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Transparency or muddy water?

Public disclosure of hospital performance quality data is a double-edged sword

Federal and state governments have required hospitals to report various levels of quality measures for some time. Now, hospitals (and other types of health care providers) may be providing similar types of "quality" reports through commercial vendors. Transparency in quality and pricing is the new standard by which all health care providers may soon be measured. Although the movement invites discussion about true measures of price, value and quality in health care, obstacles remain to leveling the playing field for organizations providing this type of information.

HOW DOES IT AFFECT HOSPITALS?

For hospitals, this new era of transparency in quality reporting is a double-edged sword. On the one hand, it compels hospitals to align their care strategically toward evidence-based standards that reward clinical excellence. This, in turn, can enhance patient care and safety outcomes.

On the other hand, standards that hospitals must comply with in respect to data collection, tracking and reporting are often imprecise. This means that hospitals often don't fully understand how they should disseminate data in a meaningful way to consumers, employers and third-party payors.

WHAT ARE THE TYPES OF QUALITY REPORTING?

The transparency discussion can be divided into two types of reporting:

Government. Currently, the federal government and many states require hospitals to report quality data. By 2010, hospitals will need to report over 42 clinical measures for items such as heart failure readmission, pneumonia treatment and various surgical performance measurements.

Commercial vendors. These companies generally partner with health plans and large employers to rate hospital performance. Commercial reporting companies generally use claims-based data to analyze hospital performance. But the data often doesn't provide a good comparison of quality across providers. Likewise, although patient surveys are helpful when analyzing a specific care experience, they may not accurately reflect the technical aspects of the actual care provided. And, for a complete analysis of quality-related comparisons, vendors will need patient-specific clinical data — which is often difficult to obtain or protected under privacy laws such as HIPAA.

Although organizations, such as the Agency for Healthcare Research and Quality and the Institute of Medicine, have taken steps to provide reliable tracking measures, the process of quantifying health care quality is complex, and includes geographic and institutional limitations. Hospitals and vendors will have to engage each other to find a process for measuring patient outcomes that satisfies both.

WHAT ABOUT GOVERNMENT REPORTING?

So what can hospitals do to allow quality disclosure while still protecting their interests and avoiding liability? Complying with government reporting should be part of

your quality reporting strategic plan. At minimum, know what the state and federal government require for reporting purposes, such as how to report patient data to quality improvement organizations.

Work with your health care delivery staff and quality management staff to identify what controls and measurement systems are currently in place. Determine whether your tracking system reports what government organizations, such as the Centers for Medicare and Medicaid Services (CMS), require. According to CMS, in 2007, over 95% of all hospitals required to report quality data to CMS were able to do so. By complying with the reporting requirement, these hospitals avoided a reduction in Medicare reimbursement.

HOW DO YOU WORK WITH VENDORS?

With respect to commercial vendors operating in tandem with health plans or large employers, consult with your health care attorney to make sure your organization fully understands the implications of participating in a quality rating program that may involve sharing critical patient and health care provider data. As new vendors and reporting products enter the market, hospitals may not understand the standards under which their care will be measured. While the courts have started to address reporting issues through breach of contract and libel claims, the body of law is still being developed.

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Before engaging a commercial vendor or health plan that will produce a "quality report card," remember that, legally, medical records are deemed to be owned by the providers who control the records, subject to fiduciary and custodial duties owed to their patients (who own the information). In addition, provider data is often protected as intangible property — much like a trade secret or proprietary information. When participating with a commercial vendor, make sure the contract includes specific details as to how the vendor can use any shared data and the amount of use allowed. Clarify any approval process that the parties must adhere to before permission is granted to release data.

Moreover, make sure you understand the grading methodologies the commercial vendor implements. If approached by a vendor who claims to have a "report card," evaluate the clinical appropriateness of the benchmark used and scrutinize the methodology by which it measures performance. Your hospital board must understand the reporting process and provide oversight through hospital policy for public reporting of quality data.

Individual physicians within hospitals are also under increased scrutiny with respect to quality and overall performance. To manage an unfavorable rating of a physician, develop a policy for physicians in an employment relationship with the hospital. Understand, however, that legally challenging a rating due to alleged loss of reputation or loss of business may be difficult, as courts often will protect expression of opinion under freedom of speech.

HOW TO FIND COMMON GROUND

Transparency with respect to reporting quality outcomes is here to stay. Hospitals should continue to work with one another and with government agencies to find agreement on acceptable, universal best practices for tracking and reporting data. Finding common ground and consistency can alleviate many liability issues and fears that providers have with sharing patient care data.

What the 2009 OIG work plan means for you

Each year, the OIG announces its comprehensive work plan, identifying key areas the OIG sees as most worthy of attention with respect to audit and compliance investigations. Knowing where the OIG plans to place time and resources is helpful for providers to adequately evaluate their current risk assessment and corporate compliance plans.

CONTINUING OIG AUDIT INITIATIVES

Not all areas of focus are new. The OIG will continue to review areas it has examined in past years, including:

HIPAA privacy and security. While the OIG has focused on HIPAA in the past, it has added HIPAA privacy and security to its enforcement list after continued breaches in both the government and private sectors. Specifically, the OIG will address the security of portable devices such as laptops, jump drives and other portable media devices, scrutinizing the devices' storage, access and transport. The OIG will also review CMS's oversight, implementation and enforcement of HIPAA through the Office for Civil Rights.

IDTFs. Independent diagnostic testing facilities (IDTFs) perform diagnostic procedures independently of a physician's office or hospital and will be subject to enhanced review under the OIG's 2009 work plan. In areas with a high density of IDTFs, the OIG will examine service, provider and beneficiary profiles, as well as billing patterns.

CAH payments. The OIG will review critical access hospital (CAH) payments for services to and arrangements with Medicare Advantage organizations for services furnished to Medicare beneficiaries under the 101% provision. (CAHs are typically paid 101% of reasonable costs of providing covered inpatient and outpatient services.)

The OIG also has noted it will continue to examine:

1. Chiropractic billing of acute treatment using the proper "acute treatment" (AT) modifier,
2. Inappropriate unbundling of laboratory profile or panel tests and variation of lab pricing,
3. Durable medical equipment charges including Medicare payments for continuous positive airway pressure devices,

4. Medicare Part B drug pricing (specifically for chemotherapeutics), comparing average sales prices to widely available market prices, and
5. Various nursing home charges.

Consult with your health care attorney to discuss whether your organization is doing all it can to meet OIG requirements.

NEW FOR 2009

Notable among the new areas of focus are:

Hospital ownership of physician practices. Some hospital-owned physician practices have "provider-based" status, which means that an outpatient clinic can be treated as part of the hospital for Medicare billing purposes. Practices that have this designation may receive Medicare reimbursement for outpatient services in amounts greater than CMS's Medicare physician fee schedule under the outpatient prospective payment system (OPPS). The OIG will review the appropriateness of Medicare reimbursement to hospital-owned physician practices that have a provider-based designation to determine whether they meet the requirements to obtain the designation.

Provider-based status for inpatient and outpatient facilities. Hospitals with provider-based facilities that provide a cost report outlining the entity's actual costs in providing care may receive higher reimbursement rates. Freestanding facilities can benefit from specific payment

categories within Medicare, such as enhanced disproportionate share payments, upper payment limits and graduate medical education payments. Provider-based clinics may be able to increase coinsurance payments made by Medicare beneficiaries. The OIG will review cost reports of hospitals claiming provider-based status for improper claims.

"Never events." The OIG will review incidences of never events and Medicare's payment, denial or recoupment of payment for services as well as beneficiary payment of services related to never events. In addition, the OIG will review administrative processes aimed at detecting and paying for never events and will examine policies and practices regarding hospital compliance with them.

MS-DRG documentation. After CMS's implementation of the Medicare Severity Diagnosis Related Group (MS-DRG) — increasing the number of DRGs from 538 to 745 — the OIG will examine coding patterns and trends to determine whether some MS-DRGs are being upcoded.

Reliability of hospital-reported quality measure data. The Medicare Modernization Act established a reduction in payment for hospitals that fail to properly report quality measures to CMS. The OIG will review hospital controls for ensuring the accuracy of quality data that hospitals submit to CMS for Medicare reimbursement.

Hospital compliance with EMTALA. CMS has responsibility for evaluating EMTALA claims and referring cases that warrant investigations to state agencies. CMS will track regional variations of the number of EMTALA complaints and cases referred to states and determine whether peer reviews had been conducted prior to CMS's decision to terminate a provider from the Medicare program. The OIG plans to tighten CMS's oversight of EMTALA-based claims because of growing concern over the number of complaints and response time.

Additional Part A Medicare payments. In certain circumstances, hospitals may request additional Medicare capital payments if they incur unanticipated capital expenditures over $5 million due to extraordinary circumstances beyond their control, such as floods, fires or earthquakes. The OIG plans to review these requests.

IRF payments. The OIG intends to examine inpatient rehabilitation facility (IRF) claims for Medicare reimbursement in cases of transfers from one IRF to another IRF, a long-term care hospital, an acute inpatient hospital or a nursing home. The Social Security Act established a prospective payment system (PPS) for IRFs that provides payment for patient transfers from IRFs to specified providers. The OIG will evaluate the extent to which coding errors for claims should have been paid as transfers instead of as improper claims under the IRF PPS.

BE PREPARED

This is only a small sampling of OIG's 2009 agenda. The OIG's published report is at oig.hhs.gov/publications/docs/workplan/2009/WorkPlanFY2009.pdf. Review the full publication with your legal counsel to assess if any of the topics pertain to your practice or organization.

PAC PROVIDERS: PHASE II DEMONSTRATION CONTINUES

Under the post-acute care (PAC) demonstration project, CMS's goal is to standardize patient assessment information from PAC settings and use the data to set future reimbursement policy. CMS also hopes to better understand the acuity and care needs of Medicare beneficiaries requiring PAC care. Phase II of the project began last year and will run through 2011.

Phase II will examine information on patient health and functional status as it relates to resources and outcomes associated with treatment in each type of PAC setting. Key project objectives include:

Conducting a PAC payment reform demonstration. This will examine differences in costs and local practice variations and outcomes for PAC patients of a similar case-mix among different PAC providers.

Developing a new standardized patient assessment tool. To measure the health and functional changes and severity variations over time, providers participating in Phase II will use the continuity assessment record and evaluation (CARE) tool at discharge from an acute care hospital and all PAC admissions and discharges. The CARE tool will replace the current outcome and assessment information set (OASIS) and minimum data set (MDS) tools and will more heavily rely on Web-based technology.

In addition, CMS is developing a cost and resource tool to measure staff and ancillary resources associated with different types of patients.

CMS began the demonstration in ten markets, including Chicago, Boston, Dallas and the Lakeland/Tampa area, among others. Data collection began between May and September of 2008.

Nurse practitioners

Don't let licensing and scope of practice issues trip you up

Nurse practitioners (NPs) are increasingly being integrated into many inpatient and outpatient care settings to diagnose, treat and manage common, acute and chronic diseases. Hospitals and physician groups recognize NPs as quality care providers. According to the American Association of Colleges of Nursing (AACN), in the four years between 2000 and 2004, the number of NPs increased by nearly 40,000.

As providers seek to maximize the NP role, issues regarding their scope of practice have increased. If you're thinking about hiring an NP, you'll need to consider the licensing requirements in your state along with the boundaries of the NP practice.

LICENSING

Licensing requirements for NPs vary from state to state. However, most NPs have — at minimum — a registered nurse (RN) license with additional formal education. Many NPs have advanced clinical training and a master's degree in nursing.

Variations in state regulations of NP practice typically surround prescriptive authority. For example, some states require them to have a collaborating practice agreement with a physician. Such an agreement typically involves an NP and physician entering into a contractual arrangement whereby the collaborating physician agrees to review a percentage of charts, confer with the NP on patient care, and approve medications he or she may prescribe, including scheduled medications such as narcotics.

In states that don't require a collaborative agreement, NPs are licensed in much the same way as physicians. In these states, NPs may have no practice restrictions on prescriptive authority.

LEGAL ISSUES

If a legal issue arises with respect to an NP's scope of practice, it's often because the NP or the employer doesn't clearly understand the state regulations or licensing requirements. Or it may be because a health care organization places NPs in roles that exceed their practice capability.

Familiarize yourself with your state statutes, administrative codes and licensing requirements. Know what your

Nursing shortage: A reality

The nursing shortage and its potential impact on patient care continue to paint a concerning picture. The American Association of Colleges of Nursing (AACN) estimates that hospitals need approximately 116,000 registered nurses (RNs) to fill vacant positions nationwide; by 2020, the nursing shortage could reach one million.

According to AACN, in 2007, 40,285 qualified applicants were turned away from baccalaureate and graduate nursing programs due to insufficient faculty and training facilities. And while the average age of a nurse is 46.8 years, the nursing population under 30 has dropped to 8%. One AACN report indicates insufficient staffing is increasing nursing work-related stress, lowering the quality of patient care and causing nurses to leave the profession.

Many hospitals are trying to be creative in recruitment and retention. To help your nurses find balance and fulfillment in their professional lives, try increasing flexible scheduling and shift-sharing options. Offer continuing education and mentoring programs between younger and senior staff to enhance commitment to professional growth.

Create collaborative work environments where nurses have more autonomy and decision-making authority with respect to patient care. Increase the effective use of technology to reduce workload and increase efficiency. By providing work-friendly environments with managers who operate in a supportive and mentoring capacity, you can retain the best of your nursing staff.

state requires for NPs to practice. Clinicians and administrators alike often overlook this, giving rise to potential problems if an NP oversteps a defined legal practice boundary.

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Also, know whether your state requires collaborative practice agreements, as discussed above. If so, use wording that gives your NPs prescriptive practice authority — including prescriptive authority for scheduled medications.

If your NPs are practicing at multiple sites, determine how this might affect collaborative practice agreements under your state's law. You may need only one practice agreement. But this may not be the case in all states or when the NP is working for different employers.

HIRING

As a practical matter, NPs typically function much in the same manner as physicians — especially in the primary care setting. Yet, it may make financial sense for your hospital or physician group to hire NPs. By hiring nurse practitioners, your organization can provide patients with another team member able to provide high quality, cost-effective care with a practice philosophy that promotes treatment and wellness and prevention.

If you're considering hiring an NP, identify the role and function you will ask the NP to perform. Create a job description with clearly defined expectations. Ensure job definitions and role descriptions are consistent with your state's regulations and licensing requirements. Do this with your health care attorney — it will alleviate future legal problems.

In addition, keep a file of the NP's formal education and clinical experience, and make sure he or she meets continuing education requirements.

NPs MATTER

With many physician specialties in short supply, NPs will continue to have an expanded role working in hospital critical care settings and other specialty practices. (For more on personnel shortages, see "Nursing shortage: A reality" above.) While their role and scope of practice will continue to evolve, ensure that your NPs meet state statutory and licensing requirements. The clinical role in which NPs practice is critical, but make sure your NPs don't exceed their scope of practice — leaving you needlessly exposed to increased legal risk. ❙

A message to our clients and friends:

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We understand the value of good information when making sound business decisions. ***Practical Health Law*** is written by Hall Render's health law attorneys, each with extensive experience handling the legal issues of health care providers. We trust the information in each issue will be a valuable resource. Our attorneys stand ready to respond promptly to your questions and needs; please contact us if there are specific topics you would like to see addressed.

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