# Quality-based payments: Incentives and disincentives for improvement

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*This is the second in a series of articles by Foley & Lardner LLP published in Compliance Today designed to address the compliance risks associated with quality of care in the hospital setting. This article explores and explains the federal, state, and private initiatives to link quality measurement, reporting, and improvement to payments and reimbursement.*

Value-based purchasing (VBP) has become the new paradigm for health care purchasers, who have begun to actively exert their market leverage to drive improvements in the quality and efficiency of health care delivery. Federal and state government purchasers and employer coalitions alike are developing and testing new systems to promote health care quality improvement through payment incentives and disincentives.

The first step in incentivizing quality has been the fostering of public accountability through the measurement, reporting, and public dissemination of quality measures by health care providers and physicians. Pay for Reporting (P4R) programs are being used to gather performance and quality data; such data is then disseminated via websites such as Hospital Compare (http://www.hospitalcompare.hhs.gov).

Quality reporting programs have set the stage for Pay for Performance (P4P) programs, designed to align financials with the quality and efficiency of health care. P4P programs reward health care organizations for meeting performance targets, improving performance, or in some cases, meeting efficiency targets—based on reported quality measures of clinical outcomes, structural measures, processes of care, and consumer satisfaction.

Disincentives for poor quality care are also being rapidly adopted. Medicare, Medicaid, employer coalitions, and health plans are refusing to pay for unnecessary care. For Medicare beneficiaries, federal law prohibits payment for an expanding list of preventable hospital-acquired conditions (HACs). Nearly 20 states already have or are considering denial of payment for medical errors.

The emphasis on public reporting of quality of care data has significant implications for a hospital's reputation. Moreover, the increasingly complex federal and state regulatory standards and regulations make accurate quality reporting and integration of compliance and quality initiatives essential to avoid legal liability and achieve financial success. This represents a unique challenge and opportunity for compliance officers.

## Payment Incentives for Quality of Care

Quality reporting programs have been the first step in the progression toward VBP. The P4R programs have been characterized by a steady growth in the level of financial incentives, number of quality measures, and the types of settings in which measures are reported.

### Hospital inpatient care

In 2003, CMS created the National Voluntary Hospital Reporting Initiative, now known as the Hospital Quality Alliance. Through this initiative, a "starter set" of ten quality measures related to processes of care for treatment of heart attack, heart failure, and pneumonia and a system for voluntary reporting of these quality measures was established.[1]

This voluntary initiative soon became mandatory. To spur the development of a standardized quality data set and reporting mechanism, Congress authorized CMS to develop a P4R program, entitled the Reporting Hospital Quality Data for Annual Payment Update Program (RHQDAPU).[2] The initial regulations stipulated that a hospital that did not submit performance data for the ten quality measures would receive a 0.4 percentage point reduction in its annual payment update from CMS for Fiscal Year (FY) FY 2005, 2006, and 2007.[3]

Through the Deficit Reduction Act (DRA) of 2005, the number of RHQDAPU

measures and the financial consequences of failure to report were increased.[4] Effective FY 2007, hospitals were required to report on:

- 21 process and outcome measures;
- the Hospital Consumer Assessment of Healthcare Providers and Systems Survey; and
- three structural measures -- implementation of computerized provider order entry for prescriptions, staffing of intensive care units with intensivists, and evidence-based hospital referrals.

The annual payment update (also known as market basket update) for hospital Inpatient Prospective Payment System (IPPS) was reduced by 2.0% for FY 2007 and subsequent years if hospitals failed to report on specified quality measures.[5]

Effective October 1, 2008 (for FY 2009), hospitals are required to report 30 inpatient measures in the following sets:

- Heart attack (acute myocardial infarction) — 8 measures,
- Heart failure — 4 measures,
- Pneumonia — 7 measures,
- Surgical Care Improvement Project — 7 measures,
- 30-day risk-adjusted mortality rates — 3 measures, and
- Hospital Consumer Assessment of Healthcare Providers and Systems Survey. [6]

For FY 2010, CMS has proposed 13 new measures for the RHQDAPU, many of which are outcome measures that will be calculated by CMS based on claims data.[7]

To promote transparency, CMS also makes the RHQDAPU data publicly available on Hospital Compare (www.hospitalcompare.hhs.gov). As recently as August 2008, CMS enhanced the Hospital Compare website by posting information on hospital rates of pneumonia mortality and quality measures for the care of children. In March, CMS had added patient satisfaction and pricing data to the site. Since then, its page views have risen to more than 2.5 million per month.[8]

**Hospital outpatient care**

Federal P4R programs are also expanding to other health care settings. In 2007, Congress established the Hospital Outpatient Quality Data Reporting Program (HOP QDRP) to encourage reporting of quality information on outpatient care. For hospital outpatient services furnished on or after April 1, 2008, non-compliant providers will receive a 2.0 percentage point reduction in their Outpatient Prospective Payment System (OPPS) annual update for Calendar Year (CY) 2009 if they fail to submit data on selected measures of quality of care. [9]

The selected quality measures for the HOP QDRP include seven measures: five that capture the quality of outpatient care in hospital emergency departments for adult patients with acute myocardial infarction who are treated and then transferred to another facility for further care, and two measures related to surgical care improvement. The measures address the processes of care, such as care on arrival, promptness of interventions, and discharge care for patients presenting to a hospital with an Acute Myocardial Infarction.[10]

For CY 2010, CMS is proposing to adopt four claims-based imaging measures that CMS can calculate using Medicare Part B claims data without requiring chart abstraction. For CY 2011 and subsequent years, CMS is seeking comment on a list of 18 measures related to clinical topics, such as cancer treatment.[11]

**Future directions for hospital P4R programs**

CMS has identified the following objectives for expansion of the P4P programs:

- Expand the types of measures beyond process of care measures to include an increased number of outcome measures, efficiency measures, and experience-of-care measures;
- Expand the scope of hospital services to which the measures apply (CMS has indicated that P4R will be implemented in the Ambulatory Surgical Setting in a future rulemaking);[12]
- Consider the burden on hospitals in collecting chart-abstracted data;
- Harmonize the measures used in the RHQDAPU program with other CMS quality programs (e.g., Physician Quality Reporting Initiative, HOP QDRP) to align incentives and promote coordinated efforts to improve quality;
- Seek to use measures based on alternative sources of data that do not require chart abstraction or that utilize data already being broadly reported by hospitals, such as clinical data registries or all-payer claims data bases (CMS recently issued a final rule providing access to claims data that are presently being collected for Medicare Part D payment purposes for research, analysis, reporting, and other public health functions);[13] and
- Weigh the meaningfulness and utility of the measures compared to the burden on hospitals in submitting data under the RHQDAPU program.[14]

CMS is also considering several alternatives to encourage efficiency in the hospital outpatient setting and control future growth in the volume of OPPS services, such as reducing OPPS payment rates to account for unnecessary increases in volume, and developing payment incentives for efficiency.[15]

## P4P: Payment incentives for quality

Current Medicare hospital payment policies pay hospitals for the services that they furnish, regardless of the quality of those services, and in some cases, hospitals receive additional payment for treatment of avoidable complications.

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CMS' goal is to transform the Medicare program "from a passive payer to an active purchaser of higher quality, more efficient health care."[16] To support this transformation, CMS adopted VBP as its policy for aligning payment incentives with the quality of care.

In 2003, CMS launched the Premier Hospital Quality Incentive Demonstration (HQID) project, which involves about 250 hospitals in 36 states, to determine whether economic incentives would improve the safety, quality, and efficiency of care delivered in the nation's hospitals. CMS recently concluded, based on the outcomes from the third year of this demonstration, that paying for performance in health care can dramatically improve the quality of health care delivered to hospital patients. According to CMS Acting Administrator Kerry Weems, "Given these results, it is time to take the next step and implement hospital Value-Based Purchasing for the Medicare program, so that citizens across the nation can benefit from improved safety and quality to get the right care, every time."[17]

Congress authorized the Secretary of Health and Human Services to develop a plan to implement VBP for Medicare Inpatient Prospective Payment System (IPPS) services for FY 2009 as part of the DRA. The VBP program was intended to replace the RHQDAPU program and use both financial incentives and public reporting to drive improvements in clinical quality, patient-centeredness, and efficiency.[17]

The VBP plan, which outlines the performance model and process for calculating incentive payments, was submitted as a report to Congress on November 21, 2007.[18] The VBP program would be phased in over a three-year period, Weems said. The first year would be based entirely on reporting. The second year would be based 50% on reporting and 50% on performance. The third and all subsequent years would be based entirely on performance.

On an annual basis, CMS would assess each hospital's performance and assign the hospital a performance rate for each measure. To calculate a performance rate for a measure, CMS would divide the number of applicable patients who received the care specified in the measure by the total number of applicable patients.[19]

The VBP plan proposes to reward hospitals that improve their quality performance, as well as those that achieve high levels of performance. CMS would score a hospital's performance on each measure during a 12-month measurement period based on the higher level of "attainment" compared with national thresholds and benchmarks, or "improvement" compared with the hospital's own performance in the preceding 12-month baseline period.[20]

Incentive payments of 2% to 5% would be based on hospitals' scores. CMS would first set a benchmark performance score—such as 85% or 90%—above which hospitals would receive the full VBP incentive amount. Hospitals below the performance benchmark would receive a portion of the VBP incentive amount. CMS may set a minimum performance score threshold—such as 10%—below which hospitals would not receive any VBP incentive payment. [21]

Although Congress had initially indicated that the VBP program would commence in FY 2009, it has not yet authorized the agency to proceed with implementation.[22] Currently, the plan is being tested using RHQDAPU data to generate performance scores and financial incentives. CMS plans to analyze the results by individual IPPS hospitals, by segment of the hospital industry, and in aggregate for all IPPS hospitals in order to further refine the plan. Issues still being addressed include methods for addressing the small numbers issue and development of a composite scoring methodology for the outcomes domain.[23]

Even though P4P has not yet been implemented for Medicare, it has become imbedded in the private sector. More than half of commercial health maintenance organizations have implemented P4P programs, and the number of private programs is increasing exponentially. A 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 P4P programs. Of these P4P plans, 90% were for physicians and 38% were for hospitals.

Several states—Minnesota, Wisconsin, Massachusetts, and Washington—are also at the forefront of VBP initiatives, some of which have already proven effective in reducing costs. These systems involve publicly reporting health plan performance, using tiered premiums as incentives to members to purchase more efficient plans, and giving financial rewards to health plans that display favorable cost and quality.[24] In Minnesota, for example, the Department of Employee Relations (DOER) reported achieving about $20 million in cost savings in 2006 through use of incentive programs combined with disease management programs. DOER is partnering with the Minnesota Smart Buy Alliance, a group of public and private health care purchasers, which represents more than 60% of state residents to develop and implement common VBP principles and strategies.[25]

## Reimbursement disincentives for poor quality care

Creating disincentives for poor quality care is another aspect of VBP. Payment denial for preventable HACs has been the first effort to hold hospitals financially accountable for the overall quality of care.

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**Medicare payment denial for preventable HACs**

In its landmark 1999 report "To Err is Human: Building a Safer Health System," the Institute of Medicine found that medical errors, particularly HACs caused by medical errors, are a leading cause of morbidity and mortality in the United States.[26] To address this issue, CMS implemented a new VBP initiative to create disincentives for poor quality care by payment denial. The HAC conditions selected for the IPPS payment provisions are ones that:

- are high cost, high volume, or both;
- are assigned to a higher-paying Medicare severity diagnosis-related group (MS-DRG) when present as a secondary diagnosis; and
- could reasonably have been prevented through the application of evidence-based guidelines.[27]

Beginning October 1, 2008, Medicare can no longer assign an inpatient hospital discharge to a higher-paying MS-DRG if a selected HAC condition was not present on admission. That is, the case will be paid as though the secondary diagnosis were not present. These conditions include:

- Foreign object retained after surgery;
- Air embolism;
- Blood incompatibility;
- Pressure ulcers stages III and IV;
- Falls and trauma;
- Catheter-associated urinary tract infection;
- Vascular catheter-associated infection;
- Manifestations of poor glycemic control;
- Surgical site infection following coronary artery bypass graft;
- Surgical site infection following certain orthopedic procedures and bariatric surgery for obesity; and
- Deep vein thrombosis and pulmonary embolism following certain orthopedic procedures.[28]

CMS is also seeking comment on three National Coverage Decisions: surgery on the wrong body part, surgery on the wrong patient, and wrong surgery performed on a patient — conditions for which Medicare has proposed to discontinue coverage. A proposed decision memorandum will be released on or before February 1, 2009 for another round of public comments and then be finalized no later than April 30, 2009.[29]

CMS is analyzing options to expand the payment denial provisions: (1) to other settings, including hospital outpatient departments, end-stage renal disease facilities, and physician practices, and (2) beyond the hospital walls through requirements that hospitals pay for the follow-up care in other settings for preventable conditions that the hospital failed to prevent. CMS is also promoting these payment denial policies to state Medicaid agencies.[30]

**Medicaid agencies reimbursement prohibitions**

More than 20 states already have or are considering methods to eliminate payment for preventable adverse events.[31] Maine hospitals are prohibited from "knowingly charging a patient or the patient's insurer for health care services it provided as a result of or to correct a mistake or preventable adverse event caused by that health care facility."[32] The statute sets forth 28 mistakes or preventable adverse events that are "within the health care facility's control to avoid." The 28 mistakes or preventable events are nearly identical to the serious reportable events identified by the National Quality Forum (NQF).[33]

In a number of other states, state agencies have established policies to deny reimbursement for medical errors. In Massachusetts, four state agencies have adopted a uniform statewide policy not to pay for medical errors, consisting of the 27 serious reportable events identified by the NQF.[34] Effective October 1, 2008, the New York State Medicaid program will deny reimbursement for 14 "never events" and it plans to expand the list over time.[35] Pennsylvania denies Medicaid reimbursement to acute-care general hospitals for services made necessary by a serious preventable adverse event. The state Medicaid agency determines when to deny full or partial payment to a hospital by using a list of guidelines enumerated in a Medicaid bulletin.[36] The guidelines listed by the Pennsylvania Department of Public Welfare are: (1) the event must be preventable; (2) the event must be within the control of hospital; (3) the preventable serious adverse event must occur during an inpatient hospital admission; and (4) the event must result in significant harm. The bulletin refers to the 28 "never events" enumerated by the NQF, but the state evaluates preventable serious adverse events on a case-by-case basis.

**Private health plans payment policies**

Health plans are also "clamping down" on payments for never events. Cigna announced in April 2008 that it was joining a growing roster of payers, including WellPoint and Aetna, who are no longer paying hospitals for certain never events (when allowed under its hospital contracts, of course). Physicians will not be paid for surgical procedures on the wrong side, wrong person, wrong body part, and/or wrong site. Cigna is adding a list of "potentially non-reimbursable" mishaps that will mandate quality of care.[37]

## Conclusion

With the link between payment and quality firmly established through an array of federal and state laws, regulations, and policies, accurate quality reporting by hospitals is essential to maximize payments and comply with federal and state law. Hospital quality reporting data are being closely evaluated by government authorities and combined with other data sources, such as the Physician Quality Reporting Initiative, state adverse event reporting, and

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sentinel event data reported to The Joint Commission, to identify inconsistencies and evidence of ongoing quality problems that providers fail to address. When quality data are used to determine reimbursement, inaccurate reporting of quality data could result in the misrepresentation of the status of patients and residents, the submission of false claims, and potential enforcement action.[38]

As VBP continues to evolve, providers and their compliance officers will be challenged to understand and address a growing number of payment incentives and disincentives. Meeting this challenge will require a multidisciplinary approach to educate senior management, the board, relevant personnel, and physicians on the risks and opportunities. That same multidisciplinary approach will be needed to create a viable plan for avoiding legal risk and maximizing reimbursement in the future. ■

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