal for FY 2016

Proposed revised timelines in FY 2014 Rule for submitting reporting activities to QNET Page 886
Proposed Changes to Cost Efficiency Measures for FY 2016

<table>
<thead>
<tr>
<th>Cost Efficiency Measures FY 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Spending per Beneficiary</td>
</tr>
<tr>
<td>Hospital Risk-Standardized Payment Associated with 30-day Episode of Care for Acute Myocardial Infarction *</td>
</tr>
</tbody>
</table>

* Proposed for FY 2016
Mean 30-day Risk Standardized Payment Among Medicare FFS Patients Age 65 or older Hospitalized with Acute MI proposed rule begins on page 852

- Evidence of variation in payments at hospitals for Acute MI
- Range $15,521 to $27,317 across 1,846 hospitals in 2008
- Necessary to understand cost variations in relation to quality outcomes
- Reporting will be triangulated with AMI 30-day mortality and readmission metrics

See measure methodology report at:
http://cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html
Mean 30-day Risk Standardized Payment Among Medicare FFS Patients Age 65 or older Hospitalized with Acute MI

Inclusion Criteria

- 65 years or older at time of index admission
- Complete 12 months of FFS enrollment to allow adequate risk adjustment

Exclusion Criteria

- Fewer than 30 days post admission enrollment in Medicare
- Principal diagnosis of Acute MI during index hospitalization who were transferred FROM another acute care facility
- Discharged on same day as index admission and did not die or get transferred
- Enrolled in Medicare Hospice program any time in the 12 months prior to index hospitalization
- Discharged AMA
- Transfers to or from Veterans Administration hospitals
Planned Readmission Exclusions to be Adopted by HIQR Program

- Incorporation of **planned** readmission algorithms in 30-day readmission measures for:
  - Hospital-Wide Readmissions
  - Acute MI
  - Heart Failure
  - Pneumonia
  - Total Hip and Knee
  - COPD
  - Stroke
Proposed Changes to HIQR Validation Process

- In order to align with Value-based Purchasing, change FY 2015 validation periods from 4 quarters (Q4 2012 through Q3 2013) to 3 quarters (Q4 2012 through Q2 2013)
- Change FY 2016 back to 4 quarters (Q3 2013 through Q2 2014)
- CDACs will accept electronic copies of medical records selected for validation (on CD, DVD or flash drive shipped via FedEx) starting with Q4 2013 discharges
- Suspend validation of ED measures (no method to validate electronic data)
- No validation required for Stroke and VTE data abstraction
- IMM measures will be validated on 3 global records and any additional diagnosis-specific measure sets for up to 15 total IMM validations per quarter
- Discontinue quarterly appeals process through QIOs
ICD-9 to ICD-10 Crosswalks

- ICD-9 to ICD-10 crosswalks for measure specifications will be available for preview and comment in the July 2013 manual release.
- Midas+ to begin programming ICD-10 based measures in May 2014 and complete roll out of all measures in November 2014.
The Hospital Readmission Reduction Program

pages 464-516

Inpatient Quality

Readmission Reduction

Hospital Acquired Conditions

Value Based Purchasing

Inpatient Psychiatric Quality

Resources
Proposed Changes to the Hospital Readmission Reduction Program

1. Add COPD and Total Knee/hip Conditions for Calculation FY 2015 Adjustments
   a. Acute exacerbation of COPD (4th largest Medicare diagnosis) and elective total hip and knee arthroplasty (represents the largest procedural cost in the Medicare Budget).
   b. NOT recommending to add CABG, PCI and other vascular conditions as previously recommended by MedPAC in 2007 because inpatient admissions for PCI and other vascular conditions are shifting to outpatient settings. Continuing to explore CABG for future inclusion.

2. Add criteria to exclude “planned” readmissions from Acute MI, Heart Failure and Pneumonia measures beginning with discharges October 1, 2013
   a. Previously exclusions were limited to revascularization procedures in the Acute MI population only
   b. NQF endorsed Acute MI (NQF #0505) and Heart Failure (NQF #0330) Readmission measures in January 2013 and Pneumonia (NQF #0506) in March 2013.
COPD 30-day All Cause Risk Standardized Readmission Rate

Proposed for HRR Program beginning with FY 2015 discharges
Proposed for HIQR Program beginning with FY 2014 discharges

- NQF endorsed COPD 30-day All Cause Risk Standardized Readmission Rate (NQF #1891) in March, 2013
- Similar to Acute MI, Heart Failure and Pneumonia includes only patients ≥ 65, 30-day post discharge enrollment in Medicare FFS, excludes deaths, transfers to other acute care facilities, patients who leave AMA and planned readmissions
- Includes Acute Exacerbation of COPD as both a primary diagnosis and Acute Respiratory with COPD as a secondary diagnosis
- Median 30-day readmission rate among Medicare patients in 2008 was 22.0%.
Elective Total Hip/Knee Arthroplasty 30-day All Cause Risk Standardize Readmission Rate

Proposed for HRR Program beginning with FY 2015 discharges

- NQF endorsed Elective Total Hip Arthroplasty/Total Knee Arthroplasty 30-day All Cause Risk Standardized Readmission Rate (NQF #1551) in January 2012 and was approved for use in the Hospital Inpatient Quality Reporting Program in the FY 2013 IPPS/LTCH PPS Final Rule

- Similar to Acute MI, Heart Failure and Pneumonia includes only patients ≥ 65, 30-day post discharge enrollment in Medicare FFS, excludes deaths, transfers to other acute care facilities, patients who leave AMA and planned readmissions

- Median 30-day readmission rate among Medicare patients between 2008 and 2010 was 5.7%.
Adding Planned Readmission Exclusions to CMS Readmission Methodology Starting in 2013

- **Planned readmission algorithm** added to all readmission measures to avoid penalizing hospitals for performing scheduled procedures within 30 days of discharge.

- This method also avoids counting unplanned readmissions that occur after a planned readmission, but within 30 days of discharge from the index admission.

- This modified measurement technique reduced hospital wide 30-day all cause readmission rates from **16.5% to 16.0%** in the July 1, 2011 to June 30, 2012 data set.
Planned Readmission Exclusions

Always Planned

- Transplants (bone, kidney, organ)
- Cesarean section
- Normal pregnancy and/or delivery
- Forceps, vacuum and breech delivery
- Maintenance Chemotherapy
- Rehabilitation

Potentially Planned

*When discharge diagnosis of readmission is NOT acute or a complication of care*

- Laminectomy, spinal fusion
- Knee and hip replacement
- Limb amputation
- Thyroidectomy and endocrine surgery
- Lung resections
- Hernia repairs
- Oophorectomy, hysterectomy
- TURP, prostatectomy
- Colorectal and gastrectomy surgery
- Cardiac surgery (CABG, Valve Repair)
- Wound and burn debridement
- Laryngectomy, tracheostomy revisions
- **More!**
Impact on National Readmission Rates when Planned Readmissions are Excluded

<table>
<thead>
<tr>
<th></th>
<th>Before</th>
<th>After</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute MI</td>
<td>19.2%</td>
<td>18.2%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>24.6%</td>
<td>23.1%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>18.5%</td>
<td>17.8%</td>
</tr>
</tbody>
</table>

For More Information on Readmission Measure Methodology

Measure Methodology Reports

Readmission Measures

The methods used in the development of the 30-day risk-standardized readmission measures, as well as in subsequent annual measure updates and quality assurance activities, are described in several technical reports below. For more detailed justifications of the Centers for Medicare & Medicaid Services’ (CMS’s) methodological choices in the development and maintenance of the readmission measures, refer to the Frequently Asked Questions (FAQ) document.

2013 AMI, HF, PN, HN, and THA/KTA Readmission Measures Maintenance

CMS reviews and updates the readmission measures annually. The reports below, formerly called the Measure Maintenance Technical Reports, describe the measures maintenance activities conducted in preparation for the most recent public reporting cycle.

- 2013 Condition-Based Measure Updates and Specifications: Acute Myocardial Infarction (AMI), Heart Failure (HF), and Pneumonia 30-Day Risk-Standardized Readmission Measures, PDF: 0.4 MB (04/11/11)
- 2013 Measure Updates and Specifications: Hospital-Wide All-Cause Unplanned Readmission Measure, PDF: 0.1 MB (04/11/13)
- 2013 Measure Updates and Specifications: Elective Primary Total Hip Arthroplasty (THA) Hospital-Wide All-Cause Unplanned 30-Day Risk Standardization Measure, PDF: 0.6 MB (04/11/11)

Previous AMI, HF, PN Readmission Measures Maintenance

Annual updates of the readmission measures began in 2009. The following reports document the progression of the measure methodology as a result of the annual measure maintenance.

- 2012 Measures Maintenance Technical Report: Acute Myocardial Infarction, Heart Failure, and Pneumonia 30-Day Risk-Standardized Readmission Measures, PDF: 0.6 MB (05/01/12)
- 2011 Measures Maintenance Technical Report: Acute Myocardial Infarction, Heart Failure, and Pneumonia 30-Day Risk-Standardized Readmission Measures, PDF: 0.7 MB (05/19/11)
- 2010 Measures Maintenance Technical Report: Acute Myocardial Infarction, Heart Failure, and Pneumonia 30-Day Risk-Standardized Readmission Measures, PDF: 0.6 MB (05/19/11)
- 2009 Measures Maintenance Technical Report: Acute Myocardial Infarction, Heart Failure, and Pneumonia 30-Day Risk-Standardized Readmission Measures, PDF: 0.5 MB (05/19/11)

Readmission Measure Development (original methodology reports)

The CMS 30-day risk-standardized readmission measures were developed by teams of clinical and statistical experts from Yale and Harvard universities, using a methodology that has been published in peer-reviewed literature.

The measure methodology is described in the following reports:

- Hospital-Wide Readmission Technical Report, PDF: 2.2 MB (08/14/12)
- THA/KTA Readmission Technical Report, PDF: 1.1 MB (08/14/12)
-
Hospital Value Based Purchasing Program
pages 517-571

- Inpatient Quality
- Readmission Reduction
- Hospital Acquired Conditions
- Value Based Purchasing
- Inpatient Psychiatric Quality
- Resources
Hospital Value Based Purchasing

Funding pool started with 1.00 percent of the base-operating DRG
FY 2014 Funding Pool estimated at 1.1 Billion
Applies to subsection (d) hospitals
Each Measure Worth 0 to 10 Points

*Points are dependent upon your hospital’s performance against the rest of the nation*

<table>
<thead>
<tr>
<th>Achievement Threshold</th>
<th>Benchmark</th>
</tr>
</thead>
<tbody>
<tr>
<td>National Median (50th Percentile) during a baseline period with respect to a fiscal year</td>
<td></td>
</tr>
<tr>
<td>Note: This definition does not apply to the Medicare Spending per Beneficiary Measure; which is the median (50th percentile) of hospital performance on a measure during the performance period with respect to a fiscal year</td>
<td></td>
</tr>
<tr>
<td>Arithmetic mean of the top decile (10th Percentile) during a baseline period with respect to a fiscal year</td>
<td></td>
</tr>
<tr>
<td>Note: This definition does not apply to the Medicare Spending per Beneficiary Measure; which is the arithmetic mean of the top decile of hospital performance on a measure during the performance period with respect to a fiscal year</td>
<td></td>
</tr>
</tbody>
</table>

Definitions have been clarified in the Proposed FY 2014 IPPS/LTCH Rule
Each Measure Worth 10 Points
AMI-8a Primary PCI within 90 minutes of Arrival

Performance Period
January 1, 2013 to
December 31, 2013

Achievement
Threshold

0 Points

95.34%

100%

Benchmark

= Your Hospital’s Performance beginning with Discharges January 1, 2013
Each Measure Worth 10 Points

AMI-8a Primary PCI within 90 minutes of Arrival

Performance Period
January 1, 2013 to December 31, 2013

Achievement Threshold

100%

Benchmark

95.34%

= Your Hospital’s Performance beginning with Discharges January 1, 2013
Achievement Points
AMI-8a Primary PCI within 90 minutes of Arrival

Performance Period
January 1, 2013 to December 31, 2013

For hospitals that score better than half the hospitals in the US they can Score “Achievement Points” based on a linear scale between the Achievement threshold and the Benchmark.
Improvement Points
AMI-8a Primary PCI within 90 minutes of Arrival

Achievement Threshold
Baseline Period
Jan 2011 – Dec 2011
82%

Performance Period
Jan 2013 – Dec 2013
95.34%

Benchmark
98% 100%

A unique improvement range for each measure will be established for each hospital that defines the distance between the hospital’s baseline period score and the national benchmark score.

Improvement Range
1 2 3 4 5 6 7 8 9

8 Points
FY 2014 Value-Based Purchasing Domains
(Payment Determination for Discharges from October 1, 2013 to September 30, 2014)

- Clinical Process of Care: 45%
- Patient Experience of Care: 30%
- Outcome: 25%
## FY 2014 Value-Based Purchasing Patient Experience Domain
*(Payment Determination for Discharges from October 1, 2013 to September 30, 2014)*

### 8 Patient Experience of Care Measures

<table>
<thead>
<tr>
<th>HCAHPS Survey Dimensions</th>
<th>Baseline Period April 1, 2010 to December 31, 2010</th>
<th>Performance Period April 1, 2012 to December 31, 2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with Nurses</td>
<td>Floor (%) 42.84</td>
<td>Threshold (%) 75.79</td>
</tr>
<tr>
<td>Communication with Doctors</td>
<td>Floor (%) 55.49</td>
<td>Threshold (%) 79.57</td>
</tr>
<tr>
<td>Responsiveness of hospital staff</td>
<td>Floor (%) 32.15</td>
<td>Threshold (%) 62.21</td>
</tr>
<tr>
<td>Pain management</td>
<td>Floor (%) 40.79</td>
<td>Threshold (%) 68.99</td>
</tr>
<tr>
<td>Communications about medications</td>
<td>Floor (%) 36.01</td>
<td>Threshold (%) 59.85</td>
</tr>
<tr>
<td>Cleanliness and quietness</td>
<td>Floor (%) 38.52</td>
<td>Threshold (%) 63.54</td>
</tr>
<tr>
<td>Discharge information</td>
<td>Floor (%) 54.73</td>
<td>Threshold (%) 82.72</td>
</tr>
<tr>
<td>Overall rating of hospital</td>
<td>Floor (%) 30.91</td>
<td>Threshold (%) 67.33</td>
</tr>
</tbody>
</table>
### FY 2014 Value-Based Purchasing Clinical Process of Care Domain
*(Payment Determination for Discharges from October 1, 2013 to September 30, 2014)*

#### 13 Clinical Process of Care Measures

<table>
<thead>
<tr>
<th>Measures</th>
<th>Baseline Period</th>
<th>Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>April 1, 2010 to December 31, 2010</td>
<td>April 1, 2012 to December 31, 2012</td>
</tr>
<tr>
<td>AMI 7a Fibrinolytic agent received 30 minutes of hospital arrival</td>
<td>80.66</td>
<td>96.30</td>
</tr>
<tr>
<td>AMI 8a PCI received 90 minutes of hospital arrival</td>
<td>93.44</td>
<td>100.00</td>
</tr>
<tr>
<td>HF 1 Discharge Instructions</td>
<td>92.66</td>
<td>100.00</td>
</tr>
<tr>
<td>PN 3b Blood culture before 1st antibiotic received in hospital</td>
<td>97.30</td>
<td>100.00</td>
</tr>
<tr>
<td>PN 6 Initial antibiotic selection for CAP immunocompetent patient</td>
<td>94.46</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP 1 Antibiotic 1 hr before incision or 2 hrs if Vancomycin/Quinolone</td>
<td>98.07</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP 2 Received antibiotic consistent with recommendations</td>
<td>98.13</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP 3 Prophylactic Antibiotic Discontinued w/in 24 hrs surgery end time</td>
<td>96.63</td>
<td>99.96</td>
</tr>
<tr>
<td>SCIP 4 Controlled 6 AM postop glucose for cardiac surgery</td>
<td>96.34</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP 9 Postop urinary catheter removed postop day 1 or 2</td>
<td>92.86</td>
<td>99.89</td>
</tr>
<tr>
<td>SCIP-Card 2 Pre-admission beta blocker and periop beta blocker</td>
<td>95.65</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP-VTE-1 Recommended VTE prophylaxis ordered during stay</td>
<td>94.62</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP-VTE-2 Received VTE prophylaxis w/in 24 hrs prior to or after surgery</td>
<td>94.62</td>
<td>99.83</td>
</tr>
</tbody>
</table>
**FY 2014 Value-Based Purchasing Outcome Domain**  
*(Payment Determination for Discharges from October 1, 2013 to September 30, 2014)*

**All New for FY 2014**

<table>
<thead>
<tr>
<th>Measures</th>
<th>Threshold (%)</th>
<th>Benchmark (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute MI 30-day Mortality Rate</td>
<td>84.77</td>
<td>86.73</td>
</tr>
<tr>
<td>Heart Failure 30-day Mortality Rate</td>
<td>88.61</td>
<td>90.42</td>
</tr>
<tr>
<td>Pneumonia 30-day Mortality Rate</td>
<td>88.18</td>
<td>90.21</td>
</tr>
</tbody>
</table>
Upcoming Shifts in Domain Weighting

Established in the FY 2013 IPPS/LTCH PPS Final Rule

FY 2014

- Clinical Process of Care: 45%
- Patient Experience of Care: 30%
- Outcome: 25%

FY 2015

- Clinical Process of Care: 20%
- Efficiency: 20%
- Patient Experience of Care: 30%
- Outcome: 30%

Hospitals must have sufficient data in at least two domains to calculate a total performance score.
FY 2015 Value-Based Purchasing Experience of Care Domain
(Payment Determination for Discharges from October 1, 2014 to September 30, 2015)

Established in the FY 2013 IPPS/LTCH PPS Final Rule

8 Patient Experience of Care Measures

<table>
<thead>
<tr>
<th>HCAHPS Survey Dimensions</th>
<th>Baseline Period</th>
<th>Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>January 1, 2011 to December 31, 2011</td>
<td>January 1, 2013 to December 31, 2013</td>
</tr>
<tr>
<td>Communication with Nurses</td>
<td>Floor(%) 47.77</td>
<td>Threshold (%) 76.56</td>
</tr>
<tr>
<td></td>
<td>Benchmark (%) 85.70</td>
<td></td>
</tr>
<tr>
<td>Communication with Doctors</td>
<td>Floor(%) 55.62</td>
<td>Threshold (%) 79.88</td>
</tr>
<tr>
<td></td>
<td>Benchmark (%) 88.79</td>
<td></td>
</tr>
<tr>
<td>Responsiveness of hospital staff</td>
<td>Floor(%) 35.10</td>
<td>Threshold (%) 63.17</td>
</tr>
<tr>
<td></td>
<td>Benchmark (%) 79.06</td>
<td></td>
</tr>
<tr>
<td>Pain management</td>
<td>Floor(%) 43.58</td>
<td>Threshold (%) 69.46</td>
</tr>
<tr>
<td></td>
<td>Benchmark (%) 78.17</td>
<td></td>
</tr>
<tr>
<td>Communications about medications</td>
<td>Floor(%) 35.48</td>
<td>Threshold (%) 60.89</td>
</tr>
<tr>
<td></td>
<td>Benchmark (%) 71.85</td>
<td></td>
</tr>
<tr>
<td>Cleanliness and quietness</td>
<td>Floor(%) 41.94</td>
<td>Threshold (%) 64.07</td>
</tr>
<tr>
<td></td>
<td>Benchmark (%) 78.90</td>
<td></td>
</tr>
<tr>
<td>Discharge information</td>
<td>Floor(%) 57.67</td>
<td>Threshold (%) 83.54</td>
</tr>
<tr>
<td></td>
<td>Benchmark (%) 89.72</td>
<td></td>
</tr>
<tr>
<td>Overall rating of hospital</td>
<td>Floor(%) 32.82</td>
<td>Threshold (%) 67.96</td>
</tr>
<tr>
<td></td>
<td>Benchmark (%) 83.44</td>
<td></td>
</tr>
</tbody>
</table>

* No change in measures but Communication with Nurses had the largest increase in Floor values (up 4.93 percentage points)
### 12 Clinical Process of Care Measures

**Baseline Period**  
January 1, 2011 to December 31, 2011

<table>
<thead>
<tr>
<th>Measures</th>
<th>Threshold (%)</th>
<th>Benchmark (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI 7a Fibrinolytic agent received 30 minutes of hospital arrival</td>
<td>80.00</td>
<td>100.00</td>
</tr>
<tr>
<td>AMI 8a PCI received 90 minutes of arrival</td>
<td>95.34</td>
<td>100.00</td>
</tr>
<tr>
<td>HF 1 Discharge Instructions</td>
<td>92.09</td>
<td>100.00</td>
</tr>
<tr>
<td>PN 3b Blood culture before 1st antibiotic received in hospital</td>
<td>94.11</td>
<td>100.00</td>
</tr>
<tr>
<td>PN 6 Initial antibiotic selection for CAP immunocompetent patient</td>
<td>97.78</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP 1 Antibiotic 1 hr before incision or 2 hrs if Vancomycin/Quinolone</td>
<td>97.17</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP 2 Received antibiotic consistent with recommendations</td>
<td>98.63</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP 3 Prophylactic Antibiotic Discontinued w/in 24 hrs surgery end time</td>
<td>98.63</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP 4 Controlled 6 AM postop glucose for cardiac surgery</td>
<td>97.49</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP 9 Postop urinary catheter removed postop day 1 or 2</td>
<td>95.79</td>
<td>99.76</td>
</tr>
<tr>
<td>SCIP-Card 2 Pre-admission beta blocker and periop beta blocker</td>
<td>95.91</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP-VTE-1 Recommended VTE prophylaxis ordered during stay</td>
<td>94.62</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP-VTE-2 Received VTE prophylaxis w/in 24 hrs prior to or after surgery</td>
<td>94.89</td>
<td>99.99</td>
</tr>
</tbody>
</table>

**Performance Period**  
January 1, 2013 to December 31, 2013

---

**FY 2015 Value-Based Purchasing Clinical Process of Care Domain**  
*(Payment Determination for Discharges from October 1, 2014 to September 30, 2015)*

**Established in the FY 2013 IPPS/LTCH PPS Final Rule**

**FY 2015 Clinical Process of Care Measures**

<table>
<thead>
<tr>
<th>Clinical Process of Care Measures</th>
<th>Baseline Period</th>
<th>Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>January 1, 2011</td>
<td>January 1, 2013</td>
</tr>
<tr>
<td>AMI 7a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AMI 8a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PN 3b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PN 6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCIP 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCIP 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCIP 3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCIP 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCIP 9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCIP-Card 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCIP-VTE-1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCIP-VTE-2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**2013 Midas+ User Symposium**
FY 2015 Value-Based Purchasing Efficiency Domain
(Payment Determination for Discharges from October 1, 2014 to September 30, 2015)

Established in the FY 2013 IPPS/LTCH PPS Final Rule

New! One Cost of Care Efficiency Measure

<table>
<thead>
<tr>
<th>Measures</th>
<th>Baseline Period</th>
<th>Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>May 1, 2011 to December 31, 2011</td>
<td>May 1, 2013 to December 31, 2013</td>
</tr>
<tr>
<td>MSPB-1 Medicare spending per beneficiary</td>
<td>Median Medicare spending per beneficiary ratio across all hospitals during performance period</td>
<td>Mean of 10th percentile of Medicare spending per beneficiary ratios across all hospitals during performance period</td>
</tr>
</tbody>
</table>
### FY 2015 Value-Based Purchasing Outcome Domain

*(Payment Determination for Discharges from October 1, 2014 to September 30, 2015)*

#### Three Outcome of Care Mortality Measures

<table>
<thead>
<tr>
<th>Measures</th>
<th>Baseline Period</th>
<th>Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>October 1, 2010 to June 30, 2011</td>
<td>October 1, 2012 to June 30, 2013</td>
</tr>
<tr>
<td>Acute MI 30-day Mortality Rate</td>
<td>84.77</td>
<td>86.73</td>
</tr>
<tr>
<td>Heart Failure 30-day Mortality Rate</td>
<td>88.61</td>
<td>90.42</td>
</tr>
<tr>
<td>Pneumonia 30-day Mortality Rate</td>
<td>88.18</td>
<td>90.21</td>
</tr>
</tbody>
</table>

#### New! One Complication/Patient Safety Measure

<table>
<thead>
<tr>
<th>Measures</th>
<th>Baseline Period</th>
<th>Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHRQ PSI Composite</td>
<td>62.28</td>
<td>45.17</td>
</tr>
</tbody>
</table>

#### New! One Hospital Acquired Infection Measure

<table>
<thead>
<tr>
<th>Measures</th>
<th>Baseline Period</th>
<th>Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI (Standardized infection ratio)</td>
<td>.437</td>
<td>00.00</td>
</tr>
</tbody>
</table>
Proposed Shifts in Domain Weighting

FY 2015
- Efficiency: 20%
- Clinical Process of Care: 20%
- Patient Experience of Care: 30%
- Outcome: 30%

FY 2016
- Efficiency: 25%
- Clinical Process of Care: 10%
- Patient Experience of Care: 25%
- Outcome: 40%

Hospitals must have sufficient data in at least two domains to calculate a total performance score.
Proposed Changes for FY 2016 VBP Experience of Care (Payment Determination for Discharges from October 1, 2015 to September 30, 2016)

* No change in measures but Communication with Doctors had the largest increase in Floor values (up 5.60 percentage points)
Proposed Changes for FY 2016 VBP Clinical Process of Care
(Payment Determination for Discharges from October 1, 2015 to September 30, 2016)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>AMI 7a Fibrinolytic agent received 30 minutes of hospital arrival</td>
<td>88.62</td>
<td>100.00</td>
</tr>
<tr>
<td>AMI 8a PCI received 90 minutes of hospital arrival</td>
<td>95.34</td>
<td>100.00</td>
</tr>
<tr>
<td>HF 1 Discharge Instructions</td>
<td>92.09</td>
<td>100.00</td>
</tr>
<tr>
<td>PN 3b Blood culture before 1st antibiotic received in hospital</td>
<td>94.11</td>
<td>100.00</td>
</tr>
<tr>
<td>PN 6 Initial antibiotic selection for CAP immunocompetent patient</td>
<td>96.43</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP 1 Antibiotic 1 hr before incision or 2 hrs if Vancomycin/Quinolone</td>
<td>98.94</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP 2 Received antibiotic consistent with recommendations</td>
<td>98.95</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP 3 Prophylactic Antibiotic Discontinued w/in 24 hrs surgery end time</td>
<td>97.97</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP 4 Controlled 6 AM postop glucose for cardiac surgery</td>
<td>96.78</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP 9 Postop urinary catheter removed postop day 1 or 2</td>
<td>96.74</td>
<td>99.98</td>
</tr>
<tr>
<td>SCIP-Card 2 Pre-admission beta blocker and period beta blocker</td>
<td>97.56</td>
<td>100.00</td>
</tr>
<tr>
<td>SCIP-VTE-2 Received VTE prophylaxis within 24 hrs prior to or after surgery</td>
<td>98.09</td>
<td>100.00</td>
</tr>
<tr>
<td>IMM-2 Influenza Immunization</td>
<td>89.95</td>
<td>99.04</td>
</tr>
</tbody>
</table>

Three Measures to be removed from FY 2016 VBP calculations. AMI 8a has topped out and HF 1 and PN 3b have insufficient evidence to link process to improved outcomes.
Proposed Changes for FY 2016 VBP Outcome Domain
(Payment Determination for Discharges from October 1, 2015 to September 30, 2016)

Three Outcome of Care Mortality Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline Period</th>
<th>Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute MI 30-day Mortality Rate</td>
<td>84.77</td>
<td>86.73</td>
</tr>
<tr>
<td>Heart Failure 30-day Mortality Rate</td>
<td>88.61</td>
<td>90.42</td>
</tr>
<tr>
<td>Pneumonia 30-day Mortality Rate</td>
<td>88.18</td>
<td>90.21</td>
</tr>
</tbody>
</table>

One Complication/Patient Safety Outcome Measure

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline Period</th>
<th>Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHRQ PSI Composite</td>
<td>62.28</td>
<td>45.17</td>
</tr>
</tbody>
</table>

Three Hospital Acquired Infection Outcome Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Threshold</th>
<th>Benchmark (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLABSI (pending final NQF approval)</td>
<td>0.437</td>
<td>0.00</td>
</tr>
<tr>
<td>Catheter-Associated UTI (CAUTI)</td>
<td>0.826</td>
<td>0.00</td>
</tr>
<tr>
<td>Surgical Site Infection</td>
<td>0.737</td>
<td>0.00</td>
</tr>
</tbody>
</table>
Proposed Changes for FY 2016 VBP Efficiency Domain
(Payment Determination for Discharges from October 1, 2015 to September 30, 2016)

No Changes proposed other than new baseline and performance period

One Cost of Care Efficiency Measure

<table>
<thead>
<tr>
<th>Measures</th>
<th>Proposed Baseline Period</th>
<th>Proposed Performance Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSPB-1 Medicare spending per beneficiary</td>
<td>Median Medicare spending per beneficiary ratio across all hospitals during performance period</td>
<td>Mean of 10th percentile of Medicare spending per beneficiary ratios across all hospitals during performance period</td>
</tr>
</tbody>
</table>
CMS Not Sure How to Spin Domains for FY 2017
Asking for Public Comment
Options for FY 2017 Domain Weighting

**Option 1**
*Aligned with NQS Priorities*
- Efficiency & Cost Reduction: 25%
- Experience & Coordination of Care: 25%
- Clinical Care Process: 10%
- Clinical Care Outcomes: 25%
- Safety: 15%

**Option 2**
*Consistent with FY 2016*
- Efficiency: 25%
- Outcome: 40%
- Clinical Process of Care: 10%
- Patient Experience of Care: 25%
Proposed Option for VBP Domain Structure for FY 2017

Alignment of VBP Domains with the Six National Quality Strategy Priorities

1. Making care safer
2. Engaging patients and families
3. Effective communication and coordination of care
4. Effective prevention and treatment practices
5. Working with communities to promote health
6. Making care more affordable

New Proposed Safety Domain

Option 1
Aligned with NQS Priorities

- CAUTI
- CLABSI
- Surgical Site Infection
- AHRQ PSI-90 Composite
Possible Measures Being Considered in Future Rule Making for FY 2017 Value Based Purchasing Program

No measure changes proposed for FY 2017

**Outcome Domain**

- Methicillin-resistant *Staphylococcus aureus* (MRSA) Bacteremia
- *Clostridium difficile* (C. difficile)

**Efficiency Domain**

- Rate and/or dollar amount of billing hospital inpatient services to Medicare Part B subsequent to the denial of a Part A hospital inpatient claim
- Additional Medicare spending specific to physician services that occur during a hospital stay
  - Radiology
  - Anesthesiology
  - Pathology
Proposed Future Changes to Performance and Baseline Periods for Outcome Domain

Pages 541 and 542

<table>
<thead>
<tr>
<th>FY 2017 Hospital Value Based Purchasing Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain</strong></td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>Outcome</td>
</tr>
<tr>
<td>- Mortality</td>
</tr>
<tr>
<td>- AHRQ PSI Composite</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FY 2018 Hospital Value Based Purchasing Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain</strong></td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>Outcome</td>
</tr>
<tr>
<td>- Mortality</td>
</tr>
<tr>
<td>- AHRQ PSI Composite</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FY 2019 Hospital Value Based Purchasing Program</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domain</strong></td>
</tr>
<tr>
<td>------------</td>
</tr>
<tr>
<td>Outcome</td>
</tr>
<tr>
<td>- Mortality</td>
</tr>
<tr>
<td>- AHRQ PSI Composite</td>
</tr>
</tbody>
</table>
Proposed FY 2016 VBP Scoring Methodology

Page 551

• No proposed changes in scoring methodology!
Proposed Change to Disaster Extraordinary Circumstances Waivers

1. Submit a waiver request to the Hospital IQR Program

2. Note you also seek a waiver from the Hospital VBP program for the program year in which the same data could be used as the VBP performance data

3. Submit evidence of your extraordinary circumstance to “forestall the possibility of hospitals attempting to game their VBP scores”
Moore Hospital – May 22, 2013
New Hospital Acquired Conditions Reduction Program
pages 571-623
Why do we need another program?

- HAC related deaths are twice as high as those from HIV/AIDS and breast cancer combined
- HACs can be prevented through proper application of “best practices” but 87% of hospitals don’t follow guidelines
- 2009 Hospital Acquired Infections cost nearly $6 Billion
- HACs have been publically reported on Hospital Compare since 2010 but prevalence has not decreased
- MS DRG payment suppression for HACs has minimal impact
What is being proposed in HAC Reduction Program?

• Effective with October 1, 2014 discharges (FY 2015)
• Hospitals in the top quartile of HACs relative to the national average over a two year time period will be subject to Medicare payment reductions not to exceed 1% after and in addition to any payment adjustments are made in the VBP and Hospital Readmission Reduction Programs
• Applies to subsection (d) hospitals paid under IPPS, including sole community hospitals (SCHs) and Maryland Hospitals (unless exempted)
• Excludes LTCHs, cancer hospitals, children’s hospitals, inpatient rehab facilities and inpatient psychiatric facilities, Puerto Rico hospitals and critical access hospitals
Option 1: 8 Measures Proposed in the FY 2015 HAC Reduction Program
(this will involve more domains and options!)

AHRQ PSI Domain
- Pressure ulcer rate (PSI 3)
- Foreign object left in body (PSI 5)
- Iatrogenic Pneumothorax (PSI 6)
- Post op physiologic and metabolic derangement (PSI 10)
- Post op pulmonary embolism or DVT (PSI 12)
- Accidental puncture and laceration rate (PSI 15)

CDC HAI Domain
- CLABSI (expanded to include non-ICU)
- CAUTI (expanded to include non-ICU)
- Surgical Site Infection stratified by colon surgery and abdominal hysterectomy (2016)
- MRSA (2017)
- C. Difficile (2017)
Option 2: 3 Measures Proposed in the FY 2015 HAC Reduction Program

AHRQ PSI Domain

- Complications/Patient Safety for Selected Conditions Composite (PSI 90)
  - Pressure ulcer rate (PSI 3)
  - Iatrogenic Pneumothorax (PSI 6)
  - Central venous catheter-related blood stream infection rate (PSI 7)
  - Postop hip fracture rate (PSI 8)
  - Postop sepsis rate (PSI 13)
  - Wound dehiscence rate (PSI 14)
  - Post op pulmonary embolism or DVT (PSI 12)
  - Accidental puncture and laceration rate (PSI 15)

CDC HAI Domain

- CLABSI (expanded to include non-ICU)
- CAUTI (expanded to include non-ICU)
- Surgical Site Infection stratified by colon surgery and abdominal hysterectomy (2016)
- MRSA (2017)
- C. Difficile (2017)
HAC Reduction Scoring Methodology

• Each measure will be assigned 0 to 10 points
• More points is BAD (opposite of VBP purchasing)
• Only hospitals in the worst performing quartile for a measure get points assigned
• Hospitals NOT in the worst performing quartile get zero points automatically
• Never events get full 10 points for any occurrence
  • PSI 5: Foreign object left in body
Each Measure Worth 0-10 Points

*PSI-3 Pressure Ulcer Rate*

**0.2100**  
**0.3300**  
**0.3401**

Any score < 75th percentile is in the no point zone!

75th Percentile

Worst Value

= Your Hospital’s Performance
Each Measure Worth 0 to 10 Points

PSI-3 Pressure Ulcer Rate

For hospitals that score in the top quartile the performance scores will be rank ordered into percentiles. 1st – 10th percentile is assigned one point. 11th – 20th assigned two points, etc. Ten points are assigned to any value > 91st percentile.

0.3300

75th Percentile

HAC Point Zone

0.3378

Worst Value

1st 10 20 30 40 50 60 70 80 90 100th

8 Points

= Your Hospital’s Performance
Minimum number of cases required

AHRQ PSI Domain

- Must have complete data for at least three AHRQ measures or score will be based solely on CDC HAI Domain
- If all six measures are complete each would be weighted one-sixth of the hospital’s AHRQ PSI Domain score
- Incomplete measures would be excluded from scoring and complete measures would be weighted accordingly

CDC HAI Domain

- Hospital must have >1 predicted HAI event (calculated using the national HAI rate and the observed number of the specific HAI)
- Hospitals with <1 predicted infection will not be scored for this domain and total HAC score will be based on AHRQ PSI Domain score
HAC Reduction Scoring Methodology

\[
\text{(AHRQ Domain Score x .50)} \quad \text{(CDC HAI Domain Score x .50)}
\]

\[\text{assuming data is complete for at least three measures or assuming data is complete for at least one measure}\]

\[
\text{Total HAC Score}
\]

Hospitals with an ICU waiver for CLABSI and CAUTI, as well as those hospitals that did not have enough adverse events to calculate a SIR for any of the HAI measures will only be scored on the AHRQ Domain measures. Hospitals with ICUs who did not apply for waivers and failed to submit CLABSI and CAUTI data will be automatically penalized by receiving 10 points to each measure.

See page 609
Timelines for Reporting

AHRQ PSI Domain

- July 1, 2011 to June 30, 2013
- Data “snapshot” taken from CMS’ Common Working file 90 days after end of applicable period (September 30, 2013)
- Preliminary results posted on QNET followed by a 30-day review and correction period
- Corrections will be reprocessed followed by a second 30-day review period prior to public reporting

CDC HAI Domain

- CY 2012 and 2013 (January 1, 2012 to December 31, 2013)
- Results will be obtained from CDC NHSN database
- Data submission, review and correction process and timelines will be the same as used in the Hospital IQR program
Proposed Rules for Inpatient Psychiatric Facilities

pages 1019-1058
# Proposed Rules for Inpatient Psychiatric Facilities

<table>
<thead>
<tr>
<th>FY 2014</th>
<th>FY 2015</th>
<th>FY 2016</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>HBIPS-2 Hours of Physical Restraint</td>
</tr>
<tr>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>HBIPS-3 Hours of Seclusion Use</td>
</tr>
<tr>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>HBIPS-5 Discharged on Multiple Antipsychotic Medications</td>
</tr>
<tr>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>HBIPS-6 Post-Discharge Continuing Care Plan Created</td>
</tr>
<tr>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
<td>HBIPS-7 Post-discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge</td>
</tr>
<tr>
<td></td>
<td>✔️</td>
<td>✔️</td>
<td>SUB-1 Alcohol Use Screening</td>
</tr>
<tr>
<td></td>
<td>✔️</td>
<td>✔️</td>
<td>SUB-4 Alcohol &amp; Drug Use: Assessing Status After Discharge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>✔️</td>
<td>Follow-Up After Hospitalization for Mental Illness (NCQA)</td>
</tr>
</tbody>
</table>
Resources

- Inpatient Quality
- Readmission Reduction
- Hospital Acquired Conditions
- Value Based Purchasing
- Inpatient Psychiatric Quality
- Resources

2013 Midas+ User Symposium
# CMS Measure Matrix

<table>
<thead>
<tr>
<th>Measure No.</th>
<th>Measure Title</th>
<th>Measure Set Domain or Setting</th>
<th>CMS Hospital Inpatient Quality Reporting (IQR) Program Starting Jan 2012 for Federal Fiscal Year (FFY) 2014 Payment</th>
<th>CMS Hospital IQR Program Starting January 2013 for FFY 2013 Payment</th>
<th>CMS Hospital IQR Program Starting January 2014 for FFY 2014 Payment</th>
<th>CMS Hospital IQR Program Starting January 2015 for FFY 2015 Payment</th>
<th>Total National Initiatives That Use the Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>0139</td>
<td>Central Line catheter-associated bloodstream infection rate for ICU and high-risk nursery (HRN) patients</td>
<td>Healthcare Associated Infections</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>8</td>
</tr>
<tr>
<td>0186</td>
<td>e-WHO Discharge Instructions</td>
<td>Mortality</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>7</td>
</tr>
<tr>
<td>0138</td>
<td>Urinary catheter-associated urinary tract infection for intensive care unit (ICU) patients</td>
<td>Healthcare Associated Infections</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>7</td>
</tr>
<tr>
<td>0147</td>
<td>PPS-6: Initial antibiotic selection for community-acquired pneumonia (CAP) in Immunocompetent patients</td>
<td>Pneumonia</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>7</td>
</tr>
<tr>
<td>0148</td>
<td>PPS-SS: Blood cultures performed in the emergency department prior to initial antibiotic received in</td>
<td>Pneumonia</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>7</td>
</tr>
<tr>
<td>0103</td>
<td>AMI-Be: Primary PCI received within 90 minutes of hospital arrival</td>
<td>Acute Myocardial Infarction</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>7</td>
</tr>
<tr>
<td>0164</td>
<td>AMI-7A: fibrinolytic therapy received within 30 minutes of hospital arrival</td>
<td>Acute Myocardial Infarction</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>7</td>
</tr>
<tr>
<td>0300</td>
<td>SCIP-Inf-4: Cardiac patients with controlled day-night postoperative serum glucose</td>
<td>SCIP</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>7</td>
</tr>
<tr>
<td>0527</td>
<td>SCIP-Inf-1: Prophylactic antibiotic received within 1 hour prior to surgical incision</td>
<td>SCIP</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>7</td>
</tr>
<tr>
<td>0528</td>
<td>SCIP-Inf-2: Prophylactic antibiotic selection for surgical patients</td>
<td>SCIP</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>7</td>
</tr>
<tr>
<td>0529</td>
<td>SCIP-Inf-3: Prophylactic antibiotics discontinued within 24 hours after surgery end time</td>
<td>SCIP</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>7</td>
</tr>
<tr>
<td>0166</td>
<td>HCAHPS (excluding proposed 3-item Care Transition Measures (CTM-3) see and 2 new “About You” measures)</td>
<td>Patient Experience of Care</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>0</td>
</tr>
<tr>
<td>0167</td>
<td>SCIP-UTE-2 Surgery Patients Who Received Appropriate Versus</td>
<td></td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
<td>7</td>
</tr>
</tbody>
</table>
Support<DataVision or CPMS<Midas Measures

Midas+ Measures

Midas+ Measure Directory
The complete list of Midas+ measures, including measure number, title, Clinical Topic, and Profile.

Midas+ Measure Definition Portfolio
The complete set of all DataVision, CPMS, POP, and core measures. To view this portfolio, you need Adobe Reader 6 or later.

Midas+ CMS Measure Matrix
This Microsoft Excel spreadsheet lists the quality measures that are required by various Centers for Medicare and Medicaid Services (CMS) regulatory programs.

Custom Bundle Definition Form
To create custom bundles of Appropriateness of Care core measure Indicators on your Midas+ server, please complete and submit this form.
Shared Learning

- Slide deck of this presentation will be posted on the Midas+ Clients Only Website for Midas+ Clients to use at your organizations!
Closing Thoughts

• “Make it a meritorious act to question why we do things in a certain way. Ask how it is value added and think about doing it in a different way”.

Dr. Christopher Heller MD, FACS
July 8, 2010
“Contribution of Creative Ideas, Innovations and New Way of Thinking Period” Ends June 25, 2013 5 p.m. EDT

Submit electronic comments to http://www.regulations.gov
Or Mail to: Department of Health and Human Services,
Attention: CMS-1599-P,
P.O. Box 8011,
Baltimore, MD 21244-1850.