Overview

- What does the Government expect from P4P (also known as value-driven healthcare)?
- What are the consequences if the Government’s expectations are not met?
- How does P4P information contribute to a provider’s “footprint”?
What Does the Government Expect from Value-Driven Healthcare?

Goals for Value-Based Purchasing (per CMS):

- **Financial Viability** — where the financial viability of the traditional Medicare fee-for-service program is protected for beneficiaries and taxpayers
- **Payment Incentives** — where Medicare payments are linked to the value (quality and efficiency) of care provided
- **Joint Accountability** — where physicians and providers have joint clinical and financial accountability for healthcare in their communities

(Cont’d)

- **Effectiveness** — where care is evidence-based and outcomes-driven to better manage diseases and prevent complications from them
- **Ensuring Access** — where a restructured Medicare fee-for-service payment system provides equal access to high quality, affordable care
- **Safety and Transparency** — where a value based payment system gives beneficiaries information on the quality, cost, and safety of their healthcare
What Does the Government Expect from Value-Driven Healthcare?

- Goals for Value-Based Purchasing (per CMS): (cont’d)
  - **Smooth Transitions** — where payment systems support well coordinated care across different providers and settings
  - **Electronic Health Records** — where value driven healthcare supports the use of information technology to give providers the ability to deliver high quality, efficient, well coordinated care

Source: *Roadmap for Implementing Value-Driven Healthcare in the Traditional Medicare Fee-for-Service Program*

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Number of Quality Measures by Setting, Currently in Place

- Hospital Inpatient - 60
- Physicians and other Professionals (PQRI) - 153
- Nursing Home - 19
- Home Health - 12
- ESRD - 22
- Part D - 23
- Medicare Advantage - 59

Source: *CMS Roadmap for Quality Measurement in the Traditional Medicare Fee-for-Service Program*
CMS Reports Results – 8/17/2009

- Hospital Quality Incentive Demonstration
  - Raised overall quality by an average of 17 percentage points over 4 years
  - Designed to test payment incentives to see if they would improve safety, quality, and efficiency by linking incentives to improved quality
  - Incentive payments of $12 million to 225 top-performing hospitals (more than $36.6 million over 4 years)


CMS Reports Results – 8/17/2009

- Physician Group Practices
  - All 10 groups achieved benchmark performance on at least 28 of the 32 measures (2 achieved benchmark on all 32)
  - Over first 3 years, groups increased quality scores an average of 10 percent
  - Performance payments for 5 groups total $25.3 million (their share of $32.3 million in savings for Medicare)
CMS Reports Results – 8/17/2009

- Medicare Care Management and Performance
  - Goal to promote the use of HIT to improve quality of care for beneficiaries with chronic conditions
  - 560 of 610 participating small and solo physician practices are being rewarded for performance on 26 quality measures
  - Total of $7.5 million in payments made
    - Average payment of $14,000 (largest $62,500)

What Is Included in P4P?

- Many variations
  - Incentives for *reporting* certain quality measures
  - Denials of payments for HACs
  - Incentives related to *performance* on certain quality measures
  - Denials of payments for “never events”
Reporting Hospital Quality Data for Annual Payment Update (RHQDAPU)

- Created 2003 as part of CMS’ Hospital Quality Initiative; now in CMS Regulations at 42 C.F.R. § 412.64(d)(2)
- Provides financial incentives to report certain quality measures — IPPS Final Rule (7/31/2009) added 4 new measures, in addition to existing 43 measures

- Currently, failure to report these measures results in a 2.0% reduction in the annual market basket update (the measure of inflation in goods and services used by hospitals in treating Medicare patients)
- Requires electronic acknowledgement of completeness and accuracy of data submitted for RHQDAPU payment
Hospital Outpatient Quality Data Reporting Program (HOP-QDRP)

- Based upon Tax Relief and Healthcare Act of 2006 and the FY 2009 OPPS Final Rule (Nov. 18, 2008)
- FY 2010 Proposed Rule: Required measures as set forth below, but CMS is seeking comment on 16 potential additional quality measures
- FY 2009: 11 quality measures, including 5 that apply to EDs, 2 related to outpatient surgery (prevention of infection), and 4 related to imaging
  - CMS to publish data by 2010

Hospital [now Healthcare] Acquired Conditions (HACs)

- Effective 10/1/2008, CMS denied any additional payments under the Inpatient Prospective Payment System (IPPS) for complications due to certain preventable HACs, unless they were present on admission
  - (Secondary diagnosis not present on admission will not receive a higher severity MS-DRG for that HAC)
- Includes: Objects left in during surgery, blood incompatibility, falls and trauma, etc.
  - No new HACs for FY 2010
Hospital [now Healthcare]  
Acquired Conditions (HACs)

- CMS has indicated an intent to expand the HAC scrutiny to hospital outpatient departments, ASCs, SNFs, HHAs, physician practices, and other settings where preventable conditions can arise  
  [FY 2009 OPPS Final Rule, Nov. 18, 2008]

Physician Quality  
Reporting Initiative (PQRI)

- Created by Tax Relief and Health Care Act of 2006 (TRHCA)
- Incentive payment for eligible professionals who satisfactorily report data on quality measures for covered professional services furnished to Medicare beneficiaries
- First payments made in late summer 2008
Physician Quality Reporting Initiative (PQRI)

- Program extended indefinitely by MIPPA – incentive increased from 1.5 to 2.0 of allowed charges for covered professional services in 2009 and 2010
- 153 total measures from which eligible professionals can select for 2009 PQRI

Home Health: Pay for Reporting

- Data submitted through Outcome and Information Set (OASIS)
- If all quality data submitted as required, HHA receives full home health market basket update — If not, the market basket is reduced by 2.0%
- Quality measures are posted on the Medicare Home Health Compare website
Nursing Home VBP Demonstration (NHVBP)

- Currently in demonstration stage – project to begin 2009
- CMS anticipates that potentially avoidable hospitalizations may be reduced, and result in savings to Medicare
- Each year, CMS will assess each participant’s quality performance in four domains: staffing, appropriate hospitalizations, MDS outcomes, and survey deficiencies

Nursing Home VBP Demonstration (NHVBP)

- Those in top 20 percent on scores and those in top 20 in IMPROVED scores will be eligible for a share of the State’s savings pool
ESRD Services

- MIPPA requires that CMS implement, beginning in 2012, quality incentives into the composite rate — Proposed Rule issued September 15, 2009
- ESRD facility must achieve a total performance score that meets or exceeds a level to be determined by HHS, based on criteria to be developed by CMS with a wide range of performance standards, including anemia management and other possible factors such as patient satisfaction

“Never Events”

- CMS issued three National Coverage Determinations on January 15, 2009 precluding payment for:
  - Wrong surgical or other invasive procedures performed on a patient
  - Surgical or other invasive procedures performed on the wrong body part
  - Surgical or other invasive procedures performed on the wrong patient
“Never Events”

- NCD approach means payment is precluded for all providers and suppliers, not just in-patient hospitals

What Does the Government Expect in Terms of Coding and Documentation?
Coding Paints a Legal Picture

- Payment for services depends upon accurate coding of information necessary to support a claim
  - Most claims are processed electronically; the claim must be able to pass computer-edits in snapshot form
  - Note: for legal purposes (i.e., risk), a “claim” would include a report of quality measures which may impact upon P4P

Coding Paints a Legal Picture

- Accurate description of the service provided is key
- In many cases, P4P reporting will also require accurate coding relating to the clinical setting (e.g., physician office vs. outpatient clinic), the rendering clinician, the diagnosis, etc.
- National and local coverage determinations are part of the electronic edit process for claims – e.g., LCDs for Never Events
Documentation

- The patient chart must contain information to support the coded claim which may go beyond the information provided on the claim
  - E.g., chart documentation should clearly show medical necessity for the service provided
- Look to CMS’ goals for long range documentation expectations
  - E.g., smooth transitions between levels of care; patient satisfaction measurements

Quality Measurement Goals (from CMS):
Consider Long Range Implications for Documentation

- Safety – where care doesn’t harm patients
- Effectiveness – where care is evidence-based and outcomes driven to better manage diseases and prevent complications
- Smooth Transitions of Care – where care is coordinated across different providers and settings
Quality Measurement Goals (from CMS):
Consider Long Range Implications for Documentation

- **Transparency** – where information is used by patients and providers to guide decision-making and quality-improvement efforts, respectively
- **Efficiency** – where resources are used to maximize quality and minimize waste
- **Eliminating Disparities** – where quality care is reliably received regardless of geography, race, income, language, or diagnosis

Now the Stakes are Higher

- Coding and Documentation will be the basis for higher payments
  - Even more items to code: e.g., conditions present on admission
- Some items which must be reported may be outside the usual expertise of coders and those in medical records departments – need for more coordinated focus amongst functions
What are the Consequences of a Failure to Meet the Government’s Expectations?

Consequences of Insufficient Coding/Documentation

- Claim (either for service or for additional reimbursements) may be denied, either initially or upon subsequent review
  - Data mining ever more sophisticated
  - Whistleblowers
  - Patterns or practices may lead to audits, pre-pay reviews, payment suspensions, investigations, etc.
The Government’s Three-Prong Approach To Quality of Care

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

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Elements of a False Claim

- Submit or cause to be submitted, a claim for payment;
- Claim is false or fraudulent (false statement); and
- Scienter: “Knew or should have known” or “reckless disregard” for the truth or falsity of the claim.
  - *No specific intent needed*
What Kind of Footprint
Is Your P4P Reporting Leaving?

Your Footprint for CMS and Other Government Agencies

- Problem areas highlighted!
- Think about what CMS will be seeing and focus on any necessary actions!
Your Footprint for the Public

- Transparency of quality and cost information equips consumers to make informed decisions about their health care, while encouraging providers to improve quality and efficiency (per CMS)
  - *E.g., Hospital Compare* – a website tool developed to publicly report credible and user-friendly information about quality of care, debuted on April 1, 2005

Your Footprint for the Public

- Beginning in March 2008, CMS began posting costs in addition to quality information about selected in-patient hospital stays: includes how often Medicare patients were admitted for select conditions and what Medicare pays for those services
- Soon to be added – patient survey information
Your Footprint for Whistleblowers

- Raises the risks of whistleblower actions
  - DRA educational efforts have increased knowledge of availability of whistleblower actions
  - Demonstrated results of care provided
  - Easier to demonstrate requisite knowledge upon which to build a false claims act case

Your Footprint for Internal Compliance/Management Teams

- P4P reporting provides helpful information to address issues internally – have a process to involve your compliance department in evaluating results!
- May have indications for utilization review, peer review, etc.
Conclusions

- P4P increases the points at which information breakdowns can occur
- P4P increases the risks associated with data submission (both accurate and inaccurate data can lead to consequences)
- P4P’s transparency goals merit increased focus on and resources for processes designed to assure compliance and improving outcomes

Questions?

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