HCCA
HEALTH CARE COMPLIANCE ASSOCIATION

COMPLIANCE TODAY

Volume Fourteen
Number Three
March 2012
Published Monthly

Meet

Bret S. Bissey, Senior Vice President, Ethics and Compliance Officer at UMDNJ

PAGE 14

Feature Focus:

Focusing on Quality: CMS issues new quality-focused rules

PAGE 36

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STORM WARNING: ICE IN THE FORECAST

PAGE 9

feature focus

Focusing on Quality: CMS issues new quality-focused rules

By Janice A. Anderson, Esq. and Joseph T. Van Leer, Esq.

Editor's note: Janice A. Anderson is Shareholder and Joseph T. Van Leer is an Associate in the Chicago offices of Polsinelli Shughart PC. Janice may be contacted at janderson@polsinelli.com or by phone at 312/873-3623. Joseph may be contacted at jvanleer@polsinelli.com or by phone at 312/873-3665.

On August 1, 2011, the Centers for Medicare & Medicaid Services (CMS) published the fiscal year 2012 final rule for the Inpatient Prospective Payment System (IPPS). The IPPS final rule included several adjustments to payment rates, changes to existing regulations, and new regulations that implement many of the quality-of-care initiatives set forth in the Patient Protection and Affordable Care Act (PPACA). On November 1, 2011, CMS published the calendar year 2012 final rule for the Outpatient Prospective Payment System (OPPS). This rule modified some of the regulations set forth in the IPPS final rule. This article will address both rules and their impact on quality-of-care initiatives, and will discuss certain other payment policy changes set forth in the rules.

Hospital Inpatient Quality Reporting

CMS expanded upon the Inpatient Quality Reporting (IQR) program, which Congress enacted to improve data collection on quality of care for hospitals paid under the IPPS. The program reduces payments by 2% of the IPPS market basket update for hospitals that do not successfully participate.

Background

CMS launched the Hospital Quality Initiative in 2001, which included the National Voluntary Hospital Reporting Initiative (NVHRI). This was the product of a public-private partnership between CMS and organizations such as the American Hospital Association and the American Medical Association. Congress then established the IQR (formerly called Reporting Hospital Quality Data Annual Payment Update or RHQDAPU) under the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). In order to provide financial incentive for hospitals to participate, the MMA instituted a reduction of 0.4% of the IPPS market basket update for hospitals that do not participate. The Deficit Reduction Act of 2005 increased the penalty to 2%, which is the current rate. Congress also required public display of the measurement information submitted. As such, CMS publishes the data on the Hospital Compare website (http://www.hospitalcompare.hhs.gov/) after a 30-day review period.

Current and future measures

The IQR data is collected from an increasing array of measures as part of an effort to improve transparency and quality. The IPPS final rule requires providers to successfully report on a total of 55 measures for FY 2012, and increases the number of measures to 57 in FY 2013. Additionally, in the rule, CMS finalized the measures for FY 2014 and FY 2015. Hospitals must report data on 55 and 72 measures for those years, respectively.[1]

CMS continues to evaluate the usefulness of existing measures and will retire those that it considers "topped out," which means the measure no longer has significant room for improvement. For discharges on or after January 1, 2012, CMS is retiring four of the existing measures and not collecting data on an additional four measures. CMS did not retire these latter four measures, because many comments suggested it was premature to do so. However, it will not collect data on them unless hospital adherence to the measures unacceptably declines. CMS believes that stopping data collection in lieu of retirement balances the IQR's goal to incentivize quality while minimizing the data collection burden imposed on hospitals.

New spending-per-beneficiary measure

Additionally, for FY 2014, CMS will adopt a Medicare claims-based spending-per-beneficiary measure. The measure will be calculated using claims data for hospital discharges between May 15, 2012 and February 14, 2013. This new measure will be added to the IQR program in FY 2014 and also will likely be incorporated in the hospital Value Based Purchasing (VBP) in future years, as discussed below.

CMS plans to evaluate spending-per-beneficiary (adjusted for age, severity of illness, and other factors) using an episode of care that runs from three days prior to an inpatient admission through 30 days post-discharge, taking into account all Part A and Part B services provided to Medicare beneficiaries during the episode, with some limited exceptions, such as statistical outliers and transfers from one acute care hospital to another. Although transfers from one acute care hospital to another will be excluded at this time, CMS will consider inclusion of such transfers after further analysis.

Notably, CMS will allocate costs attributed to a readmission during the episode of care (and any transfers to another hospital occurring during a readmission), which CMS refers to as the "index hospitalization." This will take into account costs associated with a readmission, regardless of whether the readmission is related to the index hospitalization. CMS will also attribute costs for transfers to sub-acute facilities, such as a skilled nursing facility or long-term acute care hospital, to the index hospitalization.

To calculate a hospital's per-beneficiary spending amount, CMS will divide the sum of all adjusted Medicare Part A and Part B payments during each episode attributed to an index hospitalization by the total number of episodes for that hospital. The operative metric used to report this is the spending-per-beneficiary ratio, which is calculated by dividing the hospital's spending-per-beneficiary by the median spending-per-beneficiary for all hospitals nationally. CMS will post the data for the beneficiary spending measure, along with other IQR data, on the Hospital Compare website.

Inpatient Value Based Purchasing program

The IPPS final rule also expanded upon the VBP program adopted by Congress in the PPACA, and the OPPS final rule enacted a few modifications. VBP uses measures reported under the IQR and distributes incentive payments to hospitals based on the hospital's performance on these measures.

Background

Congress views VBP as an integral component to changing how services are paid for, with a focus on rewarding better value and outcomes, rather than volume. On May 6, 2011, CMS finalized the rules that will govern the first year of the VBP program, which begins in FY 2013 (for discharges on or after Oct. 1, 2012). Only subsection (d) hospitals (i.e., IPPS hospitals) are subject to the program.

CMS plans to measure hospital performance for purposes of VBP in several different areas, called

Continued on page 38

 ...continued from page 37

domains. Beginning in FY 2013, CMS will utilize two domains: the Clinical Process of Care domain and the Patient Experience of Care domain. In FY 2014, CMS will implement an additional domain, the Outcomes domain, thus creating three domains to measure performance. Although initially added in FY 2014, there also will be a fourth domain, the Efficiency domain, which CMS intends to add in future years. The domains use several measurements to calculate each respective domain score. These scores will contribute to the total performance score (TPS), which CMS will use to calculate a hospital's incentive payment.

Several of the terms used in VBP are important:

- **Baseline period** is the time period CMS will use to compare a hospital's performance with its own performance during the performance period. This time period varies by domain and fiscal year.
- **Performance period** also varies depending on each domain. It is the time period utilized to judge a hospital's improvement from its own baseline score and its achievement as compared to other hospitals.
- **Benchmark** is the mean value for the top 10% (the top decile) of overall hospital performance nationally. A hospital will receive a score of 10 if its performance is at or above the benchmark.
- **Threshold** is the 50th percentile of overall hospital performance nationally for each measure. In order to receive points for a measure, the hospital must score at or above the threshold. Thus, if a hospital's score for a measure during the performance period is below the threshold, it will receive a score of 0 for that measure.

To develop the score for each domain, CMS will calculate and compare two scores (the achievement score and improvement score) and choose the highest. CMS calculates the scores by reviewing the hospital's data from the baseline period and the performance period. The achievement score rewards achievement in the performance period as compared to hospitals nationally during the baseline period for the Clinical Process of Care, Patient Satisfaction of Care, and Outcomes domains. The improvement score measures a hospital's individual improvement in the performance period compared to its own baseline period score. However, in order to earn points on the improvement score, hospitals must still perform at or above the threshold. The achievement and improvement scores are calculated as follows.

Achievement score calculation

A hospital will earn between 0 and 10 points for achievement, based on where its performance for the measure falls relative to the achievement threshold and the benchmark. If a hospital's score is equal to or better than the benchmark, the hospital will receive 10 points. If it is equal to or better than the threshold, but worse than the benchmark, it will receive a score of 1-9, based on an established formula. If the score is worse than the threshold, then the hospital's score will be 0.

Improvement score calculation

A hospital will earn its improvement score based on a similar formula. If the hospital score is better than the hospital's own baseline (i.e., it improved), but not as good as the benchmark (top decile), then the hospital will receive a score of 1–9 based on an established formula. If a hospital score is worse than its own baseline or the threshold, it will receive a score of 0 for improvement.

Total scoring overview

The TPS takes into account the total earned points per domain and divides the total earned points by the total possible points to determine the domain score. CMS will utilize a weighting scheme for each domain to determine the TPS. In FY 2013, the TPS will use a weighting methodology of 70% for the Clinical Process of Care domain and 30% for the

Patient Experience of Care domain. For FY 2014, CMS will add the Outcomes domain and assign the following weights to the domains:

- Clinical Process of Care domain – 45%
- Patient Experience of Care domain – 30%
- Outcomes domain – 25%

CMS will adjust the weighting schemes for future years to reflect its intent to enhance focus on outcomes and patient satisfaction measures. CMS intends to implement the fourth, Efficiency domain, in future years. In the IPPS final rule, CMS implemented this domain by using the spending-per-beneficiary metric added to the IQR program, but suspended its effective date in the OPPS final rule for reasons discussed below.

The domains

Clinical Process of Care domain

The Clinical Process of Care domain includes twelve measures[2] selected from the IQR program that are evaluated using a baseline period of July 1, 2009 to March 31, 2010 and a performance period of July 1, 2011 to March 31, 2012.

Patient Experience of Care domain

The score for the Patient Experience of Care domain is based on a hospital's evaluation on eight measures included in the Hospital Consumers Assessment of Healthcare Providers Survey (HCAHPS), which is the first national, standardized, publicly reported survey of patients' experiences of hospital care. For FY 2013, the baseline period for this domain is July 1, 2009 to March 31, 2010 and the performance period is July 1, 2011 to March 31, 2012. The calculation of the Patient Experience of Care domain includes achievement and improvement scores as well as points for consistency of the measures.

Outcomes domain

Beginning in FY 2014, the Outcomes domain will consist of three mortality measures and use a baseline period of July 1, 2009 to June 30, 2010 and a performance period of July 1, 2011 to June 30, 2012. CMS originally included certain hospital-acquired conditions (HAC) measures and Agency for Healthcare Research and Quality (AHRQ) patient safety indicators, inpatient quality indicators, and composite measures, but decided in the OPPS final rule to delay the effective date for these measures. Many argued that CMS must display measure data on the Hospital Compare website for a year prior to a measure's inclusion in the VBP program, and that the proposed seven-month performance period was too short to fairly assess hospital performance on these measures. CMS recognizes that providers could benefit from posting data on any new measure at least one year prior to the performance period for that measure and that a longer performance period for the HAC and AHRQ measures would provide more data on which to compare performance. Thus, in the OPPS final rule, CMS suspended the effective dates for these measures. CMS will likely include these measures as part of the FY 2015 VBP program.

Efficiency domain

Although not included as part of the FY 2014 VBP program, CMS intends to incorporate a fourth, Efficiency domain. CMS also delayed the effective date of this measure for many of the same reasons as the HAC and AHRQ measures. CMS also noted that many providers are seeking additional information related to the specifications of the Medicare spending-per-beneficiary measure, which was the only measure originally included in the Efficiency domain under the IPPS final rule, but then delayed under the OPPS final rule. CMS will likely include this domain as part of the FY 2015 VBP program and it may, for the first year only, include the Medicare spending-per-beneficiary measure.

The payments under the VBP program will come from an across-the-board reduction in hospital's

Continued on page 40

 ...continued from page 39

diagnosis-related group (DRG) payments. Beginning October 1, 2012, a hospital's DRG payments will be reduced by 1% with an opportunity to "earn back" this amount or more, based on the hospital's TPS. This risk grows each year thereafter by 0.25% so that, in 2017, 2% of hospital DRG payments will be at risk, based on the hospitals TPS for that year. Thus, there will be winners and losers under the VBP program, all tied to hospital performance on many different measures.

Hospital Readmissions Reduction program

PPACA established the Medicare Hospital Inpatient Readmissions Reduction program, which will further reduce IPPS payments for acute care hospitals that have higher than expected readmission rates for certain conditions. CMS estimates that the cost of avoidable readmissions is more than $17 billion a year. A recent report by the Dartmouth Atlas Project found that hospitals made little progress from 2004 to 2009 in reducing readmission rates.[3] The Readmissions Reduction program, which begins on October 1, 2012, creates financial incentives to reduce preventable readmission rates by penalizing hospitals that have excessive readmissions.

The general framework of the program is that CMS will reduce "base operating DRG payments," by an "adjustment factor" that accounts for excess readmissions. The payment reduction is capped at 1% in FY 2013, 2% in FY 2014, and 3% in FY 2015 and beyond (the "floor adjustment factor"). The IPPS final rule does not explain the calculation of either base-operating DRG payments or the adjustment factor; rather, the rule focused on the conditions that will apply for the first year of the program (Oct. 1, 2012), the methodology for calculating readmission rates, and public reporting of the data. CMS will address the remaining considerations relative to the program in the FY 2013 rule-making process.

The readmissions measures that will apply for first year of the program include:

- Acute myocardial infarction 30-day risk standardized readmission measure;
- Heart failure 30-day risk standardized readmission measure; and
- Pneumonia 30-day risk standardized readmission measure.

These readmission measures are National Quality Forum (NQF)-endorsed measures that have been part of the IQR program historically, and using these measures is consistent with CMS's goal to streamline the measures used in various programs, such as the IQR, VBP, and readmissions programs.

In adopting the readmissions timeframe, CMS will count certain readmissions occurring within 30 days of a discharge from the index hospitalization. This is the same timeframe currently used for the three measures as part of IQR program. Readmissions that do not count for purposes of calculating the readmissions rate include hospital-hospital transfers, certain planned readmissions (such as coronary artery bypass graft following acute myocardial infarction) and unrelated readmissions, also consistent with the IQR program.

Additionally, CMS will use three years of data for discharges (from July 1, 2008 through June 30, 2011) as the period upon which to calculate the excess readmission ratio for each of the three proposed measures, which is consistent with the timeframe used to report the measures under the IQR program. Also consistent with the IQR program, CMS will require each hospital to have a minimum of 25 discharges for each of the three measures for the 2013 Readmissions Reduction program.

The excess readmission ratio is the ratio of actual readmissions to risk-adjusted expected readmissions and will be used to determine the adjustment factor. This essentially means that if a hospital performs better than an average hospital that admitted similar

patients, the ratio will be less than one, and if it performs worse, then the ratio will be greater than one. CMS will provide more analysis in the FY 2013 IPPS rule. Like the IQR program, hospitals will have an opportunity to review and submit corrections to CMS regarding their readmission rates and excess readmission ratios before the information is used and made public.

Although the IPPS final rule did not define how the base operating DRG payment or the adjustment factor will be calculated, PPACA provides some guidance. PPACA defined the base operating DRG payment as the payments that would otherwise be made under the IPPS, not including those payments attributable to outlier payments, disproportionate share payments, VBP payments, etc. The adjustment factor is equal to the greater of (1) the ratio of aggregate payments for excess readmissions to the aggregate payments for all discharges; or (2) the floor adjustment factor described above. Although these definitions provide some guidance, considerably more clarity is required, and CMS will include these details in the FY 2013 IPPS rule.

Preventable hospital-acquired conditions

One component of lowering health care costs and improving outcomes is punishing hospitals that provide substandard care. An indicator of substandard care is the occurrence of certain complications that were not present at the time of admission. As such, Congress (in the Deficit Reduction Act of 2005) imposed a payment reduction on hospitals that experience HACs. Under that policy, hospitals do not receive the additional payment for treating the complication in cases in which one of the HACs occurred and was not present on admission. PPACA expands on this policy by penalizing hospitals that have high rates of HACs. Thus, PPACA imposes an additional penalty for hospitals incurring HACs by reducing payment by 1% for hospitals in the top quartile relative to the national average of HACs. This applies for discharges in FY 2015 and subsequent fiscal years.

There are currently twelve HAC categories, each of which CMS identified as a condition that (1) is high cost or high volume; (2) results in the assignment of a case to an MS-DRG with a higher payment rate; and (3) could reasonably have been prevented through the use of evidence-based guidelines.

In the 2012 IPPS proposed rule, CMS proposed adopting a new HAC category: contrast-induced acute kidney injury, which is an abrupt deterioration in renal function that can be associated with use of contrast dye in medical imaging. Studies suggest the additional average cost per day for a patient who has acquired contrast-induced acute kidney injury is $2,654. Other data report that patients' hospital stays increase by 3.75 days if they suffer from the complication. The 2012 IPPS final rule did not adopt the new HAC category, citing issues with the accuracy of the data. Currently there is no specific diagnosis code for contrast-induced kidney injury. Beginning on October 1, 2013, CMS will implement a new version of the diagnosis coding system, called ICD-10, which allows for greater accuracy. The 2012 IPPS final rule indicates that it will reconsider adding the category as a new HAC at that time. Although not adding any new HACs at this time, CMS did add five new ICD-9-CM diagnosis codes to existing HAC categories.

Changes to the three-day payment window

Patients often receive outpatient services prior to admission in a hospital. These may include either diagnostic (e.g., x-ray, lab tests) or non-diagnostic (e.g., therapeutic) services. Since 1990, diagnostic services provided to a patient by a hospital, or an entity wholly owned or operated by the hospital, within three days prior to and including the date of admission are deemed to be inpatient services and

Continued on page 42

must be bundled in the inpatient payment as part of a MS-DRG. This is commonly referred to as the three-day payment window.

Although the three-day payment window also applied to non-diagnostic as well as diagnostic services, for non-diagnostic services to be bundled, they must be "related" to the admission. Historically, CMS defined related non-diagnostic services as those with an exact match between the ICD-9-CM principal diagnosis code assigned for both preadmission services and the inpatient stay, which severely limited the application of the three-day payment window for non-diagnostic services. The Preservation of Access to Care Act of 2010 changed this policy, effective June 25, 2010. Now, all non-diagnostic services provided in the three-day payment window are deemed related and, therefore, must be bundled with the inpatient admission if they occur on the date of admission or within three days of the admission, unless the hospital attests that the non-diagnostic service is unrelated to the hospital claim. The hospital must add condition code 51 if it attests that a claim is unrelated. Separate outpatient claims then may be billed on either the Medicare Physician Fee Schedule or the OPPS.

Importantly, CMS has clarified that the rule applies to physician practices that are solely owned or operated by the hospital, regardless of whether they are provider-based. There are typically two components to a patient bill in a hospital-based setting, including provider-based physician clinics: the professional component (PC) and technical component (TC). The TC includes the overhead costs associated with services (e.g., staff). Services provided at a physician office that is not provider-based do not have a TC, but instead are billed as professional services and are paid at a higher (non-facility) rate to account for overhead costs. This means that hospital-owned or operated physician practices are subject to the three-day payment window, even if they are not provider-based, and therefore, no technical bill is generated as a result of the visit. This is a significant and potentially troubling change in Medicare policy.

For physician practices that are owned or operated by the hospital, an issue arises as to how to apply the payment window if the practice does not bill provider-based. Interestingly, the CY 2012 Medicare Physician Fee Schedule final rule sets forth a new CMS policy that will require providers to code professional services subject to the payment window as performed in a facility. Therefore, the professional services are reimbursed at the lower facility rate, which excludes overhead costs, in order to avoid duplicate payment for the services. CMS contends that professional services are not subject to the payment window. However, professional services provided in a physician office wholly owned or operated by a hospital historically received payment at the higher non-facility rate. Now, for services subject to the payment window, CMS will only pay PC for codes with a TC/PC split and the facility rate for codes without a TC/PC split. This change could result in significant reimbursement losses for providers subject to this change, and may present challenges in implementation, because many hospitals and physician practices do not "talk to each other" to allow for identification of when the payment window applies.

In order to implement this change for entities wholly owned or operated by hospitals, beginning on January 1, 2012, CMS will make a new payment modifier (PD) available to append to claims subject to the window. This change will require hospitals to have mechanisms in place to recognize physician services performed in hospital-owned or operated physician practices subject to the payment window and to appropriately bill both hospital and physician claims. CMS recognizes that it will be difficult for providers to fully implement billing systems adequate to support this change, so it is delaying the effective date until July 1, 2012.

This change is in line with CMS's recent attention to incorrect place-of-service coding for physician claims that can arise when physicians perform a service in the hospital and fail to code it as performed in a facility. The Office of the Inspector General (OIG) recently released two audit reports for 2008 and 2009, addressing place-of-service coding errors. The audits focused on physician services that were not coded as being provided in a facility, but were provided for the same type of service to the same beneficiary on the same day. The audits found that physicians incorrectly coded more than 80% of the claims that were performed in a facility, resulting in $28 million in overpayments. It is likely that CMS will continue to target these types of overpayments, especially now that entities wholly owned and operated by hospitals must comply with these new billing practices. Thus, providers should carefully evaluate how to structure physician practices and implement billing systems accordingly.

Changes to the under-arrangements requirements

For several years, CMS has had concerns regarding the services which may be provided "under arrangements" with the hospital. Under-arrangement services are those which an outside entity provides under contractual arrangements with the hospital, but are billed for by the hospital.

Federal law provides that routine services (which may include bed, board, nursing, and intensive care services) are to be provided only by the hospital. CMS believes that, because federal law states that routine services must be provided "by the hospital," the law requires the hospital to exercise the same level of control over those services as it does when the services are provided by hospital employees and, therefore, the services must be provided in the hospital's facilities. CMS stated that providers were misinterpreting its rules regarding under-arrangements to mean that routine services can be provided outside the hospital by an outside entity. Thus, the 2012 IPPS final rule clarifies that routine services may only be provided by an outside entity if performed in the hospital.

In particular, CMS discussed under-arrangements between IPPS hospitals and certain "IPPS-excluded hospitals" (e.g., critical access, rehabilitation, or long-term acute care hospitals), that have resulted in IPPS hospitals receiving payments under methodologies that do not ordinarily apply to that facility. For example, if an inpatient at an excluded hospital required intensive care unit services, and the excluded hospital could not provide these services, the excluded hospital would transfer the patient to an IPPS hospital to obtain the services under arrangement. By considering the patient to be an inpatient at the excluded hospital, the services then may be billed under the excluded hospital's payment methodology, rather than the IPPS methodology, which is usually lower. CMS believes that limiting under-arrangements to services provided in the hospital will reduce the opportunity for gaming the system and ensure that hospitals exercise sufficient control and responsibility over the use of resources in treating patients.

Despite the clarification that limits application of under arrangements, the IPPS final rule confirmed that therapeutic (e.g., procedures) and diagnostic services (e.g., MRI) are allowable under-arrangement services, although therapeutic services are required to be performed in a provider-based facility, but diagnostic services are not.[4] Additionally, if a provider satisfies the provider-based requirements set forth at 42 C.F.R. 413.65 (including the limitation that all the services cannot be provided under arrangements), it may generally bill for services performed in a provider-based facility, even if it is not on the hospital's main campus.

Continued on page 44

Focusing on Quality: CMS issues new quality-focused rules

...continued from page 43

Conclusion

The focus on changing payment mechanisms in the name of value and improving patient outcomes will likely pose difficulties for many providers, because these changes are occurring rapidly. Nevertheless, many of these initiatives, albeit challenging, could result in valuable improvements to our health care delivery system. However, these policy changes, like many others, can also result in a significant loss of revenue unless hospitals have taken steps to perform well under them. This requires constant vigilance to learn about the changing rules and active efforts to change how care is delivered to ensure high-level performance. ■

1. A list of the IQR measures for FYs 2012, 2013, 2014, and 2015 is available at http://www.polsinelli.com/publications/healthcare/resources/2012-2015_IQR_Measures.pdf.
2. A list of all of the measures for the 2013 VBP and beyond can be found at http://www.cms.gov/apps/media/press/factsheet.asp?Counter=3947.
3. Dartmouth Institute for Health Policy & Practice: After Hospitalization: A Dartmouth Atlas Report On Post-Acute Care For Medicare Beneficiaries (2011). Available at http://www.dartmouthatlas.org/downloads/reports/Post_discharge_events_092811.pdf.
4. See 42 C.F.R. 410.27(a) compared to 42 C.F.R. 410.28(a).