



Reporting re Quality Measures: What Does It Mean To You?

Hospital Inpatient Quality Reporting Program

What is it?

Each year the Centers for Medicare & Medicaid Services (CMS) provides a payment adjustment for Medicare services that hospitals provide in order to account for cost increases throughout the fiscal year. This payment adjustment is called the Annual Payment Update (APU), and the intent is to provide a payment increase to account for inflation that can cause increases in the cost of health care services. In order to receive the APU, a hospital must submit valid data on a set of pre-defined quality measures. These measures are developed by the Hospital Quality Alliance (HQA), a joint effort initiated by the [American Hospital Association \(AHA\)](#), the [Federation of American Hospitals](#) and the [Association of American Medical Colleges](#), [CMS](#) and the [Joint Commission](#). These measures were recommended for public reporting in the December 2005 Institute of Medicine (IOM) report, Performance Measurement: Accelerating Improvement. The quality measures address the quality of care provided to acute myocardial infarction (AMI), pneumonia (PN), heart failure (HF), and surgery patients.

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When?

Since 2003, CMS has conducted the Hospital Quality Initiative, which is designed to stimulate improvements in hospital care by standardizing hospital performance measures and data transmission to ensure that all payers, hospitals, and regulatory entities use the same measures when publicly reporting hospital quality data. With the passage of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, Congress provided a financial incentive for all prospective payment system (PPS) hospitals to voluntarily report quality-of-care information so that consumers can compare care and make better-informed decisions [Section 501(b)].

How?

Every quarter, someone abstracts medical records for your hospital and submits the data to CMS. The rates for compliance with the quality measures are based on these abstractions. Following this submission of quality data, the Clinical Data Abstraction Center (CDAC) sends a written request to selected hospital medical record departments for randomly chosen charts. Those hospitals provide the CDAC with a copy of each of the charts. The CDAC re-abstracts these charts in order to validate the data submitted by the hospital. If a chart is not received, your hospital's data is considered invalid. If the CDAC's re-abstraction matches your hospital's abstraction for at least 75 percent of the measures, the data is considered valid.

Where?

Every hospital's rates for each of these quality measures are reported publicly on the *Hospital Compare* Web site, which is accessible to providers and consumers, at www.hospitalcompare.hhs.gov. The public can use this data to compare hospitals' performance and quality of care in order to make better-informed decisions about their health care. Insurance payers can also use this data to assess quality of care provided by hospitals.

Why?

In August 2006, the Deficit Reduction Act (DRA) signed into law by the president, included an update to the hospital reporting program, which required the secretary of the U.S. Department of Health and Human Services to increase the payment penalty for not continuously submitting data for the quality measures. Not meeting the requirements will result in a two-percentage point reduction in the Annual Payment Update (APU). This could mean hundreds of thousands, or even millions, of lost dollars to your hospital.

Resources

Information and resources are available at www.QualityNet.org.