The Crossroads of Physician Practice and Compliance

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Agenda

Fasten your seat belt for the new regulatory environment – overview of present quality measures

The work zone between physicians and compliance officers – case study

Forging the road ahead – practical tips
Health Care: Who Is In the Driver’s Seat?

Access

Quality

Cost

Driver A – Access

- Old drivers
  - People went to the doctor when they were sick
  - The more health care costs, less people can afford it
  - Inconsistent health care accounting leaves unknown how much care is provided to uninsured and at what cost

- New drivers
  - Preventative care
  - Medicaid State Children’s Health Insurance Program (SCHIP) challenges
  - Limited Medicaid for adults
  - Limited providers accepting Medicare for seniors
  - Employer cuts to health benefits
  - More uninsured and under insured
  - Higher premiums
Driver B – Cost

- Old drivers
  - Patients paid for health care out of pocket
  - Government public hospitals
  - Committee on the Cost of Medical Care (1927)
  - Private third party payors, Medicare, and Medicaid
  - Prospective Payment Systems (1983)

- New drivers
  - Health care “field” is now an “industry”
  - HMOs, PPOs, POS, MSAs
  - $2T+ in spending
  - GDP 18% (2008)
  - Estimated GDP 30% (2035)
  - Universal health care proponents and opponents

Driver C – Quality

- Old drivers
  - Case-by-case analysis
  - Identifying outliers
  - Peer review
  - Retroactive incident focus
  - Segregated efforts

- New drivers
  - Practice guidelines
  - Physician profiling
  - Trending
  - Forecasting
  - Structure changes
  - Process changes
Health Care: Who Is In the Driver’s Seat?

• Trends
  – Quality and patient safety
  – Pay for Performance (P4P)
  – Consumer driven health care
  – Physician-hospital collaboration and competition
  – Hospitalists
  – Physician compensation arrangements
  – Staffing shortages
  – Heal yourself health care

Fasten Your Seat Belt For
The New Regulatory Environment

Quality Street – The Ride So Far
**Quality Street – The Ride So Far**

- Organized medical groups
  - American Medical Association (1847)
  - American College of Surgeons Hospital Standardization Program (1917)
  - Medical Group Management Association (1926)

- Joint Commission (1952)
  - Medical record audits (1966)
  - Quality assurance (1979)
  - Continuous quality improvement (1988)

- Institute for Healthcare Improvement (IHI) (1991)
  - Measurable goals
    - No needless deaths
    - No needless pain or suffering
    - No helplessness in those served or serving
    - No unwanted waiting
    - No waste

- Leapfrog Group (1998)
  - Aims
    - Reduce preventable medical mistakes and improve the quality and affordability of health care
    - Encourage health providers to publicly report their quality and outcomes so that consumers and purchasing organizations can make informed health care choices
    - Reward physicians and hospitals for improving the quality, safety and affordability of health care
    - Help consumers reap the benefits of making smart health care decisions
Quality Street – The Ride So Far

- Institute of Medicine Report (1999)
  - *To Err Is Human: Building a Safer Health System*
    - Increased national awareness of health care quality
    - Emphasized patient safety
    - Supported mandatory error reporting systems
    - Set performance standards
    - Estimated 98,000 people die annually due to medical errors

Quality Street – The Ride So Far

- Institute of Medicine Report (2001)
  - *Crossing the Quality Chasm: A New Health System for the 21st Century*
    - Outlined how to reinvent the health care system to foster innovation and improve the delivery of health care
    - Outcome measures for health care
      - Safe
      - Effective
      - Patient-centered
      - Timely
      - Efficient
      - Equitable
Regulatory Street – The Ride So Far

- State licensing (late 1800’s)
- FDA federal medication regulation (1906)
- Social Security Act standards for maternal and children’s health care services (1935)
- Medicare Conditions of Participation (1965)
  - Medical staff credentialing
  - Utilization review
  - Physician fiscal responsibility
- Joint Commission “deemed” status (1965)
- Professional Standards Review Organization (PSRO) established to decrease hospital utilization (1972)
  - Physicians concerned that PSROs focused on cost over quality
### Regulatory Street – The Ride So Far

- **Prospective Payment Systems (1983)**
- **Peer Review Organizations (PROs) (1983)**
  - Inspect and detect approach
  - To reduce readmission and unnecessary hospitalization
  - To lower death and complication rates
  - To identify physician quality of care issues
  - Physicians concerned that PROs generated more paperwork than improvement
- **Health Care Quality Improvement Act (1986)**
  - National Practitioner Data Bank
    - Medical malpractice claims settlements and awards
    - Hospital medical staff adverse actions

### Regulatory Street – The Ride So Far

- **CMS (formerly Health Care Finance Administration) Health Care Quality Improvement Initiative (1992)**
  - Changed PROs approach to data collection, its quality of care evaluation criteria, and its role in implementing quality initiatives
  - Focus on practice patterns
  - Evaluate quality using national, disease specific guidelines
  - Work collaboratively with hospitals and physicians on quality improvement initiatives
  - 7 elements of effective compliance program
  - No "one size fits all"
  - Goals
    - Optimize payment
    - Minimize billing mistakes (erroneous v. fraudulent claims)
    - Decrease chances of audits
    - Avoid conflicts with Stark and Anti-Kickback statutes
Regulatory Street – The Ride So Far

• Quality Improvement Organizations (QIOs) (2001)
  – Expanded role of QIOs in quality improvement initiatives
  – No published assessments of whether hospitals and physicians believe QIO interventions are improving quality

• Sarbanes-Oxley Act of 2002
  – Impacts health care organizations
    • Impetus for enterprise risk management
    • Reputation is everything
    • More reliable and relevant documentation is necessary for financial statements and clinical quality measures

Regulatory Street – The Ride So Far

• Deficit Reduction Act of 2005
  – Medicare and Medicaid Integrity Programs
  – Gainsharing projects
  – Hospital Quality Data Payment Update Program expansion

• Tax Relief and Healthcare Improvement Act of 2006
  – Physician Quality Reporting Initiative
  – 1.5% bonus for physician participants
  – Quality measure registry reporting

• IPPS and OPPS Cuts Continue
  – IPPS $20B cut
  – AHA said an “unnecessary and demoralizing blow against hospitals’ ability to care for patients across America”
  – OPPS cuts to radiology and drugs
Fasten Your Seat Belt For The New Regulatory Environment

The Crossroad of Quality and Regulatory Streets

• What is P4P?
  – Payment model that rewards physicians and hospitals for achieving certain performance measures for quality and efficiency
  – Value-based purchasing
  – Concept prevalent in other industries
  – Gets away from resource-based fee-for-service reimbursement leaves little incentive for quality improvement
  – Physicians concerned that
    • Clinical practice guidelines have not undergone clinical trials
    • Patient non-compliance is out of their control
    • P4P will lead to broken physician-patient relationships
P4P Construction Zones

• CA P4P Project (2001)
  – Emerged from CA health care plans and physician groups developing a set of quality performance measures and a public report card the 1990s
  - Financial incentives based on utilization management were changed to quality measures

The Crossroad of Quality and Regulatory Streets

• National Voluntary Hospital Reporting Initiative (NVHRI)
  – Set forth in Medicare Modernization Act of 2003
  – Public-private joint effort
  – 21 quality measures
P4P Construction Zones

  - Part of CMS efforts to monitor and improve the quality of care delivered to Medicare beneficiaries
  - Early warning system for declines in quality of care
  - Quality indicators provided to Medicare beneficiaries
  - Utilization and outcome quality measures (as opposed to process quality measures) for many areas

- Medicare Quality Monitoring System (MQMS)
  - Based on administrative data
  - Trends from 1992 though 2001
  - Various clinical and topic areas
    - Characteristics of Medicare beneficiaries and their utilization of health care
    - Acute myocardial infarction
    - Heart failure
    - Stroke
    - Pneumonia
    - Cardiovascular surgeries
    - Cancer surgeries
## P4P Construction Zones

- **Medicare Quality Monitoring System (MQMS)**
- **Coming Soon**
  - Diabetes preventive services utilization as well as short- and long-term complication rates
  - Patient safety
  - Preventable hospitalizations
- **National and state-level outcomes (not hospital-level outcomes)**
- Adjusted to a standardized distribution of age and sex; not otherwise risk adjusted

## P4P Construction Zones

- **The Physician Focused Quality Initiative (2004)**
  - Implemented to
    - Assess the quality of care for key illnesses and clinical conditions that affect Medicare patients
    - Support physicians in providing appropriate treatment of the conditions identified
    - Prevent health problems that are avoidable, and
    - Investigate the concept of payment for performance
    - [http://www.cms.hhs.gov/PhysicianFocusedQualInits/](http://www.cms.hhs.gov/PhysicianFocusedQualInits/)
P4P Construction Zones

• Doctor’s Office Quality Project (DOQ)
  – Designed to develop and test a comprehensive, integrated approach to measuring the quality of care for chronic disease and preventive services in the doctor’s offices

• DOQ goals are to
  – Provide information for informed decision making
  – Support and stimulate the adoption of quality improvement strategies by practitioners in doctor’s offices

• CMS is working closely with key stakeholders such as nationally recognized physicians associations, consumer advocacy groups, philanthropic foundations, purchasers, and quality accreditation or quality assessment organizations to develop and test DOQ

P4P Construction Zones

• MGMA
  – “A pay-for-performance program that conforms to certain established principles can potentially make health care programs more effective and efficient.”
  – 9 principles
    • Goal must be to improve quality and safety
    • Physician participation must be voluntary
    • Practicing physicians must be involved in program design
    • Must use evidence-based performance measures
    • Must use adjusted data
    • Must reward physician participation
    • Medicare P4P must not be budget neutral
    • Must reimburse physicians for administrative costs
    • Physicians must be able to review and correct performance data
### P4P Construction Zones

- **Physician Group Practice Demonstrations (2005)**
  - Mandated by the Medicare, Medicaid, and SCHIP by the Benefits Improvement and Protection Act of 2000 (BIPA)
  - First P4P initiative for physicians under the Medicare program
  - Rewards physician for meeting performance measures for quality outcomes and efficiency
  - Disincentives for medical errors
  - Focused on large group practices (200+ physicians)

### P4P Construction Zones

- **Premier Hospital Quality Demonstration (2006)**
  - 260 hospitals
  - 34 quality measures
  - Public reporting of data
  - 2% or 1% bonus (49/260 received a bonus)
  - 2% or 1% penalty
P4P Construction Zones

- Medicare Health Care Quality Demonstration (2006)
  - MMA mandated 5 year demonstration program
  - Projects designed to enhance quality by
    - Improving patient safety
    - Reducing variations in utilization by appropriate use of evidence-based care and best practice guidelines
    - Encouraging shared decision making
    - Using culturally and ethnically appropriate care
  - Eligible participants include physician groups and integrated health systems

- Physician Quality Reporting Initiative (PQRI)
  - Voluntary pay for reporting program started in 2007
  - Based on the Tax Relief and Health Care Act of 2006 (TRHCA)
  - Physicians collected and reported Medicare practice data for 74 performance measures between July and December 31, 2007
  - Participating physicians reporting on at least three performance measures on 80% of the eligible patients throughout the full calendar year will receive a bonus from CMS
P4P Construction Zones

- Physician Quality Reporting Initiative (PQRI)
  - PQRI continues for January 1 through December 31, 2008
  - 2008 PQRI quality measure specifications
  - CMS physician education article on PQRI
  - PQRI is considered a precursor to mandatory pay for performance (P4P)

P4P Construction Zones

- Physician Quality Reporting Initiative (PQRI)
  - 2008 PQRI Coding For Quality Handbook provides coding and reporting principles and describes successful reporting for each measure:
    - [http://www5.mgma.com/ecom/default.aspx?tabid=64&dest=http%3a%2f%2fwww.mgma.com%2fWorkArea%2fshowcontent.aspx?id%3d15736%7cRef%3dhttp%0d%0a0zx1%2fzx1www.mgma.com%2fzx1policy%2fdefault.aspx%2f%2did%2f%2f15570](http://www5.mgma.com/ecom/default.aspx?tabid=64&dest=http%3a%2f%2fwww.mgma.com%2fWorkArea%2fshowcontent.aspx?id%3d15736%7cRef%3dhttp%0d%0a0zx1%2fzx1www.mgma.com%2fzx1policy%2fdefault.aspx%2f%2did%2f%2f15570)
  - CMS and AMA jointly developed PQRI data collection worksheets
  - 119 quality measures
P4P Construction Zones

- Medicare Care Management Performance Demonstration (2007)
  - Modeled on the “Bridges to Excellence” program
  - A 3 year P4P demonstration with physicians to promote the adoption and use of health information technology to improve the quality of patient care for chronically ill Medicare patients
  - Physicians who meet or exceed CMS performance standards in clinical delivery systems and patient outcomes will receive bonus payments for managing eligible Medicare beneficiaries
  - Focused on smaller practices in 4 states

The Crossroad of Quality and Regulatory Streets

- OIG/AHLA Publication (2007)
  - Corporate Responsibility and Health Care Quality: A Resource For Health Care Boards of Directors
  - Designed for health care organization boards
  - Consumers are demanding greater transparency and information about the care they receive
  - Medicare and other payors are linking payment to quality of care
  - Physicians are striving to deliver the highest quality care
  - Regulators are making health care quality a priority
  - Offers questions related to health care quality requirements, measurement tools, and reporting requirements that may be useful to those looking at quality of care issues
  - [http://oig.hhs.gov/fraud/docs/complianceguidance/CorporateResponsibilityFinal%209-4-07.pdf](http://oig.hhs.gov/fraud/docs/complianceguidance/CorporateResponsibilityFinal%209-4-07.pdf)
The Crossroad of Quality and Regulatory Streets

- New Joint Commission Requirements
  - Pushed by regulators
  - 6 areas of physician competency to evaluate
  - Based on physician performance data
  - Increased focus on patient safety
  - Requires physician competency feedback reports
  - No longer ok to assess competency just at reappointment
  - Help physicians use data to effect change

Enforcement – Traffic Tickets

- Medicare/Medicaid Conditions of Participation
  - The medical staff is accountable to the board to monitor quality
- Joint Commission
  - Deemed status substitute for COP
- OIG, DOJ, and State Attorneys General
  - Working together to enforce quality
  - Focus on medical necessity and failure of care
  - Penalties
    - $ fines
    - Criminal sanctions
    - Program exclusion
    - Corporate integrity agreements
The Crossroad of Quality and Regulatory Streets


NEWS RELEASE

- Arlington, Va. (January 7, 2008) – Patient care quality ranks at the top of the list of health law issues for 2008, according to an informal survey of health law attorneys by BNA's *Health Law Reporter™*. Quality of care supplants fraud and abuse, which held the top spot for the previous two years.

The Work Zone Between Physicians And Compliance Officers

Case Study
Who’s Navigating the Road Ahead?

- The intersection of work with the vehicles must be a team effort or there may be a collision ahead
  - Physicians
  - Finance
  - Patient Safety
  - Infection Control
  - Risk Management
  - Utilization Review
  - Health Information Services
  - Quality
  - Compliance

Ignition Controls: Everybody is Working

- Watch for individual construction zones
  - Duplication of work
  - Inconsistent:
    - Goals
    - Measures
    - Communication/reports
    - Education
    - Follow through
      - Acting on the data – QI
      - Monitoring change
      - Documenting the improvements
Forging the Road Ahead

Practical Tips

What Gets Measured Gets Done

Quality goals
+ Compliance standards met
= Patient focus and best practice

What’s on your organizational dashboard?
Physician Practice Trends

- Quality and patient safety
- Transparency
  - Publicly available quality data
  - Communication of unanticipated outcomes
  - Easier patient access to their own information
- Electronic health records
  - Health care lags behind other industries
  - IT can help inefficiencies
- Efficiency in health care delivery
- Physician staffing shortages
- New quality metrics
- Hospital-physician collaboration and competition

Racing Ahead

- Check in with colleagues
- Check in with hospital staff
- Check physician practice listserves
- Check compliance listserves
- Check CMS website
- Check OIG website
- Check professional association websites for P4P white papers and status updates
Resources

• OIG Physician Compliance Plans

• CMS P4P

• AMA P4P White Paper

• MGMA Position Paper on P4P

• AMGA Results-Based Payment System Initiative
  – http://www.amga.org/RPS/index_rps.asp

Questions and Comments
Conclusion