Quality of Care Breakfast Briefing Series

Quality of Care and the Medical Staff

Session II
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Executive Breakfast Briefing

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Challenges to the Current Medical Staff

Industry Trends are Changing the Relationship Between Hospitals and Physicians

- Increased national focus on issues of **Patient Safety and Quality** in the health care system
- Proliferation of **Pay for Performance**
- Physicians and hospitals are plagued by **Declining Reimbursement** plus **Increasing Costs** (malpractice expenses, regulatory compliance, technology costs)

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Challenges to the Current Medical Staff

- More **price transparency** may be required due to patients paying more of their own health care expenses (can only be achieved if physician practices at the hospital are consistent)
- More **quality transparency** may be required (can only be achieved with better infrastructure and aligned incentives to address national patient safety and quality mandates)

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Challenges to the Current Medical Staff

- Increased **consolidation of hospital systems and proliferation of large medical group practices**
- Increased focus on national goals for **Information Technology** (access to records by all providers, avoid duplication, establishing best practices, streamline reporting)
- **Blurring of specialty lines/turf wars** (ex. Interventional neurology/cardiology/radiology)

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Challenges to the Current Medical Staff

- **Increasing number of hospital-based specialties**
  - Hospitalists
  - Intensivists
  - OB hospitalists
  - Peds hospitalists
- Growing number of **primarily outpatient-based specialties**, reducing opportunities to build relationships with specialists and hospital-based colleagues

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Challenges to the Current Medical Staff

- **Increased hospital dollars** flowing out to physicians
  - Pay for ED call coverage (viewed as a hospital, not a physician problem)
  - Medical Directors
  - Employment on the rise (again)
- Status Quo is fraught with **Legal Risk** (liability for failure to comply with evidence based medicine, corporate liability, false claims liability for practicing substandard care)

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Challenges to the Current Medical Staff

- **Failure of equity joint ventures** to align physician and hospital interests in improving quality of care, reducing waste in the system, and coordinating care delivered by providers outside the venture
- **Consumer Driven Health Care** and **Increased Access to Quality Data** will eventually lead to more patient choice
- **Peer Review** is ineffective in resolving quality/safety issues or in meeting government imposed mandates (for hospitals and physicians)

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Challenges to the Current Medical Staff

- Care remains **fragmented** with little ability of hospitals and physicians to coordinate care across continuum

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Legal Issues

- So, what Legal Issues affect structuring arrangements with the medical staff
  - Anti-Kickback Statute. Section 1128B(b) of the Social Security Act prohibits the knowing and willful payment of remuneration, directly or indirectly, to induce the referral of patients for federal health care program covered items or services.

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Legal Issues

  - Stark. Subject to certain exceptions, the federal physician self-referral statute, commonly known as "Stark," prohibits physicians from referring Medicare patients for "designated health services" to any entity with which the physician has a financial relationship, and prohibits the entity from billing for services provided pursuant to a prohibited referral.

    (42 U.S.C. § 1395nn).

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Legal Issues

– CMP Statute. Section 1128A(b) of the Social Security Act, enacted in 1986, permits imposition of Civil Money Penalties ("CMPs") on any hospital that "knowingly makes a payment as an inducement to reduce or limit services" to Medicare or Medicaid beneficiaries who are under physician's direct care. Physicians are also subject to CMPs for knowingly accepting such payments.

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Legal Issues

– State Laws. Many states have statutes similar to the Anti-Kickback Statute and Stark.
– Other Laws. For tax-exempt hospitals, the prohibitions on inurement and private benefit apply; also, there are risk management/malpractice liability issues; finally, antitrust/business tort issues could arise.

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Existing Options

- Existing structures that meet current legal requirements:
  - Employment – Resurgence in physician employment, particularly specialists
  - Co-management
    - Retain Physician Group to manage a service line
    - May provide incentive for meeting quality targets
  - Lease of mid-levels to physicians to manage inpatient care (improve through-put and care delivery)

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Existing Options

- Existing structures that meet current legal requirements:
  - Gainshare
  - IT Strategy
  - Ancillary Joint Ventures
  - Whole Hospital Joint Ventures

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Existing Options

- IHI has released "Engaging Physicians in Shared Quality Agenda" which advocates a framework for engaging physicians in quality and safety that includes:
  - Develop a common purpose
  - Reframe Values
  - Engage physician leaders
  - Change process to make engagement easy
  - Board and senior management support
  - Communication and build trust

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Existing Options

- Limitations of existing structures
  - Fragmented
  - Does not align physician practices to achieve quality mandate
  - Does not result in maximizing reimbursement under new payment paradigm
  - Cajoling and coaxing doesn't work

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Potential New Structure

Goals For New Structure

- Align financial incentives
- Provide means for physicians to supplement declining reimbursement without competing with hospital
- Integrate physician and hospital clinical practices to meet safety/quality goals
- Care management across the continuum
- Eliminate waste and reduce costs

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Potential New Structure

- Keep physicians/hospitals focused on their respective core business
- Clinical integration
- Standardize work processes
- Simplify documentation
- Provide mechanism for hospitals to obtain needed physician services (i.e. ED coverage)

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Potential New Approach

- Proposed structure to reward physicians under new reimbursement paradigm (Pay for Performance)
- Start with sharing payments received from a payor or payors, not a “homemade” pay for performance initiative

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Potential New Approach

- Make the Pay for Performance Program Specific:
  - Exactly what outcomes are intended?
  - How much are they worth?
    - Fixed payments
    - Percentage of hospital’s bonus
    - Hybrid?
  - Determine fair market value

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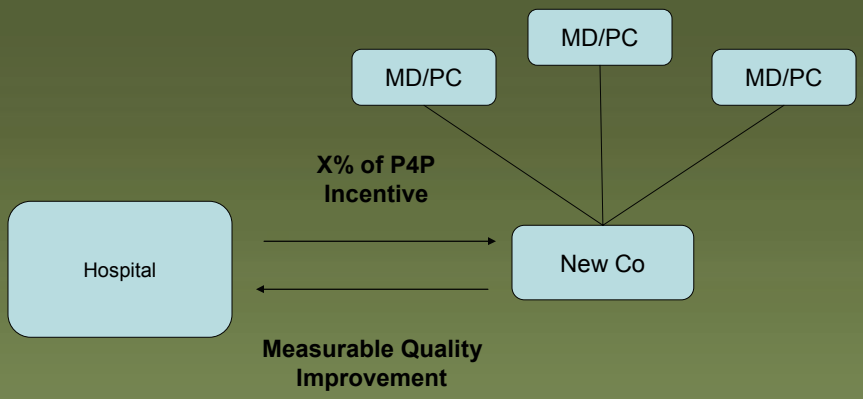
Potential New Approach



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Potential New Approach

- Build in Safeguards:
  - Consider limiting payments that can be earned to the number of patients that matches the prior year's patient base for that physician or group, to prevent incentivizing additional referrals
  - Consider limiting physician participation to existing medical staff members, to limit the risk of luring new physicians to the hospital
  - Consider outside exception to oversee quality and determine the fair market value

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Potential New Approach

- Obtain an OIG Advisory Opinion? (one currently is pending)
  - Start without an opinion, but making payments contingent on a favorable opinion?
  - Try to obtain "initial reaction" from OIG
  - Beware of delays in obtaining an opinion!
- Obtain FTC opinion as "clinically integrated" to allow for collective negotiation of payor contracts
  - Be aware of timing issues!

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Questions?

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