# MEDICARE READMISSIONS SUMMIT

## *Emerging Legal Issues*


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**June 2, 2009**

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DEFINING SUCCESS TOGETHER

# CMS' INCREASING FOCUS ON QUALITY OF CARE, OUTCOMES AND APPROPRIATE SETTING

- IMPROVEMENT OF QUALITY OF CARE
- PUBLIC REPORTING
- PAYMENT ISSUES

  IMPACT ON ANNUAL PAYMENT UPDATE TO ADJUST IPPS PAYMENT

  *versus*

  PAYMENT DENIALS FOR INDIVIDUAL READMISSIONS

# SOME RECENT CMS ACTIONS INVOLVING READMISSIONS

- RHQDAPU MEASURES ADDITIONS
- MEDICARE READMISSIONS PROJECT
- MEDICARE CONDITIONS OF PARTICIPATION REVISIONS
- OIG ACTIVITY AND EXPECTATIONS

# PUBLIC REPORTING

FINANCIAL INCENTIVES TO REPORT QUALITY

- MEDICARE MODERNIZATION ACT OF 2003:
  - CHANGED THE MANNER FOR REFLECTING THE CHANGE IN THE HOSPITAL MARKET BASKET IN IPPS PAYMENTS
  - TIES PAYMENT UPDATES TO QUALITY BY PROVIDING A FINANCIAL INCENTIVE TO HOSPITALS TO REPORT ON QUALITY TO OBTAIN THE ANNUAL PAYMENT UPDATE (APU) THROUGH REPORTING HOSPITAL QUALITY DATA FOR ANNUAL PAYMENT UPDATE (RHQDAPU) INITIATIVE
  - DEFICIT REDUCTION ACT OF 2005: ALSO PROVIDED FINANCIAL INCENTIVES TO HOSPITALS PARTICIPATING IN MEDICARE'S HOSPITAL QUALITY ALLIANCE

# PUBLIC REPORTING

- ORIGINALLY HOSPITALS SUBMITTED DATA ON 10 QUALITY MEASURES FOR ACUTE MI, HF, AND PNEUMONIA
- PROPOSED FY 2010 IPPS: QUALITY MEASURES EXPANDED FROM 30 TO 44
  - CMS CLAIMS THESE MEASURES ASSESS :
    * QUALITY OF CARE
    * EFFICIENCY OF CARE
    * PROMOTE COORDINATION OF CARE AMONG HOSPITALS AND OTHER PROVIDERS

# PUBLIC REPORTING

- THREE READMISSION MEASURES ADDED:
  1. READ-30-HF: HEART FAILURE 30-DAY RISK STANDARDIZED READMISSION MEASURE (MEDICARE PATIENTS)
  2. READ-30-AMI: ACUTE MYOCARDIAL INFACTION 30-DAY RISK STANDARDIZED READMISSION MEASURE (MEDICARE PATIENTS)
  3. READ-30-PN: PNEUMONIA 30-DAY RISK STANDARDIZED READMISSION MEASURE (MEDICARE PATIENTS)
- CMS SAID IN FINAL FY 2009 IPPS RULEMAKING THAT ALL MEASURES FINALIZED FOR FY 2010 WOULD BE NQF ENDORSED
- NQF HAS NOW ENDORSED ALL THREE READMISSION MEASURES

# PUBLIC REPORTING

- RESPONSIVE TO MedPAC CALL TO DEVELOP READMISSION MEASURES WITH HF AS A PRIORITY

- CMS: HEART FAILURE READMISSION MEASURE IS CMS' FIRST EFFICIENCY OUTCOME MEASURE

# PUBLIC REPORTING

LOOKS AT “ALL CAUSE” ADMISSIONS WITH THE INDEX HF BECAUSE:

- READMISSION FROM ANY CAUSE IS AN “ADVERSE EVENT” TO THE PATIENT
- MEASURES SHOULD NOT CREATE INCENTIVES TO GAME THE REPORTING OF THE HF BY CODING HF ADMISSIONS WITH A DIFFERENT DIAGNOSIS
- HARD TO EXCLUDE QUALITY AND ACCOUNTABILITY ISSUES BASED ON THE DOCUMENTED CAUSE OF THE READMISSIONS

# PUBLIC REPORTING

NO DATA SUBMISSION TO THE QIO CLINICAL WAREHOUSE IS REQUIRED

- CALCULATIONS WILL BE BASED ON EXISTING MEDICARE FEE-FOR SERVICES-CLAIMS DATA ALREADY IN CMS' POSSESSION
- REDUCES SUBMISSION ISSUES THAT RESULTED IN ALL OR NOTHING DENIALS OF TOTAL APU FOR PRIOR FYs
  - SOME HOSPITALS WERE DENIED TOTAL APU BASED ON FAILURE TO SUBMIT 1-2 CASES

# PAYMENTS

- RHQDAPU:
  - CMS SAYS ELIGIBILITY FOR APU NOT YET BASED ON PERFORMANCE ON THESE MEASURES
  - BUT MUST ALLOW PUBLIC REPORTING

*versus*

- PAYMENT DENIAL OF INDIVIDUAL CLAIM BASED ON QUALITY OF CARE FACTORS

# PAYMENTS

CMS IS ALREADY CONSIDERING THE IMPACT OF OTHER QUALITY OF CARE FACTORS ON PAYMENTS

- PREVENTABLE HEALTHCARE ASSOCIATED CONDITIONS (HACs) IN HOSPITALS AND OTHER HEALTHCARE SETTINGS
  - CMS FLOATING NOTION THAT IT WILL NOT PAY FOR PREVENTABLE HACs
  - SOME COMMENTERS NOTED THAT SUCH PAYMENT INCENTIVES MIGHT PROMOTE THE REDUCTION OF AVOIDABLE READMISSIONS
- NEVER EVENTS

# PAYMENTS

READMISSIONS ALREADY SUBJECT TO DENIAL OR COMBINATION WITH PRIOR ADMISSION FOR PAYMENT PURPOSES

- SAME DAY READMISSIONS
  - REQUIRED TO COMBINE THE ADMISSIONS IF RELATED TO THE PRIOR STAY'S MEDICAL CONDITION AND USE A SPECIFIC CODE
  - HOSPITAL IS RESPONSIBLE FOR SERVICES RENDERED BY OTHER PROVIDERS DURING A COMBINED STAY.
    - CMS Pub. 100-04 (Medicare Claims Processing Manual), Section 40.2.5
- 30-DAY READMISSIONS

# PAYMENTS: 30-DAY READMISSIONS

- QIO: HAD THE AUTHORITY TO REVIEW AND DENY READMISSIONS OR THE PRECEDING ADMISSION NO MATTER HOW MANY DAYS HAD ELAPSED SINCE THE PATIENT'S DISCHARGE
    - QIOs WERE RESPONSIBLE FOR POST PAYMENT UTILIZATION REVIEW AND MEDICAL REVIEW OF INPATIENT FEE-FOR-SERVICE PAYMENTS (HOSPITAL PAYMENT MONITORING PROGRAM)
    - UNDER THE 8TH SOW, QIOs WERE TO AUTOMATICALLY REVIEW HOSPITAL READMISSIONS WITHIN 30 DAYS.

# PAYMENTS: 30-DAY READMISSIONS

- AS OF 8/01/08: TRANSITION FROM QIO:
  - HPMP TO MACs, FIs, AND CERT
  - RACs?
    - RACs NOT TO REVIEW CLAIMS ALREADY REVIEWED BY OTHER MEDICARE CONTRACTORS
    - RACs WERE PERMITTED TO REVIEW "SAME DAY" READMISSIONS EVEN IF QIO INITIATED SAME DAY STAY PROJECT
    - RACs MAY BE ABLE TO REVIEW 30-DAY READMISSIONS IF CMS APPROVES AS A NEW ISSUE?
      - NOT SAME CODING ISSUE AS SAME DAY READMISSION
    - RACs PAID ON CONTINGENCY FEE BASIS

# PAYMENTS: PROPOSED BUDGET

- HOSPITALS WITH HIGH RATES OF READMISSION WOULD BE PAID LESS IF CERTAIN PATIENTS ARE READMITTED TO A HOSPITAL WITHIN 30 DAYS

- PAYMENTS TO HOSPITALS WOULD BE BUNDLED TO COVER BOTH INPATIENT CARE AND POST-ACUTE CARE FOR THE 30 DAYS FOLLOWING HOSPITALIZATION

# COMPLIANCE ISSUES

- MEDICAL REVIEWS OF READMISSIONS USE SAME PROCEDURES USED FOR REVIEWING THE APPROPRIATENESS OF ANY OTHER ACUTE OR LTCH CLAIMS. CMS Pub. 100-08 (MEDICARE PROGRAM INTEGRITY MANUAL), SECTION 6.5.7
  - DENY
    - IF MEDICALLY UNNECESSARY
    - IF IT RESULTED FROM A PREMATURE DISCHARGE FORM THE SAME HOSPITAL
    - IF IT WAS A RESULT OF CIRCUMVENTION OF PPS BY THE SAME HOSPITAL

# COMPLIANCE ISSUES

- FIs/MACs TO REFER QUALITY ISSUES
  - CIRCUMVENTION OF PPS:
    - IF THE ACTION RESULTED IN UNNECESSARY ADMISSIONS, PREMATURE DISCHARGES AND READMISSIONS, REFER TO QIO OR BENEFIT INTEGRITY CONTRACTOR. SSA 1886(f)(2), 42 CFR 476.71; CMS Pub. 100-08, SECTION 6.5.9, CMS 100-10, SECTION 4255
    - IF DISCHARGE IS FOUND TO BE PREMATURE, EITHER OR BOTH CLAIMS MAY BE DENIED. CMS Pub. 100-10 (QIO MANUAL), SECTION 4240

# COMPLIANCE ISSUES

- CIRCUMVENTION OF PPS
  - CMS 100-10, SECTION 4255: IF PROVIDER IS FOUND TO HAVE TAKEN ACTION WITH THE INTENT OF CIRCUMVENTING PPS AND THAT ACTION RESULTED IN INAPPROPRIATE MEDICAL OR OTHER PRACTICES REGARDING BENEFICIARIES OR BILLING, MAY ALSO REQUIRE CORRECTIVE ACTION.
    - LIST OF PROHIBITED ACTIONS THAT CIRCUMVENT PPS INCLUDES READMISSIONS FOR CARE THAT COULD HAVE BEEN PROVIDED DURING THE FIRST ADMISSION

# COMPLIANCE ISSUES

- FAILURE TO SUBSTANTIALLY COMPLY WITH CORRECTIVE ACTION MAY RESULT IN:
  - TERMINATION OF PROVIDER AGREEMENT PROVIDER
  - EXCLUSION FROM MEDICARE AND ANY STATE HEALTH CARE PROGRAM
- CMS RECOGNIZES THAT A PROVIDER IS GENERALLY ENTITLED TO A HEARING AND JUDICIAL REVIEW OF DENIAL
- CMS CLAIMS THAT LIMITATION OF LIABILITY PROVISIONS NOT APPLICABLE
- BENEFICIARY NOT TO BE CHARGED FOR DENIED SERVICES

# COMPLIANCE ISSUES

- CMS SEES A DANGER OF HOSPITALS "GAMING" PPS
  - MISREPRESENTING DIAGNOSES TO AVOID CLASSIFICATION AS ONE OF THE 3 READMISSION MEASURES, SO IT IS LOOKING AT READMISSIONS FOR ALL CAUSES
- OIG WORK PLAN FY 2009: OIG TO REVIEW HOSPITALS' CONTROLS FOR ENSURING THE ACCURACY OF DATA REPORTED RELATED FOR QUALITY MEASUREMENT

# COMPLIANCE ISSUES

OIG ACTIONS AND ACTIVITIES

- OIG WORK PLANS INCREASING FOCUS ON MEDICAL NECESSITY AND QUALITY
- OIG SUPPLEMENTAL COMPLIANCE PROGRAM GUIDANCE FOR HOSPITALS: JANUARY 31, 2005
  - RISK AREAS INCLUDE
    * ADMISSIONS AND DISCHARGES
    * SUBSTANDARD CARE
    * COMPLIANCE WITH QUALITY-RELATED CONDITIONS OF PARTICIPATION AND MONITORING QUALITY OF CARE IN THE HOSPITAL

# COMPLIANCE ISSUES

- HHS/OIG/AHLA GUIDANCE FOR BOARDS ON GOVERNANCE: 2007 “CORPORATE RESPONSIBILITY & HEALTH CARE QUALITY: A RESOURCE FOR HEALTH CARE BOARDS OF DIRECTORS”
  - *PURPOSE:* TO PROMOTE DIRECTORS TO BECOME INFORMED REGARDING HEALTH CARE QUALITY REQUIREMENTS, MEASUREMENT TOOLS, AND REPORTING REQUIREMENTS AS PART OF FULFILLING THEIR FIDUCIARY DUTIES TO THEIR PROVIDER ORGANIZATION

# COMPLIANCE ISSUES

- OIG CITES MEDICALLY UNNECESSARY SERVICES AND FAILURE OF CARE/SUBSTANDARD CARE AS PREDOMINANT CRIMINAL AND CIVIL FRAUD THEORIES.
- OTHER THEORIES:
  - EXCLUSIONS BASED ON QUALITY FAILURES
    * SUBSTANTIALLY IN EXCESS OF THE PATIENT'S NEEDS
    * OF A QUALITY WHICH FAILS TO MEET PROFESSIONALLY RECOGNIZED STANDARDS OF HEALTH CARE

# COMPLIANCE ISSUES

- CIVIL MONEY PENALTIES FOR QUALITY
  - NOT MEDICALLY NECESSARY
  - PROVIDING FALSE OR MISLEADING INFORMATION THAT COULD BE EXPECTED TO LEAD TO PREMATURE DISCHARGE
  - HOSPITAL PAYMENTS TO PHYSICIANS TO REDUCE SERVICES

# COMPLIANCE ISSUES

- COMPLIANCE WITH MEDICARE CONDITIONS OF PARTICIPATION AND THEIR FOCUS ON OUTCOMES AND QUALITY OF CARE
  - 42 CFR 482.21: QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM
  - 42 CFR 482.22: MEDICAL STAFF
  - 42 CFR 482.30:  UTILIZATION REVIEW
  - 42 CFR 482.43: DISCHARGE PLANNING

# QUESTIONS?