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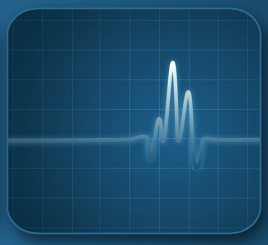


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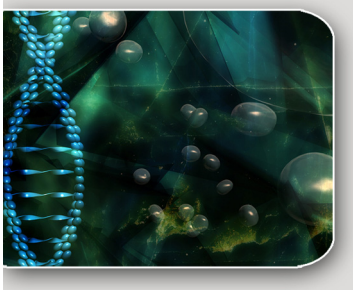

What Hospitals Should Know About Payment Changes for 2013

A Polsinelli Shughart Update

In response to the government's continued focus on improving quality of care through payment policy, several changes to new and existing regulatory requirements recently came about through the 2013 Inpatient Prospective Payment System (IPPS), Outpatient Prospective Payment System (OPPS), and the Medicare Physician Fee Schedule (MPFS) Final Rules ("Final Rules"). As a result, hospitals will be faced with new challenges in 2013 and beyond.

What Hospitals Should Do

In 2013, hospitals should pay particular attention to these requirements in the Final Rules:

- Closely monitor the IQR and OQR reporting requirements;
- Understand the development of the Value Based Purchasing program and the new measures that will apply in future years;
- Immediately focus on strategies to reduce readmission rates to avoid future penalties;
- Know the process for appealing CMS decisions related to quality-based payment programs;
- Immediately implement mechanisms to respond to changes in the 3-day payment

window and its impact on hospital-owned physician practices; and,

- Be aware of other payment policies that could change in the future.

Following is a discussion of important updates to payment programs and policies contained in the Final Rules, as every hospital should know about these changes to position themselves for success in the upcoming year.

Hospitals will be penalized for unsuccessfully reporting on quality measures.

As the foundation for several key payment reforms, the Hospital Inpatient Quality Reporting (IQR) and Hospital Outpatient Quality Reporting (OQR) programs will continue in 2013. These programs seek to improve quality of care through public reporting, and CMS publishes the data submitted by hospitals on the Hospital Compare website, located here. To incentivize participation in these reporting programs, hospitals that fail to successfully report on the requisite measures in each program will respectively face a 2% reduction in their market based update for IPPS and OPPS payments. The FY 2013 IPPS final rule confirmed that IPPS hospitals must successfully report on 57 measures in FY 2013, 55 in FY 2014, 59 in FY 2015, and 60 in FY 2016. Failing to meet this requirement will result in the 2% market basket update reduction, which translates to a 0.8% net increase in a hospital's market basket for 2013.

Hospital payments will be based on quality metrics even more in the future.

Mandated by the Patient Protection and Affordable Care Act, the Value Based Purchasing (VBP) program makes payments to a hospital based on quality of care. Starting in 2013, hospitals' DRG payments are reduced by 1% across the board, and hospitals can earn back that reduced amount, and more, by performing well on certain quality and patient satisfaction metrics. In determining the payment amount, CMS first measures a hospital's performance on quality measures across several areas, or domains, to calculate a domain score. For 2013, there are only two domains (Clinical Process of Care and Patient Satisfaction). A third domain based on Outcomes will be added in 2014, and the final fourth domain to address Efficiencies will be added in 2015. CMS scores a hospital for each measure in each domain based on its achievement relative to all other hospitals nationally and its improvement relative to the hospital's own baseline performance. CMS adds the scores for all the measures in each domain, and the higher of the achievement score or improvement score in each domain. Finally CMS weights each domain to calculate a total performance score (TPS), which is the ultimate basis for determining a hospital's incentive payment. For FY 2014, there are three domains; the Clinical Process of Care, Patient Satisfaction, and Outcomes domains. CMS will begin to measure the fourth and newest domain in FY 2015, the Efficiency domain, the FY 2013, and the final rule established a weighting scheme for all four domains for FY 2015. The final rule also indicated that CMS will provide a TPS to hospitals receiving domain scores on at least 2 of the 4 domains and will re-weight the domains proportionately.

For 2014, the Outcome domain has three mortality measures (30 day mortality rates for acute myocardial

infarction, heart failure, and pneumonia). In the final rule, CMS added two more measures to this domain for FY 2015: PSI-90, a AHRQ Patient Safety Indicator measure; and, the Central Line-Associated Bloom Stream Infection measure. CMS also adopted the Medicare Spending per Beneficiary measure to the new Efficiency domain for FY 2015. This claims-base measure assesses Medicare Part A and B payments across an episode of care, a period extending from 3 days pre-admission to 30 days post-discharge. The final rule also established case minimums for both the Outcomes domain morality measures and the Efficiency domain Medicare Spending per Beneficiary measure. As a result of all of these changes to the VBP program in the 2013 Final Rules, hospitals will be held more accountable for quality performance across an increased number of measures and an increased patient population.

Excess readmissions will result in additional payment reductions.

The Medicare Hospital Inpatient Readmissions Reduction program began on October 1, 2012 and will potentially result in additional reductions in IPPS payments to acute care hospitals. Those hospitals with excessive readmissions will be at risk for Medicare payment reductions up to 1 % in FY 2013, 2% in FY 2014, and 3% in FY 2015 and beyond. To implement this program, CMS will reduce base-operating DRG payments by an "adjustment factor" based on the hospital's readmission rate during a baseline period (July1, 2008-June 30, 2011) for three 30-day risk-adjusted readmissions measures. The measures applicable for FY 2013 focus on readmissions for heart attack, heart failure, and pneumonia, but CMS intends to measure readmissions for additional conditions in the future.

The FY 2013 IPPS final rule finalized the "adjustment factor" to be the higher of either a "floor adjustment factor" or 1 minus the ratio of aggregate payments for excess readmissions and aggregate payments of all discharges. Because the "floor adjustment factor" yields the maximum reduction, hospitals with excess readmissions will see payments decline each year until 2015 when the penalty stabilizes at 3%. Due to this, hospitals should act now to curb readmissions for the conditions identified in the rule.

Revisions and appeal processes are available for CMS decisions related to quality-based payment programs.

Should CMS determine that a hospital failed to meet the fiscal year requirements for the IQR and OQR programs, the hospital may submit to CMS a written request for reconsideration no later than 30 days from the date of the IQR or OQR Program Annual Payment Update notification letter. If CMS denies this request, hospitals may then appeal to the Provider Reimbursement Review Board. For the VBP program, beginning in FY 2014, CMS will provide hospitals with TPS reports and confidential reports containing claims-based measure rate calculations and other discharge data. Based on these reports, hospitals can review and submit corrections to their condition-specific performance, domain performance, and TPS scores, provided the hospital does so within 30 days of the report's posting on QualityNet. If the hospital receives notice of an adverse determination, the hospital has 30 days to submit an administrative appeal. Similarly, for

the Hospital Readmissions Reduction Program, hospitals have 30 days from the date their Hospital-Specific Reports and discharge-level information are posted on their QualityNet accounts to review and submit corrections to information used to calculate their "Excess Readmission Ratios." If the hospital is unsuccessful, it can appeal the adverse determination. However, if it fails to ask for the corrections within the 30-day period, its ability to later appeal is lost. Thus, it is important that hospitals seek corrections on a timely basis, where indicated, to preserve its appeal options for the future.

Changes in current reimbursement policies may result in further reimbursement loss.

For over 20 years, hospitals or entities owned or operated by a hospital that provide diagnostic and "related" non-diagnostic services to a patient within 3 days of admission receive payment for those services through a bundled inpatient payment. Since 2010, unless the provider indicates otherwise, all non-diagnostic or therapeutic services provided in the 3-day window are considered "related" and, therefore, reimbursed through the inpatient payment. In the CY 2012 MPFS final rule, CMS clarified that hospital owned or operated physician practices are subject to the 3-day payment window, even if they are not provider based and would have normally generated a bill based on higher, non-facility rates. Thus, hospital-employed physicians that perform services in non-provider based settings must now code those services provided during the 3-day payment window as performed in a facility, which translates to lower reimbursement rates. This may cause hospital owned or operated physician practices to experience reimbursement losses for services performed during the 3-day payment window.

The 2013 OPPS final rule also eluded to future policy changes that could further affect reimbursement due to changes in how patient status differences are paid for and in E/M office visit payments. CMS did not finalize a new policy for defining or changing patient status in the final rule; however, it set forth various options to provide clarity and sought input on this issue. Additionally, CMS referenced a Medicare Payment Advisory Commission report recommending Congress to reduce E/M service payments provided in hospital outpatient departments to the same level that is paid in physician's offices. Although these proposals have not been finalized, hospitals should monitor them closely as they could have significant financial consequences for hospitals. ■

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For More Information

For any questions, please contact

- Janice A. Anderson | 312.873.3623 | janderson@polsinelli.com
- Randy S. Gerber | 314.889.7038 | rgerber@polsinelli.com
- Ann C. McCullough | 303.583.8202 | amccullough@polsinelli.com
- Colleen M. Faddick | 303.583.8201 | cfaddick@polsinelli.com
- Joseph T. Van Leer | 312.873.3665 | jvanleer@polsinelli.com
- Sara V. Iams | 202.626.8361 | siams@polsinelli.com

Matthew J. Murer
Practice Area Chair
Chicago
312.873.3603
mmurer@polsinelli.com

Colleen M. Faddick
Practice Area Vice-Chair
Denver
303.583.8201
cfaddick@polsinelli.com

Bruce A. Johnson
Practice Area Vice-Chair
Denver
303.583.8203
brucejohnson@polsinelli.com

Alan K. Parver
Practice Area Vice-Chair
Washington, D.C.
202.626.8306
aparver@polsinelli.com

Janice A. Anderson
Chicago
312.873.3623
janderson@polsinelli.com

Douglas K. Anning
Kansas City
816.360.4188
danning@polsinelli.com

Jane E. Arnold
St. Louis
314.622.6687
jarnold@polsinelli.com

Jack M. Beal
Kansas City
816.360.4216
jbeal@polsinelli.com

Cynthia E. Berry
Washington, D.C.
202.626.8333
ceberry@polsinelli.com

Mary Beth Blake
Kansas City
816.360.4284
mblake@polsinelli.com

Gerald W. Brenneman
Kansas City
816.360.4221
gbrenneman@polsinelli.com

Teresa A. Brooks
Washington, D.C.
202.626.8304
tbrooks@polsinelli.com

Jared O. Brooner
St. Joseph
816.364.2117
jbrooner@polsinelli.com

Anika D. Clifton
Denver
303.583.8275
aclifton@polsinelli.com

Lawrence C. Conn
Los Angeles
310.203.5336
lconn@polsinelli.com

Anne M. Cooper
Chicago
312.873.3606
acooper@polsinelli.com

Lauren P. DeSantis-Then
Washington, D.C.
202.626.8323
ldesantis@polsinelli.com

S. Jay Dobbs
St. Louis
314.552.6847
jdobbs@polsinelli.com

Thomas M. Donohoe
Denver
303.583.8257
tdonohoe@polsinelli.com

Cavan K. Doyle
Chicago
312.873.3685
cdoyle@polsinelli.com

Meredith A. Duncan
Chicago
312.873.3602
mduncan@polsinelli.com

Erin Fleming Dunlap
St. Louis
314.622.6661
edunlap@polsinelli.com

Fredric J. Entin
Chicago
312.873.3601
fentin@polsinelli.com

Jennifer L. Evans
Denver
303.583.8211
jevans@polsinelli.com

T. Jeffrey Fitzgerald
Denver
303.583.8205
jfitzgerald@polsinelli.com

Michael T. Flood
Washington, D.C.
202.626.8633
mflood@polsinelli.com

Kara M. Friedman
Chicago
312.873.3639
kfriedman@polsinelli.com

Rebecca L. Frigy
St. Louis
314.889.7013
rfrigy@polsinelli.com

Asher D. Funk
Chicago
312.873.3635
afunk@polsinelli.com

Randy S. Gerber
St. Louis
314.889.7038
rgerber@polsinelli.com

Mark H. Goran
St. Louis
314.622.6686
mgroan@polsinelli.com

Linas J. Grikis
Chicago
312.873.2946
lgrikis@polsinelli.com

Lauren Z. Groebe
Kansas City
816.572.4588
lgroebe@polsinelli.com

Brett B. Heger
Dallas
314.622.6664
bheger@polsinelli.com

Jonathan K. Henderson
Dallas
214.397.0016
jhenderson@polsinelli.com

Margaret H. Hillman
St. Louis
314.622.6663
mhillman@polsinelli.com

Jay M. Howard
Kansas City
816.360.4202
jhoward@polsinelli.com

Cullin B. Hughes
Kansas City
816.360.4121
chughes@polsinelli.com

Sara V. Iams
Washington, D.C.
202.626.8361
siams@polsinelli.com

George Jackson, III
Chicago
312.873.3657
gjackson@polsinelli.com

Lindsay R. Kessler
Chicago
312.873.2984
lkessler@polsinelli.com

Joan B. Killgore
St. Louis
314.889.7008
jkillgore@polsinelli.com

Anne. L. Kleindienst
Phoenix
602.650.2392
akleindienst@polsinelli.com

Chad K. Knight
Dallas
214.397.0017
cknight@polsinelli.com

Sara R. Kocher
St. Louis
314.889.7081
skocher@polsinelli.com

Dana M. Lach
Chicago
312.873.2993
dlach@polsinelli.com

Jason T. Lundy
Chicago
312.873.3604
jlundy@polsinelli.com

Ryan M. McAteer
Los Angeles
310.203.5368
rmcateer@polsinelli.com

Jane K. McCahill
Chicago
312.873.3607
jmccahill@polsinelli.com

Ann C. McCullough
Denver
303.583.8202
amccullough@polsinelli.com

Ryan J. Mize
Kansas City
816.572.4441
rmize@polsinelli.com

Aileen T. Murphy
Denver
303.583.8210
amurphy@polsinelli.com

Hannah L. Neshek
Chicago
312.873.3671
hneshek@polsinelli.com

Gerald A. Niederman
Denver
303.583.8204
gniederman@polsinelli.com

Edward F. Novak
Phoenix
602.650.2020
enovak@polsinelli.com

Thomas P. O'Donnell
Kansas City
816.360.4173
todonnell@polsinelli.com

Aaron E. Perry
Chicago
312.873.3683
aperry@polsinelli.com

Mitchell D. Raup
Washington, D.C.
202.626.8352
mraup@polsinelli.com

Daniel S. Reinberg
Chicago
312.873.3636
dreinberg@polsinelli.com

Donna J. Ruzicka
St. Louis
314.622.6660
druzicka@polsinelli.com

Charles P. Sheets
Chicago
312.873.3605
csheets@polsinelli.com

Kathryn M. Stalmack
Chicago
312.873.3608
kstalmack@polsinelli.com

Leah Mendelsohn Stone
Washington, D.C.
202.626.8329
lstone@polsinelli.com

Chad C. Stout
Kansas City
816.572.4479
cstout@polsinelli.com

Steven K. Stranne
Washington, D.C.
202.626.8313
sstranne@polsinelli.com

William E. Swart
Dallas
214.397.0015
bswart@polsinelli.com

Tennille A. Syrstad
Denver
312.873.3661
etremmel@polsinelli.com

Emily C. Tremmel
Chicago
303.583.8263
tysrstad@polsinelli.com

Andrew B. Turk
Phoenix
602.650.2097
abturk@polsinelli.com

Joseph T. Van Leer
Chicago
312.873.3665
jvanleer@polsinelli.com

Andrew J. Voss
St. Louis
314.622.6673
avoss@polsinelli.com

Joshua M. Weaver
Dallas
214.661.5514
jweaver@polsinelli.com

Emily Wey
Denver
303.583.8255
ewey@polsinelli.com

Mark R. Woodbury
St. Joseph
816.364.2117
mwoodbury@polsinelli.com

Janet E. Zeigler
Chicago
312.873.3679
jzeigler@polsinelli.com

Additional Health Care Professionals

Julius W. Hobson, Jr.
Washington, D.C.
202.626.8354
jhobson@polsinelli.com

Harry Sporidis
Washington, D.C.
202.626.8349
hsporidis@polsinelli.com

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