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As Pay-for-Performance Programs Increase, Compliance Faces Complex New Challenges

With Medicare reimbursement increasingly tied to quality of care, compliance monitoring will have to push further into patient outcomes and data integrity. In a few years, hospitals that drop the ball on quality-improvement initiatives — which include value-based purchasing and the readmission-reduction program — could lose up to 6% of their Medicare revenue. Some of the penalties that kick in down the road are based on past as well as current performance, another reason for hospitals to focus on quality-improvement initiatives now.

"Payments will now be based more on quality, and therefore quality failures are more likely to lead to false claims and payment denials," said Chicago attorney Janice Anderson, with Polsinelli Shughart. "It's really important that compliance officers understand the link between quality and compliance and restructure their programs so that quality information is looked at through the lens of compliance." For example, hospitals will have to improve discharge planning, which means better documentation.

The payment-for-quality movement is kicking into high gear, accelerated by the health reform law. "Payment policy at CMS is changing," Anderson said during an interview and a Jan. 27 webinar sponsored by the Health Care Compliance Assn. CMS is shifting from a passive payer of services based on volume to an active purchaser of quality through pay for performance, added attorney Joseph Van Leer, who also spoke at the webinar. "There will be rapid escalation of these initiatives over the next few years," he said (see box, p. 7).

It's important for compliance officers to understand the new payment models and why payment based on quality creates both financial and compliance risk for the organization, Anderson says. They also need to educate the board, management and staff about these new risks and integrate quality into their compliance programs. CMS is expected to audit hospital data in this context because it translates into penalties or rewards.

The payment-for-quality movement has its origins in the 1999 Institute for Medicine Report, *To Err Is Human* (see timeline, p. 6). CMS first linked payments to hospital quality with the Inpatient Quality Reporting (IQR) program, which began in 2003. It's grown since then, with hospitals expected to report to CMS on 55 quality measures in fiscal year 2012 or face a 2% reduction in the market basket update, Anderson says.

There is now a companion quality reporting program on the outpatient side. Hospitals must report 15 measures in 2012 and 23 measures in 2013. In 2014, CMS will add three more measures:

(1) Cardiac rehabilitation patient referrals from an outpatient setting;

(2) Use of a safe surgery checklist; and

(3) Hospital outpatient all-patient volume on selected outpatient surgical procedures for certain procedure categories.

CMS is also expanding its crackdown on poor quality through penalties for hospital-acquired conditions (HACs). Since Oct. 1, 2008, Medicare won't bump up MS-DRG payments if the increase stemmed from any of 12 HACs (e.g., pressure ulcer, air embolism). And there are more developments of this nature on the horizon, according to Anderson and Van Leer.

For starters, the worst HAC offenders will be in for trouble beginning in fiscal year 2015, when CMS imposes a 1% payment penalty on all discharges at hospitals in the top 25% of HACs, Anderson says. "It is potentially significant. It's another reason why hospitals need to start taking action to manage HACs and not just deal with them as they occur during an admission," she says. Meanwhile, CMS was slated to report to Congress in January on expanding the reduction of HACs to other types of facilities (e.g., inpatient rehabilitation facilities), so stay tuned. Also, Medicaid faces HAC payment restrictions as of July 2011.

In another new initiative, CMS is developing a Medicare-spending-per-beneficiary measure for every hospital, which probably will be an element of the value-based purchasing program, Van Leer notes.

The measure will be calculated according to the amount of money spent during the episode of care, which begins three days before the beneficiary's admission (to include preadmission services) and ends 30 days after discharge, she says.

To calculate spending per episode, CMS will divide the sum of all Part A and Part B payments for the epi-

sode by the total number of episodes for that hospital, Anderson says. Then CMS will determine the hospital's ratio by dividing the hospital's spending per beneficiary by the median spending per beneficiary of all hospitals nationally. Hospitals will get a score that's above or below the median, which probably will be posted on Hospital Compare, a public website with quality data, she says.

Some Readmissions Will Be Costly

Hospitals also will soon face payment consequences for certain readmissions through CMS's readmission reduction program. "There is the belief that readmissions within 30 days and ambulatory-sensitive readmissions could be prevented if appropriate ambulatory care is provided, so the focus is on establishing a payment penalty for hospitals that have higher-than-expected readmission rates," Anderson says. For starters, CMS will focus on the initial admission (called the "index hospitalization") for heart failure, heart attack and pneumonia. The penalty for having a higher-than-expected readmission rate is a 1% cut in a hospital's base DRG payment in 2013, 2% in 2014 and 3% in 2015. More conditions will be added, with CMS considering readmissions for chronic obstructive lung disease, coronary artery bypass grafting, percutaneous coronary intervention and vascular procedures, Anderson says. Payments will be cut according to an "adjustment factor," she says. It's unclear how this will work, but it's based on three years of discharge data: July 1, 2008, to June 20, 2011. The readmission reduction program will be refined in future rules, but meanwhile, it takes effect on Oct. 1, 2012 — a good reason to "focus on this and other quality-focused programs immediately," Van Leer says.

The most comprehensive pay-for-performance program is value-based purchasing, which was finalized in a May 6, 2011, regulation. Starting Oct. 1, 2013, CMS will take away 1% of the MS-DRG rate for all hospitals, a figure that will rise to 2% by fiscal year 2017. "It's a front-end reduction in payments. If providers perform well, they will get their money back and possibly more, but if they perform poorly, they lose that money," Van Leer says. Hospitals have to earn it back by improving patient care and satisfaction and, in the future, reducing Medicare spending per beneficiary. How much they get back depends on their performance in certain "domains," Van Leer says. Medicare will start with assessments of two domains:

(1) 12 measures of clinical processes, including acute myocardial infarction, heart failure, pneumonia, health care-associated infections and the surgical care improvement project; and

(2) Eight measures of patients' experience of care, such as pain management and how well nurses and physicians communicate with patients.

In fiscal year 2014, CMS will incorporate the outcomes domain, which includes 30-day mortality measures for acute myocardial infarction, heart failure and pneumonia. Eventually, CMS may add a fourth domain — for efficiency— which will likely be Medicare spending per beneficiary.

Hospitals will be scored from zero to 10 for each domain measure. When their performance is at or above a national benchmark, hospitals will get 10 points. When they are below a national threshold, they will get zero points. Between the threshold and the benchmark are one to nine points, depending on how hospitals score in each area, Van Leer says.

CMS will evaluate hospital performance in the domains on two levels: (1) achievement, which is a national comparison, and (2) improvement, which compares the hospital to itself in the baseline year. Performance scores will be weighted. For fiscal year 2013, CMS will allocate 70% to clinical process of care measures and 30% to patients' experience of care measures. The year after, CMS proposes 45% for clinical processes, 30% for patient experiences and 25% for outcomes.

"We are already in the performance period of the program," which will affect payment for discharges on or after Oct. 1, 2012, he says.

When you lump together all the Medicare programs that link payment to performance, there's the potential for hospitals to lose 6% of their reimbursement, Anderson says. "That will really erode margins at most hospitals today," she says. "Hospitals need to be refocusing on alignment strategies with their physicians that help them improve their quality performance." For example, hospitals may be able to use financial rewards to engage physicians to improve hospital quality metrics, she says.

And with the connection between payment and quality, compliance officers will have to put mechanisms in place to monitor outcomes without jeopardizing traditional oversight functions, such as peer review, Anderson says. That's a hot potato. "How can compliance officers reformulate compliance programs so they can capture quality to evaluate compliance without jeopardizing privilege?" Anderson says. "Compliance officers need to be thinking about compliance very differently as they approach the changes to a quality-based payment system."

Discharge planning, for example, will take center stage now that hospitals must comply with the readmission payment reduction program, says Madison, Wis., consultant Glenn Krauss. "Often patients are readmitted because the medication administration record or the discharge summary is not accurate. Patients don't get the medications or the tests they need after

admission, so they bounce right back," he says. If the discharge summary doesn't say, for example, "waiting for results of pathology report" or "continued management pending results of reports," the patient's primary care physician doesn't know how to follow up, Krauss says. Unfortunately, a lot of discharge summaries are short and not very descriptive. The physician may say "patient was admitted for shortness of breath, decision was made to admit, patient started on four liters oxygen, desaturated and transferred to ICU and was there for four days and discharged on day five. See H&P for further detail." That may not be enough to ensure the primary care physician or nursing home physician takes steps and follows treatment plans that reduce the risk of readmissions to the hospital (e.g., prescribes medication).

The reason, Krauss says, is that physicians traditionally don't dictate the discharge summary until after discharge because they view it as another "chore or necessary evil" of practicing medicine. "The best practice of medicine from a standard of care standpoint is to dictate the discharge summary at the time of discharge to facilitate a complete and accurate picture of the inpatient hospitalization, including patient follow-up," Krauss says. *One solution:* the physician's dictation of discharge summaries can be included as part of the discharge evaluation and management service provided on the day of the discharge.

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