OBER | KALER
Attorneys at Law

Payment Matters®
Update on Medicare and Medicaid Payment Issues

Subscribe | Payment Group | Payment Matters Archive

May 13, 2011

www.ober.com

IN THIS ISSUE

Quality & Efficiency: Key Themes in the Fiscal Year (FY) 2012 IPPS Proposed Rule

FFY 3023 IPPS Proposed Rule Would Eliminate Hospice Data from the IME and DSH Calculations, and Would Modify the ESRD Add-On Payment Calculation

Stay Tuned for Changes to CMS 855 Enrollment Forms

New Information Technology Grant Funding Opportunity for Existing Rural Health Networks

Editors: Leslie Demaree Goldsmith and Carel T. Hedlund

CMS Capitulates, Issues Ruling Granting Quality & Efficiency: Key Themes in FY 2012 IPPS Proposed Rule

By: Sarah E. Swank and Kristin Cilento Carter

The Centers for Medicare and Medicaid Services (CMS) continued its focus to seek high quality care and reduction of costs with the fiscal year (FY) 2012 inpatient prospective payment system (IPPS) proposed rule. Below is a summary of some of the key quality proposals in the IPPS proposed rule, including (1) the Hospital Inpatient Quality Reporting (IQR) program; (2) the Hospital Value Based Purchasing (VBP) program; (3) the Hospital Readmissions Reduction Program and (4) the Hospital Acquired Conditions payment limitation.

CMS is seeking industry input on these quality initiatives to ensure compliance and success of these quality programs. Although these quality programs currently target hospital payments, these programs contemplate partnerships between hospitals and community providers and in the future may expand to other providers. Comments related to the FY 2012 IPPS Proposed Rule are due to CMS on June 20, 2011.

1. **Hospital Inpatient Quality Reporting (IQR) Program**
   a. **FY 2014 Proposed Measures**

   CMS proposes to require hospitals to report on a total of 56 measures for the FY 2014 payment determination.

   This number reflects the proposed retirement of the following 7 measures, which CMS had previously determined were "topped out" (i.e., performance on these measures is uniformly high and there is little variability between hospitals) in its proposals for the VBP program:

- AMI-1 Aspirin at arrival
- AMI-3 ACEI/ARB for left ventricular systolic dysfunction
- AMI-4 Adult smoking cessation advice/counseling
- AMI-5 Beta-blocker prescribed at discharge
- HF-4 Adult smoking cessation advice/counseling
- PN-4 Adult smoking cessation advice/counseling
- SCIP INF-6 Appropriate hair removal

In addition, CMS proposes retiring the measure, PN-5c Timing of receipt of initial antibiotic following hospital arrival, because of potential unintended consequences associated with the measure. These 8 measures would no longer be reported effective with January 1, 2012 discharges.

CMS proposes adding the following 2 healthcare acquired infection (HAI) measures, 1 chart-abstracted measure, and 1 structural measure for the FY 2014 payment determination:

- Central Line Insertion Practice Adherence (CLIP) Percentage
- Catheter Associated Urinary Tract Infection (CAUTI)
- Medicare Spending Per Beneficiary (see discussion below)
- Participation in a Systematic Clinical Database Registry for General Surgery

The first two measures would be reported through the National Healthcare Safety Network (NHSN), a secure, internet-based surveillance system maintained by the Centers for Disease Control (CDC). As explained under the discussion of the VBP proposed changes below, CMS proposes to add a measure to evaluate the Medicare Spending Per Beneficiary for hospitals during an “episode” of care utilizing claims data. For the FY 2014 payment determination, CMS proposes reviewing claims associated with discharges occurring between May 15, 2012 and February 14, 2013.

b. **Proposed Measures for FY 2015 and Future Years**

For the FY 2015 payment update, CMS proposes to retain all of the measures required for the FY 2014 payment update and to add 17 additional measures, for a total of 73 measures. Included within the additional measures are three HAI proposed measures: (i) Methicillin-resistant Staphylococcus Aureus (MRSA) Bacteremia measure; (ii) C. Difficile SIR; and (iii) Healthcare Personnel (HCP) Influenza Vaccination. In addition, CMS proposes two sets of chart-abstracted measures relating to conditions of significant relevance to the Medicare population: (i) 8 proposed stroke measures and (ii) 6 proposed venous thromoboembolism (VTE) measures.

Recognizing the need to reduce the administrative burden on hospitals, CMS states that it anticipates that as EHR technology evolves, CMS and hospitals will be able to switch to complete EHR-based reporting of all chart-abstracted measures under the Hospital IQR program. CMS seeks comments as to whether establishing a future date for the completion of this transition, such as 2015, would be appropriate.

c. **Other Proposed Changes**

Data Submission Deadlines. For the FY 2014 payment determination, CMS is proposing to shorten the quarterly submission deadline for chart-abstracted measures from 4.5 months to 104 days after the last discharge date in a calendar quarter. CMS likewise seeks to reduce the deadline for submission of aggregate inpatient population and sample size counts from 4 months to 3 months. CMS states that the purpose of the deadline period reductions would be for CMS to allow for a correction period, which CMS states it will propose in future rulemaking.

Ober|Kaler's Comments: Assuming CMS follows through on its promise to propose a correction period, this is potentially good news for providers who are not currently given any opportunity to correct incomplete or erroneous submissions after the deadlines.

HCAHPS Requirements. CMS underscores the importance that hospitals ensure compliance with HCAHPS survey and administration protocols noting that the HCAHPS patient survey data will be a significant component of the VBP program that will effective hospital payment. CMS seeks comments on whether it should require that all hospitals, with the exception of non-subsection (d) hospitals, utilize a neutral third-party vendor to administer the survey to ensure reliable results.

Proposed Changes to Validation Requirements. CMS is proposing to shorten the time period for hospitals selected for the validation process to submit medical records to the CDAC contractor from 45 to 30 days to reduce the time to complete validation. Hospitals that fail validation requirements under the Hospital IQR program are excluded from receiving incentive payments under the hospital VBP program.

Serious Reportable Events. Seeking to improve patient care by providing Quality Improvement Organization's (QIO) with more rapid access to provider information following the occurrence of "serious reportable events," CMS is proposing to revise its regulations to require hospitals to submit medical information to the QIO within 21 days of a "serious reportable event" or other circumstance identified during the course of QIO review. "Serious reportable events" include such things as surgery performed on the wrong body part, patient deaths associated with the use of contaminated drugs, devices or biologics provided by a health care facility, or unintended retention of a foreign object in a patient after surgery or other procedure. CMS seeks public comment on this proposal, which CMS believes would enable QIOs to better respond to adverse events through the quality reporting program.

Proposed Changes to Appeals Process. Significantly, CMS is proposing to shorten the time period for the request for reconsideration in connection with the Hospital IQR program effective, with the FY 2012 payment determination, to 30 days from the date of receipt of the payment determination notification. CMS also will require hospitals to submit all supporting documentation and evidence for reconsideration at the time that the hospital submits the request, including all copies of any communications, such as emails that the hospital believes demonstrate compliance with program requirements and paper medical records where the hospital is contesting validation results.

2. **Hospital Value-Based Purchasing Program**

Citing its intention to transform Medicare from a system that rewards volume of service to one that rewards efficient and effective care, CMS proposes to include a measure to evaluate Medicare spending per beneficiary under both the Hospital IQR program and VBP program. Under the proposal, CMS would use claims data to measure the Medicare spending for each beneficiary discharge during an "episode." CMS is proposing to define an "episode" as the period from 3 days prior to an inpatient PPS hospital admission through 90 days post hospital discharge. CMS will evaluate all Medicare Part A and Part B payments (including beneficiary cost sharing amounts) made during a beneficiary episode to determine the spending during that episode of care. CMS states that it has proposed 90 days post-discharge in order to emphasize the importance of care transitions and care coordination in improving care, but seeks comments as to whether this time period should be shortened to, for example, 30 days.

In evaluating the Medicare payments made during an episode, CMS states that it will adjust the amounts to account for age and severity of illness, but will not take into account any geographic payment rate differences in order to standardize the spending per beneficiary. CMS will calculate a hospital's total Medicare spending per beneficiary amount by adding all the adjusted Medicare Part A and Part B payments for discharges during the relevant time period, and

dividing such amount by the total number of beneficiary episodes. In addition, CMS will calculate a hospital's Medicare Spending per Beneficiary Ratio which will compare the hospital's determination with the median Medicare spending per beneficiary across all hospitals.

CMS proposes that it will use claims data for hospital discharges occurring between May 15, 2012 and February 14, 2013, for purposes of determining a hospital's Medicare Spending per Beneficiary for the FY 2014 Hospital IQR program. This same time period will be utilized as the "performance period" for purposes of payment determination under the VBP program.

Under the VBP program, CMS proposes that it will calculate an "achievement score" of 0 to 10 points for each hospital by comparing the hospital's Medicare spending per beneficiary ratio with an achievement threshold, which will be set at the median Medicare spending per beneficiary ratio across all hospitals during the performance period, and an achievement benchmark, which will be the mean of the lowest decile of Medicare spending per beneficiary ratios during the performance period. Hospitals will also have an opportunity to score improvement points based on reduction in their Medicare Spending Per Beneficiary Ratio during the performance period as compared with a baseline period of May 15, 2010 through February 14, 2011.

CMS proposes to create a new "Efficiency" domain under the VBP program, which will at first include only the measure for Medicare spending per beneficiary. CMS has not yet determined how much weight the Efficiency domain will receive in determining a hospital's overall performance, which it intends to propose in the CY 2012 Hospital Outpatient Prospective Payment System proposed rule.

> *Ober|Kaler's Comments:* The addition of the Medicare Spending per Beneficiary measure seems to follow the natural evolution of CMS's continued focus on how it can reduce Medicare expenditures; however, it represents the first time that CMS proposes to explicitly measure costs under the Hospital IQR and

VBP programs. CMS seeks comments on these proposals, and hospitals should consider how their anticipated costs per beneficiary compare with other hospitals nationally. Moreover, in commenting, hospitals should consider that this measure not only focuses on their own costs in providing care to beneficiaries, but will also look at all Medicare Part A and Part B costs associated with care post-discharge, including physician follow-up visits and long-term care costs.

Finally, CMS issued the Final Rule for the Hospital Value-Based Purchasing Program on May 6, 2011. The Final Rule closely mirrors the proposed rule discussed in Ober|Kaler's February 9, 2011 Article – Rewarding Quality? Not Exactly – CMS Proposes Value Based Purchasing Rule. The Final Rule can be access at the following link: www.gpo.gov/fdsys/pkg/FR-2011-05-06/pdf/2011-10568.pdf. It will be the subject of an upcoming Payment Matters article.

3. **Hospital Readmissions Reduction Program**

In addition to the proposed expansion of quality measures evaluated under the Hospital IQR and VBP programs, the FY 2012 IPPS Proposed Rule includes proposals to create a Hospital Readmissions Reduction Program effective for discharges on or after October 1, 2012, as required under the Affordable Care Act (Act). Under the program, hospitals will be subject to payment adjustments to account for excess readmissions for applicable conditions that are high volume or high expenditure in the hospital. The goal of the Hospital Readmissions Reduction Program is to improve quality outcomes of patients, while decreasing the cost of care. Often CMS sees readmissions as adverse events. This is especially true during transitions of patients between an acute setting to a non-acute setting. These are the same goals seen throughout many of CMS's quality programs.

The FY 2012 IPPS proposed rule provides for: (i) the selection of conditions for the first program year starting on October 1, 2012; (ii) the definition of "readmissions;" (iii) the proposed readmission measures and related

methodology used for those measures, as well as the calculation of the readmission rates; and (iv) public reporting of the readmission data. While the FY 2012 IPPS Proposed Rule addresses a number of key elements of the Readmission Reduction Program, CMS states that it will address a number of other key elements of the Hospital Readmission Reduction Program, such as the aggregate payments for excess readmissions and the definition of "applicable hospital," in future IPPS rulemakings, implementing the program over the next two years.

a. **Proposed Applicable Conditions**

During the first program year, CMS proposes that payment adjustments for "applicable hospitals" be based on the occurrence of readmissions associated with three "applicable conditions." The conditions are as follows:

- Acute myocardial infarction
- Heart failure
- Pneumonia

CMS believes these conditions meet the two-prong test set out in the Act for "applicable conditions": (1) the conditions are "high volume or high expenditure" and (2) the measures have been endorsed by the contract entity under the Act (currently the National Quality Forum (NQF)). With regard to the first prong, CMS note that these three conditions are among seven conditions associated with 30% of potentially preventable readmissions. CMS is seeking comments on whether these three conditions should be included in the program for FY 2013 and subsequent years.

b. **Proposed Definition of "Readmission"**

CMS is proposing to define "readmission" as the admission of an individual to the same or another applicable hospital within a 30 day time

period following discharge from an applicable hospital. This period starts once a patient is discharged from a hospital to a non-acute setting. A "readmission" would occur if, for example, a patient is discharged to another level of care such as a home health, skilled nursing or rehabilitation hospital and is readmitted within this specific period of time. CMS is seeking comments on this proposed timeframe.

c. **Proposed Readmission Measures and Related Methodology**

CMS is adopting wholesale the underlying methodology of NQF as it relates to the 30-day time frame, risk-adjustment methodology and exclusions for the three readmissions measures. CMS expressed concerns that it cannot modify these measurements, as any modification may be seen as not adopting an "endorsed measure" under the Act. The Act requires that the measurements for readmission must be "endorsed by the entity with a contract under section 1890(a)," which at this time is NQF. CMS welcomes comments on the existing three measures endorsed by NQF as well as its methodology related to risk adjustment and excess readmission ratio, the later of which is related to public reporting of hospital performance.

d. **Public Reporting**

CMS proposes to publish data collected under the program on Hospital Compare, a CMS website. On Hospital Compare, each hospital will be categorized as follows:

- Better than the US national rate
- No different than the US national rate
- Worse than the US national rate

For the FY2013 Hospital Readmissions Reductions Program, CMS proposes to use three years worth of discharge dating starting from July 1, 2009 through June 30, 2011. This three year period is used to calculate

excess readmission ratios for the three proposed measures. CMS believes that this three-year timeframe allows for more precise data to distinguish hospitals apart from each other, although they will be placed into one of the three buckets mentioned above. CMS is still considering whether to use a shorter or longer data reporting periods for this program and the impact of the timeframe on public reporting of hospitals.

Minimum Number of Discharges. The Acts allows CMS to exclude readmissions for an applicable condition when there is "fewer than a minimum number." Under the current reporting in the IQR program, hospital must have at least 25 discharges for each of the three proposed readmission measures on Hospital Compare. At this time, CMS is proposing that the Hospital Readmissions Reduction Program also use a minimum of 25 discharges for each of the three measures for public reporting and CMS data analysis purposes. In CMS's experience, less than 25 cases caused unreliable data on hospital performance, but CMS invites public comments on the appropriate minimum number of hospital discharges for purposes of the three proposed readmission measures.

Process for Reporting Data Mistakes. Under the IPPS proposed rule, CMS also seeks comments related to its proposal to allow a hospital to preview its readmission rates on Hospital Compare 30 days before being made public. If a hospital were to find a mistake in its data, it would submit the mistake to CMS for correction in advance of it being made public. CMS states that it will "carefully review all such correction submissions and determine the appropriateness of any revision."

> *Ober|Kaler's Comments:* What is not clear is the timeframe from when a correction is submitted to CMS until it is corrected on the public website. In the meantime, it appears that the mistaken information will be made public and will later be corrected. Also, it is unclear what form the correction will take - a change on the public reporting without comment or a change that may be highlighted or noted?

e. *All Patient Data Submission.* Finally, at this time, CMS will not address the scope of patients that will be included in data submissions and postings on Hospital Compare. The Act requires that an "applicable hospital" submit readmission rate data on "all patients." The Act goes on to define "all patients" as patients cared for on an inpatient basis and later discharged from a specific hospital. CMS is not proposing any specific policies related to the definition of "all patients" but is welcoming any suggestions related to the issue such as:

- data collection,
- identifiers that allow tracking of patients across multiply care settings,
- what other entities report data on behalf of hospitals, and
- any general comments on all patient date submission.

Ober|Kaler's Comments: Hospitals should take this opportunity to provide CMS with real world suggestions to ensure that the data reporting process runs smoothly and that this statutory mandated "all patients" requirement is not too onerous.

4. **Hospital Acquired Conditions**

Effective with discharges occurring on or after October 1, 2008, CMS no longer provides additional reimbursement for the higher costs of care associated with "hospital acquired conditions" (HAC), which are specified conditions that were not present on admission. In the FY 2012 IPPS Proposed Rule, CMS proposes to add one condition to the existing list of HACs: contrasted-induced acute kidney injury. This condition is a complication association with the use of iodinate contrast media that accounts for a large number of cases of hospital-acquired kidney injury. CMS seeks comments regarding the adoption of this condition, including whether adding this condition meets the statutory requirements that the condition: (a) is high cost, high volume, or both; (b) is assigned to a higher paying MS-DRG when present as a secondary diagnosis

and (c) could reasonably have been prevented through the application of evidence-based guidelines. CMS has placed specific emphasis on whether the health care industry finds there are evidenced- based guidelines for prevention of this condition.

In addition, CMS proposes to add new diagnosis codes to already existing HACs. These new codes are proposed to be subject to the HAC payment provision for FY2012. The codes are broken down as follows:

- 2 new codes for the falls and trauma,
- 2 new codes for the surgical site infection following certain bariatric procedures, and
- 1 new code for the deep vein thrombosis and pulmonary embolism.

Ober|Kaler's Comments

As expressed through the various proposals above, and in CMS's other programs, such as the Medicare Shared Savings Program and HITECH Meaningful Use standards, hospital quality reporting and improvement has become increasingly important and integral to reimbursement under the Medicare program. To continue to meet the demands of these quality programs, hospitals will undoubtedly be required to adopt, maintain and upgrade their electronic health records systems and focus significant resources on point of care quality initiatives. CMS ultimately envisions a uniform set of reporting requirements but is not seeking public comments at this time under the proposed IPPS rule since these comments are more appropriate under the HITECH.

In preparation for implementation of the Hospital Readmission Reduction program and Hospital VBP program, hospitals should begin to consider partnering with other providers who care for Medicare beneficiaries after hospital stays, such as primary physicians, specialists and long term care providers. Those providers are in the best position to assist hospitals by promoting health education, establishing care plans and ensuring compliance with discharge instructions to reduce readmissions and Medicare spending per beneficiary. This type of partnership, either in the form of an affiliation or ownership, will be key to meeting the increasingly targeted

quality goals under the Act and meeting the needs of beneficiaries for coordination of care after leaving the acute care setting.