

Governmental Initiatives to Drive Quality of Care & Strategies to Perform Well Under Them

HCCA Quality of Care Conference



*Presented by:
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Update on Payment Reform



Incentivizing Quality of Care Through Payment Reform

- The new paradigm for reimbursement
- CMS is transforming payment policy from passive payor of services to active purchaser of high value health care
- Private payors also are changing payment policies to pay for quality



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Incentivizing Quality of Care Through Payment Reform

- Pay for Performance Plans have emerged as a payment model that improves quality and reduces cost
- 2006 – NEJM reports that 50% of U.S. Health Plans included some form of P4P, mostly focused on physicians
- March 2009 – America's Health Insurance Plan "Innovation in Recognizing & Rewarding Quality" features the positive effects on quality and cost that have been achieved by P4P programs in private sector

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Medicare Value-Based Purchase Plan (“VBP”)

- The Deficit Reduction Act mandated CMS to develop a “Value Based Purchasing Plan” for hospitals and CMS issued its final report to Congress on Hospital VBP November 21, 2007
- The VBP will build on the CMS hospital reporting program
- Will health reform include VBP?



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The Success of VBP Demonstration Project (August 2009)

- Physician group demonstration project
 - 3rd year results showed benchmark performance by all 10 physician groups on 28 out of 32 measures. 5 groups received \$25.3 million (CMS saved \$32.3 million)
- Premier hospital quality incentive demonstration project
 - 4th year results showed significant improvement in all quality targets. 225 hospitals earned \$12 million



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Hospital Acquired Conditions



- No payment for poor quality
 - Effective October 1, 2008, hospitals will not be paid for certain “hospital acquired conditions” unless present on admission
 - CMS intends to extend policy to “healthcare associated conditions” occurring in outpatient departments, physician offices and other settings



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CMS National Coverage Determination (NCD)

- On January 15, 2009, CMS issued three NCDs to establish uniform national policies that will prevent Medicare from paying for certain serious, preventable errors in medical care
 - 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



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Measure Physician/Provider Resource Use

Practice Variation



Map of the United States showing practice variation in Medicare quality indicators.

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Measure Physician/Provider Resource Use

Practice Variation

Performance on Medicare Quality Indicators, 2000-2001



Source: G.F. Arora, F.D. Hall and T. Combs, "Change in the Quality of Care Delivered to Medicare Beneficiaries, 1999-2000 to 2000-2001," *Journal of the American Medical Association* 285 (2001): 265-271.

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Measures of Physician/Provider Resource Use

- Physician and Hospital Resource Use (PHRU) Work Group will develop efficiency measures and tools
- MIPPA requires CMS to implement program to provide confidential reports to physicians on resource use
- Physician Group Practice (PGP) Demonstration – rewards physician for improving quality AND efficiency. Encourage coordination of Part A – Part B services through P4P and sharing of cost savings



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Alignment of Financial Incentives

- Goal: Breakdown “silos” of Part A and Part B
- Acute Care Episode Demonstration Project – testing payments for “episodes of care” and allocate between physicians and hospitals
- Accountable Care Organizations (ACO) – collaboratives of physicians, hospitals and other providers that will be clinically and financially accountable for healthcare delivery. Could allow for competitive bidding, shared savings and P4P
- Gainsharing – Stark exception, two demonstration projects, and OIG approval
- OIG approves “pay for quality” model



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And the Current Status of
Health Reform is . . . ?



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Hospital/Physician Alignment Strategies



Why Align Physicians and Hospitals?

- Hospitals need to enlist physician support to meet quality targets and earn the pay for performance incentive payments
 - It is often difficult to enlist physician support by simply coaxing, cajoling, scolding, etc.
 - Particularly true if you do not (or cannot) employ physicians
- Physicians need to enlist hospitals to help with systems to drive quality across the continuum of care
- CMS recognizes need for ACOs to reach goals of quality and efficiencies



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Why Align Physicians and Hospitals? *(continued)*

- Independent medical staff structure is not conducive to drive quality under new paradigm **because**
 - Peer review/quality management is retrospective and often incident-based
 - No mechanism to standardize care processes or require evidenced-based medicine
- “Pay for Quality” and Gainsharing are structures designed to align medical staff with hospital to achieve quality of care



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- What is “Pay for Quality”?
 - New legal entity to which medical staff members can join (PHO can be used)
 - Hospital pays the entity (*i.e.* physician-owners) to meet quality targets. Includes a broad array of services necessary to achieve compliance
 - Pay for performance dollars may provide funding source
 - Payments made based on achievement of targets (CMS quality indicators) set annually
 - Preamble to new proposed Stark exception recognizes benefits to be achieved through quality incentive program



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(continued)

- What is the Rationale for New Structure?
 - National mandates for safety/quality and price transparency are difficult to meet without physician/hospital collaboration
 - “Carrot v. Stick” approach
 - Pay for performance ties reimbursement to achievement of quality outcomes
 - Manage legal risk arising from quality of care (liability for failing to comply with evidence based guidelines, corporate liability; false claims liability for poor quality or unnecessary care, negligent credentialing)



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(continued)

- What are the benefits of new structure?
 - Integrate physician and hospital clinical practice to meet safety/quality goals
 - Establish structure to provide quality across the continuum
 - Standardize clinical practice
 - Eliminate waste and reduce cost (may include gainsharing)
 - Creates a financial “win/win” for physicians and hospitals, but keeps physicians and hospitals focused on their respective core business



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(continued)

- How is “Pay for Quality” structured?
 - A legal entity is created to which all physicians who have been on the active medical staff in relevant departments for at least one year can join
 - Each physician who joins pays an equal capital contribution to provide for the entity’s working capital
 - The physicians joining the entity commit to practice in compliance with certain quality targets established by CMS that form the basis for pay for performance awards under contracts with private insurers (and CMS in the future when Value Based Purchasing is implemented)



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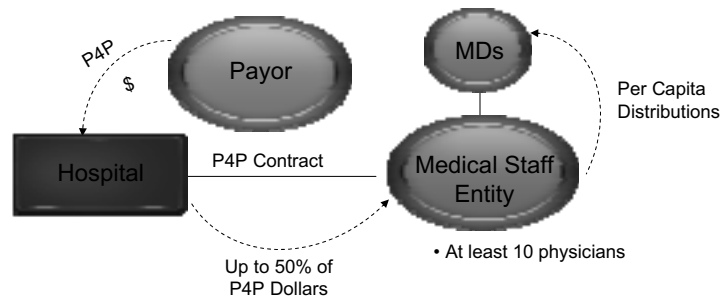
- The entity contracts with the hospital to provide a variety of tasks and services to improve quality
- Payment to the entity is based on a percentage of pay for performance dollars earned by the hospital (up to 50%) and then distributed to the physicians on a per capita basis



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- Participating physicians are members of Medical Staff for at least one year
- Participating physicians equally capitalize Medical Staff Entity
- Quality Targets are measurers listed in CMS' Specification Manual for Hospital Quality Measures
- Payments to Medical Staff Entity are capped at 50% of base year P4P dollars (with inflation adjuster)
- Quality targets and payments renegotiated annually
- Monitoring to protect against inappropriate reduction or limitation in patient care services
- Termination of physicians who change referral patterns (e.g., cherry pick patients) to meet targets
- Maintain records of performance
- Patients informed of Program in writing

Gainsharing

- Shared savings from identified activities to reduce costs
- OIG has approved multiple gainsharing models, all under the same structure
- CMS and OIG recognize importance of gainsharing as a component of VBP
 - demonstration projects
 - new proposed Stark exception
- Guidance available to structure a program to meet hospital/physician needs
- Efficiencies (*i.e.* surgical turn around time, LOS, readmissions rates, etc.) also can be incentivized – risk under CMP law must be addressed



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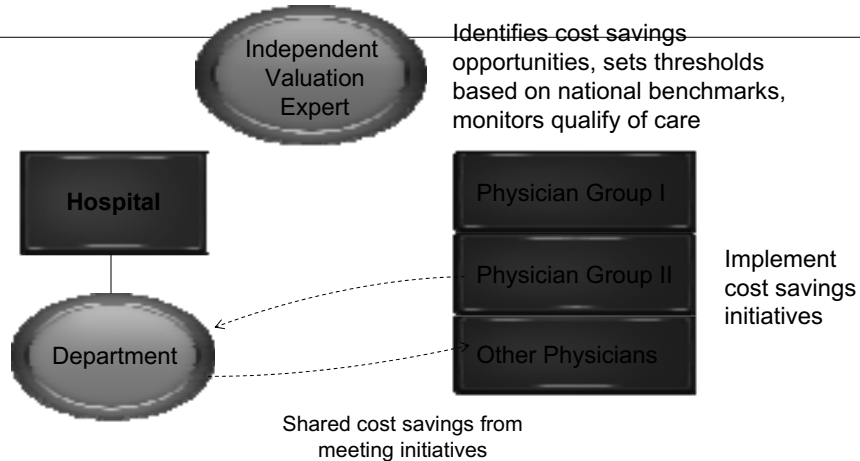
Permissible Gainsharing Arrangements

- Focus on product standardization, product substitution, “open as needed”, or limiting use of certain drugs or supplies
- Safeguards are present
 - Transparency (not a “black box” program)
 - Quality controls (independent review of measures to ensure quality of care. Measures have “floor” based on objective quality data beneath which no savings are shared)
 - Limits on ability to change referral patterns (1 year program only, limited to existing active staff members, distributions to physicians on per capita basis, volume is limited to base year)
 - Other safeguards such as disclosure to patients, not rewarding changes to case mix, etc.



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Gainsharing Model



Cost savings initiatives may be product standardization, product substitution, "open as needed," and others but cannot withhold or limit care

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Clinical Integration

- Antitrust law prohibits agreements on price between competitors
 - Price fixing is illegal *per se*
 - If sharing financial risk, not illegal *per se* but still subject to *rule of reason* analysis
- Members of independent medical staff are competitors
 - Independent practitioners who are not sharing financial risk cannot agree on price

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Clinical Integration

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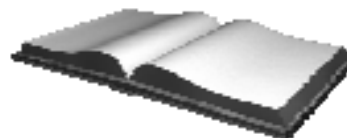
- Physician competitors who do not share substantial financial risk but engage in clinical integration will not be illegal *per se* but given *rule of reason* analysis if:
 - Establish and implement mechanisms creating high degree of interdependence and cooperation in order to control costs and assure quality
 - Rule of reason
 - Do efficiencies outweigh anticompetitive effect?



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Clinical Integration Guidance

- 1996 Statements of Antitrust Enforcement Policy in Health Care – FTC and DOJ
- 2002 FTC Advisory letter MedSouth
- 2004 FTC/DOJ Report – “Dose of Competition”
- 2006 FTC Advisory letter Suburban Health Organization
- 2007 FTC MedSouth follow-up letter
- 2007 Greater Rochester Independent Practice Association
- 2009 FTC Advisory letter TriState PHO



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FTC Remains Skeptical

- Will not give approval if integration and potential efficiencies are limited and competitive restraints are unnecessary to achieve potential efficiencies
 - Suburban Health Organization
- Will reserve right to monitor for increases in prices without improvement in quality
 - MedSouth second request
- Will look for sham activities
 - North Texas Specialty Physicians



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Important Criteria and Factors

- Market power
 - Less than 30% of specialists
- Significant investment to achieve clinical integration goals
 - Information technology
 - Physician time and financial resources
 - Reinvestment of incentive compensation in infrastructure



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Important Criteria and Factors *(continued)*

- Physician collaboration to create clinical protocols, evidence-based practice guidelines and quality benchmarks
- Monitoring of individual and group performance
 - Process and outcomes



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Important Criteria and Factors *(continued)*

- Regular performance reporting to physicians
 - Entity-specific and national benchmarks
- Corrective action for physician non-compliance
 - From education up to and including termination
- Regular review of performance measures
 - Evidence of improvement
 - Regular raising of targets
- Individual physician fee information not accessible to other physicians



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Important Criteria and Factors *(continued)*

- Non-exclusive
 - Physicians free to contract individually with payers
- Referral guidelines and standards
 - Within network except in unusual circumstances
- NCQA certification
- Direct contact and education of patients
 - Chronic diseases and conditions
 - High risk patients



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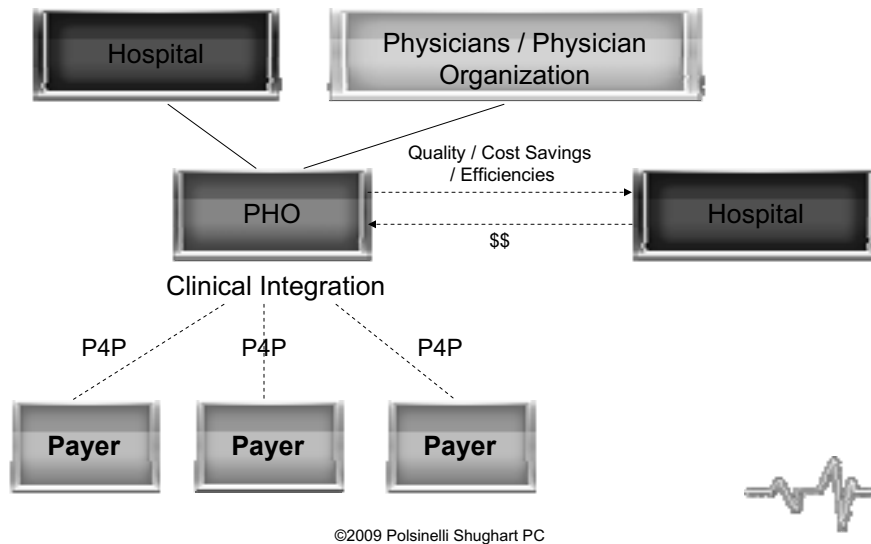
Important Criteria and Factors *(continued)*

- Physicians agree to serve on peer review committees if selected
- Physician acknowledgment and agreement to follow protocols and guidelines
- Tracking physician investment in time and financial resources



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Clinical Integration “Hybrid” Model



About the Presenter

Janice Anderson is a Shareholder at Polsinelli Shughart PC and has 25 years’ experience focusing on health regulatory and compliance issues as well as over 30 years’ experience working in the health care industry.



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Thank you



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