

# WHY IN THE WORLD IS THE COMPLIANCE OFFICER ASKING ABOUT QUALITY?

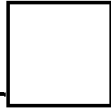
**Deborah Grimes**, Chief Diversity Officer, UAB Health System

**Eugena White**, Compliance Officer, Medical West, an affiliate of the UAB Health System

## Objectives

- Define compliance and quality, explore CMS's value-based reimbursement model, evaluate the alignment of quality care with reimbursement, and examine work models requiring synergy between compliance and quality to meet CMS requirements;
- Introduce key programs related to value-based reimbursement, examine the implications for the receipt of quality-based reimbursement, and discuss the compliance professionals' role in monitoring compliance with CMS regulations
- Learn effective techniques to monitor and share data
- Study effective tools to aid collaboration between senior leadership and the medical staff regarding operations, finances, and clinical outcomes for value-based reimbursement

## About The Speakers...



**Deborah Grimes,**  
**JD, MSHQS, RN, CHC, CPHQ**  
Chief Diversity Officer

- B.S. Nursing
- M.S. Healthcare Quality & Safety
- Juris Doctor (Law)
- **32 years of healthcare experience**
  - - Registered Nurse (RN)
  - - Healthcare Attorney, Risk Management
  - - Director, Joint Commission
  - - VP, Quality/Regulatory Affairs
  - - Chief Compliance Officer
  - - Chief Diversity Officer
  - - Adjunct Professor (Healthcare)



**Eugena White,**  
**JD, MSHQS, RHIA, LSSGB, CHC**  
Compliance Officer

- B.S. Health Information Management
- M.S. Healthcare Quality & Safety
- Juris Doctor (Law)
- **18 years of healthcare experience**
  - - HIM Professional (RHIA)
  - - Data Analyst, Quality / Risk Management
  - - PI Coordinator, Hospital Quality
  - - Hospital Compliance Manager
  - - Compliance Officer
  - - Adjunct Professor (Healthcare)

## UAB Health System – University Hospital

Birmingham, Alabama



- 1,157 –bed flagship facility for the UAB Health System and primary teaching site for the UAB Health System
- Only Level 1 Trauma Center and Burn Center in Central Alabama
- Largest comprehensive transplantation program in the southeastern United States
- Regional Neonatal Intensive Care Unit (NICU)
- 57 Operating Rooms
- State-of-the-art Heart and Vascular Center
- Only Adult Magnet Nursing Program in Alabama
- Among the 100 “Most Wired” hospitals in the United States
- Largest hospital in Alabama
- Third-largest public hospital in the nation

## UAB Health System – The Kirklin Clinic

Birmingham, Alabama



- 38 Multi-specialty Clinics
- 490,000+ Arrived Annual Appointments
- 1,500 Average Unique Patients per Day
- 600 Physicians
- 300 Non-Physician Providers
- 500+ Staff
- 440,000+ square footage of clinical space

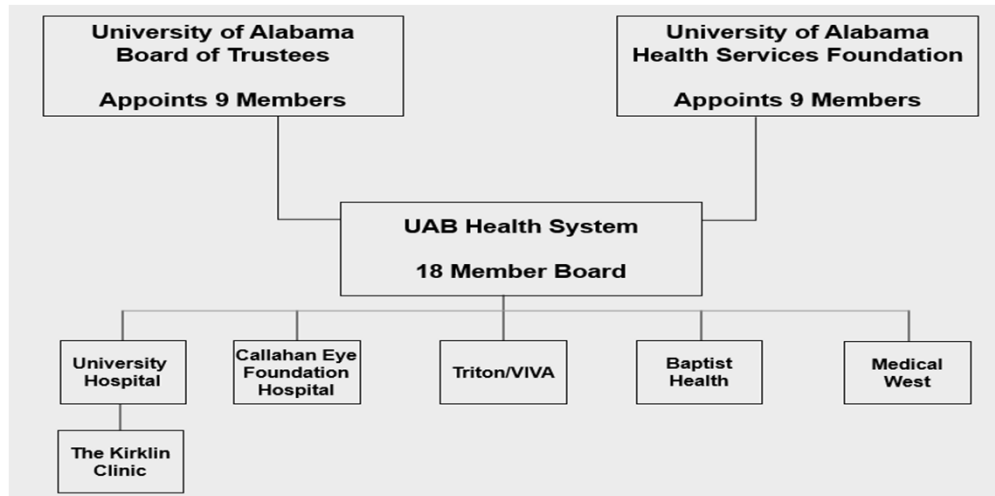
## Medical West, an affiliate of UAB Health System

Bessemer, Alabama



- 310-bed acute care community hospital located in Bessemer, Alabama – fifteen minutes from downtown Birmingham, Alabama
- 1,200 employees, 300 medical staff
- 16 outpatient health centers; 21-bed Main Campus Emergency Department
- Freestanding Emergency Department (first in the State of Alabama) located fifteen minutes from the main Hospital campus.
- In 2017: 7,065 inpatient admissions, 75,256 outpatient visits, 70,587 ER visits (42,845 at Main ER and 27,742 at FED) , 9,407 surgeries, and 363 live births.

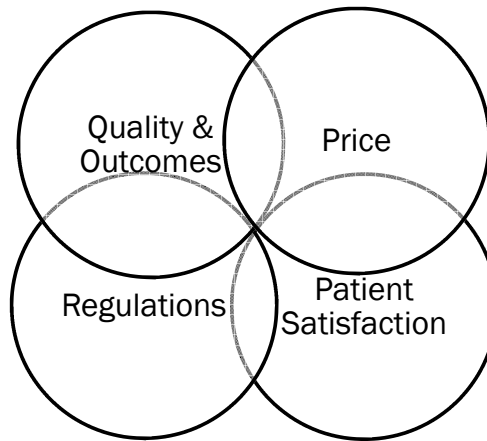
## UAB Health System: Governance Structure



## The Current Healthcare Landscape

**Population Health**   **Funding Reductions**  
**Meaningful Use**   **High Deductible Health Plans**  
**Organizational Alignment**   **Public Reporting**  
**Readmission Rates**   **Bundled Payments**   **ICD-10**  
**Intergenerational Workforce**   **Two Midnight Rule**  
**Aging Population**   **Affordable Care Act**  
**Accountable Care Organizations**   **IRS 501(r)**  
**Value-Based Purchasing**   **Payment Schedules**  
**Declining Reimbursement**   **Consumerism**  
**Medicaid Expansion**   **Collaboration**   **External Audits**  
**Transparency**   **CMS Core Measures**  
**New Provider Models**   **Clinical Effectiveness**  
**Direct Contracting**   **Employer-Driven Wellness**

## Healthcare Requires Us To Think More Than One-Dimensionally...



## Why?: Our New Environment

- Everything is transparent and available to the consumer
    - Quality/outcomes
    - Profiling by institution and physician
    - Cost for care
    - Comparison to other organizations
  - Payment for “Value”
    - Significant hospital financial impacts
    - Pending physician impacts
  - High Deductible Health Plans or employers will push patients to high quality/low cost organizations
- Quality can be a “strategic advantage”; however, we must achieve quality while adhering to compliance and regulatory guidelines.

## Quality (Defined)

- Quality can be defined based on the Institute of Medicine's Six Domains of Quality (STEEEP model) – care that is **S**afe, **T**imely, **E**fficient, **E**ffective, **E**quitable, and **P**atient-centered.
- Quality is doing the right things right.
- The QI/PI Plan – A Necessity!
  - demonstrates a systematic, organization-wide approach to providing uncompromising, safe, highest quality care and service to patients;
  - prioritizes goals at the organizational level;
  - benchmarks internal and external system goals (metrics, dashboards);
  - goals (targets) are driven down to the unit level and map back to the overall organization goals.



- The Methodology: PDCA – Plan, Do, Check, Act

## Healthcare Quality...The Journey

<u>Early 1900's</u>	<u>1940's</u>	<u>1950's</u>	<u>1960's</u>	<u>1980's</u>	<u>1990's</u>	<u>2000s</u>
<ul style="list-style-type: none"> <li>Ernest Codman, MD tracked hospital patients to determine treatment effectiveness.</li> <li>1918: American College of Surgeons (ACS) developed Minimum Standard for Hospitals and performed the first on-site hospital inspections.</li> </ul>	<ul style="list-style-type: none"> <li>Joseph Juran and Edward Deming established Quality Improvement</li> </ul>	<ul style="list-style-type: none"> <li>1952: Joint Commission on Accreditation of Hospitals created (JCAHO/JC)</li> </ul>	<ul style="list-style-type: none"> <li>1965: Medicare and Medicaid programs enacted</li> <li>Avedis Donabedian, MD published "Evaluating the Quality of Medical Care", demonstrating a new perspective on analyzing healthcare quality based on structure, process, and outcome.</li> </ul>	<ul style="list-style-type: none"> <li>Edward Deming principles eyed by healthcare</li> <li>1989: The Agency for Healthcare Research and Quality (AHRQ) created to improve quality, safety, efficiency, and effectiveness of healthcare through research.</li> </ul>	<ul style="list-style-type: none"> <li>1990: National Clinical Quality Association (NCQA) founded.</li> <li>1991: Institute for Healthcare Improvement (IHI) founded.</li> <li>1999: National Quality Forum (NQF) founded.</li> </ul>	<ul style="list-style-type: none"> <li>2000: Leapfrog Group founded.</li> <li>2000: IOM Report "To Err is Human"</li> <li>Quality dashboards</li> <li>Public reporting</li> <li>Six Sigma/Lean</li> <li>Culture of Safety/High Reliability Organizations</li> <li>STEEEP</li> <li>The Triple Aim</li> </ul>

## Compliance (Defined)



## Compliance (Defined)

### **EXPECTATION**

(Ethics, Values, Principles, Regulations, Laws)

### **PREVENTION**

(Education, Code of Conduct, Policies/Standards, Controls)

### **LOOKING FOR PROBLEMS**

(Auditing, Monitoring, Anonymous Reporting, Risk Assessment)

### **EVALUATION**

(Investigation, Measure for Effectiveness)

### **FIX AND FOLLOW-UP**

(Corrective Action, Enforce and Discipline)

### **REPORT**

(Compliance Activities, Disclosures, Updates to Board)

# Compliance (Defined)

## Compliance is...

- An operational plan for detecting and preventing liability and risk in healthcare
- Meeting the legal, ethical, and professional standards that apply to healthcare organizations and hospitals
- Oversight (policies, procedures, processes)
- Following the rules, laws, and policies that apply to your organization

# Healthcare Compliance...The Journey

<u>1970's</u>	<u>1980's</u>	<u>1990's</u>	<u>2000's</u>
<ul style="list-style-type: none"> <li>1976: The first Office of Inspector General (OIG) was established in what is now known as the Department of Health and Human Services.</li> </ul>	<ul style="list-style-type: none"> <li>1986: The False Claims Act was amended to include a whistleblower provision, penalties of up to triple damages, and per-claim penalties for healthcare.</li> <li>1987: Anti-Kickback Statute enacted.</li> </ul>	<ul style="list-style-type: none"> <li>Focus on healthcare fraud</li> <li>U.S. Sentencing Commission Guidelines established, noting penalty mitigation up to 95% if an "effective compliance program" was in place.</li> <li>1995: Stark Law enacted.</li> <li>1996: HIPAA enacted.</li> <li>1998: OIG Compliance Guidance (7 Elements of an Effective Compliance Program)</li> </ul>	<ul style="list-style-type: none"> <li>Updates to Federal Sentencing Guidelines</li> <li>Updates to HIPAA/HITECH Act</li> <li>2002: Corporate Responsibility Act (Sarbanes-Oxley) – financial fraud/governance accountability</li> <li>2008: Supplemental Compliance Guidance released</li> <li>2017: Compliance Program Effectiveness Measures released</li> </ul>



# The History of Quality and Compliance

<u>Quality</u>	<u>Compliance</u>
• Responsibility of the Medical Staff	• Administrative Responsibility
• Privileging/Credentialing	• Coding/Billing/Reimbursement Matters
• Peer Review	• Stark/Anti-Kickback
• Survey Accreditation	• False Claims Act
• Patient Safety	• HIPAA
• Medical Necessity	• Issue / Complaint Reporting
• Medical Staff Committees	• Conflict of Interest
• Quality Metrics Reporting	• Regulatory Compliance

## Quality and Compliance: Overlapping Priorities

- Hospital-Acquired Conditions and Sentinel Events
- Medical Necessity
- Substandard Care
- Disruptive Provider Behavior and Work Outside Scope of Practice
- Medication Errors, Drug Diversion, Opioid Management
- Medical Identity Theft
- Patient Complaints
- Informed Consent
- Physician Utilization Patterns
- Quality Metrics Reporting / Validation
- Physician Utilization Patterns
- Survey and Accreditation

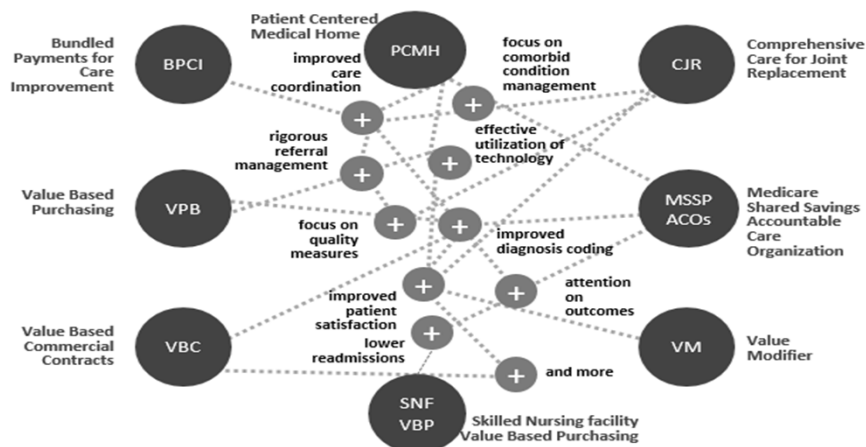
## The Quality – Compliance Synergy

An increasing regulatory environment has forced an integration of Quality and Compliance functions:

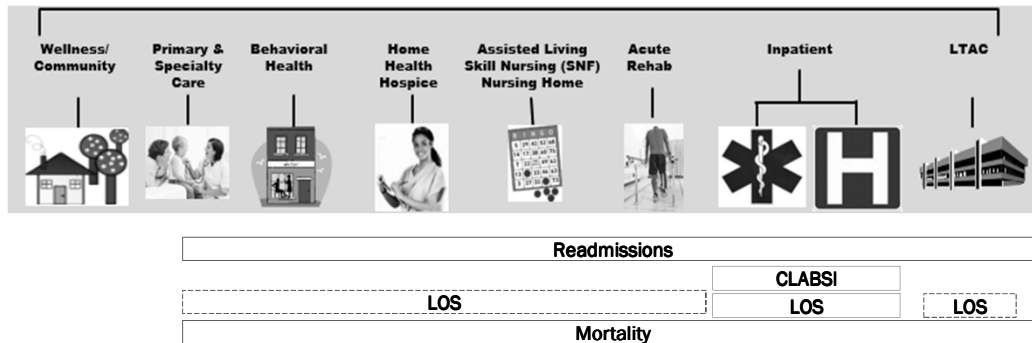
- Patient Protection and Affordable Care Act
- Patient Safety Improvement Act
- Conditions of Participation
- Hospital Readmissions Reduction Program
- Hospital-Acquired Condition Reduction Program
- Pay-for-Performance/Value-Based Purchasing



Better performance in one Program positively impacts initiatives across the continuum of care



# Manage Across The Continuum of Care

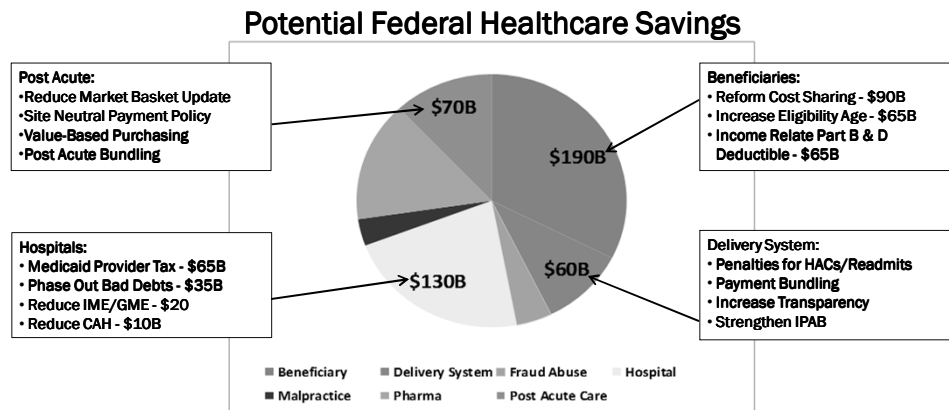


## Expansive view required for:

- Quality Outcome Reporting and Penalties
- Bundled Payment Reimbursement
- Effective Management of Acute LOS and Readmissions
- Direct Contracting

# Why Synergy? Healthcare Cost Savings

The 2013 Bowles-Simpson Plan Suggests \$585 Billion in Healthcare Savings

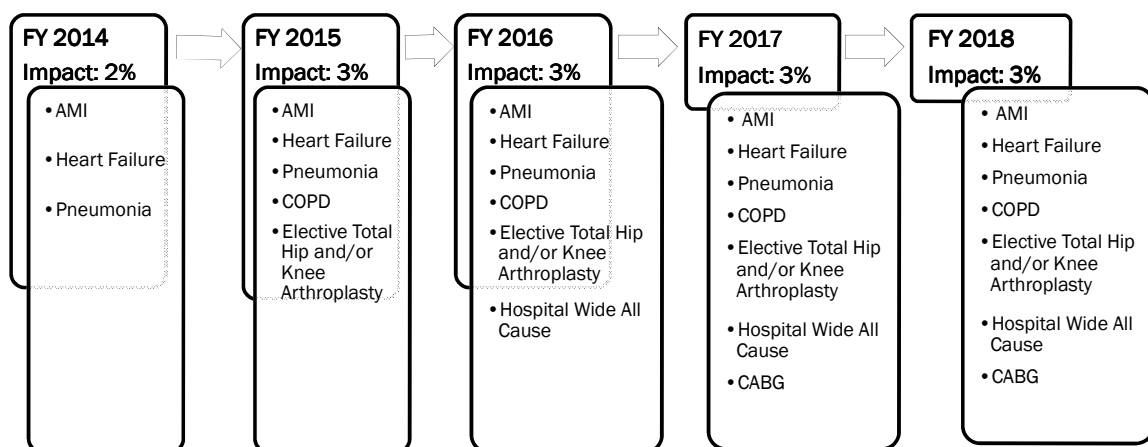


## Hospital Readmission Reduction Program: Purpose and Focus

- **Program Purpose:** Mandatory program to reduce payment to Hospitals with excessive Medicare beneficiary readmissions.
- 9% of current and future Medicare reimbursement at risk
  - 3% penalty of Medicare reimbursement at risk each program year
  - Measured populations 30 days post-discharge
- Performance Periods: 3 Year Rolling Program

FY 2017	July 1, 2012 – June 30, 2015	3%
FY 2018	July 1, 2013 – June 30, 2016	3%
FY 2019	July 1, 2014 – June 30, 2017	3%

## Hospital Readmission Reduction Program



# Medicare and Value-Based Payment

- For more than two decades, “traditional” fee-for-service Medicare has been shifting towards a value-based payment

- The Programs

<u>For Hospitals</u>	<u>For Clinicians</u>
Hospital Inpatient and Outpatient Quality Reporting	Physician Quality Reporting System (PQRS)
Hospital Value-Based Purchasing	Value-Based Payment Modifier (VM)
Hospital Compare	Physician Compare
CMS Alternative Payment Models (APM)	

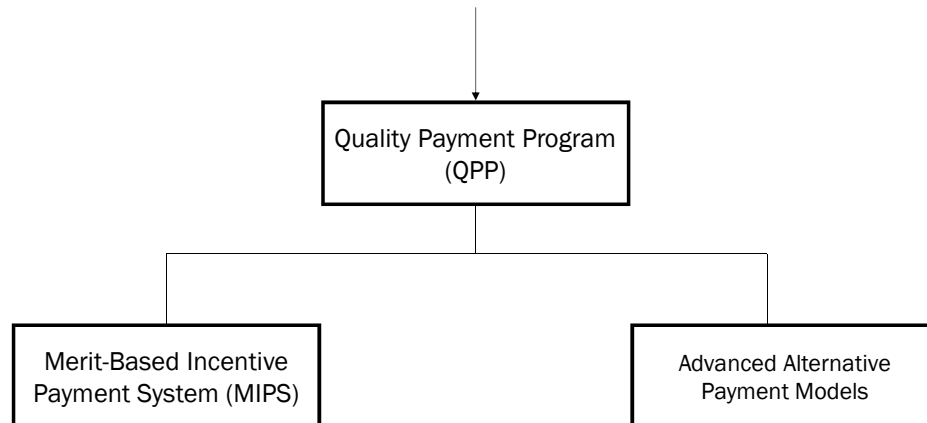
- MACRA and the Medicare Quality Payment Program (QPP) mark a significant step towards tying payment for clinicians’ professional services to quality and value.

## How Did We Get Here?

- April 2015: Medicare Access and CHIP Reauthorization Act (MACRA) signed into law
- MACRA repealed the much-despised sustainable growth rate (SGR) formula for determining Medicare Physician Fee Schedule (MPFS) payments.
- In place of MPFS, Congress directed CMS to implement the Merit-based Incentive Payment System (MIPS) that incentivizes quality and efficiency rather than merely rewarding volume.



## Medicare Access and CHIP Reauthorization Act of 2015 – (MACRA)



## MACRA

- Effective January 1, 2017; Impacts revenues in 2019
- A new value-based approach to payment for Medicare covered professional services provided to fee-for-service beneficiaries
- Ends the existing Medicare quality reporting programs and the “Meaningful Use” Program
- Streamlines and combines the existing quality and electronic health record (EHR) incentive programs into a single “Quality Payment Program”
- Provides incentive payments as encouragement for participation in Advanced Alternative Payment Models (APMs)

# MACRA

■ Two tracks:

1. The Merit-Based Incentive Payment System (MIPS)

- Quality track

2. Advanced Alternative Payment Models (APMs)

- Advanced value-based purchasing models
- Shared risk/capitation track

## Who Can Participate?

### 2017 and 2018

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists

### 2019 +

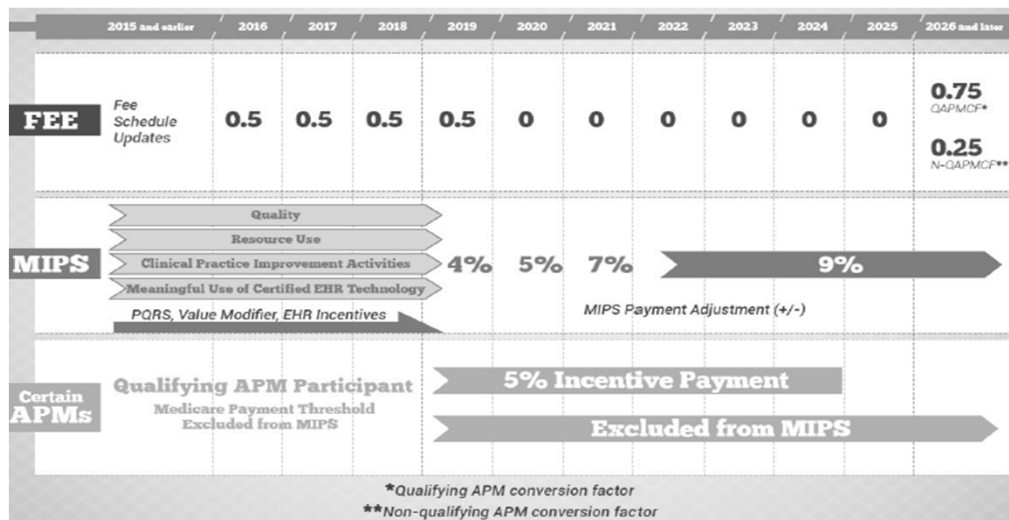
- Physical/Occupational Therapists
- Speech-Language Pathologists
- Audiologists
- Nurse Midwives
- Clinical Social Workers
- Clinical Psychologists
- Dietitians/Nutritional Professionals

# Participation Options

Providers can participate in MIPS to report on quality measures:

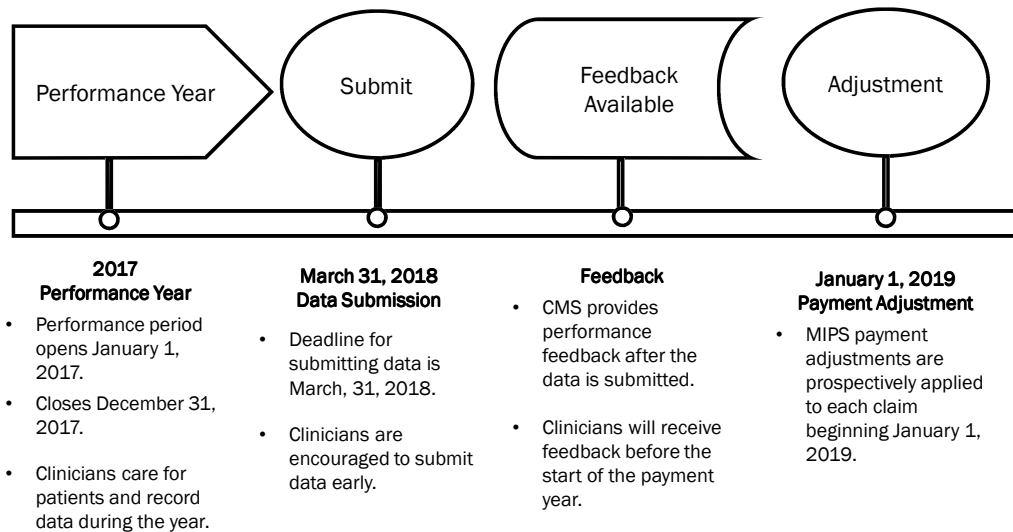
- Individually, or
- As a Group - 2 or more clinicians with reassigned billing to a single Tax ID number (TIN)
- In the Group, high performers or low performers may be positively or negatively affected by the group score, and assessed as a group across all categories.

# MACRA Timeline

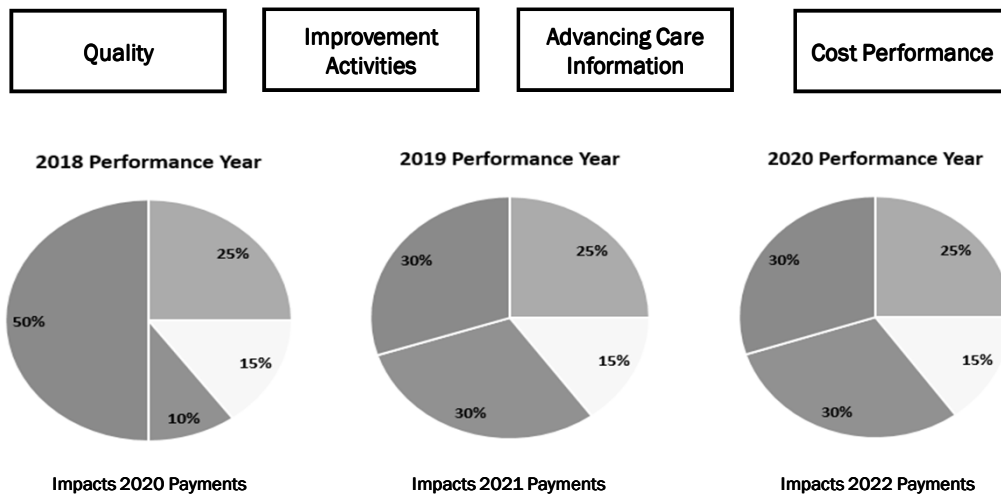




## MIPS Cycle



## MIPS Score Components



## MIPS Score Components

- No participation in the transition year (2017) will result in a negative 4% payment adjustment.
- Two year lag between performance and payment adjustment – e.g., performance in 2018 affects Medicare PFS payment in 2020.
- Clinical quality measures and technical specifications to be published annually; similar to Physician Quality Reporting System
  - focus on clinical process and patient health outcomes measures
- CMS will selectively audit on these measures

## Alternative Payment Models (APMs)

- Requirements:
  - Use certified EHR technology
  - Links payment with quality measures comparable to MIPS
  - Bear more than nominal financial risk (8%), or
  - Follow the Patient-Centered Medical Home model
  - Must meet volume/financial thresholds
- Opportunity to earn a +5% annual bonus payment if revenue threshold met in 2019-2024.

Payment Year	2019	2020	2021	2022	2023	2024+
% of payments	25%	25%	50%	50%	75%	75%
% of patients	20%	20%	35%	35%	50%	50%

- Physician scores will be posted on sites like Physician Compare and available to the public.

## MACRA Compliance Risk Areas

- Data integrity of clinical quality data
- Accurate clinical documentation to support quality measures
- Remaining current with rules – evolving and complex
- HIPAA violations
- Physician contracting
- EHR platform functionality required to document, capture, and report quality measures
- Misuse of EHR: Cloned notes and Copy/Paste
- Use of Scribes

## MACRA Compliance Strategies

- Know which track providers are on and understand the rules
- Provide MIPS and/or APM education for providers and staff
- Ensure providers, coders, and staff understand requirements for selected quality measures
- Update compliance plan to include monitoring and validation of quality measures
- Conduct a risk assessment to understand and evaluate how quality data is collected and reported
- Review prior quality performance and define baseline measurements
- Frequently monitor quality dashboards
- Ensure compliance has a seat on the quality committee/team

We are Compliance Professionals...  
We MUST Audit!



## MIPS and APM: Audit Points

Consider the following:

- MIPS or APM?
- Group or Individual Reporting?
- Impact of reporting mechanism?
  - Cost
  - Burden
  - Measure selection

## Audit Points: Physician Compare

- Consumers are aware of online physician rating websites and are using them to make selections for healthcare providers.
- By 2019, all physicians may expect to see actual individual QPP quality rating scores on public internet sites
- Patients are seeking more transparency in physician quality and cost
- MIPS scores will follow physicians from one organization to the next
- Check MIPS scores for physician recruiting, credentialing, contracting, and compensation plans
- Positive quality data reported online can be a competitive advantage

We are Compliance Professionals...  
We MUST evaluate risk!



## Physicians and Quality Payment Program Risk

- Physicians face reputational risk by not participating in QPP, or participating and earning low scores
- Poor MIPS scoring and quality data (reported online by CMS) may take years to improve or reverse
- Physicians reporting in groups will have scores only as good as the group score
- MIPS scores are part of a physician's profile and public reputation for the succeeding two years after the score is earned

## Physician Response to MACRA

The following are physician options in response to MACRA:

- Drop out of the Medicare Program
- Do not actively participate or take payment under MACRA
- Partner with other small practices to work with a vendor
- Affiliate with a hospital or large practice
- Seek hospital employment





## Fraud and Abuse Law Refresher

<b>Stark Law</b>	Prohibits a physician from making referrals for certain designated health services to an entity with which he or she (or a family member) has a financial relationship
<b>Anti-Kickback Statute</b>	Provides criminal penalties for individuals or entities that knowingly and willfully offer, pay, solicit, or receive remuneration to induce or reward the referral of business reimbursable under Federal health care programs
<b>Beneficiary Inducement Law</b>	Prohibits the provision of certain items or services (remuneration) to Medicare or Medicaid beneficiaries that are likely to influence that beneficiary to receive a reimbursable service from a particular provider
<b>Gainsharing Law</b>	Prohibits hospitals from knowingly making a payment to induce a physician to limit medically necessary services
<b>False Claims Act</b>	Establishes liability for any person who knowingly presents to the government a false or fraudulent claim or record for payment, or makes a false record or statement to conceal, avoid, or decrease an obligation to pay

## MACRA: Key Legal and Compliance Considerations

Activity	Applicable Fraud and Abuse Laws
Physician alignment; provider integration	Stark Law, Anti-Kickback Statute
Data accuracy and documentation	False Claims Act
Under-utilization; risk avoidance	Gainsharing law
Beneficiary incentives/engagement	Beneficiary inducement law

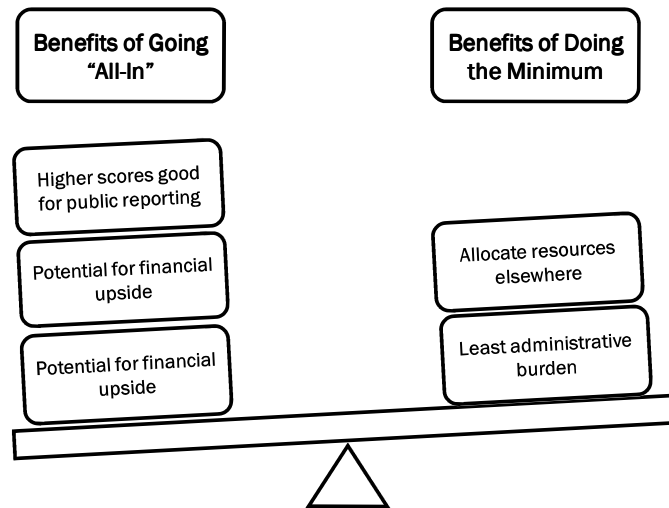
## Compliance Issue-Spotting

Questions to ask...

- Should hospitals reevaluate commercial reasonableness, fair market value (FMV), volume or value standards, particularly when physicians are being paid under a variety of complex payment methodologies?
- Can hospitals provide infrastructure, start-up costs to bring non-employed physicians into alignment?
- Can hospital provide care management, quality/performance improvement to support the physicians?
- Could non-compliance with quality reporting specifications lead to False Claims Act risk?



## Strategize for 2018



## Practical Tip: All Systems Go

Is your EHR system ready?

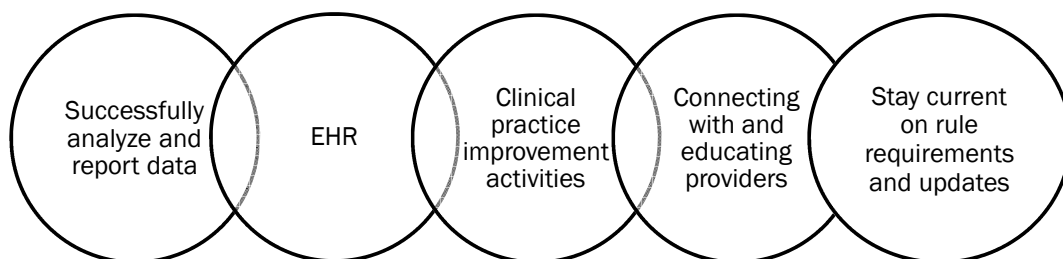
- The EHR is integral to pay-for-performance/value-based program participation
- Include validation of EHR accuracy in future auditing and monitoring plans
- Ensure timeliness and accuracy of entries
- Ensure completeness of record

## Practical Tip: Spread The Word

Do key players know about the Medicare Quality Payment Program?

- Educate all stakeholders on the impact of payment based upon quality, including the risks to individual providers.
- Educate doctors and management
- Reverse the “not my monkey, not my circus” paradigm. Value-basing is the future.

## Tools For Success



Questions ?