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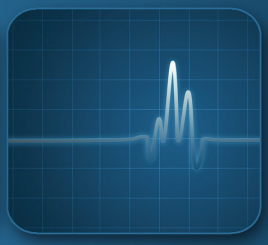


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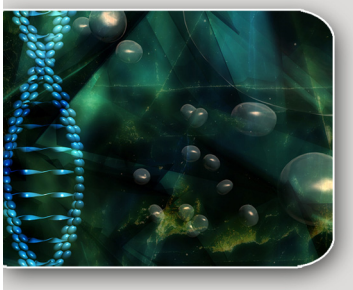

FY 2013 IPPS Final Rule Released

A Polsinelli Shughart Update

On August 1, 2012, the Centers for Medicare and Medicaid Services ("CMS") released the fiscal year (FY) 2013 Inpatient Prospective Payment System ("PPS") Final Rule (the "Rule"). The Rule contains several updates to Affordable Care Act ("ACA") programs implemented in prior rulemakings. The Rule also finalized the market basket update of 2.8% for IPPS hospitals.[1] This e-alert focuses on many of the programs meant to improve quality of care for patients. For more information on these subjects, you can access other Polsinelli Shughart Updates here.

Hospital Inpatient Quality Reporting (IQR) Program

In the Rule, CMS proposes programmatic changes to the Hospital IQR program for the FY 2015 payment determination and subsequent years. The IQR program requires that IPPS hospitals successfully report on 55 measures in FY 2012, 57 in FY 2013, 55 in FY

[1] This reflects an update of 2.6 percent for the hospital market basket adjusted by a multi-factor productivity adjustment of -0.7 percentage point and an additional -0.1 percentage point in accordance with the Affordable Care Act; this is increased by 1.0 percent for documentation and coding. [Click here to learn more.]

2014, 59 in FY 2015, and 60 in FY 2016. Providers that do not successfully report face a 2% reduction in their market basket update. For 2013, this means hospitals that fail to report will only see a 0.8% increase in their market basket.

The proposed changes are intended to reduce burdens on hospitals, create a more streamlined data set, and improve care generally through increased focus on various areas of hospital services. Notably, the Rule reduces the number of measures from 72 to 59 for the FY 2015, and 60 for the FY 2016 payment determination. More specifically, CMS removes one chart-abstracted measure and 16 claims-based measures.

Changes to the Value Based Purchasing (VBP) Program

The Rule also made a number of changes to the Value Based Purchasing ("VBP") program, which was mandated by the ACA. CMS began rulemaking to implement the VBP program in May 2011 with changes to the initial rule made in both the FY 2012 IPPS and FY 2012 OPPS rules released thereafter.

The VBP program pays hospitals based upon how well they perform on a specific set of quality measures. Additional details regarding the establishment of the VBP program and the applicable measures for FYs 2013 and 2014 may be found in previous Polsinelli Shughart Updates found here and here. Some of the notable changes made in the FY 2013 Rule include the following:

Additional Outcomes Measures for FY 2015. CMS added two additional measures to the Outcomes domain for FY 2015. The two measures are (1) PSI-90, the AHRQ Patient Safety Indicator ("PSI") composite measure, and (2) the Central Line-Associated Blood Stream Infection ("CLABSI") measure. The AHRQ PSI composite measure is a risk-adjusted comprisal of several individual PSI measures. The CLABSI measure assesses the rate of laboratory-confirmed cases of bloodstream infection or clinical sepsis among ICU patients.

Additional Efficiency Measure for FY 2015. CMS also 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 thirty days after discharge and is adjusted for age, severity of illness, geography and other payment factors. This was an expected addition, as CMS originally proposed this measure in the FY 2012 IPPS Final Rule, but later removed it in the CY 2012 OPPS Final Rule.

Case Minimums for FY 2015. CMS also established the case minimums for FY 2015. The ACA requires the Secretary to exclude hospitals that do not report a minimum number of cases per measure and a minimum number of measures per domain. 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.

For FY 2015, CMS is increasing the minimum number of cases for the three 30-day mortality measures

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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 a hospital must report on twenty-five cases for the only Efficiency domain measure (Medicare Spending per Beneficiary measure).

Scoring Methodology for FY 2015. CMS finalized the scoring methodology for FY 2015, with the addition of the efficiency measurement. These four domains will be weighted in FY 2015, as set forth below:

- Clinical Process of Care domain: 20%
- Patient Experience of Care domain: 30%
- Outcomes domain: 30%
- Efficiency domain: 20%

In prior years, CMS required that a hospital report on the minimum number of measures for each domain in order to receive a total performance score. Recognizing that increased minimums could result in the exclusion of many hospitals from the VBP program, CMS is relaxing its policy to allow hospitals that meet minimum targets for at least two domains to participate beginning in FY 2015. These hospitals will receive a proportionally re-weighted total performance score ("TPS") that is still based on 100 possible points. To illustrate, if a hospital failed to successfully report on the Efficiency domain but not the minimums in the other three domains, then the adjusted weights for each measure would be:

- Clinical Process of Care domain: 25%
- Patient Experience of Care domain: 37.50%
- Outcomes domain: 37.50%

FY 2016 Measures. CMS finalized certain Outcome measures for FY 2016. These include the three 30-day mortality measures from the FY 2014 and FY 2015 VBP programs and the AHRQ PSI composite measure. CMS also declined to reclassify the domains to reflect the six priorities of the National Quality Strategy as proposed in the FY 2013 IPPS Proposed Rule. The reclassifications would have added new domains such as: Person- and Caregiver-Centered Experience and Outcomes; Care Coordination; and Community/Population Health, to name a few. CMS indicated it may revisit this proposal in future rulemaking.

Review and Corrections Process for Claims-based Measures.

CMS also established a process through which hospitals could review and correct their claims-based measure rates, their condition-specific scores, domain-specific scores and TPS. In the FY 2013 IPPS Proposed Rule, CMS proposed to provide hospitals with confidential reports that contained 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. As part of this process, CMS would provide hospitals with a separate TPS report that would allow them to review and correct their chart-abstracted and HCAHPS data. Hospitals would have 30 days to review and submit corrections to their confidential reports and TPS reports once they are posted to QualityNet. These proposals will become effective in FY 2014.

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Appeals Process.

CMS 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 receive an adverse determination. Hospitals will have thirty days from the date they receive notice of an adverse determination to submit an appeal. Further, hospitals will be limited to the issues and determination they can appeal. Thus, it is important that hospitals implement the review and correction process on a timely basis to preserve any appeal rights they may have.

Readmissions Reduction Program

The ACA 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 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").

CMS addressed this program in a two-part rulemaking process. The FY 2012 IPPS Final Rule focused on the conditions that will apply for the first year of the program, the methodology for calculating readmission rates, and public reporting of the data, and established the following:

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.

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

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.

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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 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 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 below.

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%.

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 here. 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.

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 penalties in the future when the amount at risk increases to up to 3% of total DRG payments.

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

*Based on claims data from July 1, 2008 to June 30, 2011 for FY2013

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Expiration of Certain Payment Rules to LTCHs & Moratorium

Beginning in 2007, several statutory changes were enacted that imposed a three-year moratorium on the development of new LTCHs and LTCH satellite facilities as well as bed increases in existing LTCHs and LTCH satellite facilities. Although the ACA extended these moratoria by two years, they expire on December 29, 2012.

Through various statutory and regulatory changes starting in 2005, certain LTACHs are subject to a payment adjustment based on admissions that come from co-located or non co-located hospitals. When fully implemented, the payment adjustments apply to admissions that exceed a 25% threshold from a co-located or non co-located hospital. In the Rule, CMS extends the existing delay on the full implementation of the 25-percent payment adjustment threshold for an additional year[2], based on results from an ongoing research initiative indicating the policy may soon be unnecessary.

Hospital Acquired Condition Program

CMS also made changes to the Hospital-Acquired Condition (HAC) program. 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 Iatrogenic Pneumothorax 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 Rule. The new condition will apply to discharges occurring on or after October 1, 2012.

CMS also added another procedure to the Surgical Site Infection HAC. As of FY 2013, Surgical Site Infection (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.

[2] Please note that some LTACHs may be subject to the threshold rule for a short period of time in 2012 depending on when their cost-reporting period begins.

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For More Information

Hospitals should continue to monitor guidance on these changes, and begin developing ways to address many of the value-based programs. If you have further questions about the Rule or other programs, please contact:

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