



Quality of Care: Important Changes to Reimbursement and Enforcement

Presenters:

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Today's Presenters



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Overview

- The Quality Revolution
 - Three-Prong Approach to Quality of Care
 - Payment Reform
 - Public Reporting
 - Government Enforcement
 - Problems Under Current Structures
 - Recommended Solutions



The Quality Revolution

- Since the 1999 IOM report, *To Err is Human*, there has been an increased national focus on quality
- Quality of care is the top priority for health care entities in 2008

The Government's Three-Prong Approach To Quality of Care



Prong 1: Incentivizing Quality of Care Through Payment Reform

- The new paradigm for reimbursement
- CMS is transforming payment policy from passive payor of services to active purchaser of high value health care
- Private payors also are changing payment policies to pay for quality



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Incentivizing Quality of Care Through Payment Reform (cont'd)

- ***“I 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

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Incentivizing Quality of Care Through Payment Reform (cont'd)

Pay for Performance

- Financial incentives for:
 - Adhering to recommended tasks or processes
 - Adopting desired tools or infrastructure
 - Meeting or improving measured outcomes
- Sometimes includes cost savings or efficiency targets (aka “gainsharing”)



Incentivizing Quality of Care Through Payment Reform (cont'd)

Dramatic Increase in Pay for Performance Payments

- The number of private programs is increasing exponentially
- Bonuses for physicians in their office practices, and for hospitals
- November 2, 2006 issue of *The New England Journal of Medicine* reported that 52% of 252 HMOs in geographic areas with at least 100,000 residents enrolled in HMOs had pay for performance programs
- Of these pay for performance plans, 90% were for physicians and 38% were for hospitals



Incentivizing Quality of Care Through Payment Reform (cont'd)

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Medicare Demonstration Project with Premier

- 270 hospitals participating
- Measures 34 selected processes of care and outcome measures for five common clinical conditions
- Heart attack, coronary artery bypass, heart failure, hip and knee replacement, and pneumonia
- Hospitals were given financial rewards for better outcomes
- Outcomes improved (although this has been questioned in the June 6, 2007 JAMA report on CRUSADE study)

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Incentivizing Quality of Care Through Payment Reform (cont'd)

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Medicare Physician Group Practices Demonstration Project

- Began April 1, 2005
- Ten participating physician groups
- July 11, 2007 CMS Press Release – All achieved benchmark performance on at least seven of ten diabetes clinical quality measures, and two met all ten
- “...all participating physician groups improved the clinical management of diabetes patients in the first year...”
- Earned \$7.3 Million of the \$9.5 Million in savings to the Medicare program

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Incentivizing Quality of Care Through Payment Reform (cont'd)

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Medicare Value Based Purchase Plan

- Hospitals are now reporting quality data to CMS under RHQDAPU program
- As required by DRA, CMS is developing a Value Based Purchasing plan to be implemented by CMS in 2009
- CMS issued final report to Congress on November 21, 2007
- The VBP will build on the RHQDAPU program



Incentivizing Quality of Care Through Payment Reform (cont'd)

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Design of the VBP Program

- The VBP program would be implemented in FY 2009 (October 1, 2008). A specified percentage of hospital payments would be conditional on hospital performance
- All measures would be publicly reported
- Hospitals must submit data on **all** measures applicable to their patient population and service mix to **qualify** for incentive payment
- The VBP program would use **both** financial incentives and public reporting to drive quality improvement
- The VBP program would transition from and replace the current RHQDAPU program



Incentivizing Quality of Care Through Public Reporting

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Physician Quality Reporting Initiative (PQRI)

- Voluntary program to provide financial incentives to physicians who successfully report quality data to CMS
- Physicians who successfully reported received a bonus based on 1.5% of Medicare allowed charges during the period
- 119 measures for 2008. Reporting not public at this time, but likely in the future
- Medicare has proposed a cut of greater than 10% to the Physician Fee Schedule for 2008 re-directing payments to PQRI. Congress delayed implementation to July 1, 2008
- CMS has publicly stated PQRI is first step to linking quality with physician payments



Incentivizing Quality of Care Through Payment Reform

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No Payment for Poor Quality

- Effective October 1, 2007, hospitals must report all secondary diagnoses present on admission (POA)
- Effective October 1, 2008, hospitals will not be paid for eight “hospital acquired conditions” unless present on admission
 - Object left in during surgery
 - Air embolism
 - Blood incompatibility
 - Catheter associated UTI
 - Pressure ulcers
 - Vascular catheter associated infection
 - Surgical site infection following CABG
 - Falls



Incentivizing Quality of Care Through Payment Reform (cont'd)

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- Effective October 1, 2009, “hospital acquired conditions” will include:
 - Ventilator associated pneumonia
 - Staph septicemia
 - Deep vein thrombosis

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Prong 2: Driving Quality of Care Through Public Reporting

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Sources of Data

- PEPPER
- Hospital Quality Initiative
- PERM
- CERT
- PQRI
- Adverse event reporting
- Medical malpractice litigation
- *Qui tam* relators

REPORT CARD
Crest Care

Category	EPICU	EPUB	EDM	Other
A	I	A	I	A
A	I	A	I	A
A	I	A	I	A
A	I	A	I	A
A	I	A	I	A
A	I	A	I	A
A	I	A	I	A
A	I	A	I	A
A	I	A	I	A

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Driving Quality of Care Through Public Reporting (cont'd)

The Hospital Quality Initiative

Data Generated by Hospitals through the Initiative

- The 27 inpatient measures currently reported through the Initiative are:
 - Heart attack (MI) – 8 measures
 - Heart failure (HF) – 4 measures
 - Pneumonia (PN) – 7 measures
 - Surgical Care Improvement Project (SCIP) – 5 measures
 - Mortality – 2 measures
 - Experience of Care (HCAHPs survey) **Should be published today, March 28, 2008!**
- Seven outpatient measures
- Uses website known as Hospital Compare to publicly report the data (www.hospitalcompare.hhs.gov)



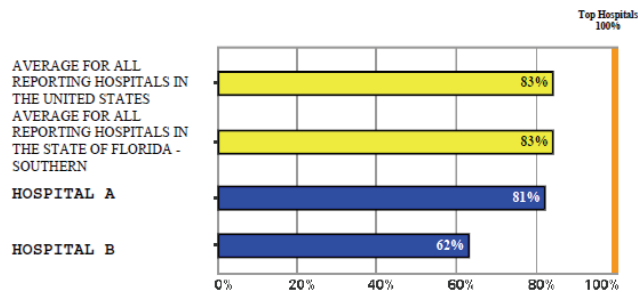
Hospital Compare

HHS - Hospital Compare - Process of Care Measure Graphs

Graph 1 of 4

■ Percent of Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)

The rates displayed in this graph are from data reported for discharges April 2006 through March 2007.



Top Hospitals represents the top 10% of hospitals nationwide. Top hospitals achieved a 100% rate or better.



Driving Quality of Care Through Public Reporting

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- March 6, 2008 GAO report on accuracy and reliability of hospital data reporting to CMS
- Found: CMS has processes for ensuring accuracy, but none for reliability (*i.e.*, completeness of quality data)

Nursing Home Compare

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About the Nursing Home	<u>Quality Measures</u>	<u>Total Number of Health Deficiencies</u> <u>Fire Safety Deficiencies</u>	<u>Nursing Staff Hours per Resident per Day</u>	<u>CNA Hours per Resident per Day</u>
NURSING HOME A Mapping/Directions View all information about this nursing home	Information for 19 of the 19 quality measures is available	1 Health Deficiency 0 Fire Safety Deficiencies	1 hour 26 minutes	3 hours 5 minutes
			Total Number of Residents: 110	
NURSING HOME B Mapping/Directions View all information about this nursing home	Information for 19 of the 19 quality measures is available	25 Health Deficiencies 1 Fire Safety Deficiency	1 hour 19 minutes	3 hours
			Total Number of Residents: 216	

Driving Quality of Care Through Public Reporting

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Performance Measurement Reporting System

- September 12, 2007. Fed. Reg. Vol. 72, No. 176 p. 52133-52140
- Proposed new master system of records
- Public reporting of price/quality transparency in health care (physicians & hospitals)
- Pools and analyzes information about quality, performance and cost across provider types
- Uses both public and private payor data



Driving Quality of Care Through Public Reporting (cont'd)

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- February 12, 2008 HHS proposed rule created a system of voluntary reporting to PSOs
- HHS has oversight and credentialing responsibilities
 - Create and maintain a network of patient safety databases, providing interactive data for providers
 - Analyze the data provided by PSOs, maintain confidentiality of data, and create statistic reports, trend reports, and patterns of error reports
 - The final data reports will be public
- These proposed rules raise issues regarding confidentiality of information and how the federal scheme will interact with state peer review laws. CMS is seeking feedback and not likely to be finalized immediately



Data Mining

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- ***“We are reviewing assorted sources of quality information on your facility to see what it says and if it is consistent. You should be doing the same.”***

James G. Sheehan

Medicaid Inspector General, New York

February 6, 2007



Data Mining (cont'd)

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- 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.



Data Mining (cont'd)

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Goals

- Correct inappropriate behavior
- Identify overpayments
- Deny payment



Prong 3: Enforcing Quality of Care Through the False Claims Act

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- The FCA is emerging as the government's most powerful tool to enforce quality of care
- Physicians, executives, and board members face *real risks* for poor quality of care



Enforcing Quality of Care Through the False Claims Act (cont'd) 29

■ ***"You will see more and more physicians going to jail."***

- Kirk Ogrosky, Deputy Chief for Health Care Fraud, Department of Justice, Criminal Division (Dec. 4, 2007)

■ ***"We're holding those individuals accountable." "You may not go to jail ... but we will take your money."***

- Lewis Morris, Chief Counsel to the Office of Inspector General, U.S. Department of Health and Human Services (Dec. 4, 2007)



Enforcing Quality of Care Through the False Claims Act (cont'd) 30

■ 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



Enforcing Quality of Care Through the False Claims Act (cont'd)

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Traditional Theories

- Claims for services not rendered
- Unbundling
- Claims for services not covered
- Duplicate payments

Quality of Care Theories

- Express False Certification
- Implied False Certification
- Worthless Services
- Criminal Statutes

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Enforcing Quality of Care Through the False Claims Act (cont'd)

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- In 2007, California regulators imposed a \$3 million fine on a hospital system for failure to provide adequate oversight of quality assurance programs, including peer review and patient complaint management. The problems were discovered by analyzing randomly-selected charts following patient complaints.
- In 2004, rural hospital was accused of allowing physicians to perform unnecessary cardiac catheterizations, angioplasty, and open heart surgeries. The hospital's parent organization entered into a \$54 million settlement with DOJ and agreed to divest the hospital by selling it to an unrelated third party.

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Enforcing Quality of Care Through the False Claims Act (cont'd)

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- In 2006, a FCA action against a Baton Rouge, Louisiana hospital for medically unnecessary surgeries resulted in a \$3.8 million settlement.
- In 2003, a medical center in Chicago, Illinois was found to have paid physician kickbacks that resulted in medically unnecessary care. The hospital administrator and several physicians received prison sentences and were required to make restitution payments totaling over \$26 million.
- In 2006, a Louisiana cardiologist was indicted on multiple counts of healthcare fraud and one count of criminal forfeiture for performing unnecessary angiograms and angioplasties.

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Enforcing Quality of Care Through the False Claims Act (cont'd)

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- In 2002, the CEO and members of the Medical Executive Committee at a Michigan hospital were indicted on charges of criminal conspiracy, mail fraud and wire fraud by billing for medically unnecessary pain procedures.

The government's case centered on the hospital's allegedly deficient peer review procedures, which failed to curtail the unnecessary pain procedures.

After the anesthesiologist who performed the procedures was convicted of mail fraud and sentenced to three years in prison, the hospital and other individual physician defendants pleaded guilty, serving over 1,000 hours community service and paying over \$1,000,000 in fines.
- In 2007, a Florida hospital and its current and former owners paid \$15.4 million to settle a FCA lawsuit involving allegations that the hospital paid kickbacks to physicians in return for patient admissions that resulted in medically unnecessary treatments on elderly patients.

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Enforcing Quality of Care Through the False Claims Act (cont'd)

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- *U.S. ex rel Landers v. Baptist Memorial Health Care Corp.*, W.D. Tenn., (12/17/07)
 - Distinguished between Conditions of Participation and Conditions of Payment. Violation of Conditions of Participation insufficient to trigger FCA liability
 - The Court found that conditions of participation are not the equivalent of conditions of payment, but are quality of care standards directed towards an entity's continued ability to participate in the Medicare program rather than a prerequisite to a particular payment

■ ***Exercise caution!***

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Enforcing Quality of Care Through the False Claims Act (cont'd)

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- 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

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Problems for Physicians and Hospitals Under Current Structures

- Hospital Peer Review and Quality Management
- Traditional Medical Staff Structure
- Other Structural Problems (Siloing)
- Board Education and Oversight
- Physician and Hospital Collaboration



Problems Under Current Structures

Number 1 Problem

- Hospital Peer Review and Quality Management are Not Structured to Proactively Drive Quality of Care
 - Historical process is retrospective and based on incidents
 - Processes may be lengthy, biased (friends or competitors), and ineffective
 - Delays can lead to evidence of a pattern of poor quality or unnecessary care
 - Is evidence based medicine now the standard of care?
 - According to “Survey on Medical Professionalism” by the Institute of Medicine as a Profession, *Annals of Internal Medicine* (December 4, 2007, nearly **half** of physicians do not report medical incompetence by peers



Problems Under Current Structures (cont'd)

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Number 2 Problem

- Traditional Medical Staff Structure is Not Designed For New Paradigm
 - Blurring of specialty lines (ex. Interventional radiology / cardiology / neurology)
 - Increasing number of hospital based physicians (ex. Hospitalists intensivists, OB hospitalists, Peds hospitalists)
 - Growing number of outpatient based physicians, reducing collegiality with specialists and hospital-based physicians and impacting credentialing
 - Regulators mandating change (i.e. competency based credentialing, standardization of care processes, and increased medical staff oversight of quality)

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Number 3 Problem: A Siloing of Responsibility

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- ***“When looking at some of these very large [health care] corporations, there is a siloing of responsibility, which has the effect of inadequate cross of information between the peer review/quality people and the compliance people. The different components of a health care organization need to communicate and exchange information with each other and boards of directors can encourage this process.”***

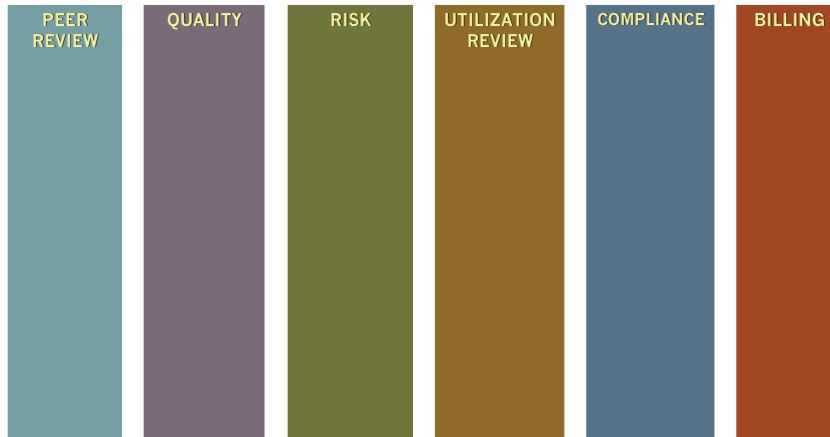
Lewis Morris
Chief Counsel to the Office of Inspector General,
U.S. Department of Health and Human Services
September 25, 2007

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Problems Under Current Structures

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SILO Approach



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Problems Under Current Structures (cont'd)

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Number 4 Problem

■ Lack of Board Education and Oversight

- "Getting the Board on Board: Engaging Patient Boards in Quality and Patient Safety," 32 *Joint Commission Journal on Quality and Patient Safety* 179-187 (April 2006)
- 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
- "Driving for Quality in Long-Term Care: A Board of Directors Dashboard," HHS and HCCA joint report (January 2008)

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Problems Under Current Structures (cont'd)

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Number 5 Problem

- Lack of Effective Physician-Hospital Collaboration Strategies
 - 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

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Recommended Solutions

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What is needed for the future

- Five solutions to consider:
 - Audit quality controls/legal risks
 - Integrate quality and compliance
 - Improve board education and oversight
 - Redesign medical staff structure
 - New strategies for hospital/physician collaboration

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Recommended Solutions (cont'd)

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Solution No. 1

■ Audit Quality Controls/Legal Risks

- Audit for
 - Compliance with Medicare requirements (*i.e.* COPS)
 - Internal quality controls
 - Fraud & abuse risks
- Red Flags
 - "The Buzz"
 - Failure to take appropriate or timely action

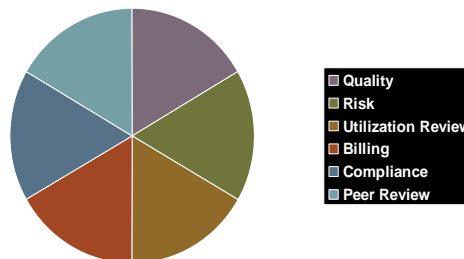


Recommended Solutions (cont'd)

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Solution No. 2

■ Integrate Quality and Compliance



Be careful to maintain the privilege



Recommended Solutions (cont'd)

Solution No. 3

- Improve Board Education and Oversight
 - Board must recognize quality/safety as a core fiduciary obligation

- On September 13, 2007, OIG and AHA 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

Recommended Solutions (cont'd)

Solution No. 3

- Board and medical staff need to frame an agenda for quality – IHI campaign, Joint Commission, quality measures

- Governance responsibility for quality – measures and goals

- Board needs to receive regular reports (errors, outcomes)

- Increasing board education on quality – part of orientation
 - Ex: MA quality improvement training program for hospital trustees (endorsed March 20, 2008).

- Recruiting one or more board members with expertise on quality

Problems Under Current Structures (cont'd)

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Solution No. 3

- “Driving for Quality in Long-Term Care: A Board of Directors Dashboard,” HHS and HCCA joint report (January 2008)
- Government-industry roundtable addressed practical ways for boards to monitor the quality of care issues in long-term care facilities
- The Report addresses four distinct areas:
 - Demonstrating and improving a commitment to quality
 - Key structural processes
 - Key outcome categories
 - Challenges and opportunities for Boards



Recommended Solutions (cont'd)

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Solution No. 4

- Redesign Medical Staff Structure
 - Standardization of care drives Quality and Safety under the new Paradigm
 - Only Qualified and Aligned Physicians on Staff (voting vs. non-voting status)
 - Multi-disciplinary Peer Review
 - Cross-discipline departments
 - Competency based credentialing
 - Appoint only excellent physicians
 - Set and communicate expectations
 - Measure performance (case review, outcomes data (rate indicators), compliance with quality targets (rule indicators))
 - Proctoring
 - Manage poor performance



Recommended Solutions (cont'd)

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Solution No. 5

■ Strategies for Physician/Hospital Collaboration on Quality

- Existing structures that meet current legal requirements:
 - Employment (different from employment wave of 1990s)
 - Co-management
 - Provision of mid-level support to physicians
 - Ancillary/whole hospital joint ventures
- Limitations of existing structures



Recommended Solutions (cont'd)

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■ IHI has released *Engaging Physicians in Shared Quality Agenda*, which advocates a framework for engaging physicians in quality and safety:

- Develop a common purpose
- Reframe values
- Engage physician leaders
- Change processes to make engagement easy
- Board and senior management support
- Communication and build trust





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Recommended Solutions (cont'd)

- New Structures/Models
- Advisory Opinion pending... ***STAY TUNED!***



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Questions & Answers

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