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Quality of Care: Transforming Health Care Through Payment Reform, Public Reporting and Enforcement

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CMS' Progress Toward Implementing Value-Based Purchasing



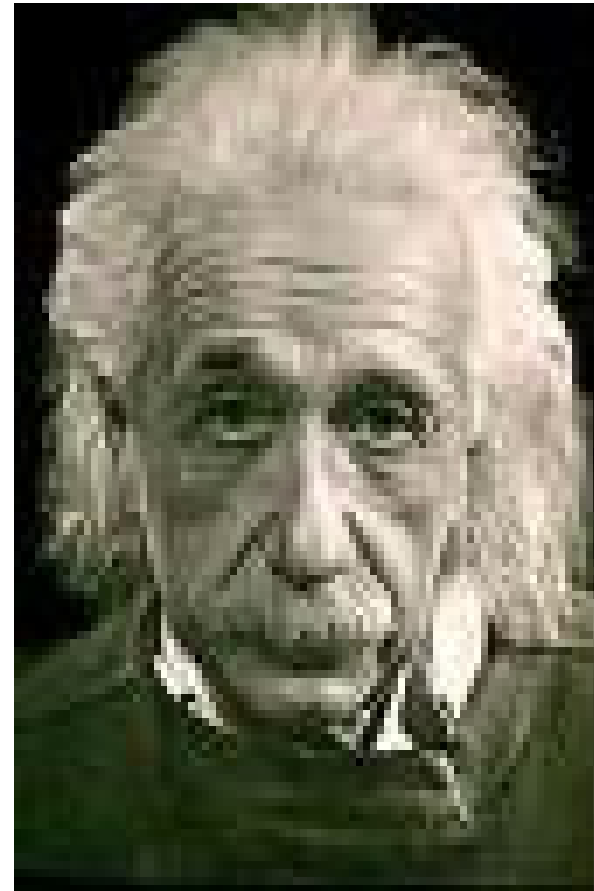
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Presentation Overview

- The Challenge of Transformation
- Stakeholders in Defining Value
- Value Based Purchasing: CMS Priorities
- Value Based Care: The Stakeholder Challenge

Einstein on Transformation

- *“You can never solve a problem on the level on which it was created.”*
- *“Perfection of means and confusion of ends seem to characterize our age.”*



Defining Value

- Defining value requires a judgment and can be subjective
- Value in Healthcare defined by:
 - Individual and their families
 - Physicians
 - Healthcare systems
 - Payers
 - Insurers
 - Employers
 - Public Payers

VBP Demonstrations and Pilots

- Premier Hospital Quality Incentive Demonstration
- Physician Group Practice Demonstration
- Medicare Care Management Performance Demonstration
- Nursing Home Value-Based Purchasing Demonstration
- Home Health Pay-for-Performance Demonstration
- ESRD Bundled Payment Demonstration

VBP Demonstrations and Pilots (cont'd)

- ESRD Disease Management Demonstration
Medicare Health Support Pilots
- Care Management for High-Cost Beneficiaries
Demonstration
- Medicare Healthcare Quality Demonstration
- Gainsharing Demonstrations

Premier Hospital Quality Incentive Demonstration

- Authority
 - CMS' demonstration authority
- Purpose
 - To determine if financial incentives and public recognition are effective in improving quality of care
- Timing
 - Initial 3-year project ended September 2006
 - Recently extended for additional 3 years
- Target
 - Approximately 250 hospitals

Premier Hospital Quality Incentive Demonstration (cont'd)

- Compensation
 - Bonus payment model for quality attainment in five clinical conditions (AMI, CHF, Pneumonia, joint replacement, CABG)

Physician Group Practice Demonstration

- Authority
 - Benefits Improvement and Protection Act (BIPA) Section 412
- Purpose
 - To provide physicians with the opportunity to demonstrate that improving care in a proactive and coordinated manner is cost effective
- Timing
 - 3-year project began April 2005
- Target
 - 10 large physician groups

Physician Group Practice Demonstration (cont'd)

- Compensation
 - Shared savings based on quality measures

Medicare Care Management Performance Demonstration

- Authority
 - Medicare Modernization Act (MMA) Section 649
- Purpose
 - To promote the use of health information technology and improve the quality of care for chronically ill beneficiaries
- Timing
 - 3-year project
- Target
 - Doctors in solo to medium-sized group practices, who meet clinical performance measure standards in AR, CA, MA and UT

Medicare Care Management Performance Demonstration (cont'd)

- Compensation
 - Bonus payment based on quality measures and EHR functionality

Gainsharing Demonstrations

- Authority
 - Deficit Reduction Act (DRA) Section 5007
 - Medicare Modernization Act (MMA) Section 646
 - In the absence of statutory authority, gainsharing is restricted law
- Purpose
 - To allow hospitals to provide gainsharing payments designed to improve quality and efficiency of care to physicians
- Timing
 - 3-year projects

Gainsharing Demonstrations (cont'd)

- Target
 - Hospitals and physicians
- Compensation
 - Hospitals may share savings with physicians

CMS' VBP Programs

- Hospital Quality Initiative
- Hospital VBP Plan & Report to Congress
- Hospital-Acquired Conditions & Present on Admission Indicator
- Physician Voluntary Reporting Program
- Physician Quality Reporting Initiative
- Physician Resource Use
- Home Health Care Pay for Reporting

Hospital Quality Initiative

- www.hospitalcompare.hhs.gov
- 2008
 - AMI, HF, Pneumonia
 - 30 Day Mortality
 - AMI
 - Heart Failure
 - HCAPS- Patient Experience of Care

Hospital Value Based Purchasing Plan

- Performance assessment model
 - Reward absolute improvement
 - Reward attainment of benchmarks
- Measures
 - Role measures into the program
 - Expansion
- Data infrastructure & validation
 - Improve process
 - Redefine validation
- Public reporting
 - Easier for consumers
 - Drive change

Additional Measure Topics for FY 2010 and Beyond

| FY 2010–FY 2011 | FY 2012 and Beyond |
|--|---|
| <p>Efficiency measures</p> <p>Outcomes measures</p> <p>Emergency care measures</p> <p>Care coordination measures</p> <p>Patient safety measures</p> <p>Structural measures</p> | <p>Performance areas to address measure gaps</p> <p>Expect need for new measure development</p> |

Hospital-Acquired Conditions & Present on Admission Indicator

POA Reporting Dates

- **Phased Implementation:**
 - October 1, 2007: Hospitals must begin reporting POA indicator on claims for payment
 - January 1, 2008: CMS will begin processing POA data and will inform hospitals if they did not submit the information correctly, while continuing to process claims for payment
 - April 1, 2008: Claims will be returned if a POA indicator is not submitted for each diagnosis

POA Reporting Options

- Five reporting options
 - Yes: Present at the time of inpatient admission
 - No: Not present at the time of inpatient admission
 - U: Documentation is insufficient to determine if condition is present on admission
 - W: Provider is unable to clinically determine whether condition was present on admission or not
 - Blank: Exempt from POA reporting

IPPS FY2008 Final Rule – Category 1

1-3. Serious Preventable Events

- Object left in during surgery
- Air embolism
- Blood incompatibility

4. Catheter Associated Urinary Tract Infection

5. Pressure Ulcers

6. Vascular Catheter Associated Infections

7. Falls and Trauma

CMS' Value-Based Purchasing Initiatives

Physician Quality Reporting Initiative (PQRI)

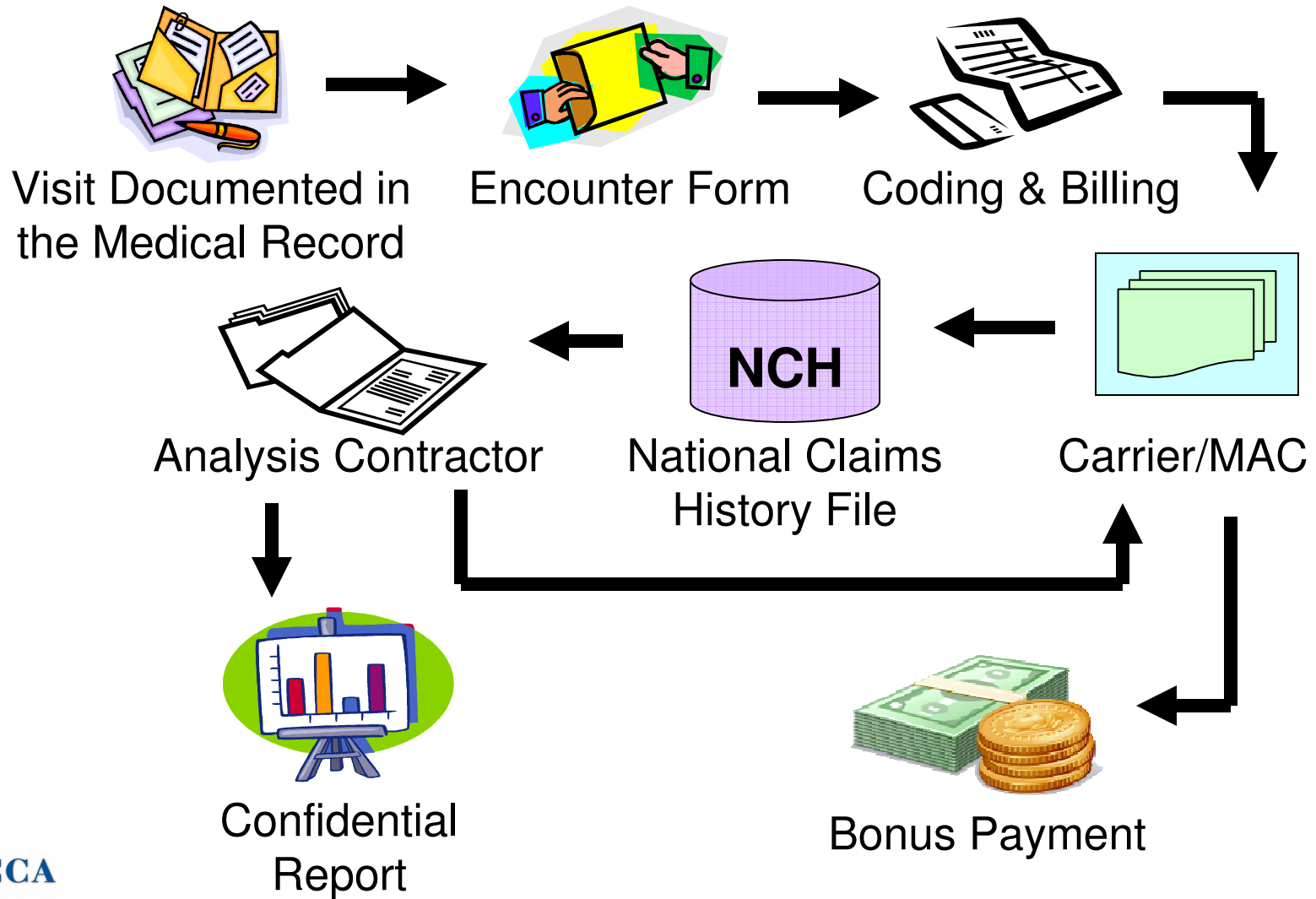


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Quality and PQRI

- PQRI reporting will focus attention on measuring quality of care
 - Foundation is evidence-based measures developed by professionals
 - Reporting data for quality measurement is rewarded with financial incentive
 - Measurement enables improvements in care
 - Reporting is the first step toward pay for performance

Successful Quality Data Reporting



Claims Based Reporting: PQRI Measure Construct

Numerator: Clinical action required for reporting and performance

Denominator: Eligible cases for a measure (the eligible patient population associated with the numerator)

PQRI Feedback Reports

- Confidential Feedback Reports
 - Individual participants' 2007 PQRI quality data will not be publicly reported
 - Reports will be available at or near the time of the bonus payments in 2008
 - No interim reports during 2007
 - Reports are expected to include reporting and performance rates by NPI for each TIN

PQRI 2008: Statutory Requirements

For Measures

- Adopted or endorsed by a consensus organization, such as the AQA Alliance or National Quality Forum (NQF)
- Include measures that have been submitted by a physician specialty
- Used a consensus-based process for development
- Include structural measures, such as the use of electronic health records or electronic prescribing technology
- For Reporting
- Must consider a mechanism for registry-based reporting

PQRI 2008: 119 Measures

- Seven Categories of Proposed Measures
 - National Quality Forum-endorsed 2007 PQRI Quality Measures
 - AMA Physician Consortium for Performance Improvement developed measures
 - Measures for non-physician eligible professionals developed by Quality Insights of Pennsylvania
 - Structural measures related to EHRs and e-prescribing developed by Quality Insights
 - Measures from the AQA Alliance starter set
 - Other NQF-endorsed measures not included in 2007 PQRI
 - Measures under development by the American Podiatric Medical Association

PQRI 2008: Additional Reporting Options

- Registry-based reporting
 - Use of a data system that collects PQRI measure data and quality data codes for electronic submission to a CMS-designated clinical data warehouse using a CMS-specified record layout based on PQRI measure specifications
- Electronic health record (EHR)-based reporting
 - Specifications recently posted on the CMS website for the electronic reporting of 5 measures

Review of Accomplishments

- Launch of PQRI
- Partnership with physicians and their organizations
- Developed new model for education and outreach
 - Partnerships
 - Reached critical stakeholders
 - Toolkit (AMA worksheets)
- Overcoming inertia
- Largest implementation of PCPI measures across continuum of care and specialties
- Moved IT agenda forward

Physician Resource Use

Physician Resource Use: The Vision

- Value Based Purchasing will require a payment system that rewards high quality, appropriate care at the beneficiary level
- Measurement systems and tools that are fair, meaningful and actionable
 - Require Cost of Care Measures
 - Fair, meaningful, and actionable physician resource use reports
 - Physician resource use in the context of episodes of care

Physician Resource Use: The Environment

Premise: CMS can use claims data to develop confidential feedback reports to physicians on their utilization of imaging.

- Private sector experience
- MedPAC recommendation

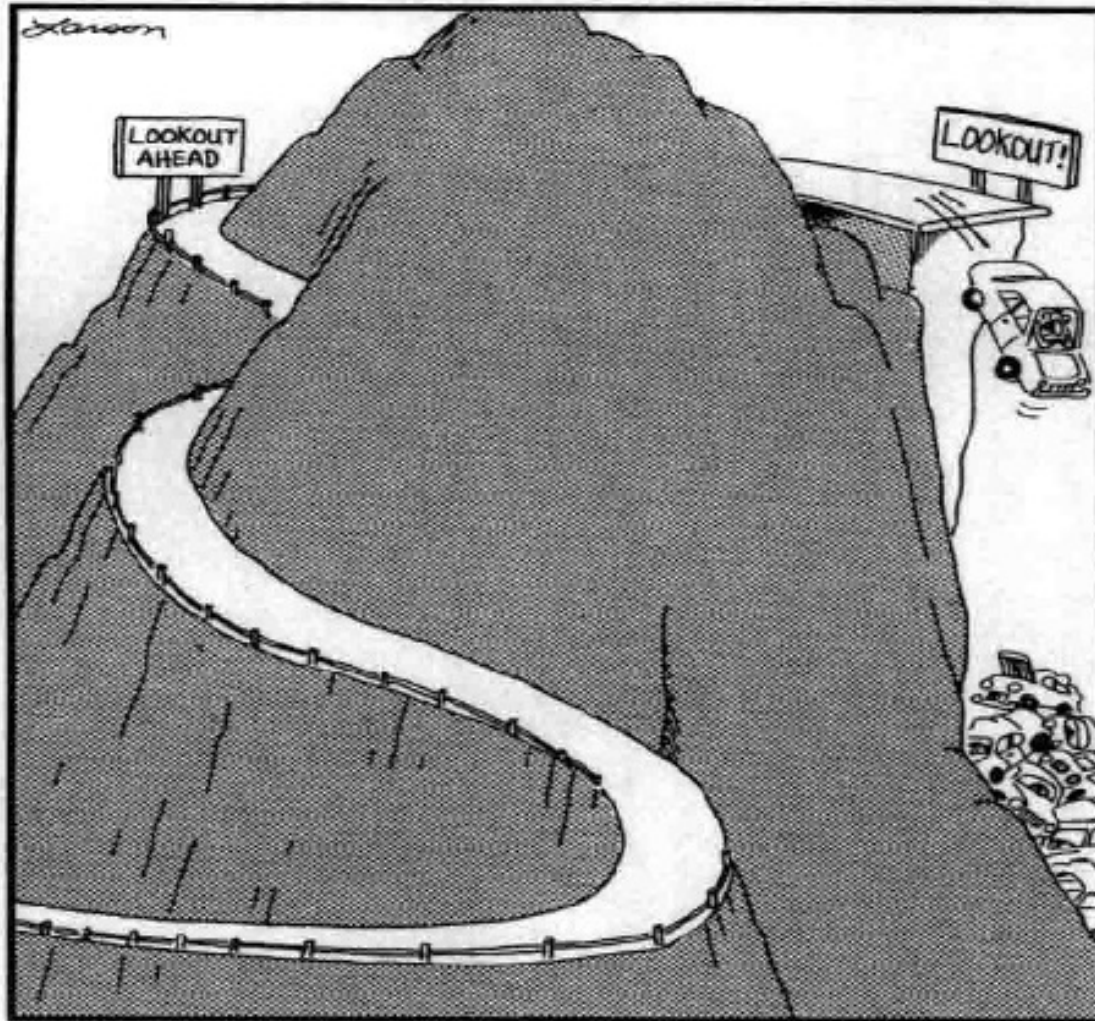
Conclusion

- The rate of change in healthcare is being driven by fiscal constraints, aging population, and innovation.
- Alignment of the community, the medical staff and the hospital with regards to quality is essential for success.
- CMS will continue to implement programs that reward high quality, safe, patient focused, efficient care.

Quality of Care: Transforming Health Care Through Payment Reform, Public Reporting and Enforcement



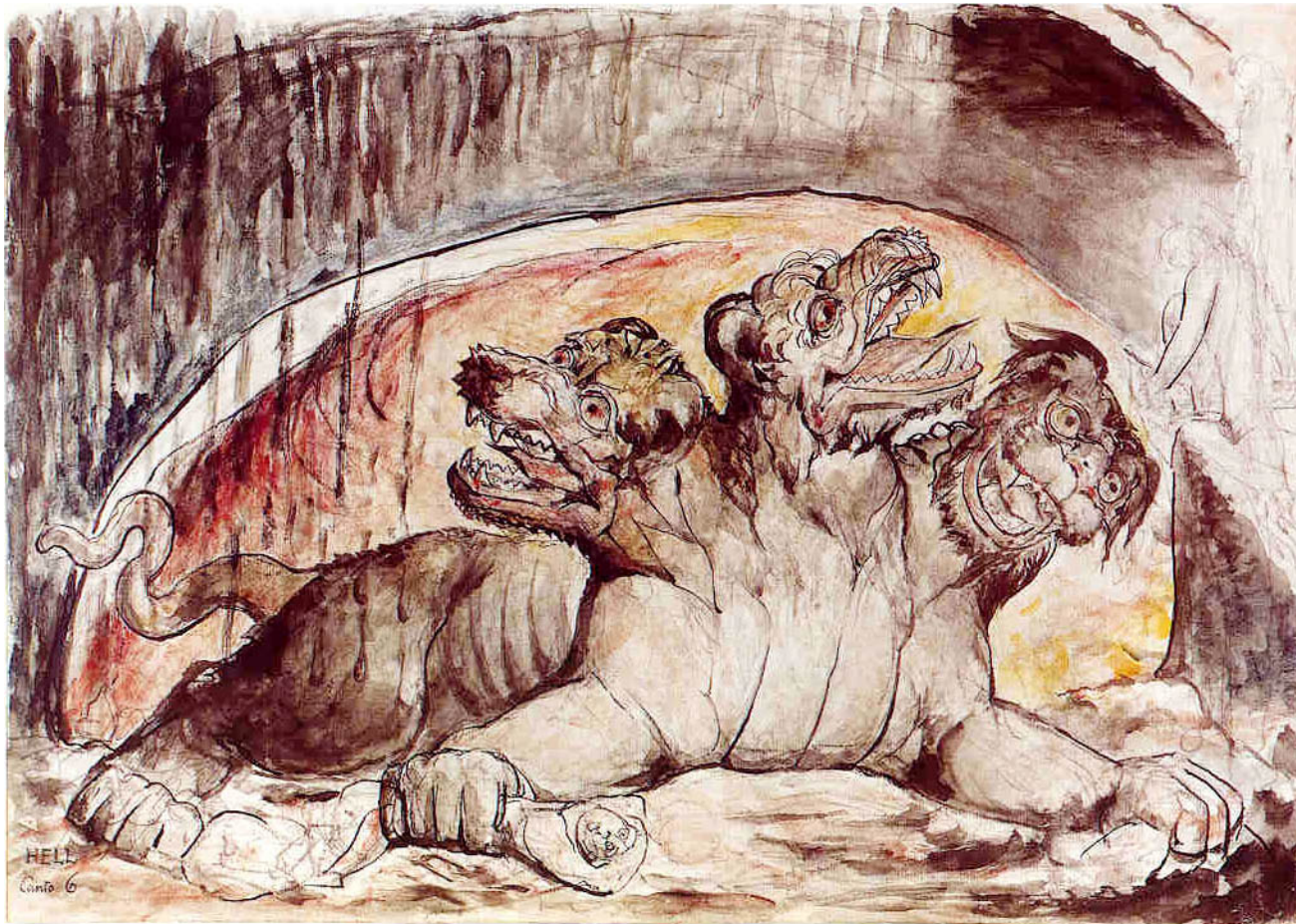
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Overview

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

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



Cerberus, William Blake (1757-1827)

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

- Incentivizing Quality Care Through Payment Reform (already addressed)
- Driving Quality of Care Through Public Reporting
- Enforcing Quality of Care Through the False Claims Act

Prong 2: Driving Quality of Care Through Public Reporting

Sources of Data

- PEPPER
- Hospital Quality Initiative
- PERM
- CERT
- PQRI
- State adverse event reporting
- Medical malpractice litigation
- *Qui tam* relators (whistleblowers)

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

Driving Quality of Care Through Public Reporting

- ***“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

Driving Quality of Care Through Public Reporting

Deficit Reduction Act Impact

- 2005 Deficit Reduction Act requirement effective January, 2007
 - Advise work force on federal and state False Claims Acts and whistleblower statutes.
 - Likely to generate additional government enforcement activity.

Driving Quality of Care Through Public Reporting

Performance Measurement Reporting System

- September 12, 2007.
- Proposed new system for public reporting of price/quality transparency in health care (physicians & hospitals).
- Pools and analyzes information about quality, performance and cost.
- Uses both public and private payor data.

Driving Quality of Care Through Public Reporting

Performance Measurement Reporting System (cont'd)

- Information disclosed to:
 - Consumers
 - CMS contractors
 - Other agencies (state & federal)
 - Chartered Value Exchangers and data aggregators, who will generate single or multi-payor performance measurement
 - Providers/physicians
 - Quality Improvement Organizations
 - Law enforcement
- PMRS will be a springboard for data mining and government enforcement actions.

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

- Physicians, executives, and board members face real risks for poor quality of care
 - ***"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

- Government prosecutions based on quality issues have grown exponentially in recent past.
- Six themes present in cases:
 - Unnecessary treatment/procedures
 - Kickbacks
 - Big admitters receiving special treatment
 - Poorly structured, or failure to follow, internal process
 - Underlying regulatory violations
- Examples
- Cardiac procedures especially risky

Enforcing Quality of Care Through the False Claims Act

Elements of a False Claim

- Submit or cause to be submitted, a claim for payment;
- Claim is false or fraudulent (false statement); and
- Scianter: “Knew or should have known” or “reckless disregard” for the truth or falsity of the claim.
 - *No specific intent needed*

Enforcing Quality of Care Through the False Claims Act

Traditional Theories

- Claims for services not rendered
- Unbundling
- Claims for services not covered (e.g., wound care kits, urinary incontinence devices)
- Duplicate payments

Quality of Care Theories

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

Enforcing Quality of Care Through the False Claims Act

“[F]raudulent furnishing of medically unnecessary invasive procedures not only causes financial harm but puts patients at significant risk. The Office of Inspector General will vigorously investigate such cases and require appropriate corrective action to safeguard future patient care.”

Daniel Levinson,
Inspector General
U.S. Department of Health and Human Services
August 17, 2006



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

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

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).

Number 3 Problem: A Siloing of Responsibility

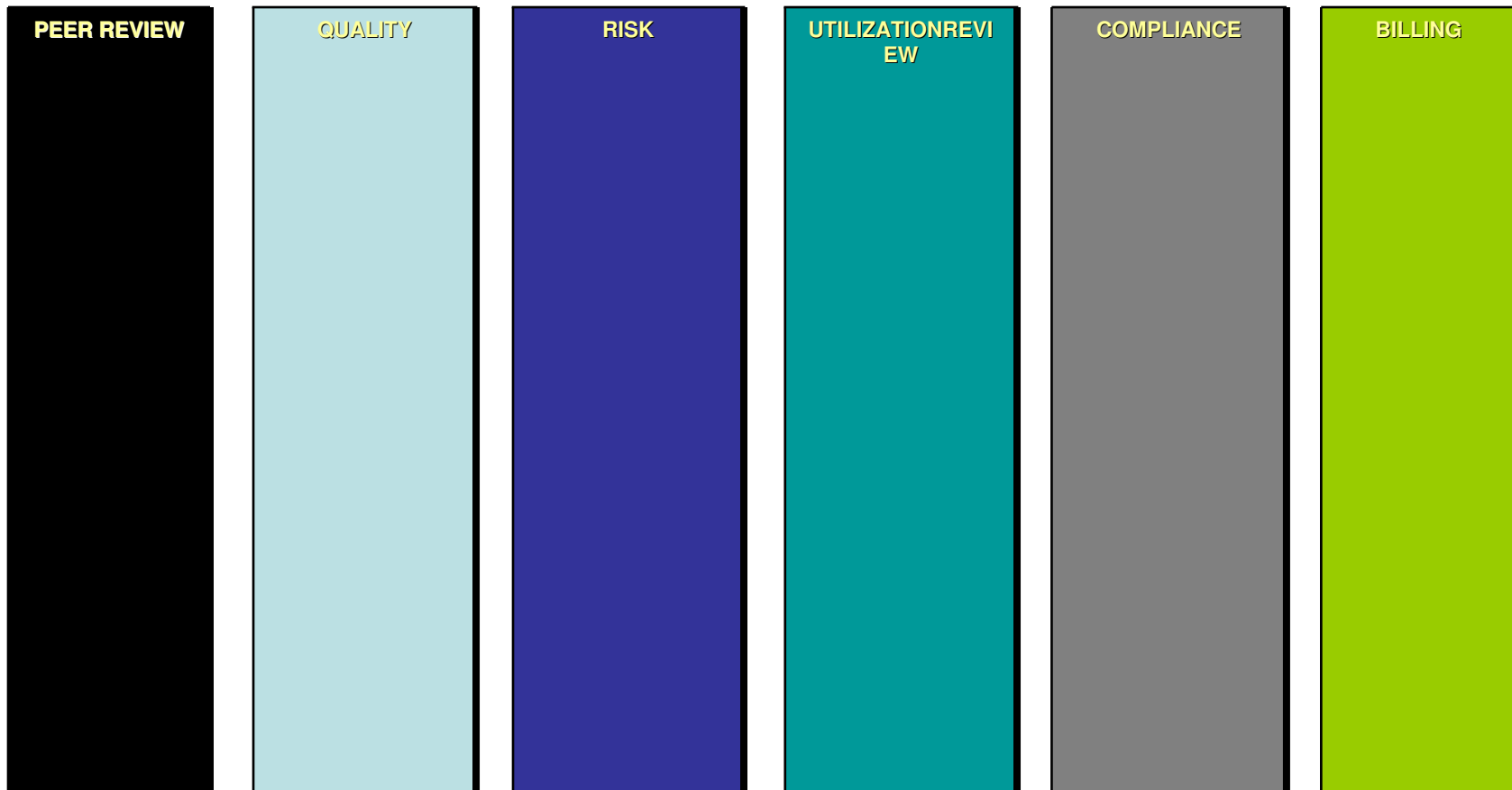
- ***“When looking at some of these very large [health care] corporations, there is a siloing of responsibility, which has the effect of inadequate cross of information between the peer review/quality people and the compliance people. The different components of a health care organization need to communicate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



Problems Under Current Structures

SILO Approach



Problems Under Current Structures

Number 4 Problem: 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.

Problems Under Current Structures

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.

Recommended Solutions

What is needed for the future

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

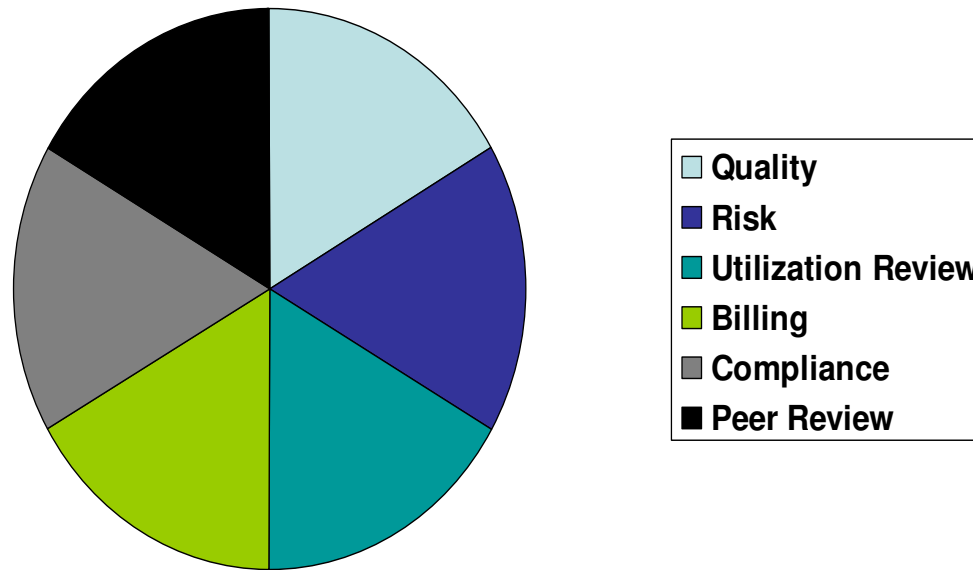
Recommended Solutions

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

Solution No. 2: Integrate Quality and Compliance



Be careful to maintain the privilege

Recommended Solutions

Solution No. 3: Board Education and Oversight

- Board must recognize quality/safety as a core fiduciary obligation.
- On September 13, 2007, OIG and AHCA 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

Board Education and 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.
- Board needs to receive regular reports (errors, outcomes).
- Increasing board education on quality – part of orientation.
- Recruiting one or more board members with expertise on quality.

Recommended Solutions

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

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

- 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

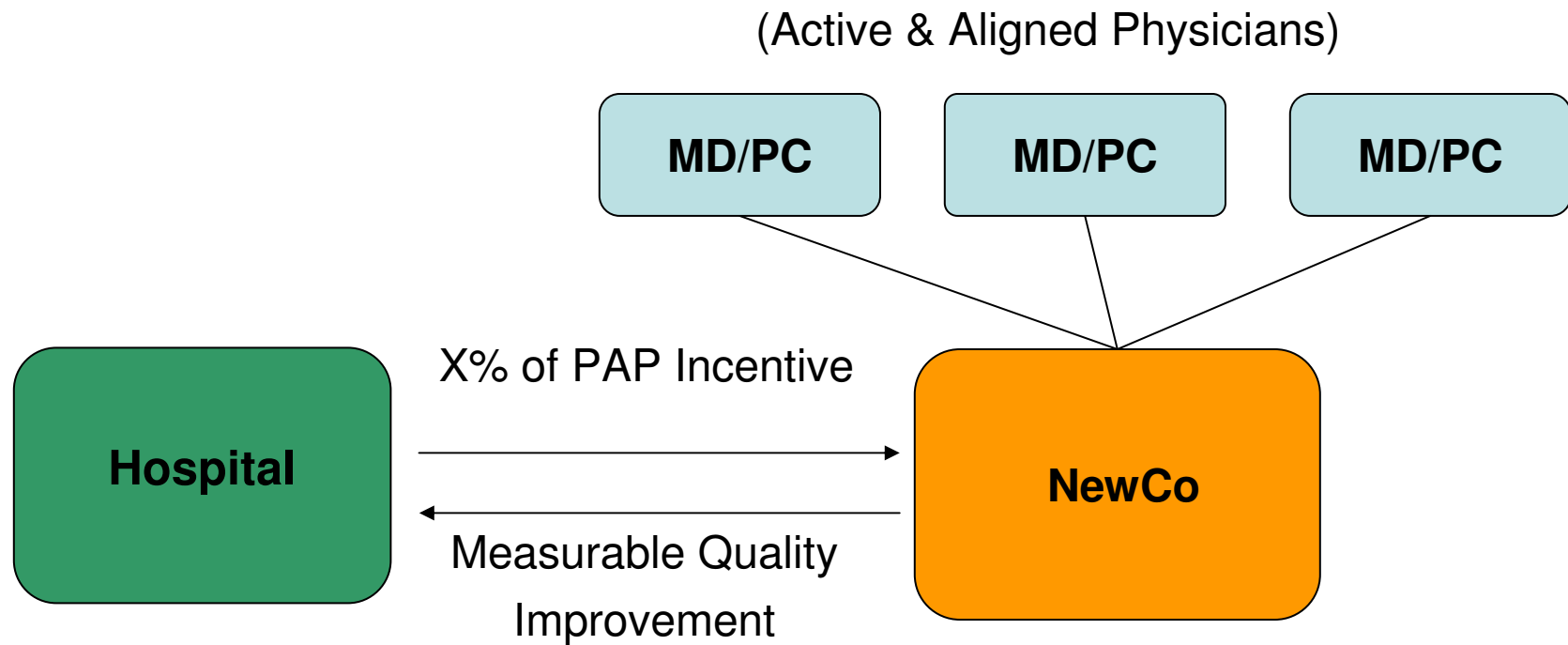
Recommended Solutions

Potential New Approach (Advisory Opinion pending)

- New legal entity to allow sharing of payments received from a payor or payors.
- Make the program specific:
 - Exactly what outcomes are intended?
 - How much are they worth?
 - Fixed payments?
 - Percentage of hospital's bonus?
 - Hybrid?
 - Determine fair market value.

Recommended Solutions

Proposed structure to reward physicians under P4P reimbursement



Recommended Solutions

- **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 expert to oversee quality and determine fair market value.
 - Consider disclosure to patients.

Questions?



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