Morgan Lewis

Incentivizing Quality Improvement – Better to Appeal to Professional Pride or Pocketbook?

AHLA – Legal Issues Affecting Academic Medical Centers and other Teaching Institutions

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Importance of Value Based Purchasing

- Percentage of Base DRG Payment at Risk Under ACA Quality Provisions

VBP
- **Begin FY 2013**
- **1-2% reduction (phased in over 4 years)**
- **Opportunity to recoup full amount and more**

Readmissions
- **Begin FY 2013**
- **1-3% reduction cap (phased in over 3 years)**

Hospital Acquired Conditions
- **Begin FY 2015**
- **1% reduction**

- Potential to have 6% of base DRG payments at risk by 2017!

HACs

A. Current Program

1. Results from DRA of 2005
2. CMS disregards HACs when assigning a discharge to a DRG.

HACs *(cont.)*

A. Current Program (cont.)

3. CMS chooses HACs based on whether the condition:

   a. Is associated with cases that have a high cost or a high volume;

   b. Results in assignments to a DRG with a higher payment rate than if the condition were not present; and

   c. Could reasonably have been prevented by following evidence based guidelines.

II. HACs *(cont.)*

A. Current Program (cont.)

4. Based on "Present on Admission" Coding

a. **Y** – Condition POA

b. **W**- Provider has determined that it is not possible to document when onset of condition occurred

c. **N** – Condition not POA

d. **U** – Documentation insufficient to determine when onset of condition occurred

e. **1** – Signifies exemption from POA reporting

A. Current Program (cont.)

5. Failure to properly code could result in program integrity issues.

HACs *(cont.)*

B. Current HACs

1. **Foreign Object Retained After Surgery**;
2. Air Embolism;
3. Blood Incompatibility;
4. Pressure Ulcers Stages III & IV;
5. Falls and Trauma – Fractures, Dislocations, Intracranial Injury, Crushing Injury, Burn, Electric Shock;
6. Catheter-Associated Urinary Tract Infections;
7. Vascular Catheter-Associated Infection;
8. Manifestations of poor glycemic control;

HACs *(cont.)*

B. Current HACs (cont.)

9. Surgical site infections following certain orthopedic procedures and bariatric surgery for obesity;

10. Surgical Site Infection – Mediastinitis After Coronary Artery Bypass Graft;

11. Surgical Site Infection following Cardiac Implantable Electronic Device Procedures;

12. Deep vein thrombosis or pulmonary embolism associated with certain orthopedic procedures;

13. Iatrogenic pneumothorax with venous catheterization.

HACs *(cont.)*

C. Several of these are surgery-related, meaning that they are within the control of physicians.

D. The estimated net savings of current HACs in FFY 2011 were roughly $19.4 million.

1. Pulmonary Embolism & DVT Orthopedic ($8.3 million)
   a. Preventive guideline include a drug regimen.
2. Falls and Trauma ($7.4 million)
3. Pressure Ulcer Stages III & IV ($1.85 million)

HACs *(cont.)*

E. ACA

1. Effective for FY2015 and subsequent years
2. Hospitals in the top quartile as compared to national rates of HACs will have their Medicare payments for ALL DISCHARGES reduced by 1%
3. Requires confidential reports to hospitals in the top quartile prior to FY 2015
4. Requires public reporting and posting on Hospital Compare

III. Readmissions

A. Effective October 1, 2012, payments reduced to Medicare PPS hospitals with readmission exceeding an expected level.

1. Comparison of actual risk-adjusted readmission payment to expected risk-adjusted readmission payments.
2. In FY 2013 and 2014, the payment reduction cannot exceed 1% and 2%, respectively.
3. For FY 2015 and subsequent years, the reduction is limited to 3%.

Readmissions *(cont.)*

B. CMS suggestions for mitigation risk include:

1. ensuring patients are ready for discharge
2. reducing infection risk
3. **reconciling medications**
4. **improving communication with community providers responsible for post-discharge patient care**
5. **improving care transitions**
6. ensuring understanding of discharge plans
7. **participating in home-based follow-up**

Readmissions *(cont.)*

C. Readmissions subject to policy include:

1. Readmission within 30 days of the initial hospitalization
2. Readmission to the original hospital or to another hospital
3. There is no difference due to cause of the readmission or who the payer is
4. In FY 2013, the specified conditions are heart attack, heart failure, and pneumonia
5. The data are taken from the “applicable period” which is for FY 2013 the three year period from July 1, 2008 through July 1, 2011

Readmissions *(cont.)*

D. Review, Challenge, and Public Reporting of the data.

1. CMS submits reports to hospitals using Quality Net.
2. Hospitals have 30 days to review and submit corrections, but they cannot reference any changes to the applicable DRGs that were made after "snapshot" date.
3. If CMS agrees, will send a revised report to the hospital. The hospital then has 30 more days to re-review.
4. After this next exchange, CMS uses the data for payment penalty purposes and for public reporting purposes.
5. **There is no appeals process for the readmissions claims**.

Readmissions *(cont.)*

E. Challenges for Hospitals

1. The readmissions data on Hospital Compare does not facilitate rapid-cycle improvement.

   a. The data is old by the time hospitals see it.

2. No way to know whether a patient is readmitted to another facility

3. 30-day timeframe and “all cause” do not tie closely enough to a hospital’s performance related to a specific condition

4. Patient and community level factors, such as socioeconomic status, are not adequately addressed in the measure, therefore holding hospitals responsible for some factors beyond their control

Readmissions *(cont.)*

F. Implication for collaboration with physicians

1. Conduct post-discharge is at least as important as during admission
2. Hospitals need to incentivize physicians to be involved in post-discharge care
3. Question of furnishing services to patients at no charge that might replace obligations of physicians

VBP

A. From October 1, 2012, hospitals that meet certain performance standards during a performance period are to receive incentive payments
    1. The amount of the total DRG pool allocated to VBP rises from 1% in FY 2013 to 2% by FY 2017
B. Based on certain quality indicators, which change over time.

VBP *(cont.)*

VBP Program Quality Measures for FYs 2014 and 2015			
Measure ID	**Measure Description**	**2014**	**2015**
Process of Care Measures			
AMI-7a	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	X	X
AMI-8a	Primary PCI Received Within 90 Minutes of Hospital Arrival	X	X
HF-1	Discharge Instructions	X	X
PN-3b	Blood Cultures Performed in the Emergency Department Prior to I Antibiotic Received in Hospital	X	X
PN-6	Initial Antibiotic Selection for CAP in Immunocompetent Patient	X	X
SCIP-Inf-1	Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	X	X
SCIP-Inf-2	Prophylactic Antibiotic Selection for Surgical Patients	X	X
SCIP-Inf-3	Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time	X	X

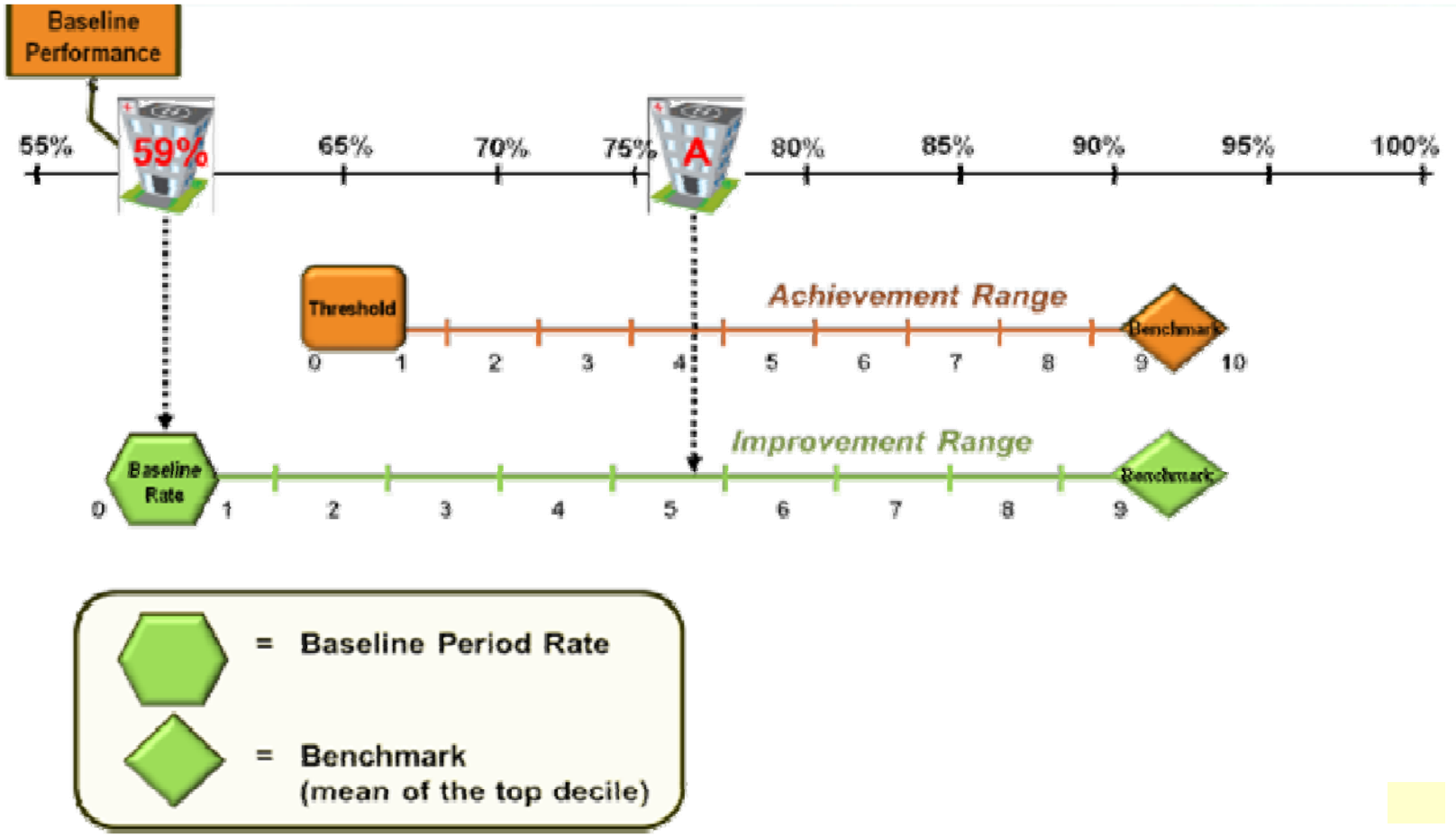
VBP *(cont.)*

VBP Program Quality Measures for FYs 2014 and 2015			
Measure ID	**Measure Description**	**2014**	**2015**
SCIP-Inf-4	Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose	X	X
SCIP-Inf-9	Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2	X	X
SCIP–Card-2	Surgery Patients on a Beta Blocker Prior to Arrival That Received Beta Blocker During the Perioperative Period	X	X
SCIP-VTE-1	Surgery Patients with Recommended Venous Thromboembolism Prophylaxis Ordered	X	Removed
SCIP-VTE-2	Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	X	X
Patient Experience of Care Measures			
Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)			
Communication with Nurses		X	X
Communication with Doctors		X	X
Responsiveness of Hospital Staff		X	X
Pain Management		X	X
Communication About Medicines		X	X
Cleanliness and Quietness of Hospital Environment		X	X
Discharge Information		X	X
Overall Rating of Hospital		X	X
Outcome Measures			
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	X	X
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate	X	X
MORT-30-PN	Pneumonia (PN) 30-Day Mortality Rate	X	X
AHRQ PSI 90	Complication/patient safety for selected indicators (composite)		X
CLABSI	Central Line-Associated Blood Stream Infection		X
Efficiency Measures			
MSPB-1	Medicare spending per beneficiary		X

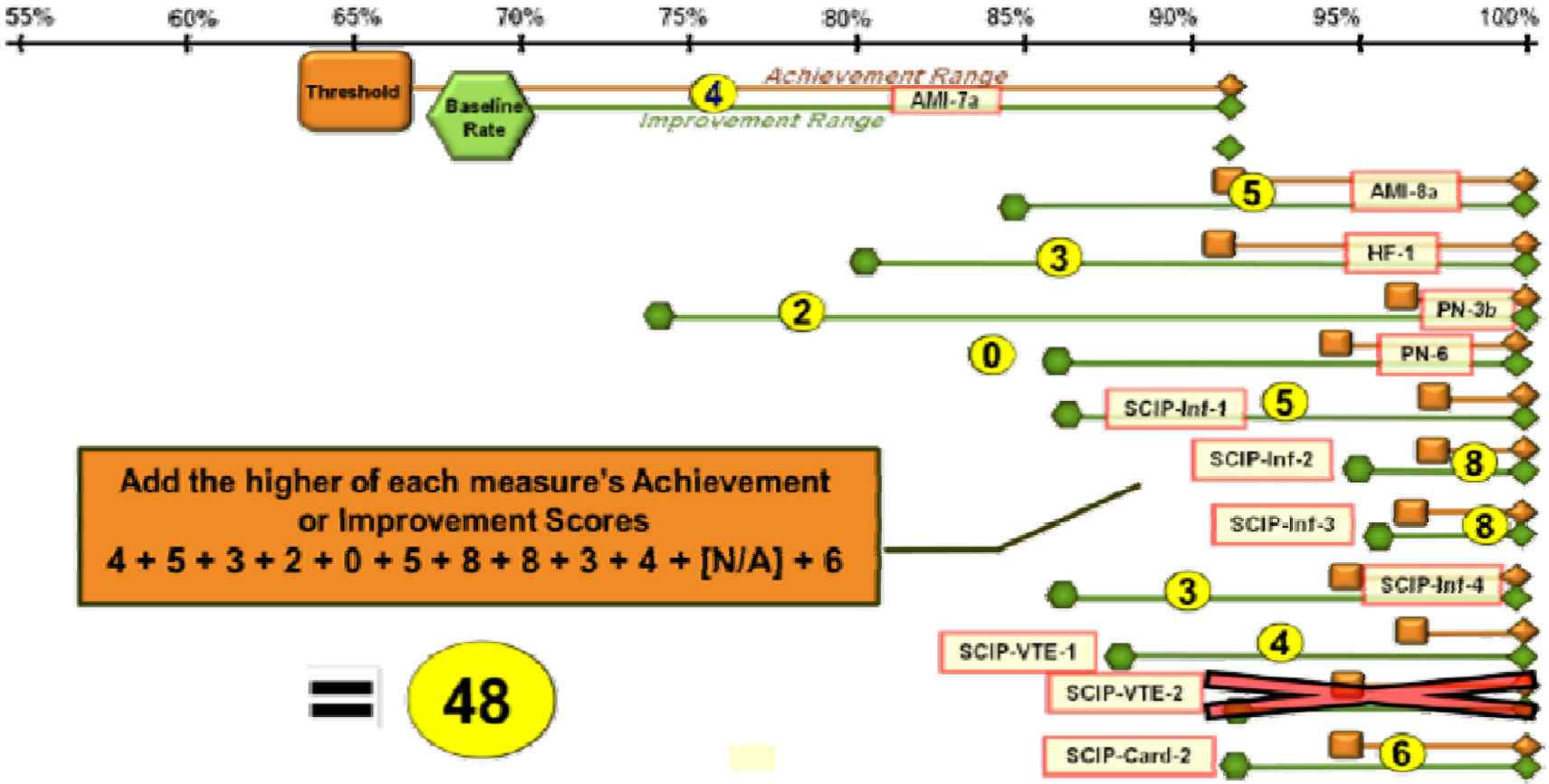
VBP *(cont.)*

D. Achieving a high score involves significant physician cooperation, including medication management, timing of procedures, and physician communication with patients.

VBP *(cont.)*


Baseline Performance
55%
59%
65%
70%
75%
A
80%
85%
90%
95%
100%
Threshold
Achievement Range
Benchmark
0 1 2 3 4 5 6 7 8 9 10
Baseline Rate
Improvement Range
Benchmark
0 1 2 3 4 5 6 7 8 9
= Baseline Period Rate
= Benchmark
(mean of the top decile)

VBP (cont.)



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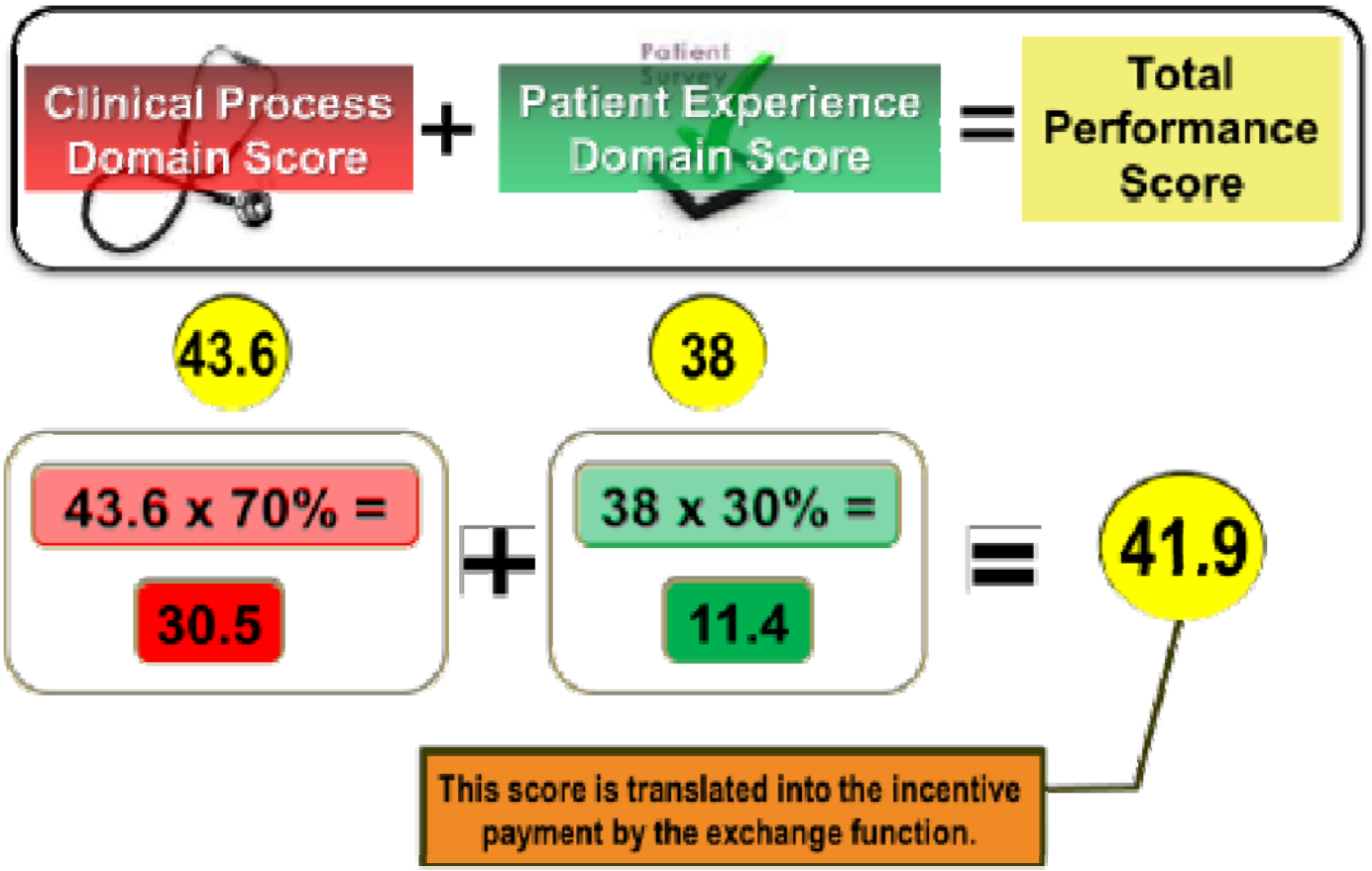
VBP *(cont.)*

G. Broken into Domains

VBP Program Weighting (Fiscal Year)			
Domain	**2013**	**2014**	**2015**
Clinical process of care	70%	45%	20%
Patient experience of care	30%	30%	30%
Outcomes		25%	30%
Efficiency			20%

VBP (cont.)


Clinical Process Domain Score
+
Patient Experience Domain Score
=
Total Performance Score
43.6
38
43.6 x 70% =
30.5
+
38 x 30% =
11.4
=
41.9
This score is translated into the incentive payment by the exchange function.

VBP *(cont.)*

H. CMS uses a linear function to translate into a payment amount.

   1. Very compacted results.

VBP *(cont.)*

I. Appeals process

1. Hospitals given 30 days to review initial report regarding claims data.
2. If changes requested, CMS reissues report, and hospitals have another 30 days.
3. Next step is an appeal through Quality Net.
4. A separate report is issued to hospitals regarding scoring. Hospitals can seek a reconsideration.
5. If a hospital is dissatisfied with CMS' response to a request for a correction, it can appeal the decision by launching an appeal on Quality Net.

VBP *(cont.)*

I. Appeals process (cont.)

6. Appeal can include any of the following:

   a. CMS' decision to deny a hospital's correction request that the hospital submitted under the review and corrections process;

   b. Whether the achievement/improvement points were calculated correctly;

   c. Whether CMS properly used the higher of the achievement/improvement points in calculating the hospital's measure/dimension score;

   d. Whether CMS correctly calculated the domain scores, including the normalization calculation;

VBP *(cont.)*

I. Appeals process (cont.)

6. Appeal can include any of the following (cont.)

e. Whether CMS used the proper lowest dimension score in calculating the hospital's HCAHPS consistency points;

f. Whether CMS calculated the HCAHPS consistency points correctly;

g. Whether the correct domain scores were used to calculate the TPS;

h. Whether each domain was weighted properly;

i. Whether the weighted domain scores were properly summed to arrive at the TPS; or

j. Whether the hospital's open/closed status (including mergers and acquisitions) is properly specified in CMS' systems.

VBP *(cont.)*

J. Issues associated with score improvement

1. Get BOD, MEC, and individual physician buy-in.
   a. OIG has identified that BOD involvement in quality of care issues is necessary to avoid fraud and abuse violations
2. Build it into compliance policies
   a. Legal risks now associated with errors in the medical record, such as FCA liability
3. Make sure that there are redundancies as to who is responsible for checking Quality Net
4. Discuss measures with QA and decide whether they are fair
   a. Monitor changes in measures and decide whether to submit comments

ACOs

A. Providers continue to get paid on a FFS basis, but then an adjustment is made after the performance year.
   1. Comparison of actual cost to Medicare against a benchmark
   2. Gain threshold and, if applicable, loss threshold (referred to as “minimum savings” and “minimum loss”)
   3. Percentage of savings awarded as bonus payment (the “shared savings rate”)
   4. Cap on savings and losses

ACOs *(cont.)*

B. Performance on quality measures affects amount of payments received or made.

   1. Mostly physician measures.

   2. Similar to VPB, in that quality indicator data maps to specific domains, resulting in a total score.

Anti-Kickback Statute

A. Knowingly and willfully paying remuneration in exchange for referrals of Federal healthcare program business.
B. Available safe harbors
    1. Employee safe harbor
    2. Personal services safe harbor
    3. OIG AMC opinions show that there is some understanding that AMCs are different
C. Gainsharing concerns largely inapplicable in the quality indicator context

Stark

A. Physicians cannot refer patients to entities with which they have a financial relationship for designated health services, which include hospital services

B. Exceptions include:

   1. Employment
   2. Personal services
   3. AMC exception

C. Indirect compensation generally falls outside of Stark

D. But much harder to protect payments to community physicians

ACO Waiver

A. Protects most planning and post-implementation allocation of resources

Co-Quality Management Models

A. Potentially tie some portion of mission support funding to attaining hospital goals
   1. Could be passed down to physicians, so long as not tied to referrals
   2. Should be FMV and tied to specific measurable goals, such as quality indicator measurements

Co-Quality Management Models *(cont'd)*

B. Could cover a wide range of services:
   1. Medical directorship
   2. Budget committee
   3. Patient satisfaction initiatives
   4. Clinical protocols
   5. Patient throughput improvement