Obstacles to Improving Quality of Care and How to Overcome Them

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CMS’ Strategic Direction

- Incentivizing quality care through payment reform
- Driving quality of care through public reporting
- Enforcing quality of care through the False Claims Act
UPDATE ON PAYMENT REFORM

―awi strongly support linking provider payment to quality care as a way to make Medicare a better purchaser of health care services. Today, Medicare rewards poor quality care. That is just plain wrong and we need to address this problem.‖

Sen. Chuck Grassley,
Budget Hearing with Michael Leavitt
February 7, 2007
Building Blocks for Value Based Purchasing

- Pay for Reporting
- Pay for Performance
- Measure Resource Use
- Pay for Value (efficient resource use and quality)
- Align financial incentives
- Transparency and public reporting
- EHR, PHR and interoperability between payment and quality data

Hospitals, HHAs, SNFs, physicians and ESRD facilities are CMS priorities

The Hospital Quality Initiative

- The Hospital Quality Initiative was created in 2003 to improve quality of care through public reporting
- Hospitals are required to report on quality measures to receive their full annual payment update (RHQDAPU)
- 2% reduction in payment update in 2007 and beyond for failing to report
The Hospital Quality Initiative

- For 2010, 42 measures to be reported including:
  - Heart Attack (AMI) (removed one as of 4/09);
  - Heart Failure (HF);
  - Pneumonia (PN);
  - Surgical Care Improvement Project (SCIP);
  - Mortality;
  - Experience of Care (HCAHPs survey);
  - certain re-admission rates;
  - nursing – failure to rescue;
  - 9 AHRQ – Patient Safety & Quality Indicators;
  - participate in cardiac surgery database.

Hospital Outpatient Quality Data Reporting Program (HOP-QDRP)

- 2009 OPPS Final Rule expanded outpatient reporting requirements from the initial 7 measures to a total of 11 measures
  - Emergency Department – 5 measures
  - Surgery – 2 measures
  - Imaging – 4 measures (new)
- CMS will apply a 2% reduction in OPPS payment rates for failing to report by reducing the conversion factor used to calculate the rate.
Medicare Value Based Purchase Plan (“VBP”)  

- The Deficit Reduction Act mandated CMS to develop a “Value Based Purchasing Plan” for hospitals, and CMS issued its final report to Congress on Hospital VBP November 21, 2007  
- The VBP will build on the RHQDAPU program  
- Premier Demonstration Project supports VBP

Hospital Acquired Conditions

No Payment for Poor Quality  
- Effective October 1, 2008, hospitals will not be paid for certain “hospital acquired conditions” unless Present on Admission  
  - Object left in during surgery  
  - Air embolism  
  - Blood incompatibility  
  - Catheter associated UTI  
  - Pressure ulcers (Stage III and IV)  
  - Vascular catheter associated infection  
  - Surgical site infection following CABG, Bariatric Surgery and certain orthopedic surgery  
  - Falls and trauma  
  - Certain manifestations of poor Glycemic control  
  - DVT/PE following knee or hip replacement
Hospital Acquired Conditions

- HAC will continue to evolve and expand
- CMS is considering ways to make HAC more precise, including risk-adjusting for a condition’s prevalence and assessing rates of a condition’s occurrence over time
- CMS is also looking into expanding the policy to “Healthcare Associated Conditions” other payment settings, including outpatient hospitals, ambulatory surgery centers, physicians’ offices, home health agencies, and skilled nursing facilities
- Listening session held December 18, 2008

CMS National Coverage Determination (NCD)

- On January 15, 2009, CMS issued 3 NCDs to establish uniform national policies that will prevent Medicare from paying for certain serious, preventable errors in medical care
  - Wrong surgical or other invasive procedures performed on a patient
  - Surgical or other invasive procedures performed on the wrong body part
  - Surgical or other invasive procedures performed on the wrong patient
OIG Adverse Event Reports

- Three New Reports Issued by OIG in December, 2008 Regarding Research into “Adverse Events” in Hospitals
  - Overview of Key Issues
  - State Reporting Systems
  - Case Study of Incidence Among Medicare Beneficiaries in Two Selected Counties
- Reports Required by Tax Relief and Health Care Act of 2006

OIG Adverse Event Reports

- Significant Findings From OIG Adverse Event Reports
  - County Report suggests adverse event incidence rate much higher than previously thought
  - Reducing adverse events is a high priority for the government
  - Measuring incidence rate of adverse events is difficult and needs to be defined
  - Overall positive view of policy to deny payment of adverse events as a means to prevent them
OIG Adverse Event Reports

- Current structures not conducive to implementation of recommended practices
- Need a national reporting system and CMS may propose modification to PSO legislation to provide for mandatory national reporting
- OIG committed to undertake further analysis

Physician Quality Reporting Initiative

- PQRI is a voluntary program to provide financial incentives to “eligible professionals” who successfully report quality data to CMS
- “eligible professionals” are physicians, mid-level practitioners, occupational therapists, speech-language therapists and audiologists
- Reporting only applies to measures applicable to the services rendered to Medicare beneficiaries
- Reporting non-compliance also encouraged
2009 PQRI

- 2009 PFS Final Rule expands PQRI to include 153 measures with 7 measure groups
- Bonus equals 2% of allowed Medicare charges for services during reporting period
- Final 2009 PFS Rule signaled CMS intent to use PRQI as basis for professional VBP

2009 – E-Prescribing Incentive Program

- Combination of financial incentives and payment reductions to encourage “eligible professionals to use e-prescribing
  - 2009-2013 successful e-prescribing can earn up to 2% of allowed Medicare charges for 2009; bonus declines in subsequent years until it is eliminated in 2013
  - 2012 payment reduction of 1% imposed for failure to use e-prescribing, increasing to 2% reduction by 2014
- Coupled with EHR Demonstration, CMS’ goal is to have interoperable EHR by 2014
Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)

- The transition to a VBP program for physicians and other professionals is required by MIPPA
- By May 1, 2010, CMS is required to submit a report to Congress with recommendations for legislation and administrative action
- “One possible approach would be to have multiple parallel tracks: a track appropriate for participation by virtually all physicians and other professionals, a track focused particularly on primary care for the management of beneficiaries with multiple chronic diseases, and a track focused on medical groups and entities that link professionals and institutional providers with the scope of practice broad enough to achieve cost savings,” according to a November 26, 2008 issue paper from CMS

Measures of Physician/Provider Resource Use

- Physician and Hospital Resource Use (PHRU) Work Group will develop efficiency measures and tools
- MIPPA requires CMS to implement program to provide confidential reports to physicians on resource use
- Physician Group Practice (PGP) Demonstration – rewards physician for improving quality AND efficiency. Encourage coordination of Part A – Part B services through care management
  - P4P and sharing of cost savings
  - Year 2 – physicians earned $16.7 million in incentive payments
Alignment of Financial Incentives

- **Goal:** Breakdown “silos” of Part A and Part B
- **Acute Care Episode Demonstration Project** – testing payments for “episodes of care” and allocate between physicians and hospitals
- **Accountable Care Organizations (ACO)** – collaboratives of physicians, hospitals and other providers that will be clinically and financially accountable for healthcare delivery. Could allow for competitive bidding, shared savings and P4P
- **Gainsharing** – Stark exception, 2 demonstration projects, and OIG approval
- **OIG approves “pay for quality” model**

PUBLIC REPORTING
Public Reporting

Hospital Compare

- Consumer-oriented website to allow viewing of hospital performance on quality measures
- Contains process of care and outcome measures
- HCAHPS measures added in Spring, 2008
- Volume and price data added in Spring, 2008
- HOPQDRP data to be added by 2010
Hospital Compare: HCAHPS

Would patients recommend the hospital to friends and family?

These results are from patients who had overnight hospital stays from October 2006 through June 2007. The survey asked patients whether they would recommend the hospital to their friends and family.

Bars below tell the percent of patients who reported YES, they would definitely recommend the hospital.

- Average For All Reporting Hospitals In The United States: 67%
- Average For All Reporting Hospitals In Louisiana: 72%
- HOSPITAL A: 75%
- HOSPITAL B: 62%

Hospital Compare: Payments

<table>
<thead>
<tr>
<th>Hospital Information</th>
<th>Accredited</th>
<th>Provides Emergency Services</th>
<th>Hospital Quality Information</th>
<th>Pneumonia and Prophylaxis In Adults With Complications of Preexisting Conditions (DRG 089)</th>
<th>Average Medicare Payment to Hospital</th>
<th>Number of Medicare Patients Treated</th>
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<tbody>
<tr>
<td>Name, Address, Telephone, Type of Hospital and Distance</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>HOSPITAL A</td>
<td>Yes</td>
<td>Available</td>
<td>Not Available</td>
<td>Available</td>
<td>$6,744</td>
<td>135 Medicare Patients</td>
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<tr>
<td>HOSPITAL B</td>
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<td>Available</td>
<td>Not Available</td>
<td>Available</td>
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<td>60 Medicare Patients</td>
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<td>Available</td>
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<td>Available</td>
<td>$8,264</td>
<td>16 Medicare Patients</td>
</tr>
</tbody>
</table>

Medicare Payment Range for Hospitals in the United States for this Diagnosis Related Group $5,241 - $6,415

Total Number of Medicare Patients Treated in the United States for this Diagnosis Related Group 470,498

Medicare Payment Range for Hospitals in Louisiana for this Diagnosis Related Group $4,955 - $5,639

Total Number of Medicare Patients Treated in Louisiana for this Diagnosis Related Group 7,953
Expansion of Public Reporting

- Physician and Other Health Care Professionals Directory – posted 2007 PQRI participants
- CMS intends that 2009 PQRI will be reported publicly on “Physician and Other Health Care Professional Compare” website in 2010
- Successful e-prescribers to be included

ENFORCEMENT
Enforcement of Quality of Care

- The government uses a variety of legal theories under the FCA to attack quality failures, but all follow the same principle: **the government will not pay for medically unnecessary or substandard care**
- Physicians, executives, and board members face *real risks* for poor quality of care

Enforcing Quality of Care Through the False Claims Act

- Six themes present in cases:
  - Unnecessary treatment/procedures
  - Kickbacks
  - Big admitters receiving special treatment
  - Fraudulent documentation
  - Poorly structured, or failure to follow, internal process
  - Underlying regulatory violations
Driving Quality of Care Through Public Reporting

Data Mining

- Defined:
  - Data mining is a technology that facilitates the ability to sort through masses of information through database exploration, extract specific information in accordance with defined criteria, and then identify patterns of interest to its user.

- Goals
  - Correct inappropriate behavior
  - Identify overpayments
  - Deny payment

OIG 2009 Work Plan

- 2 Initiatives focused on quality of care
  - Reliability of quality reporting
  - Serious medical error

- Commitment to investigate health care fraud related to quality of care, i.e. billing for unnecessary services or for substandard care (“failure of care”)

- ROI – for 2008, recovered $17 for each $1 invested
Enforcing Quality of Care Through the False Claims Act

- New legal/compliance risks to consider:
  - Knowledge arising from data reporting
  - Work force encouragement to “whistleblow”
  - Processes and structures are not effective in identifying quality failures

- May lead to:
  - False Claims Act liability
  - Corporate liability
  - Liability of board members, owners and high-ranking officers

Overcoming Obstacles to Quality of Care – Get the Board on Board
Get the Board on Board

- Interviews conducted with CEOs and board chairs at 30 hospitals in 14 states
- “The level of knowledge of landmark IOM quality reports among CEOs and board chairs was remarkably low…”
- There were significant differences between the CEOs’ perception of the knowledge of board chairs and the board chairs’ self-perception
- “We are beginning to look to boards to ensure fiscal integrity and CIA oversight.” Lewis Morris, September 25, 2007

Get the Board on Board

- On September 13, 2007, OIG and AHLA issued a joint publication, Corporate Responsibility and Health Care Quality: A Resource For Health Care Boards of Directors
  - Health care quality is a key component of corporate mission and a core fiduciary obligation for the board
  - Elevate quality to the same level of fiduciary obligation that financial viability and regulatory compliance currently constitute
- Government/Industry Roundtable on Hospital Board of Directors Oversight of Quality of Care held November, 2008
Get the Board on Board

The Board Must Be Informed
- Board must recognize quality/safety as a core fiduciary obligation
- Does the board know the answers to the OIG/AHLA ten questions?
- Board needs to receive regular reports (errors, outcomes)
- Increasing board education on quality – part of orientation
- Has the organization assessed its compliance risk related to quality?
- How informed is the board regarding the organization’s top quality and compliance risks?

Get the Board on Board

Improve Board Oversight
- Board and medical staff need to frame an agenda for quality – IHI campaign, Joint Commission, quality measures
- Governance responsibility for quality – measures and goals
- Does management and the Board address quality issues on a systematic basis?
- Has the organization failed to make required reports?
- Has the organization profited from ignoring poor quality, or ignoring providers of poor quality?
- Does peer review work to drive quality?
Get the Board on Board

- Recruiting one or more board members with expertise on quality
- Use of dashboards is key finding of Government/Industry Roundtable
- Is there a Silo approach to quality, peer review and compliance?
- What is the Medical Staff/Hospital relationship and does it meet the changing circumstances of today?

Overcoming Obstacles to Quality of Care – Align Physicians and Hospitals
Align Physicians and Hospitals

- Hospitals need to enlist physician support to meet quality targets and earn the pay for performance incentive payments
  - It is often difficult to enlist physician support by simply coaxing, cajoling, scolding, etc.
  - Particularly true if you do not (or cannot) employ physicians
- Physicians need to enlist hospitals to help with systems to drive quality across the continuum of care
- CMS recognizes need for ACOs to reach goals of quality and efficiencies

Align Physicians and Hospitals

- Independent medical staff structure is not conducive to drive quality under new paradigm
  BECAUSE
  - peer review/quality management is retrospective and often incident-based
  - no mechanism to standardize care processes or require evidenced based medicine
- Service Line Co-Management, Gainsharing and “Pay for Quality” are structures designed to align medical staff with hospital to achieve quality of care
Service Line Co-Management Arrangements

- The purpose of the arrangement is to recognize and appropriately reward participating medical groups/physicians for their efforts in developing, managing, and improving quality and efficiency of a hospital service line (e.g., orthopedics, cardiovascular, general surgery)

- The arrangement is contractual in nature
- There are typically two levels of payment under the contract:
  - Base fee – a fixed annual base fee that is consistent with the fair market value of the time and efforts participating physicians dedicate to the service line development, management, and oversight process
  - Bonus fee – a series of pre-determined payment amounts contingent on achievement of specified, mutually agreed, objectively measurable, program development, quality improvement and efficiency goals
Service Line Co-Management Direct Contract Model

- Payors
- Hospital
- Service Line
- Operating Committee
- Specialty Group I
- Specialty Group II
- Other Specialty Group (s)

Payors → Hospital → Operating Committee → Specialty Groups

- Designees
- Facility
- Equipment
- Staff
- Hospital licensed
- Services contract
- Allocates effort and reward between groups

OIG Advisory Opinion 08-16

- What is “Pay for Quality”?
  - New legal entity to which medical staff members can join
  - Hospital pays the entity (i.e. physician-owners) to meet quality targets. Includes a broad array of services necessary to achieve compliance
  - Pay for Performance dollars may provide funding source
  - Payments made based on achievement of targets (CMS quality indicators) set annually
  - Preamble to new proposed Stark exception recognizes benefits to be achieved through quality incentive program
OIG Advisory Opinion 08-16

What is the Rationale for New Structure?
- National mandates for safety/quality and price transparency are difficult to meet without physician/hospital collaboration
- “Carrot vs. Stick” approach
- Pay for Performance ties reimbursement to achievement of quality outcomes
- Manage legal risk arising from quality of care (liability for failing to comply with evidence based guidelines, corporate liability; false claims liability for poor quality or unnecessary care, negligent credentialing)

What are the Benefits of New Structure?
- Integrate physician and hospital clinical practice to meet safety/quality goals
- Establish structure to provide quality across the continuum
- Standardize clinical practice
- Eliminate waste and reduce cost (may include gainsharing)
- Creates a financial “win/win” for physicians and hospitals, but keeps physicians and hospitals focused on their respective core business
OIG Advisory Opinion 08-16

- How is “Pay for Quality” Structured?
  - A new legal entity is created to which all physicians who have been on the active medical staff in relevant departments for at least one year can join.
  - Each physician who joins pays an equal capital contribution to provide for the entity’s working capital.
  - The physicians joining the entity commit to practice in compliance with certain quality targets established by CMS that form the basis for pay for performance awards under contracts with private insurers (and CMS in the future when Value Based Purchasing is implemented).

- The entity contracts with the hospital to provide a variety of tasks and services to improve quality.
  - Payment to the entity is based on a percentage of pay for performance dollars earned by the hospital (up to 50%) and then distributed to the physicians on a per capita basis.
OIG Advisory Opinion 08-16

- Participating physicians are members of Medical Staff for at least one year
- Participating physicians equally capitalize Medical Staff Entity
- Quality Targets are measurers listed in CMS’ Specification Manual for Hospital Quality Measures
- Payments to Medical Staff Entity are capped at 50% of base year P4P dollars (with inflation adjuster)
- Quality targets and payments renegotiated annually
- Monitoring to protect against inappropriate reduction or limitation in patient care services
- Termination of physicians who change referral patterns (e.g., cherry pick patients) to meet targets
- Maintain records of performance
- Patients informed of Program in writing

Gainsharing

- Shared savings from identified activities to reduce costs
- OIG has approved multiple gainsharing models, all under the same structure
- CMS and OIG recognize importance of gainsharing as a component of VBP
  - demonstration projects
  - new proposed Stark exception
- Guidance available to structure a program to meet hospital/physician needs
Gainsharing Model

Identifies cost savings opportunities, sets thresholds based on national benchmarks, monitors quality of care

Independent Valuation Expert

Hospital

Department

Physician Group I
Physician Group II
Other Physicians

Implement cost savings initiatives

Shared cost savings from meeting initiatives

Cost savings initiatives may be product standardization, product substitution, “open as needed,” and others but cannot withhold or limit care