Washington Healthcare News

wahcnews.com

Articles, Interviews and Statistics for the Healthcare Executive

VOLUME 5, ISSUE 7 JULY 2010

# Hospital Medicare Reimbursement: Moving to Reimbursement Based on Quality of Care

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The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care Education Affordability Reconciliation Act of 2010 (collectively "Healthcare Reform") will force a dramatic change in the Medicare payment methodology.[1] Within the next two-and-a-half years Medicare will undergo a complete transformation so that Medicare reimbursement will be based on *quality* of care delivered and not just *quantity* of care delivered. In order to compel this change in Medicare payment methodology, Healthcare Reform not only sets in place the process to establish financial rewards for hospitals that attain certain quality measures and improve from baseline measurements, but also penalizes hospitals financially for poor performance or failure to improve.

This article explores a few of the ways in which changes to Medicare reimbursement for hospitals will create winners and losers under Medicare since some hospitals will receive additional money under Medicare and others will receive less.

## A Carrot (maybe)—Hospital Value-Based Purchasing

Healthcare Reform directs the Secretary of the Department of Health and Human Services (HHS) to establish for implementation by fiscal year 2013, a hospital value-based purchasing (HVBP) program. The HVBP will establish positive incentive payments for each fiscal year for hospitals that meet or exceed the performance standards of the HVBP for that fiscal year. Since the HVBP is to be implemented for fiscal year 2013, it will apply to Medicare payments for discharges occurring on or after October 1, 2012.

The performance standards or measurements, once decided upon, must be posted on the "Hospital Compare" website maintained by HHS. No measure may be included for use in the HVBP unless it has been identified and posted on "Hospital Compare" at least 60 days before the beginning of the fiscal year.

For fiscal year 2013, HHS is directed to contain measures that include at least the following five specific conditions or procedures: (1) acute myocardial infarction; (2) heart failure; (3) pneumonia; (4) surgeries; and (5) healthcare associated infections.

For fiscal year 2014 and beyond, HHS is directed to establish performance standards taking into account factors such as: (1) practical experience with the measures involved, including whether a significant proportion of hospitals failed

to meet the performance standard during the previous performance periods; (2) historical performance standards; (3) improvement rates; and (4) the opportunity for continued improvement.

HHS is directed to develop a methodology for assessing the "total performance" for each hospital based on the performance standards established which will result in a "hospital performance score." The methodology established must ensure an "appropriate distribution" of value-based incentive payments among hospitals achieving different hospital performance scores, with hospitals achieving the highest hospital performance scores receiving the largest value-based incentive payments. Each hospital will receive as its "hospital performance score" the achievement score, which measures its ability to meet or exceed the performance standards, or its improvement score, which measures its improvement as compared to an established baseline, whichever is higher.

The starting point for Medicare payments for hospitals will be their "base DRG payment amount." Beginning in fiscal year 2013, every hospital will have its "base DRG payment amount" reduced for each fiscal year (prior to considering any value-based incentive payments awarded to the hospital) as follows:

(i) Fiscal year 2013 base DRG payment reduction, 1.0 percent;

(ii) Fiscal year 2014 base DRG payment reduction, 1.25 percent;

(iii) Fiscal year 2015 base DRG payment reduction, 1.50 percent;

(iv) Fiscal year 2016 base DRG payment reduction, 1.75 percent; and

(v) Fiscal year 2017 and beyond, base DRG payment reduction, 2.00 percent.

The reductions in Medicare payments noted above will then be used to fund the payments for the hospital value-based incentives. The total cost to Medicare for the HVBP program must be budget neutral. Therefore, the amount paid out for value-based incentives cannot exceed the amount collected by the base DRG payment reductions noted above.

The bottom line for hospitals is that their Medicare payments will be reduced automatically and they will suffer overall reductions in Medicare payments unless they can recoup these guaranteed loses through the HVBP program or some other new payment source.

**The First Stick—**
**"Excessive Readmissions"**

In addition to the financial incentives noted above, Healthcare Reform also contains financial reductions in Medicare payments as disincentives. For example, beginning in fiscal year 2013, if a hospital experiences "excessive readmissions" when compared to "expected" levels of readmissions for certain conditions, the hospital's Medicare inpatient payments will be reduced. Healthcare Reform identifies three initial conditions to evaluate for "excessive readmissions": (1) heart attack; (2) heart failure; and (3) pneumonia. The reduction in Medicare payments would be the larger of a floor adjustment factor established under the Healthcare Reform laws[2] and the "excess readmissions ratio."[3] Beginning with fiscal year 2015, HHS is instructed to expand the list of applicable conditions beyond the three noted above to include the conditions identified by the Medicare Payment Advisory Commission in its report to Congress in June of 2007 and also include "other conditions and procedures as determined appropriate by [HHS]." HHS is also instructed to make all of the readmission rate information available to the public. Hospitals will be provided with the opportunity to review and comment on their hospital-specific data prior to this information being made public.

It should be noted that this portion of the Medicare payment changes does not apply to critical access hospitals or post-acute care providers.

**The Second Stick—Payment Adjustments for "Hospital Acquired Conditions"**

Beginning in fiscal year 2015, and thereafter, hospitals in the top 25 percent of all hospitals for certain hospital acquired conditions (HAC) for the previous fiscal year will have their payments for discharges for the current fiscal year set at 99 percent of the amount of payment that would otherwise have applied to the discharges. In other words, hospitals that make it into the top 25 percent for HACs for the prior fiscal year will have their payments reduced by 1 percent in the current fiscal year.

The Inpatient Prospective Payment System (IPPS) Final Rule issued in fiscal year 2009 by CMS included 10 categories of conditions that were identified as "Hospital Acquired Conditions": (1) foreign objects retained by the patient after surgery; (2) air embolisms; (3) blood incompatibility; (4) Stage III and Stage IV pressure ulcers; (5) falls and traumas (e.g. fractures

and dislocations); (6) manifestations of poor glycemic control such as diabetic ketoacidosis; (7) catheter-associated urinary tract infections; (8) vascular catheter-associated infections; (9) surgical site infections; and (10) deep vein thrombosis (DVT)/pulmonary embolism associated with total knee replacement or hip replacement.

In addition to the 10 identified above, HACs will also include "any other condition determined appropriate by [HHS] that an individual acquires during a stay in an applicable hospital. . . ."

**Conclusion**

This article touches on only a very small portion of Healthcare Reform and its impact on Medicare payments to hospitals. There are many other incentives and disincentives included within the Healthcare Reform laws. Healthcare Reform will directly impact what Medicare pays and how hospital payments are calculated. Hospitals should begin now assessing their capabilities to meet the expected new quality standards and make the necessary adjustments to ensure full Medicare payments in the future.

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[1]The "official" name of Title III of the Patient Protection and Affordable Care Act is "Title III—Improving the Quality and Efficiency of Health Care; Subtitle A—Transforming the Health Care Delivery System; Part 1—Linking Payment to Quality Outcomes Under the Medicare Program.

[2]The floor adjustment factors are: for fiscal year 2013, 1 percent; for fiscal year 2014, 2 percent; and for fiscal year 2015 and subsequent fiscal years, 3 percent.

[3]The excess readmissions ratio is defined as 1 minus the ratio of the aggregate payments for excess readmissions and the aggregate payments for all discharges.

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