Hospital-Acquired Conditions and Present on Admission Indicator Reporting

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CMS' Quality Improvement Roadmap

- Strategies
  - Work through partnerships
  - Measure quality and report comparative results
  - Value-Based Purchasing: improve quality and avoid unnecessary costs
  - Encourage adoption of effective health information technology
  - Promote innovation and the evidence base for effective use of technology

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VBP Program Goals

- Improve clinical quality
- Reduce adverse events and improve patient safety
- Encourage more patient-centered care
- Avoid unnecessary costs in the delivery of care
- Stimulate investments in effective structural components or systems
- Make performance results transparent and comprehensible
  - To empower consumers to make value-based decisions about their health care
  - To encourage hospitals and clinicians to improve quality of care

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Why VBP?

- Improve Quality
  - Quality improvement opportunity
    - Wennberg's Dartmouth Atlas on variation in care
    - McGlynn's NEJM findings on lack of evidence-based care
    - IOM's Crossing the Quality Chasm findings
- Avoid Unnecessary Costs
  - Medicare's various fee-for-service fee schedules and prospective payment systems are based on resource consumption and quantity of care, NOT quality or unnecessary costs avoided
    - Physician Fee Schedule and Hospital Inpatient DRGs
    - Medicare Trust Fund insolvency looms

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Support for VBP

- President's Budget
  - FYs 2006-08
- Congressional Interest in P4P and Other Value-Based Purchasing Tools
  - Medicare Modernization Act, Deficit Reduction Act, and Tax Relief and Health Care Act provisions
- MedPAC Reports to Congress
  - P4P recommendations related to quality, efficiency, health information technology, and payment reform
- IOM Reports
  - P4P recommendations in *To Err Is Human* and *Crossing the Quality Chasm*
  - Report, *Rewarding Provider Performance: Aligning Incentives in Medicare*
- Private Sector
  - Private health plans
  - Employer coalitions

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VBP Initiatives

- Hospital Quality Initiative: Inpatient & Outpatient
- Hospital VBP Plan & Report to Congress
- Hospital-Acquired Conditions & Present on Admission Indicator
- Physician Voluntary Reporting Program
- Physician Quality Reporting Initiative
- Physician Resource Use
- Home Health Care Pay for Reporting
- Ambulatory Surgical Centers Pay for Reporting
- Medicaid – State Partnerships

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Value-Based Purchasing & Hospital-Acquired Conditions

- The Hospital-Acquired Conditions provision is a step toward Medicare VBP for hospitals
- Strong public support for CMS to pay less for conditions that are acquired during a hospital stay
- Considerable national press coverage of HAC has prompted dialogue of how to further eliminate healthcare-associated infections and conditions

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Statutory Authority: DRA Section 5001(c)

- CMS was required to select <u>at least two</u> conditions by October 1, 2007 that are:
  1. High cost, high volume, or both;
  2. Assigned to a higher paying DRG when present as a secondary diagnosis;
  3. Reasonably prevented through the application of evidence-based guidelines

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Coding Implications

- To implement HAC provisions, the following are needed
  - Clear and unique ICD-9-CM code(s) for condition
  - Code must be a Major Complication or Comorbidity (MCC) or Complication or Comorbidity (CC)

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Inpatient Prospective Payment System

- Set payment to hospitals for given diagnosis or procedure
- However, complications, such as infections, acquired in the hospital can trigger higher payments in two ways.
  - Outlier payments
  - Complication or Comorbidity DRG Payments
    - 121 sets of DRGs that split based on the presence or absence of a complication or comorbidity (CC)
    - The CC DRG in each pair would generate a higher Medicare payment.
    - ~3000 ICD-9 diagnoses qualify as CC

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Statutory Authority: DRA Section 5001(c)

- Beginning October 1, 2007, hospitals must begin submitting data on their claims for payment indicating whether diagnoses were present on admission (POA)
- Beginning October 1, 2008, CMS cannot assign a case to a higher DRG based on the occurrence of one of the selected conditions, if that condition was acquired during the hospitalization
- This provision does not apply to Critical Access Hospitals, Rehabilitation Hospitals, Psychiatric Hospitals, or any other facility not paid under the Medicare Hospital IPPS

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Conditions selected for implementation

- These conditions will have payment implications beginning in October 1, 2008.

- Serious Preventable Events
  - Object left in during surgery (998.4 CC)
  - Air embolism (999.1 MCC)
  - Blood incompatibility (999.6 CC)
- Catheter Associated Urinary Tract Infection, 996.64 CC & one of the following specific infection codes: 112.2, 590.10, 590.11, 590.2, 590.3, 590.81, 590.89, 590.9, 595.0, 595.3, 595.4, 595.81, 590.89, 595.9, 597.0, 597.80, 599.0
- Pressure Ulcers (707.00-.01 & 7-7.09 CCs; 707.02-09 MCCs)
- Vascular Catheter Associated Infection (999.31 CC)
- Surgical Site Infection – Mediastinitis after Coronary Artery Bypass Graft (CABG) Surgery (519.2 MCC & 36.10-.19)
- Falls and Trauma – Fractures, Dislocations, Intracranial Injuries, Crushing Injuries, and Burns (Codes will be considered in FY2009 IPPS Proposed Rule)

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Conditions being considered for FY2009 IPPS rulemaking

- These conditions raise one or more implementation or policy issues that need to be resolved before they can be selected. CMS will work to address these issues and propose to reconsider these conditions during the FY 2009 IPPS rulemaking process.

- Ventilator Associated Pneumonia (VAP) (Codes will be considered in FY2009 IPPS Proposed Rule)
- Staphylococcus Aureus Septicemia (038.11 + 995.91, 998.59, 999.3 MCCs)
- Deep Vein Thrombosis (DVT)/ Pulmonary Embolism (PE) (DVT: 453.40-.42 CCs; PE: 415.11 & 415.19 MCCs)

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Conditions needing further analysis

- After exhaustive consideration, CMS determined that further analysis is required before considering these conditions.

- Methicillin Resistant Staphylococcus Aureus (MRSA) (Codes will be considered in FY2009 IPPS Proposed Rule)
- Clostridium Difficile-Associated Disease (CDAD) (008.45 CC)
- Wrong Surgery (Codes will be considered in FY2009 IPPS Proposed Rule)

Opportunities for Public Involvement

- Listening Session
  - Verbal Statements
  - Written Comments
    - E-Mail: hacpoa@cms.hhs.gov
- IPPS Rulemaking
  - Proposed Rule
    - April of every calendar year
    - Instructions for submitting comments
  - Final Rule
    - August of every calendar year
- Listserv Messages
- Updates to the webpage
- Open Door Forums

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HAC & POA Indicator Reporting

- The best resource for information is the HAC & POA Indicator website

http://www.cms.hhs.gov/HospitalAcqCond/

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Hospital-Acquired Conditions (Present on Admission Indicator)

- Overview
- Statute/Regulations/Program Instructions
- Affected Hospitals
- Reporting
- Coding
- Hospital-Acquired Conditions
- Educational Resources

Overview

The Centers for Medicare & Medicaid Services (CMS) has announced details of a public Listening Session that is being held Hospital-Acquired Conditions and Present on Admission (POA) Indicator. For further information, click on the "Education Resources" tab on the left.

On February 8, 2006 the President signed the Deficit Reduction Act (DRA) of 2005. Section 5001(c) of DRA requires the Secretary to identify, by October 1, 2007, at least two conditions that are (a) high cost or high volume or both, (b) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (c) could reasonably have been prevented through the application of evidence based guidelines.

For discharges occurring on or after October 1, 2008, hospitals would not receive additional payment for cases in which one of the selected conditions was not present on admission. That is, the case would be paid as though the