The Quality Tsunami: PQRS, Practice Guidelines, Healthcare Fraud, & Malpractice

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Speakers’ Disclaimer

- Richard E. Moses, DO, JD and D. Scott Jones, CHC do not have any financial conflicts to disclose.
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Presentation Goals

- Examine the quality reporting mandates, timeliness, and reimbursement penalties of PPACA.
- Discuss establishing compliance systems that meet and monitor these standards.
- Review the risk to compliance programs, including health care fraud, and medical malpractice/fraud.
INTRODUCTION

- The Changing Health Care System
- Quality Reporting Measures Under PPACA
- Risk to Compliance Programs
- When Quality Fails: Healthcare Fraud & Medical Malpractice
- Summary & Conclusions
THE CHANGING HEALTH CARE SYSTEM

Demands on the System

President Obama Signs PPACA
March 23, 2010
DEMANDS: Major Intersection

- Healthcare Reform Goals
  - Improve Access
  - Universal Coverage
  - Increase quality reporting to include outcomes for reimbursement
  - Increase integration of care through partnerships of physician networks & hospitals
  - Cost control & cost reduction
- Government is focused on reducing “unnecessary” medical costs
Demands on the System

- Patient Protection and Affordable Care Act (PPACA 2010) was amended by the Health Care and Education Affordability Reconciliation Act (HCERA 2012)
  - 21.3% scheduled reduction in Medicare physician pay (postponed by the Continuing Extension Act of 2010)
  - Quality and Cost Payment (Title III, §§ 3002, 3003, 3007) – Adjusts physician payments based on quality and cost through a value-based modifier, beginning January 1, 2015
  - PQRS – possible penalties for not reporting beginning in 2015 up to 2% of the prevailing fee schedule
  - Fee-for-service → value based reimbursement (“quality”)


Demands on the System

- Increase from 260.2 Million Americans with health insurance to 292.6 Million under PPACA
- 32 Million Americans may acquire new health insurance with PPACA
- U.S. physician workload expected to increase by 29% from 2005-2025
- Over 50% of physicians are health system employees

Demands on the System

- Fee-for-service → Value-based/Quality-based reimbursement system
  - Goal is to reward doctors & hospitals for improving quality of care
- Subsequent trends:
  - Outcome-based payments
  - Lower demand for hospitals
  - Increased number of insured patients
  - Improving patient experience
  - Hospital competition on outcomes and total value
  - Increased physician employment

Health Affairs October 11, 2012

QUALITY REPORTING MEASURES UNDER PPACA
**Hospital Value-Based Purchasing**

- PPACA Title III, Subtitle A: Transforming the Health Care Delivery System
  - Incentive Payments to Hospitals meeting performance standards in
    - MI, Heart Failure, Pneumonia, Surgery, Infections, Pulmonary Embolism and DVT Prophylaxis, Stroke
    - ED, Readmissions, Children’s Asthma
  - Performance Scores increase/decrease DRG payments
  - Incentives up to 2% of the Medicare FS by 2017
  - Data and Scores on Hospital Compare Internet Site
  - GAO reports October 2015 and January 2016

http://www.medicare.gov/hospitalcompare

**Hospital Acquired Conditions Payment Reductions**

- PPACA Section 3008
  - FS Payments for Hospital Acquired Conditions will equal 99% of the FS
  - The Secretary will determine a list of “hospital acquired conditions”
  - Confidential reports to hospitals tracking conditions
  - This program will be expanded to all other types of providers
  - Possible CMS reports on Hospital Compare Internet Site
  - Effective FY 2015
Long Term Care, Rehabilitation, Hospice, PPS Exempt Cancer Hospitals, SNF, HHA

- PPACA Sections 3304-3006
- Quality Reports required 2014 for all types of facilities
- CMS “Compare” Internet sites to post data
- Reduction in the “increase factor” of payments, up to 2%
- Increase Factor can = 0%, resulting in a 2% reduction

Integrated Care Demonstration Project

- PPACA Section 2704
- Project continues through December 31, 2016
- Goal: Establish bundled payments for services and providers involving an episode of care and hospitalization
- Severity of illness adjusted payment
- Data collection monitors outcome, cost, quality
- Report to Congress: December 31, 2017
Medicaid Global Payment System Demonstration Project

- 2010-2013 Demonstration Project
- Five States
- Establishes a Global Capitated Payment Model to replace the Fee for Service (FFS) system
- Safety Net Hospitals and Networks serving Medicaid beneficiaries
- Center for Medicare and Medicaid Innovation (CMI) issued full report in December 2013

Physician Compare Website

- PPACA Section 10331(a)(1)
  - PQRS Measures Reported
  - Assessment of Patient Health Outcomes
  - Assessment of continuity and coordination of care
  - Assessment of efficiency and cost
  - Assessment of patient experience
  - Assessment of safety, effectiveness, and timeliness of care
  - 2014: User Interface; reports published online
  - January 1, 2015: CMS Report to Congress
Physician Compare Website

- Website required by Affordable Care Act
  - § 10331(a)(1)
- Provides information regarding
  - Physicians enrolled in Medicare Program
  - Other eligible professionals participating in PQRS
- Information is publically displayed

www.medicare.gov/physiciancompare

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Physician Compare Website

- Site Must Include:
  - Measures collected under PQRS
  - Assessment of patient health outcomes & functional status of patients
  - Assessment of continuity & coordination of care & care transitions
  - Assessment of efficiency
  - Assessment of patient experience & patient, caregiver, & family engagement
  - Assessment of safety, effectiveness, & timeliness of care
Physician Compare Website

- CMS must allow physicians & other professionals to have reasonable opportunity to review their results before posting
  - 30 day preview period for all measurement data
- CMS will provide details of review process
  - www.cms.gov

PPACA Section 10331(a)(2): CG-CAHPS

- Clinician and Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS)
  - Patient surveys begin 2014...individual physician surveys by 2015
  - Timely care, appointments, information
  - How well doctors communicate
  - Patient ratings of doctors
  - Health promotion and education
  - Shared decision making
  - Health status/functional status as a result of care rendered
- “Certified Survey Vendor” created
PPACA Rule CMS-1600-P
Quality Reporting Measures

- Physician Quality Reporting System (PQRS) 2014:
  - 9 Measures must be reported
  - 3 from National Quality Strategy domains
  - For 50% of the entire Medicare-eligible patient population
- Effect of not reporting PQRS occurs in 2016
- Failure to report a selection of the measures = up to 2% reduction in prevailing Medicare Fee Schedule (FS)
- Qualified Clinical Data Registries created for sub-specialists dealing with specific diagnoses, conditions (§ 1848(m)(3)(E)(ii))

Value Based Modifier (VBS)

- How quality data reported under PQRS equals modification to payments under the Fee Schedule
- VBS use begins 2015; full implementation 2017
- Physician groups of 10 or more must report beginning 2016; expect all physicians to report by 2017
- Quality tier system results in FS reductions of up to 2%
- QRUR (Quality and Resource Use Reports) will report how the value based modifier will impact individual physician reimbursement, beginning 2014
National Strategy for Quality Improvement in Health Care

- PPACA Part S, Subpart I, Section 399HH(2)(B)(i-iii)
- Establishes Priorities that will:
  - Have the greatest potential for improving health outcomes, efficiency, and patient-centeredness...
  - Identify areas...that have the potential for rapid improvement in the quality and efficiency of patient care...
  - Address gaps in quality...

National Strategy for Quality Improvement

- HHS Annual Report to Congress, 2012
- “Key Measures and Long Term Goals”
  - “...reducing the harm caused in the delivery of care...reduce harm from inappropriate or unnecessary care....”
  - CDC: 5% of hospital patients acquire health care associated infections
  - 145 Health Care Acquired Conditions (HACs) occur per 1,000 admissions
  - AHRQ: Hospital Readmissions occur at a rate of 14.4%
  - Compliance Officers are now Quality Officers
RISK TO COMPLIANCE PROGRAMS:

CONNECTION BETWEEN COMPLIANCE, QUALITY OF CARE, HEALTH CARE FRAUD, & MEDICAL MALPRACTICE

INTERDISCIPLINARITY

- No one discipline can accomplish compliance
- Integration between compliance disciplines is necessary
- Interdisciplinarity uses integration to produce a cognitive advancement resulting in a positive and productive outcome

INTERDISCIPLINARITY

- PPACA INTERDISCIPLINARITY
  - Electronic Medical and Health Records
  - Quality of Care Reporting
  - Risk Management
  - Medical Error Reduction
  - Medical Error Disclosure
  - Self Disclosure of Overbilling
  - Patient–Staff–Physician Communications and Portals
  - Quality of Care Violations/Medical Malpractice
  - Physician/Medical Practice Management

INTERSECTION:
Compliance, Quality, Fraud, & Malpractice

- OIG Work Plan 2014
- PPACA & Quality
- Government Accountability Office (GAO)
  - “…beneficiaries...who receive healthcare from providers who adhere to PPACA...may receive higher quality of care...Conversely, those who receive care from providers who fail to do so may receive lower quality of care.”
INTERSECTION:
Compliance, Quality, Fraud, & Malpractice

- General Accounting Office (GAO)
  - “…it is possible that, if these (PPACA) standards and
guidelines become accepted medical practice, they could
impact the standard of care against which provider
conduct is assessed in medical malpractice litigation.”

When Quality Fails:
Enforcement, Repayment,
& Compliance
Never Events

- §5001(c) of the Deficit Reduction Act of 2005 (DRA)
  - Never events are not reimbursable by CMS
  - Hospital acquired conditions are not reimbursable
  - Implementation Timeline
    - Medicare 2008
    - Medicaid 2011
    - States July 2012

Office of Evaluations & Inspections (OEI)

- July 19, 2012
  - “…hospitals reported only 1% of (never) events. Most of the events...were not identified by internal hospital incident reporting systems.”

- Compliance Officer responsibilities
  - Monitor frequency of reports & quality of data
  - Educate staff members on reporting
  - Monitor billing for all adverse medical events

- National Academy for State Health Policy (NASHP)
  - List of never event reporting requirements
PPACA Repayment Obligation Rule

- PPACA: Provider must report & repay Medicare overpayment within 60 days after the overpayment is identified...or by the date a corresponding cost report is due
- Overpayment is identified “when the provider has actual knowledge...or acts in deliberate indifference or reckless disregard of the existence of an overpayment”
- Look back provision: providers must report any overpayment that occurred within the past 10 years

PPACA Reportable Overpayments

- Medicare payments for non-covered services
- Medicare payments in excess of allowable amount
- Errors in cost reports
- Duplicate payments
- Receipt of Medicare payment when another payer has the primary responsibility for payment
  - Medicare Secondary Payer Act (MSP)
Duties of Overpayment Contractors

- Preventing fraud
- Identifying potential fraud
- Investigating fraud allegations: beneficiaries, providers, CMS, OIG, MFCU, & corporate anti-fraud unit
- Deny or suspend payments
- Refer case to OIG for civil & criminal prosecution
- Refer providers to OIG for exclusion from program
- Recommend prospective review of claims

CONCLUSIONS & SUMMARY
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Thank You

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