

CMS Hospital-Acquired Condition (HAC) Measures for RHQDAPU **FREQUENTLY ASKED QUESTIONS**

1. What are HACs?

HACs are hospital-acquired conditions. Section 5001(c) of Deficit Reduction Act of 2005 requires the Secretary of the Department of Health and Human Services (DHHS) to identify HACs 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. On July 31, 2008, in the Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2009 Final Rule, the Centers for Medicare & Medicaid Services (CMS) selected ten categories of conditions for a HAC payment provision. For discharges occurring on or after October 1, 2008, hospitals no longer receive additional payment for cases in which one of the selected ten conditions was not present on admission. That is, the case would be paid as though the secondary diagnosis were not present.

Recently, as part of the IPPS FY 2011 Final Rule, CMS adopted eight of the ten HACs for the Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU) program. These eight HAC measures complement the outcome and process-of-care quality measures that were previously adopted under the RHQDAPU program.

2. Will the HAC measures be publicly reported?

CMS anticipates publishing results for all IPPS hospitals participating in the RHQDAPU program in a separate downloadable file accessible via the *Hospital Compare* website [<http://www.hospitalcompare.hhs.gov>] in the fall 2010 following a preview period. At this time, these measures will not be shown as part of the consumer-oriented “Compare Hospitals” feature on *Hospital Compare*; they will only reside in a separate downloadable file on www.cms.gov [http://www.cms.gov/HospitalQualityInits/11_HospitalCompare.asp#TopOfPage].

During a separate preview period prior to reporting CMS is providing all IPPS hospitals that were open as of May 7, 2010 a hospital-specific report (HSR) to allow them to become familiar with the HAC measures and their production using Medicare data. Hospitals that were not open as of May 5, 2010 or did not have any qualifying data during the time frame will be able to access a “mock” HSR on the *QualityNet* [<http://www.qualitynet.org>] website.

3. Why are the HAC measures only calculated and reported for Inpatient Prospective Payment System (IPPS) hospitals?

Coding of the HAC measures relies on complete coding of Present on Admission (POA) fields. Only IPPS hospitals are currently required to submit complete POA coding, though other types of hospitals can and do report these codes. To avoid any bias

against hospitals that are exempt and are not reporting POA codes, the HAC measures are only calculated among IPPS hospitals.

A list of hospitals exempt from POA coding is provided on the CMS website http://www.cms.gov/HospitalAcqCond/03_AffectedHospitals.asp#TopOfPage

4. Will these measures be used for payment?

The hospital HAC measures are being adopted under the FY 2012 Reporting Hospital Quality Data for Annual Payment (RHQDAPU) program. Under this program, hospitals must allow reporting of these measures to receive their full annual payment update. The hospital rates are not being used for any other purpose.

Note that the occurrence of a HAC on a claim submitted to CMS for payment may result in a revised MS-DRG and payment, as described more fully at <http://www.cms.gov/HospitalAcqCond>.

5. If the HAC measures are not being added to the RHQDAPU program until FY 2012, why is CMS reporting them on Hospital Compare in the fall of 2010?

CMS strives to make data for measures available to the public as soon as possible. CMS is in a unique position to be able to calculate and post these particular claims-based HAC measures in the early fall of 2010.

6. Are these measures adjusted for our patient case-mix?

The HAC rates are not adjusted for hospital case-mix. Many of these measures are considered “never events” or “serious reportable events” that should not occur regardless of how sick the patient is.

CMS is considering whether risk-adjustment is appropriate for some of the HACs, including those HACs that are not considered never events, and are considered outcome measures, such as infection-related HACs.

7. How are multiple HACs on the same claim treated when calculating our rate?

The HAC measure methodology adopted for the RHQDAPU program counts unique occurrences of HAC diagnosis codes, not a count of discharges with a HAC. One discharge record could contain multiple HACs. However, if one stay record has multiple diagnosis codes for the same HAC, only one is counted.

8. Where can I get more information on POA

More information on POA coding can be found on the CMS website at <http://www.cms.gov/HospitalAcqCond>.

9. Are the HAC measures endorsed by the National Quality Forum (NQF)?

Many of the HACs are part of the list of NQF recognized serious reportable events. The HAC measures also reflect consensus among affected parties as required for RHQDAPU program measures by section 1886(b)(3)(B)(viii)(V) of the Act because their definition was the subject of public listening sessions, rulemaking, and public comment.

10. Why did CMS not include surgical site infections and deep vein thrombosis / pulmonary embolism as part of the RHQDAPU program?

CMS does not believe that it is necessary to adopt the other two current HAC categories (surgical site infections and deep vein thrombosis / pulmonary embolism) for the RHQDAPU program because the topics would substantially overlap with other RHQDAPU program measures that CMS proposed to adopt for future payment determinations as chart-abstracted measures. By contrast, the eight proposed HAC measures are claims-based measures for which CMS can only (at this time) collect data on Medicare beneficiaries.

11. Why is the diagnosis code for Blood Incompatibility (999.6) used in the fall 2010 reporting period different than what is in the 2011 Inpatient Rule for RHQDAPU?

The proposed codes (999.60, 999.61, 999.62, 999.63, 999.69) for the Blood Incompatibility HAC in the 2011 IPPS Final Rule reflect updates to the coding for Complications and Comorbidities (CCs). The measures being calculated for reporting for the time period October 1, 2008 through June 30, 2009 reflect the coding in place at the time of the discharges.