Arnall Golden Gregory LLP

Client Alert

Contact Attorneys Regarding This Matter:

Tracy M. Field
404.873.8660 - direct
404.873.8661 - fax
tracy.field@agg.com

Jessica Tobin Grozine
404.873.8690 - direct
404.873.8691 - fax
jessica.grozine@agg.com

Medicare Payment Initiatives to Promote Quality Improvement for Patient Care in Hospitals

In an effort to reduce costs and increase the quality of patient care, the Centers for Medicare & Medicaid Services ("CMS") is developing programs to promote efficiency and improve health care quality. Indeed, CMS' initiatives use financial incentives based on receiving and reporting of quality information in attempt to improve patient care. The following article provides an overview of some of the newer CMS programs involving quality improvement.

Market Basket Update Quality Measures

CMS' reporting programs have been one of the most publicized steps in the implementation of so-called value-based performance programs. For instance, under the Reporting Hospital Quality Data for Annual Payment Update Program (RHQDAPU), CMS stipulates that a hospital that does not submit performance data for certain quality measures in the form and manner specified by CMS will receive a reduction of 2% in its annual payment update. The RHQDAPU initiative was developed pursuant to Section 501(b) of the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003 and was revised with a new set of requirements pursuant to Section 5001(a) of the Deficit Reduction Act of 2005.

Importantly, as of October 1, 2008, the RHQDAPU Program requires that hospitals report on 30 inpatient measures, with hospital discharges randomly sampled and data extraction performed as one of the measures. In addition, another required measure is the Hospital Consumer Assessment of Healthcare Providers and Systems Survey (HCAHPS), a patient survey designed by the government to measure patients' perspectives of hospital care.

Some providers have reported technical difficulties in uploading data to meet CMS' deadlines for the RHQDAPU. In some instances, CMS has reportedly reduced the hospital's annual payment update by 2% for data that is only one day late, a particularly harsh outcome. In other instances, providers have reported that in reviewing inpatient measures, reviewers have disagreed with characterizations of a patient's clinical course, resulting in the facility's failure to meet the 80% reliability threshold for payment and thus not qualifying for the 2% payment.

If CMS determines that a hospital did not meet all the RHQDAPU program requirements to qualify for the 2% update, the hospital may request reconsid-

Arnall Golden Gregory LLP
Attorneys at Law
171 17th Street NW
Suite 2100
Atlanta, GA 30363-1031
404.873.8500
www.agg.com

eration and ultimately file an appeal with the Provider Reimbursement Review Board (PRRB). We understand that providers have appealed CMS denials based on "late" submission of data, to the PRRB. We also understand that CMS has ultimately settled these appeals, but only once a hearing is imminent. Thus, to avoid delays or incurring additional costs, providers should make every effort to meet filing deadlines.

As mentioned, chart abstraction and review of clinical courses are another factor in CMS' determination that a hospital qualifies for the 2% payment upgrade. If a reviewer disagress with the hospital's assessment of a patient's course, it may result in the facility not qualifying for the RHQDAPU payment. Notably, hospitals can appeal such a finding and we understand that the PRRB has heard the first appeal related to this issue. A decision from the board is expected on this issue at any time.

Importantly for providers under the RHQDAPU program, CMS makes the quality data available online at www.hospitalcompare.hhs.gov in an effort to promote transparency to patients. The website now includes patient satisfaction and pricing data. CMS plans to expand these programs beyond process of care measures to include outcome, efficiency, and experience-of-care measures. Thus, hospitals are focusing on this program to enhance quality performance for reimbursement and community relations.

Never Events

In another initiative designed to promote enhanced quality of care, CMS has announced that it will refuse to pay for "unnecessary" care. Specifically, as of October 1, 2008, Medicare will no longer pay providers for an expanding list of what it characterizes as "reasonably preventable complications" that often occur during the course of hospitalization. These hospital-acquired conditions ("HACs" or "Never Events") are those that are high cost, high volume, or both, are assigned to a higher-paying Medicare severity diagnosis related group (MS-DRG) when present as a secondary diagnosis, and, in the government's view, could reasonably have been prevented through the application of evidence-based guidelines. The current HAC conditions include the following:

- Foreign object retained after surgery
- Air embolism
- Blood incompatibility
- Pressure ulcers stages III and IV
- Falls and trauma
- Catheter-associated urinary tract infection
- Vascular catheter-associated infection
- Manifestations of poor glycemic control
- Surgical site infection following coronary artery bypass graft
- Surgical site infection following certain orthopedic procedures and bariatric surgery for obesity
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures

Notably, CMS will continue to make outlier payments for patients with costs that substantially exceed the average for the appropriate DRG, even in situations where the increased costs are associated with a HAC.

Overall, CMS' quality initiatives are designed to promote enhanced care for patients and facilitate transparency between and among providers. Although this article briefly reviews highlights of a few programs, it is clear that the payment system are becoming even more complicated with the implementation of these programs. Moreover, these quality initiatives should not be considered in a vacuum since clearly there are implications for providers' compliance and risk management programs.