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DEFINING SUCCESS TOGETHER

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Goals:

- Provide meaningful insurance coverage to approximately 32 million people
- Improve quality of care
- Reduce medical errors
- Create savings in federal healthcare expenditures
- “Bend” the cost curve

Areas of primary focus:

- Increased importance of primary care
- Overall care coordination among providers/institutions
  - Movement towards clinical integration among providers
  - Establishment of a “medical home”
  - Establishment of accountable care organizations
- Use and further increased use of information technology for sharing of “best practices” and achievement of quality metrics

Areas of primary focus:

- Risk-based payment to providers
  - Bundled payments
  - Shared savings
- New Payments
  - Primary care services
  - Preventive services
  - Initiatives
- New Payment Penalties
  - Quality reporting
  - Hospital acquired conditions
  - Hospital readmissions
- Value-Based Purchasing
- State experiments with payment reform

New payments

- Expanded payments for primary care services under Medicare and Medicaid
- Expanded Medicare coverage of preventive care services

New funding for payment-related initiatives

New Payment Penalties

- Preventable readmissions
- Hospital acquired conditions (“HACs”)

CMS:

- Report Quality
- Penalize unwanted readmissions
- Avoid unwanted healthcare outcomes

CMS: Looks at “all cause” admissions with the index Heart Failure, for example, because:

- Readmission from any cause in an “adverse event” to the patient
- Measures should not create incentives to game the reporting of the HF by coding HF with a different diagnosis
- Hard to exclude quality and accountability issues based on the documented cause of the readmission

PPACA Section 3025

Preventable Readmissions:

- Effective October 1, 2012, (Federal fiscal year 2013) payments for all DRGs to hospitals are reduced to account for “excess, preventable readmissions.”
- Reduction is limited to 1%, 2% and 3% in initial years.
- Defining applicable “readmissions”
  - Will be based on National Quality Forum endorsed measures
  - Will exclude readmissions unrelated to prior discharge
  - Readmissions time window to be specified by HHS Proposed Rule: 30 days
  - Initially applies only to heart attack, heart failure and pneumonia
- Limited Administrative and Judicial Review.

Quality Reporting:

- Beginning in 2014, LTCH, Rehab and Hospice entities not meeting quality reporting requirements will be penalized with 2% reductions in market basket updates
- Quality measures will be determined by HHS in 2012
- Quality measures must be endorsed by a consensus-based entity such as the National Quality Forum

Hospital Acquired Conditions – “HACs”:

- Beginning in 2015, CMS will impose a 1% penalty on all discharges for hospitals in the top quartile for hospital-acquired conditions
- “Hospital acquired conditions” are those defined at 42 U.S.C. 1395ww(d)(4)(D)(iv) and others to be identified by HHS.
- HAC penalties will apply to Medicaid hospital admissions as well.

Hospital Acquired Conditions – "HACs" (cont.):

- All hospitals will be subject to HAC penalties, except:
  - Psychiatric hospitals
  - Rehabilitation hospitals
  - Children's hospitals
  - LTCHs
  - Hospitals participating in demonstration projects
- HHS will study expansion to inpatient rehab, LTCHs, outpatient departments, SNFs, ASCs and clinics.

Patient Protection and Affordable Care Act:

- VBP Rules run on a parallel, but different, track than the Medicare Readmissions Rules
- PPACA states that “the Secretary shall establish a hospital value-based purchasing program…under which value-based incentives are made in a fiscal year to hospitals that meet the performance standards.”
- Value-based purchasing provisions do not go into effect until federal fiscal year 2013.
- However, payment adjustments will be based upon performance periods that begin on July 1, 2011.

- Covered Conditions
  - Clinical Process of care measures
  - Patient experience of care measures
- Quality Measures
- Performance Standards
- Scoring Methods
- Incentive Payment

- Final regulations were formally published in the Federal Register on May 6, 2011.
- Hospitals will receive reimbursement incentives for either achieving a baseline performance score or for achieving a specific level of improvement relative to their baseline score
- Funding is based on DRG payment withholds which began at 1% for fiscal year 2013 and ramp up to 2% by fiscal year 2017

- For a hospital that meets or exceeds the performance standards for a fiscal year, CMS will increase the base operating DRG payment amount, as determined after application of a payment adjustment for a hospital, for each discharge occurring in the fiscal year by the value-based incentive payment amount.
- Each hospital has a value-based incentive payment percentage for each fiscal year as set by CMS.
  - The value-based incentive payment percentage will be specified by the Secretary based on a hospital's performance score for the fiscal year, with a goal of ensuring that the
  - total amount of value-based incentive payments made to all hospitals in a fiscal year will equal the total amount available for such payments for such fiscal year as estimated by the Secretary.

- A single prospective price for all services needed by the patient over an episode of care
- Defined on parameters of time and services

March 31, 2011 – CMS publishes proposed regulations for the Medicare Shared Savings Program

Also released concurrently:

- Joint CMS and OIG notice with proposals for Stark, AKS and CMP waiver;
- Joint FTC and DOJ "Proposed Statement of Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Savings Program; and
- IRS notice regarding the need for guidance on participation by tax-exempt organizations in ACOs.

Quality Reporting and Performance:

- 65 quality performance metrics divided among five categories:
  - Patient experience of care
  - Care coordination
  - Patient safety
  - Preventive health
  - At-risk population/frail elderly health
- Year one: reporting only
- Year two: must meet quality metrics
- Additional measures to be developed in future years

- Health information technology (HIT)
  - At least 50% of the primary care physicians within an ACO must be “meaningful EHR users” by 2nd year
- Antitrust review
  - ACOs must perform detailed analysis of their market shares
  - If shares exceed a 50% threshold, the ACO must obtain FTC approval to participate in shared savings program
- Limited Stark, anti-kickback and CMP waivers
  - Agencies asking for additional comment on whether and how to broaden the proposed waiver in order to encourage more participation

- Foundation or other type of clinic
- Shared risk payments
- Bonuses (quality and/or cost savings)
- Joint marketing / branding
- Shared / integrated IT

- Medicare Administrative Contractors (MACs), Fiscal Intermediaries (FI)
  - Readmissions may be reviewed for appropriateness.
    - CMS Pub. 100-08 (Medicare Program Integrity Manual), Section 6.5.7
    - Readmissions are subject to medical reviews and the stays may be denied:
      - If medically unnecessary
      - If resulted from a premature discharge from the SAME hospital
      - If resulted from circumvention of PPS by the SAME hospital

MACs/FIs are to refer quality issues, including circumvention of PPS

- If the action resulted in unnecessary admissions, premature discharges and readmissions, then refer to the QIO or Benefit Integrity Contractor.
  - SSA 1886(f)(2); 42 CFR 476.71; CMS Pub. 100-08, Section 6.5.9, CMS Pub. 100-10, Section 4255
  - CMS Pub. 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, corrective action may be imposed.
    - The list of prohibited actions that circumvent PPS includes readmissions for care that could have been provided during the first admission
    - Failure to substantially comply with corrective action may result in:
      - Termination of Provider Agreement
      - Exclusion form Medicare and State Health Care Programs
- If the discharge is found to be premature, either or both claims for the stay may be denied. CMS Pub. 100-10 (QIO Manual), Section 4240

- Denial of claim for readmission or original stay
  - Claim Administrative Appeal Process and Judicial Review
- Provider Agreement Termination
  - Administrative Appeal Process and Judicial Review
- Exclusion from Medicare and State Health Care Programs
  - Administrative and Judicial Review

- Concern that diagnoses will be misrepresented to avoid classification as one of the 3 readmission measures, and thus looks at readmissions for all causes

- RACs were permitted to review “same day” readmissions

- OIG Work Plan FY 2009: OIG to review hospitals' controls for ensuring the accuracy of data reported for quality measurement
  - 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
        - 42 CFR 482.21(Governing Body)
        - 42 CFR 482.21 ? (Quality Assessment and Performance Improvement Program)
        - 42 CFR 482.22 (Medical Staff)
        - 42 CRF 482.30 (Utilization Review)
        - 42 CFR 482.43 (Discharge Planning)

- 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 about health care quality requirements, measurement tools, and reporting requirements as part of fulfilling their fiduciary duties to their provider organizations

- Not medically necessary
- Providing false or misleading information that could be expected to lead to premature discharges
- Hospital payments to physicians to reduce services

- Antitrust prohibitions
- Physician incentive prohibitions
  - SSA Section 1128A(B)(1) (CHECK CITE): CMP per patient if a hospital knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services provided with respect to Medicare or Medicaid patients who are under the direct care of the physician and CMP per patient if a physician knowingly accepts such payment..
- Physician self-referral prohibitions
- Anti-Kickback prohibitions
- Insurance laws
- Corporate practice of medicine prohibitions in some states

“Hospitals can work with their communities to lower readmission rates and improve patient care in a number of ways:

- How connected now to the provider/supplier continuum of care outside the hospital’s doors?
- Are the techniques being employed to assist in helping to manage care outside the hospital’s doors appropriate or generating risk of liability, particularly care in the patient’s home?
  - For example, mobile phone apps
    - Who bears the risk if a message is not properly handled?