SEP/OCT 2010

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The Joint Commission's "Hot Button" 2010 Compliance Challenges: Enhancing the Quality of Care through Improved Compliance

The Joint Commission ("TJC") views its emphasis on quality of care and the elimination of preventable complications as an integral part of the current health care reform effort.

The quality of patient care has always been central to The Joint Commission's mission "to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations." The Joint Commission ("TJC") views its emphasis on quality of care and the elimination of preventable complications as an integral part of the current health care reform effort. The reduction in preventable complications alone will save the health care system billions of dollars, which can be directed toward the treatment of individuals in need.

In keeping with its quality-focused mission, TJC has identified three (3) "hot button" compliance challenges for health care organizations in 2010. These challenges were identified by TJC based on the 2009 accreditation program findings. The Joint Commission is recommending that health care organizations direct their attention to and improve their compliance with these standards in 2010.

1. National Patient Safety Goal ("NPSG") 02.03.01. This patient safety standard addresses measuring, assessing and resolving timeliness issues for critical tests and results. Organizations struggle to meet this goal because they fail to define the "critical tests" that should be monitored. This year, TJC modified the goal to emphasize the measuring and addressing of the time between the availability of "critical test" results and the reporting of the results to the appropriate provider.

RECOMMENDATION. The Joint Commission recommends that organizations clearly identify the "critical tests" that will be monitored and diagram the testing and reporting process, including appropriate timeframes for processing and reporting. The organization can then accurately track performance against their goals. CONTINUED ON PAGE 2

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"Hot Button" Compliance Challenges
(Continued)

2. Medication Management ("MM") 03.01.01. This standard concerns the proper and safe storage of medications. Many organizations fail to establish clear guidelines for medication security. Some of the organizational challenges include ensuring the security of medication that is removed from its storage area but is not immediately administered to a patient, or is refused by a patient. Organizations should also address the handling and disposal of expired medications.

RECOMMENDATION. The Joint Commission recommends that organizations clearly establish and implement guidelines for the safe storage and disposal of medications. Staff members should know the timeframe within which they must administer a medication taken from its secure location, and there must be clear standards for the return or disposal of refused medications. Expired medications must be disposed of in accordance with policy. The Joint Commission urges organizations to establish these medication policies and closely monitor compliance.

3. Medical Staff ("MS") 08.01.01. This standard addresses the circumstances under which a practitioner's performance must be monitored and evaluated. Organizations must define those instances that warrant monitoring of a practitioner based on certain triggers. Triggers may include a decline in job performance, or inappropriate behavior in the workplace. In addition, organizations must monitor and evaluate practitioners when they initially seek and receive privileges.

RECOMMENDATION. The Joint Commission encourages organizations to examine their current policies and identify any triggers for monitoring that may be lacking. According to TJC, organizations are often good at monitoring and evaluating new practitioners, but fail to develop or implement standards to monitor existing practitioners. After developing appropriate standards, TJC emphasizes the need for organizations to apply the standards in a uniform manner to all affected practitioners.

Through the implementation of policies and standards addressing the National Patient Safety Goal, Medication Management and Medical Staff "hot button" compliance challenges, organizations will continue to advance TJC's longtime mission of improving the quality of patient care. ■

Quality as the New Compliance Enforcement Tool

Government authorities, including the Office of Inspector General ("OIG"), the Department of Justice, and state Attorneys General, are increasingly focusing on quality of care as a compliance enforcement priority. Several tools are available for enforcement, from monetary penalties and heightened oversight, to exclusion from federal and state health care programs, to incarceration. These penalties may be imposed for violations such as the provision of medically unnecessary services or services failing to meet professionally recognized standards of care. They may be employed at all levels of the organization, from direct care providers to those causing others —including through failure of oversight—to commit the violations.

The genesis of the enforcement authorities' focus on the intersection of quality and compliance is the increasing public policy concern that substantial deficiencies exist within the current U.S. medical community, such as inefficiency, mortality due to medical error, and high cost. In light of a projected doubling of health care spending over the next decade, there is a demand for the realignment of financial incentives to create a safer, more integrated, and more efficient system.

There are two primary theories of corporate compliance-type liability for sub-quality care, predominantly under the False Claims Act. The first is the provision of medically unnecessary services. The second is the provision of care so deficient that it amounts to no care at all, such that the claims are essentially for services not rendered. Institutions have been penalized under both theories for conduct such as chronic understaffing and the reckless imposition of budgetary constraints that impair patient care. In addition to permissive exclusion, the OIG is statutorily required to exclude anyone convicted of patient neglect or abuse. The OIG has also begun using corporate integrity agreements with board-level obligations as an enforcement tool.

There is also a high expectation that boards of directors include quality of care and corporate compliance in their oversight responsibilities. The third of a series of co-sponsored documents by the OIG and the American Health Lawyers Association entitled *Corporate Responsibility and Health Care Quality: A Resource for Health Care Boards of Directors* includes a list of questions that are provided as a reference for boards of directors to use in establishing and overseeing a quality of care program. A copy can be accessed at http://oig.hhs.gov/fraud/docs/complianceguidance/CorporateResponsibilityFinal%209-4-07.pdf. For example, the document calls for boards of directors to ensure their organizations have addressed and incorporated quality assessment and improvement into the compliance program and corrective action plans.

In conclusion, health care organizations are recognizing the need to elevate quality to the same level that financial and regulatory compliance currently occupy, in light of these substantial legal consequences, as well as opportunities for positive financial and charitable results. To this end, it is essential for health care organizations to develop the requisite understanding of the relevant patient safety and quality issues, and put into place a system of performance goals and monitoring elements to ensure compliance. ■

Tax Implications of Quality Incentive Bonuses

With the focus on quality initiatives on the rise, hospitals have turned to physicians for assistance in meeting quality requirements imposed by regulatory agencies and accreditation organizations. Often this assistance is incorporated into a physician's contract as quality goals with corresponding quality bonuses. Tax-exempt bond-financed facilities that wish to incorporate quality bonuses into physician contracts face complications related to potential private use concerns.

Tax-exempt bond-financed space must meet certain IRS-mandated ownership and use requirements. If the space does not meet the use requirements due to private use, the interest on the bonds may become taxable.

Therefore, it is imperative to determine whether a management contract for financed space with a quality bonus results in private use. A management contract means a management, service or incentive payment contract under which a service provider provides services involving all, or a portion or any function, of a bond-financed facility. CONTINUED ON PAGE 4

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Tax Implications (Continued)

Management contracts include (i) contracts for management services for the entire hospital or a specific department and (ii) incentive payment contracts for physician services to patients.

Management contracts generally result in private use of bond-financed space if the contract provides for compensation for services that is based, in whole or in part, on a share of net profits from the operation of the facility. In analyzing this type of situation, certain contracts are specifically excluded from the definition of a management contract (e.g., mere granting of admitting privileges to a physician). In addition, Rev. Proc. 97-13 provides safe harbors for contracts involving specific types of compensation arrangements and term lengths, under which a management contract will not result in private use. Contracts that do not fall within one of the safe harbors are to be judged based on all of the facts and circumstances of the contract. However, most bond counsel are reluctant to render bond counsel opinions in financings that involve management contracts outside the approved safe harbors.

Although none of the safe harbors contemplate or directly speak to quality bonuses, certain quality bonuses may be structured to meet one or more safe harbor. For example, one potentially applicable safe harbor provides that to the extent at least 50% of the compensation for services is a fixed fee, then remaining compensation may be based on other measures, not to include profit. IRS private letter rulings suggest that quality bonuses may be included in the non-fixed fee percentage of compensation if they are based on pre-established quality goals, provided that the goals are not based upon the number of patients treated by the physician at the facility or the facility's productivity or net profits. Thus, care should be taken to ensure that any efficiency-related quality bonuses could not be deemed to be based, in whole or in part, upon the net profits of the facility.

In contrast, if the contract involves a split-billing arrangement (i.e., the physician bills for the professional component of services) and the quality bonus is a specific dollar figure based on the attainment of a particular quality goal, it is unlikely the contract can be structured to fit within any of the Rev. Proc. 97-13 safe harbors. However, if the quality bonus is based on a percentage of the contract's base compensation or can be re-cast as an additional per-unit fee, it may be possible to shoehorn the contract into a safe harbor. Nevertheless, the parties must consider the implications and potential restrictions of the federal Stark Law and Anti-Kickback Statute on such percentage or per-unit fees. Alternatively, the facility may consider incorporating quality goals into the contract without tying a bonus payment to those goals. Without clear guidance from the IRS, bond-financed facilities must continue to navigate the less-than-ideal current provisions under Rev. Proc. 97-13. ■

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