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Regulatory and Reimbursement Penalties for "No Pay" Events

The first installment of this four part HC Topics Series: Infection Control and Patient Safety in an Era of Never Events reviewed the evolution of patient safety and infection control from inception to the current industry climate and current regulations regarding mandatory public reporting and "*never events."* This second installment will discuss the regulatory framework for reimbursement penalties surrounding occurrences of preventable and never events, referred to as "*no pay*" events.

Spurred to action by the Institute of Medicine's report "*To Err is Human*," the healthcare industry's movement towards improving quality clinical care and patient safety moved from a suggestion, to a necessity, for hospitals when Congress passed the Deficit Reduction Act of 2005. Section 5001 of the Act stipulated that as of October 1, 2008, payment for certain designated *hospital acquired infections (HAI)*, or *hospital acquired conditions (HAC)* would be adjusted so as to not result in a higher payment for that diagnosis related group (DRG).[1] This regulation was passed as "*…part of an array of Medicare value-based purchasing…tools that CMS is using to promote increased quality and efficiency of care*" and "*…is transforming Medicare from a passive payer to an active purchaser of higher value health care services*."[2] The fiscal year (FY) 2009 final rules for the Hospital Inpatient Prospective Payment System published further regulations regarding HACs, namely, the designated list of conditions that would be considered "*never events*" and would result in the prohibition of billing for services related to their occurrence for all hospitals billing under the inpatient prospective payment system (IPPS).[3] Eight HACs were initially chosen: (1) foreign object retained after surgery; (2) air embolism; (3) blood incompatibility; (4) pressure ulcer stages III and IV; (5) falls resulting in trauma; (6) catheter-associated urinary tract infection; (7) vascular catheter-associated infection; and, (8) surgical site infection (SSI) for mediastinitis after coronary artery bypass graft. These conditions were chosen based on the cost associated with treatment and the volume of infections, and because they are considered to be "*reasonably preventable.*" In FY 2007, the Centers for Medicare and Medicaid Services (CMS) calculated that these conditions occurred between 24 (blood incompatibility) and 257,412 times (pressure ulcers), with an average cost of $33,894 (falls with trauma) to $299,237 (surgical site infection) per hospital stay.[4] In FY 2009, the cost of vascular catheter-associated infections to Medicare was estimated to total $38.5 million based on an independent multivariate analysis.[5] As of FY 2013, the list of HACs expanded to include an additional six conditions.[6]

The DRG payment system encourages efficiency of care by providing a fixed payment to hospitals for care of a health condition, regardless of how much equipment, time, or labor it requires to treat.[7] The advent of reimbursement reductions for HACs dovetails with enforcement of healthcare fraud and abuse prevention efforts regarding "*upcoding*" of DRGs for higher payments. To combat potential overpayment associated with inappropriate medical coding, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 established a three-year demonstration project of recovery audit contractors (RAC) to identify and recoup improper overpayments for Medicare.[8] This project resulted in recovery of over $900 million overpayments,[9] prompting establishment of a permanent recovery audit program to be implemented no later than January 1, 2010.[10] Significantly, third party and private payors have begun aligning payment programs with the CMS "*no pay*" policies for never events, though discrepancies and non-standardization in billing practices may pose challenges in uniform implementation.[11]

Similar to HAC reporting requirements and reimbursement penalties, beginning in January 2010, CMS required reporting of certain HAIs and other clinical process of care indicators to the National Healthcare Safety Network (NHSN) for public consumption, available on hospitalcompare.hhs.gov. To assure data accuracy, CMS conducts both random and targeted selection of IPPS hospitals on an annual basis for the validation of reported (and unreported) data as a part of the *Hospital Inpatient Quality Reporting (IQR)* program.[12] Eligible hospitals that choose not to participate in the IQR program, or hospitals that choose to participate but fail to fulfill the requirements of the program (i.e., receive less than 75% on a validation survey), are subject to a two percent reduction in the annual payment update (APU) provided by CMS.[13]

With the various regulatory and reimbursement measures which have been implemented by federal government agencies in recent years, monetary penalties associated with lagging quality of care have created a

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"business case" for prevention of HAIs/HACs. As evidenced by the 21 hospitals that failed to receive the full APU in FY 2013 (based on validation of data submitted in 2011),[14] and the $797.4 million in overpayments identified by RACs in FY 2011,[15] there still exist significant gaps and opportunities for improvement in quality of care and infection prevention in hospitals across the country. The reimbursement topics introduced in this installment will be expanded upon in the next installment of this series, which will further delve into details with regard to the measurement, accuracy, and implications of HAI/HAC reporting programs on hospital finances. The fourth, and final, installment in this series will discuss the impact these reporting programs have on the healthcare industry and stakeholders as a whole, and how attention to these topics will serve to guide and change the quality of healthcare delivery in the U.S. in the future.

[1] Section 5001 of the Deficit Reduction Act of 2005, Public Law 109-171 (February 8, 2006), STAT 30

[2] "Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2009 Rates; Payments for Graduate Medical Education in Certain Emergency Situations; Changes to Disclosure of Physician Ownership in Hospitals and Physician Self-Referral Rules; Updates to the Long-Term Care Prospective Payment System; Updates to Certain IPPS-Excluded Hospital; and Collection of Information Regarding Financial Relationships Between Hospitals: Final Rule", by Centers for Medicare and Medicaid Services, Federal Register, Vol. 73, No. 161 (August 19, 2008), p. 48471

[3] *Ibid*

[4] *Ibid*, Deficit Reduction Act of 2005, Public Law 109-171 (February 8, 2006), STAT 30; *Ibid*, Centers for Medicare and Medicaid Services, August 19, 2008, p. 48473-48474

[5] "Analysis Report: Estimating the Incremental Costs of Hospital-Acquired Conditions (HACs)", by Amy Kandilov, Kathleen Dalton, and Nicole Coomer, RTI International, April 18, 2012, p.40

[6] "FY 2013 Final HAC List", by Centers for Medicare and Medicaid Services, http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/FY_2013_Final_HACsCodeList.pdf (Accessed 6/15/13)

[7] Ibid, Centers for Medicare and Medicaid Services, August 19, 2008, p. 48471

[8] Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, H.R. 1 (January 7, 2003), STAT 191

[9] "Recovery Audit Program", by the Centers for Medicare and Medicaid Services, last modified May 20, 2013, http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program/# (Accessed 6/16/13)

[10] Section 302 of the Tax Relief and Health Care Act of 2006, Public Law 109-432 (December 20, 2006), STAT 2991-2992

[11] "Health Care Purchaser Toolkit: Hospital-Acquired Condition Payment Policy", by the National Business Coalition on Health, August 2009, p. 3

[12] "Data Validation Overview: Hospitals-Inpatient", by QualityNet, http://www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic%2FPage%2FQnetTier2&cid=1140537255912 (Accessed 6/16/13)

[13] "Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Long Term Care Hospital Prospective Payment System Changes and FY2011 Rates; Provider Agreements and Supplier Approvals; and Hospital Conditions of Participation for Rehabilitation and Respiratory Care Services; Medicaid Program: Accreditation for Providers of Inpatient Psychiatric Services; Final Rule", by Centers for Medicare and Medicaid Services, Federal Register, Vol. 75, No. 157 (August 16, 2010), p. 50220-50231; "APU Recipients: Hospital Inpatient Quality Reporting Program", by QualityNet, http://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier3&cid=1154977996543 (Accessed 6/16/13)

[14] "Hospitals Not Receiving Annual Payment Update (APU) – Fiscal Year 2013", by QualityNet and Centers for Medicare and Medicaid Services, September 2012, p. 1

[15] "Recovery Auditing in the Medicare and Medicaid Programs for Fiscal Year 2011", by Centers for Medicare and Medicaid Services, http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/FY2011-Report-To-Congress.pdf (Accessed 6/16/13), p. 10

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Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, serves as Chief Executive Officer of **HEALTH CAPITAL CONSULTANTS** (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

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