Hospital Quality Incentive Demonstration (HQID)
Quality Incentive Payment

Calculation of Incentive Award

CMS will use the MedPAR database Fiscal Year 2004, for HQID year 1, MedPAR year 2005, for HQID year 2, and MedPAR year 2006, for HQID year 3) to determine the dollar incentive amount for each hospital eligible for an incentive payment. The payment population will be those patients identified as in the HQID clinical area topics/population determined by the principal diagnosis or principal procedure (as applicable for the clinical focus area). The payment populations are those who meet the criteria in the HQID clinical area population without exclusions being applied, and for the demonstration project year, have 30 cases in the HQID clinical area.

Some hospitals may have patients that meet the criteria in more than one disease area. The same logic is applied and the hospital is paid based on the clinical area determined by the principal ICD. Example: CABG – 36.10, 36.11, 36.12, 36.13, 36.14, 36.15, 36.16, 36.17, 36.19: Use all CABG patients as identified by these ICD-9 procedure codes in the principal procedure field and pay based on the number of CABG patients the hospital treated. Apply the appropriate 1% or 2 % to the total Medicare fee-for-service of these patients.

Note – the clinical measure definition includes these codes in principal or secondary positions. Just to clarify, the intention of CMS is to identify patients for payment only by the applicable ICD-9 codes present in the principal diagnosis or procedure fields. This would ignore any patients who had the procedure / diagnosis in secondary fields but would also ignore patients who had any exclusionary criteria (e.g., in the case of CABG would include patients who did not have an isolated CABG but would not include patients who had CABG in the secondary procedure field).

For the top decile hospitals, the bonus was 2 percent of the Diagnosis Related Group (DRG) based prospective payment for the patients in the measured condition for all Medicare fee for service beneficiaries.

Hospitals in the second decile were paid a bonus incentive of 1 percent of the DRG based prospective payment amount. The DRG – based prospective payment consists of the operating and capital prospective payment for each Medicare fee-for-service case, as adjusted for local costs.

The DRG payment does not include payments for disproportionate share hospitals (DSH), indirect medical education (IME), or any pass-through payments such as direct graduate medical education (GME). It does not include outlier payments. Incentive payments will be made annually in a lump sum. For hospitals not paid using the DRG-based prospective payment system, CMS will calculate a bonus (or payment adjustment reduction in year 3) when appropriate using a simulation of DRG-based payments.