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Why are so many DLA Piper employees certified in compliance?

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What every compliance officer should know about payment changes for 2013

» The Inpatient Prospective Payment System (IPPS), Outpatient Prospective Payment System (OPPS), and the Medicare Physician Fee Schedule (MFPS) final rules further implement the quality-related payment programs of the ACA.

» Payments based on quality metrics could result in False Claims Act liability if hospitals do not accurately report or the metrics indicate poor quality care.

» Timeframes are short to appeal quality-based payments and each step in the review and correction process must be met before an appeal will be permitted.

» Keep abreast of changes to current reimbursement policy (i.e., patient status), because these changes impact compliance policies and practices.

» Hospitals must immediately implement processes to respond to changes to the 3-day payment window and its impact on hospital-owned physician practices.

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The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act (collectively, the ACA) established several new programs designed to connect payments for health care services to quality. The Centers for Medicare & Medicaid Services (CMS) has begun implementing these programs over recent years, and thus, hospitals are faced with new challenges. These programs and other recent payment changes are increasingly important for compliance officers to consider. This article will discuss key topics related to quality-based payment programs that every compliance officer should know for 2013, based on regulations enacted under the Inpatient Prospective Payment System (IPPS), Outpatient Prospective Payment System (OPPS), and the Medicare Physician Fee Schedule (MFPS) final rules.

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Quality metrics and the False Claims Act

Several new programs demonstrate the government's eagerness to align payment with quality of care. The motivating factor for this change is not just to improve the quality and safety of the health care system, but also because poor quality care is becoming a very real expense. Reports of medical errors and the accompanying staggering costs leave no question as to why the government's attention is directed at making quality of care a top compliance concern for health care providers.

Hospitals are also a principal target of overpayment recovery and fraud enforcement, which is expected due to the extraordinary amount of federal funds spent on hospital

services. The ACA created new resources devoted to enforcement, including new programs, enhanced penalties, and increased funding to ensure that quality care is a priority for regulatory enforcement. In using its primary tool to combat health care fraud, the False Claims Act (FCA), the government relies on a variety of legal theories to determine whether submitting claims for payment based on poor quality or medically unnecessary care is tantamount to fraud. Understanding these legal theories and how they will apply when payment is directly tied to quality of care can help providers understand these areas of compliance risk. Below is a brief overview of some to the key programs addressed in the IPPS and OPPS 2013 final rules, and how a failure to properly handle these new quality-based payment requirements could result in FCA liability.

Quality overview

The Hospital Inpatient Quality Reporting (IQR) program, which is the backbone of several of the key payment reforms, will continue in 2013. Congress 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, CMS instituted a reduction of 2% of the IPPS market basket update for hospitals that do not participate. CMS publishes the data on the Hospital Compare website (http://www.hospitalcompare.hhs.gov) after a 30-day review period. CMS has also begun instituting similar programs for the hospital outpatient services, ambulatory surgery centers, long-term acute care hospitals, and other providers.

In the FY 2013 IPPS final rule, CMS proposed programmatic changes to the Hospital IQR program for the FY 2015 payment determination and subsequent years, and still requires that IPPS hospitals successfully report on 57 measures in FY 2013, 55 in FY 2014, 59 in FY 2015, and 60 in FY 2016. For 2013, hospitals that fail to report will see only a 0.8% increase in their market basket.

Value Based Purchasing

The ACA mandated the implementation of the Value Based Purchasing (VBP) program. The VBP program pays hospitals based upon how well they perform on a specific set of quality measures. To date, only subsection (d) hospitals (i.e., IPPS hospitals) are subject to the program. CMS is measuring hospital performance for purposes of VBP in several different areas, called domains. The domains use several measures to calculate each respective domain score. These scores contribute to the total performance score (TPS), which CMS uses to calculate a hospital's incentive payment. (This program was discussed in greater detail in the June 2012 *Compliance Today* article, *"A timeline for change: A discussion of Affordable Care Act Provisions."*)

In the FY 2013 final rule, CMS added both new domains and new measures within each domain, along with a revised domain-weighting scheme for FY 2015. CMS also added two additional measures to the Outcomes domain for FY 2015: (1) PSI-90, the AHRQ Patient Safety Indicator composite measure,[1] and (2) the central line-associated blood stream infection (CLABSI) measure.

As expected, CMS added the Medicare Spending per Beneficiary measure to a new Efficiency domain for FY 2015. This measure assesses Medicare Part A and Part B payments per beneficiary from the date of a beneficiary's hospital admission through 30 days after discharge and is adjusted for age, severity of illness, geography, and other payment factors. This was an expected addition, because CMS originally proposed this measure in the FY 2012 IPPS final rule, but later removed it in the CY 2012 OPPS final rule.

Additionally, CMS established case minimums for FY 2015. The ACA requires the Secretary to exclude from a hospital's VBP calculation those measures and domains where the hospital does not report a minimum number of cases. For FY 2013, CMS established minimums of 10 cases per measure and a minimum of four total measures for the Clinical Process of Care domain and a minimum of 100 completed surveys for the Patient Experience of Care domain. For FY 2014, CMS will require the same minimums for the Clinical Process of Care and Patient Experience of Care domains and a minimum of 10 cases for the three 30-day mortality measures.

In FY 2015, CMS is increasing the minimum number of cases for the three 30-day mortality measures to 25, establishing minimums of three cases for any of the underlying indicators for the AHRQ PSI composite measure, and requiring a minimum of one predicated infection for the CLABSI measure. In order to receive a score for the Outcomes domain, a hospital must report on two measures and must report on 25 cases for only the Efficiency domain measure (Medicare Spending per Beneficiary measure).

Readmissions reduction

The ACA also 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. The program, which began 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 [diagnosis-related group] 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 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.

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 to apply.

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 means that the ratio will be less than one if the hospital performs better than average, and the ratio will be greater than one if it performs worse. 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 to reduce payments and made public.

In the FY 2013 final rule, CMS finalized the definition of base-operating DRG payments to include the wage-adjusted DRG payments and any technology add-on payments, but it does not include outlier payments, disproportionate share payments, VBP payments, etc.

The 2013 final rule also explained the calculation of aggregate payments for excess admissions. In order to calculate aggregate

payments for excess readmissions, CMS will, for that condition, multiply the sum of the base operating DRG payments for each of the three conditions used in the program (i.e., acute myocardial infarction, heart failure, and pneumonia) by the excess readmission ratio (as defined above). The sum for all three conditions that are included in the Readmissions Reduction program then will be divided by the aggregate payments for all discharges. A visual of this calculation is provided in figure 1.

The base-operating DRG payment will be adjusted by multiplying the adjustment factor to the hospital's base DRG payments. The adjustment factor equals the greater of (1) 1 minus the ratio of aggregate payments for excess readmissions to the aggregate payments for all discharges; or (2) 0.99 (1% reduction) in FY 2013, 0.98 (2% reduction) in FY 2014, and 0.97 (3% reduction) in FY 2015. Thus, in FY 2013, the maximum penalty is 1%.

> …hospitals should immediately focus on strategies to reduce readmissions rates… to avoid future penalties when the amount at risk increases to up to 3% of total DRG payments.

Unfortunately, there is little that hospitals can do to prevent a payment reduction for poor readmissions data in 2013, because CMS will use data for past discharges (July 1, 2008 through June 30, 2011). In fact, CMS has already published the FY 2013 results for individual hospitals, which can be found on its website. According to *Kaiser Health News*, more than 2,000 hospitals will be penalized by the program, accounting for a savings of approximately $280 million in Medicare funds.[2]

Aggregate payments* for excess readmissions =
[sum of base operating DRG payments for AMI x (Excess Readmission Ratio for AMI-1)]
+ [sum of base operating DRG payments for HF x (Excess Readmission Ratio for HF-1)]
+ [sum of base operating DRG payments for PN x (Excess Readmission Ratio for PN-1)]

Aggregate payments* for all discharges =
sum of base operating DRG payments for all discharges

Ratio =
1 – (Aggregate payments* for excess readmissions/Aggregate payments for all discharges)

Readmissions Adjustment Factor for FY 2013 is the higher of the ratio or 0.99

* based on claims data from FYs 2008-2011
NOTE: AMI means acute myocardial infarction, HF means heart failure, and PN means pneumonia.

Figure 1: Calculation of aggregate payments for excess admissions

TIP: Given the increase in penalties in future years, hospitals should immediately focus on strategies to reduce readmissions rates for these and other conditions to avoid future penalties when the amount at risk increases to up to 3% of total DRG payments.

Hospital-Acquired Condition program

CMS has made further changes to the Hospital-Acquired Condition (HAC) program in the 2013 final rules. Under the HAC program, hospitals do not receive the additional DRG payment for treating a complicating condition, if one of the HACs occurred during a hospitalization and was not present on admission. Currently, there are 12 HAC categories, each of which CMS identified as a condition that (1) is high cost or volume, (2) results in the assignment of a case to an MS-DRG with a higher payment rate, and (3) can reasonably be prevented through the use of evidence-based guidelines. CMS projects $24 million in total savings from the HAC program for FY 2013 alone.

For FY 2013, CMS added iatrogenic pneumothorax with venous catheterization as a new HAC condition. CMS had considered adding this to the program in FY 2009, but declined to do so, due to a lack of consensus in the medical community regarding its preventability. In response to commentators' concerns, CMS reviewed changes in the standard-of-care and evidence-based guidelines relative to iatrogenic pneumothorax to identify specific situations where there was consensus that the condition is reasonably preventable. Based on this review, CMS concluded that iatrogenic pneumothorax is reasonably preventable in the context of venous catheterization, and therefore, added it as a new condition in the 2013 final rule. The new condition applies to discharges occurring on or after October 1, 2012.

CMS also added another procedure to the surgical site infection (SSI) HAC. As of FY 2013, SSI following cardiac implantable electronic device procedures is added to the SSI HAC category.

We anticipate that CMS will continue to expand this program in the future. Additionally, the ACA requires CMS to impose an additional penalty for hospitals that incur a high rate of HACs by reducing payment by 1% for hospitals with HAC rates in the top quartile (25%) relative to the national average of HACs. This additional penalty is expected to take effect in FY 2015 and likely will be addressed in future rulemaking.

Potential False Claims Act liability

The FCA delivers harsh penalties to deter providers from engaging in dishonest or fraudulent billing practices. It also contains a whistleblower or "*qui tam*" provision whereby private individuals may recover a portion of the recovery when a lawsuit is successful, further incentivizing parties who have insider information to come forward.

Generally, a FCA violation must meet three statutory elements: (1) the claim must be submitted to the U.S. government; (2) the claim must be false; and (3) the claim must have been submitted knowingly (i.e., either known to be false or made with reckless disregard for its truth or falsity). Additionally, states have adopted their own versions of the FCA and offenders may be prosecuted on either or both fronts. The ACA and the Fraud Enforcement Recovery Act (FERA) of 2009 expanded the FCA to make it easier for the government to sustain convictions by, among other changes, lowering the public disclosure standard, amending the original source provisions, and making the failure to return an "identified" overpayment clearly a false claim.

Compliance officers should understand the potential FCA liability resulting from the quality-related payment programs, specifically as it relates to inaccurate quality reporting, which may result in a false certification. Notably, prosecutors have alleged that false certifications may violate the FCA, even in

cases where the defendant has not made an expressly false certification. Fraud under a theory of "false certification" is based on the premise that the submission of a claim for payment to the government creates representation (express or implied) that the underlying care complies with all applicable legal requirements necessary to bill for the service.

Many measures utilized in the programs discussed above are claims-based, meaning that CMS will extract data from claims submitted by each provider. However, several measures are still "chart-abstracted," meaning that hospital staff will review patient records to determine results on each measure. This enhances the potential for mistakes, and thus, the potential for false certifications.

Courts also recognize FCA claims based on the theory of worthless services. This theory holds that a claim may be fraudulent if the care performed, although otherwise medically indicated and in compliance with regulations, is of such poor quality as to be deemed worthless. This theory of liability is distinct from the false certification theory (discussed above) in that it focuses squarely on the quality of care provided, rather than on certifications to support billing or compliance with laws and regulations.

"Worthless services" is a high standard. One court required a showing that "the performance of the service is so deficient that for all practical purposes it is the equivalent of no performance at all."[3] Nevertheless, as the government turns a spotlight on the quality of care through the quality-related payment programs, worthless-services claims may proliferate.

The rules and the appeals processes

The IPPS and OPPS final rules address requirements for appealing CMS decisions related to VBP, readmissions, HAC, and other quality-related payment programs. We summarize some of the procedures below, but urge readers to seek legal guidance in the event they wish to submit such an appeal.

IQR & OQR reconsideration

Hospitals that fail to successfully report on the IQR and the Outpatient Quality Reporting programs face a 2% reduction in their market basket update under each payment system. When CMS determines that a hospital did not meet the requirements in a fiscal year, the hospital may submit a request for reconsideration to CMS no later than 30 days from the date identified on the Hospital IQR or OQR Program Annual Payment Update notification letter. Upon denial of a reconsideration request, the hospital may submit an appeal with the Provider Reimbursement Review Board.

VBP program corrections and appeals

CMS established a process through which hospitals could review and correct their claims-based measure rates, their condition-specific scores, domain-specific scores, and TPS. Beginning in FY 2014, CMS will provide hospitals with confidential reports that contain the claims-based measure rate calculations and additional confidential discharge-level data, and a process through which hospitals could review and submit corrections to their condition-specific performance, performance on each domain, and their TPS.

> [To preserve appeal rights, hospitals] will have 30 days to review and submit corrections to their confidential reports and TPS reports once they are posted to QualityNet.

As part of this process, CMS will provide hospitals with a separate TPS report that would allow them to review and correct their chart-abstracted and HCAHPS data. Hospitals will have 30 days to review and submit corrections to their confidential reports and TPS reports once they are posted to QualityNet.

CMS has also created an administrative appeals process for VBP. Under this process, a hospital may appeal the calculation of its TPS, measure/dimension score, condition-specific score, domain-specific score, or measure rate/data. Prior to engaging in the appeals process, a hospital must have submitted a review and correction under the process described above, and received an adverse determination. Hospitals will have 30 days from the date they receive notice of an adverse determination to submit an appeal. Further, hospitals will be limited in the issues and determinations they can appeal**.**

TIP: Hospitals must implement the review and correction process on a timely basis to preserve any appeal rights they may have.

Readmissions Reduction Program appeals

For the Hospital Readmissions Reduction Program, CMS will also provide hospitals with a period of 30 days to review and submit corrections on information used to calculate their excess readmission ratios. This 30-day period begins the day a hospital receives its confidential Hospital-Specific Reports (HSRs) and the accompanying discharge-level information is posted to its QualityNet accounts. For FY 2013, the 30-day review period was from June 20, 2012, to July 19, 2012. As with VBP, participation in the review and correction process is necessary before an appeal can be submitted.

Current reimbursement policy

Compliance officers should keep abreast of changes in the reimbursement policies. In addition to the newly developed programs, the IPPS and OPPS final rules also made changes to existing reimbursement policies, including the rules governing patient status, the 3-day payment window, and site-of-service differentials. We anticipate that similar policy changes will continue to occur in future years. As such, hospitals must monitor such changes to adjust compliance programs in a timely manner.

Patient status

CMS continues to focus on patient status and how to define inpatient, outpatient, and observation for purposes of Medicare reimbursement. In the FY 2013 OPPS proposed rule, CMS solicited comments from the industry on this issue. Although CMS did not establish a new policy in the final rule, it weighed the industry comments and outlined several options for providing clarity and building consensus regarding this issue, including:

- Continuing the focus on the Medicare Parts A/B re-billing demonstration project, which permits hospitals to rebill Medicare and to receive 90% of the allowable Part B payment where a Part A inpatient stay is subsequently denied for lack of medical necessity, but would qualify for Part B payment as an outpatient procedure. Currently CMS does not permit such re-billing;
- Clarifying admission instructions, including clinical criteria;
- Implementing a prior authorization requirement for admissions, with certain limitations including an exception for emergency care;
- Implementing time-based criteria for inpatient admissions (e.g., patients monitored for more than 24 hours as outpatients under observation are automatically admitted); and,
- Developing a short-stay DRG payment mechanism, which would align payment for short inpatient stays and outpatient stays.

Compliance officers should continue to pay close attention to this issue, as we anticipate CMS will provide additional guidance in future years.

MedPAC recommendation: Eliminate site of service differential

The FY 2013 OPPS final rule highlighted a March 2012 report from the Medicare Payment Advisory Commission (MedPAC), which recommended that Congress enact legislation to reduce payments for evaluation and management (E&M) office visits furnished in a hospital outpatient department to the rate paid for such services in a physician's office. This proposal, while not yet implemented, could have significant financial consequences for hospitals. It was discussed again at the most recent MedPAC meeting in November 2012, and we advise all hospitals to keep a close eye on the issue in 2013.

This is in line with CMS's comments in recent years. CMS has paid particular 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 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 if changes like the one described above are implemented.

Impact of 3-day payment window on hospital-owned physician practices

CMS has made significant changes to the 3-day payment window rules to implement changes imposed by Congress in 2010. 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 by a hospital or an entity wholly owned or operated by the hospital to a patient within three days prior to and including the date of admission are deemed to be inpatient services and must be bundled in the inpatient payment as part of a MS-DRG. This is commonly referred to as the 3-day payment window.

Although the 3-day payment window also applied historically to non-diagnostic (i.e. therapeutic) as well as diagnostic services, for non-diagnostic services to be bundled, they must be "related" to the admission. CMS originally 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 3-day payment window for non-diagnostic services. The Preservation of Access to Care Act of 2010 changed this policy (effective June 25, 2010) when Congress required that all non-diagnostic services provided in the 3-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. To implement this policy change, CMS now requires that hospitals to add condition code 51 if they attest that a claim is unrelated. These unrelated outpatient claims then may be billed on either the Medicare Physician Fee Schedule or the Outpatient Prospective Payment System.

Patient bills typically have two components in a hospital-based setting, including provider-based clinics: the professional component and the technical component. The technical component 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 technical component, but instead are billed as professional services and are paid at a higher (non-facility) rate to account for overhead costs.

Importantly, in the CY 2012 Medicare Physician Fee Schedule final rule, CMS clarified that the 3-day payment window applies to physician practices that are solely owned or operated by the hospital, regardless of whether they are provider-based. This means that hospital owned or operated physician practices are subject to the 3-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.

…hospital owned or operated physician practices are subject to the 3-day payment window, even if they are not provider-based, and, therefore, no technical bill is generated as a result of the visit.

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, in the CY 2012 Medicare Physician Fee Schedule final rule, CMS required that professional services performed in non-provider-based settings by hospital-employed physicians now must be coded as performed in a facility. This is similar to how professional services would be billed if the practice were provider-based and the technical component was bundled. This requires hospitals to have mechanisms in place to recognize physician services performed in hospital owned or operated physician practices subject to the payment window and appropriately bill both hospital and physician claims. Additionally, a significant loss in reimbursement for hospital owned or operated physician practices can occur now that all hospital owned physician practices must bill services occurring during the 3-day payment window at the lower facility rate.

Conclusion

2013 will be a difficult year, as changing payment mechanisms in the name of value and improving outcomes will likely pose challenges for many health care providers. As such, compliance officers need to play a role in educating, monitoring, and adapting to respond to the changes brought about in 2013.

1. DHHS Agency for Healthcare Research and Quality: AHRQ Quality Indicators: Composite Measures User Guide for the Patient Safety Indicators (PSI). Version 4.2, September 2010. Available at http://www.qualityindicators.ahrq.gov
2. *See* Jordan Rau: "Medicare Revises Hospitals' Readmissions Penalties." *Kaiser Health News*, Oct. 2, 2012. Available at http://www.kaiserhealthnews.org/Stories/2012/October/03/medicare-revises-hospitals-readmissions-penalties.aspx
3. *Mikes v. Straus*, 274 F.3d 687, 703 (2d Cir. 2001).

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