CMS

CMS withdraws planned limits on hospice drugs in U.S.

CMS pulled its proposed restrictions of private insurance coverage for hospice drugs under Medicare because they were blocking some terminally ill patients' access to drugs. Prior approval for coverage of anxiety drugs, laxatives, anti-nauseants and analgesics will now be required, instead of for all hospice drugs under Medicare Part D as announced in March. "Based on discussions with stakeholders, we are adjusting our rules so that beneficiaries enrolled in hospice will continue to have access to their medications," said CMS spokesman Raymond Thorn.

Source: Reuters 7/18

CMS needs to improve Recovery Audit Data Warehouse

A report from the Government Accountability Office found that the data available on the CMS's Recovery Audit Data Warehouse are not reliable and will not enable the detection and prevention of all duplicative Medicare claims reviews. The GAO called on the agency to take steps to improve post-payment reviews, including ensuring that Medicare contractors are entering all required information on the database. The report looked at four types of contractors:

1. Medicare administrator contractors, who process and pay claims
2. Zone program integrity contractors, who investigate potential fraud
3. Recovery audit contractors (RACs) who investigate improper payments not previously reviewed by other contractors, and
4. Comprehensive error rate testing contractors, who reviews claims used to annually estimate Medicare's improper payment rate.

Source: Healthcare IT News 8/11
The Centers for Medicare & Medicaid Services (CMS) has renewed Joint Commission deeming authority for the accreditation of hospitals. The designation is effective July 15, 2014, through July 15, 2020, and means that Joint Commission–accredited hospitals may request to be "deemed" as meeting Medicare and Medicaid Conditions of Participation.

Effective January 1, 2015, hospitals and critical access hospitals that are unable to identify the minimum number of core measure sets required to meet ORYX® performance measure reporting requirements for the purpose of accreditation will no longer be required to supplement their core measure set selections with the use of noncore measures.

As of July 1, 2014, The Joint Commission will import all open Plans for Improvement (PFIs) accepted during survey into the full decision report for organizations accredited under the ambulatory care, behavioral health care, critical access hospital, hospital, and nursing care center programs.

TJC has made some modifications to accreditation and certification decision reports for all surveys and reviews completed after July 1, 2014. In addition to including open Plans for Improvement, reports will include single observations of noncompliance with Category “C” elements of performance (which will continue to not require follow-up action) in a new section called Opportunities for Improvement. (Sounds a bit like Baldrige!)

For Laboratory: Note 2 to the Rationale for Standard QSA.02.04.01, which was announced in March 2014 has been removed to minimize confusion regarding Joint Commission expectations during the education-and-transition period for CMS's Individualized Quality Control Plan (IQCP).

Four of the top 10 most-cited standards in hospitals stem from Life Safety Code® deficiencies.

Source: Joint Commission Perspectives. July & August 2014
CMS made hospital quality improvement a major part of its fiscal year 2015 Inpatient Prospective Payment System (IPPS) final rule, which was released at the beginning of August. Several of the changes to the quality initiatives are mandates from the Affordable Care Act. A significant portion of the updates to the rule focus on the Hospital Value-Based Purchasing Program, the Hospital Readmissions Reduction Program, and the Hospital-Acquired Condition Reduction Program. As a result, the focus requires increased interdisciplinary collaboration between quality, health information management, revenue cycle, compliance, and technology.

Use of data is ever-increasing with these initiatives to guide quality and future decision-making. Organizations will need to establish strong data governance in the near future. The 2015 IPPS rule emphasizes that hospitals, physicians, coders, and clinical documentation integrity staff must understand the risk-adjustment methodologies inherent to value-based purchasing which directly correlates to the patient experience, regardless of the size and complexity of the hospital or system.

An additional consideration is that complex documentation requirements must be woven into the hospital’s EMR fabric in order to facilitate ease of use by providers.

**Hospital Value-Based Purchasing**
CMS finalized an increase in the applicable percent reduction to 1.5% of base operating DRG payment amounts to all participating hospitals as part of the VBP program. CMS will use that money, estimated at $1.4 billion, to make value-based incentive payments to hospitals meeting established performance standards. For FY 2017, CMS will add two new safety measures and one new clinical care-process measure, re-adopt the current version of the central line-associated blood stream infection (CLABSI), and remove six “topped-out” clinical process measures. CMS will adopt one new hospital-level risk-standardized complication rate following elective hip and knee arthroplasty measure with a 30-month performance period for FY 2019 and a 36-month performance period for FY 2020.

**HAC Reduction Program**
This group of reasonably preventable conditions that patients did not have upon admission to a hospital, but developed during the hospital stay will be monitored and CMS will reduce payment by 1% for hospitals that rank in the 25% with the highest rate of HACs.

**Hospital Readmissions Reduction Program**
CMS finalized the third increase in the Hospital Readmissions Reduction Program maximum penalty, raising it from 2% to 3%, as required by the ACA. CMS will assess hospitals’ readmission penalties using these five readmissions measures:
1. Heart attack
2. Heart failure
3. Pneumonia
4. Chronic obstructive pulmonary disease
5. Hip/knee arthroplasty

As part of the FY 2015 IPPS final rule, CMS finalized an updated method to account for planned readmissions.

**Hospital Inpatient Quality Reporting Program**
CMS is finalizing a total of 63 measures (47 required and 16 voluntary electronic clinical quality measures) in the Hospital IQR Program measure set for the FY 2017 payment determination and subsequent years.

*Source: cms.gov*