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INSIDE

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Pandemic Quality Reporting Eased, But Consider Benefits of Sending Data

Hospital quality leaders already strained by the COVID-19 pandemic welcomed the decision from the Centers for Medicare & Medicaid Services (CMS) to delay reporting deadlines for the Merit-Based Incentive Payment System (MIPS) and not require reporting or use data from the initial pandemic period for Medicare quality reporting and value-based purchasing programs for future payment years.

However, there are important issues to consider as hospitals move forward and regroup in the post-pandemic months. It is possible CMS will offer further extensions, even as far as excluding some quality reporting for all of 2020. CMS delayed the March physician reporting period for a month. If the deadline was scheduled for April or May 2020, providers can choose whether to submit data.

For any MIPS provider that did not submit MIPS data by April 30, 2020, CMS will make a neutral payment adjustment for the 2021 MIPS payment year, according to guidance posted by CMS. For 2020 reporting data, CMS has said it is looking at options and will make further announcements.

CMS also said data reporting for fourth quarter 2019 (Oct. 1 through Dec. 31, 2019) is optional. Fourth quarter data, if submitted, will be used to determine performance and payment adjustments. If a hospital chooses not to provide fourth quarter data, CMS will assess performance with data from Jan. 1 through Sept. 1, 2019.

CMS also instructed hospitals not to submit data for Jan. 1 through June 30, 2020, for hospital or post-acute care program performance or payment programs. For some types of healthcare organizations, including home health providers and hospice facilities, CMS extended the non-reporting period through Sept. 30, 2020.

The one-month extension was for physician reporting periods, like the

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MIPS program, and not directly for hospital reporting programs, explains **Anna M. Timmerman**, JD, partner with McGuireWoods in Chicago. For hospitals with physician groups, after this one-month extension, CMS has announced enforcement discretion, and reporting will be at the provider's option.

"In other words, CMS has stated that, for MIPS, if the provider does submit information after this extension, then these data will be used for performance and payment adjustments," Timmerman explains. "However, if a provider does not submit the information, CMS will give the provider a neutral payment adjustment for 2021 under the MIPS program."

The CMS changes recognize that during this pandemic, hospitals are focusing on the most immediate, necessary tasks at hand, Timmerman says. Facilities are reassigning staff to ensure care is provided to those hardest hit and that the hospital's operations are focused on what is needed, she says.

"To the extent data professionals preparing quality reports can assist in other data processing or operations, this direction from CMS, that fourth quarter quality numbers are optional, and that Q1 and Q2 2020 data will not be accepted, will allow such professionals to focus on other, more pressing entity needs. Further, hospitals may also avoid the expense of some third-party vendor costs if no reporting is required," she says. "Of course, this assumes that hospitals make the determination to simply not report. If hospitals instead want to calculate the data to determine if it would be in their best interest to report, then quality professionals may need to perform the same amount of work to prepare the information necessary for the hospital to make such a determination."

Report Good Data

If hospitals believe that fourth quarter data will improve its 2019 metrics, then failing to report could be detrimental, says **Timothy J. Fry**, JD, an associate with McGuireWoods. Hospital administrators may want to proceed with reporting if fourth quarter data would improve its scores. This may assist both their finances and public information.

"On the other hand, it is possible that hospitals will determine that fourth quarter data would harm their 2019 metrics and thus not submit the information. If this determination is made, other hospital providers could see negative adjustments to their payments on a go-forward basis due to Medicare budget neutrality rules," Fry explains. "Effectively, if everyone submits to maximize their individual facility's reimbursement, there will be less money for others."

If the pandemic lasts longer, and CMS takes further alleviation efforts, hospitals should monitor and make determinations in the future, Timmerman advises.

"We expect that providers may begin to raise concerns to CMS on using quality measures for future payments if the no-reporting period extends beyond six months. At some point, if the reported data is limited because there are no applicable measures for an extended period, many hospitals may not view the data as properly validated," Timmerman says. "In other words, if reporting is only three months,

will smaller hospitals have the census where such reporting is properly used for quality payments? At six months, we are not there. But if the extension continues, CMS and providers will likely want to revisit and discuss further."

Timmerman says she and her colleagues expect CMS to continue to monitor and provide further guidance on reporting in the future. Clearly, CMS is providing flexibility and trying to address acute needs of providers by removing these reporting burdens, she says.

"We would not expect that CMS would begin the pandemic with such flexibility, and then take a different approach later. Ultimately, what happens after these first extensions and options will depend in part on how long the pandemic lasts and what the economic impact on providers is," Timmerman says. "If the pandemic ends shortly, we would expect CMS to return to reporting and quality measures as quickly as they can. If it lasts longer, we would expect further alleviation efforts."

Leapfrog Supports Options

The current CMS changes should be helpful when hospitals are under the enormous stress brought on by the pandemic, stresses that will continue after the initial shock and most intense period of the crisis, says **Leah Binder**, president and CEO of The Leapfrog Group in Washington, DC. Leapfrog also is delaying the deadline on its survey by 60 days, giving hospitals until Aug. 31 to submit surveys.

"Hospitals need other priorities taken off their plate at this time, so we are sympathetic to their need for relief for a brief time in quality reporting," Binder says. "That said, we would recommend that quality professionals who have the capacity to report these data voluntarily do so. Especially now, hospitals are paying very close attention to infection control and protocols for paying absolute vigilance to following all the rules in a hospital setting. Their data for this period will probably look better than normal."

Some hospitals will find it infeasible to assemble and report the data because they must prioritize the immediate response to the pandemic, Binder says. Those hospitals should take advantage of the CMS changes without any guilt over failing to report. But other hospitals should not assume that is the right choice before assessing their ability to report.

"Hospitals should be recognized when they are stepping up their safety. Reporting the data is one way to acknowledge the hard work by your physicians and staff who went the extra mile in this time of need. Reporting their success is a way to recognize them," Binder says. "They also should try to have the most up-to-date information on their safety on their websites and available to CMS. It's to their great advantage to report the information."

Old Data Inevitable

Binder worries that if a large proportion of hospitals forgo reporting data, the effect down the road could be that consumers and purchasers will have to rely on old data to make healthcare decisions. Older data are never as valuable as newer data, but there may be no choice for a while. "For a short time, we will have to live with older data. We can do that once, we just shouldn't do it all the time. We can't make it a habit, but we're talking about a one-time thing brought on by extraordinary circumstances," Binder says. "This isn't something hospitals should worry about right now. Report the data if you can, but if you can't, get to work, and save some lives."

The impact of the CMS decisions could be significant for some hospitals and other healthcare organizations, says **Ruth Tabak**, associate director at Berkeley Research Group (BRG), a consulting firm in Washington, DC. She previously worked for CMS.

The extensions and exemptions may allow quality professionals to direct their attention and other resources to more pressing needs during and after the pandemic, she says.

"CMS is trying to reduce the administrative burden on hospitals of quality reporting during this extraordinary time. Some hospitals may be able to pivot their quality professionals to higher-priority activities, such as tracking coronavirus patient volume, outcomes, and facility readiness," Tabak says. "In past natural disasters — for example, hurricanes — CMS has also delayed quality reporting deadlines for providers and plans. We were not surprised to see this as one of the first steps the agency took."

Hospital quality professionals should consider the potential cost of reporting when deciding whether to take advantage of the CMS changes and delay reporting, or continue as they normally would have, Tabak says.

"It really depends on the hospital. If quality metrics are queued up and ready to submit, hospitals

should probably proceed," she says. "However, if submission will take staff time and resources that could otherwise be redirected to coronavirus response, hospitals should take advantage of the new CMS flexibility — and expect that more is coming."

Few Risks in Not Reporting

There are likely few, if any, risks for hospitals choosing not to submit quality reporting data under the new CMS guidance, Tabak says. The agency will do anything it can to free up resources for hospitals during the pandemic, and it will not retroactively impose any punitive measures on hospitals that do not report, she adds.

"Depending on the severity and length of the outbreak in the United States, it is likely CMS will offer a second suspension or delay of quality measures, perhaps extending to all of 2020," Tabak offers. "The agency may also develop specific 'hold harmless' policies for hospitals whose performance on certain quality metrics suffers during the period of the pandemic."

Tabak notes that many of the hospital quality reporting metrics are in statute rather than CMS policy. That means while CMS can grant exceptions and hold providers harmless under its "extreme and uncontrollable circumstances policy," it is not possible to forgo required quality reporting indefinitely.

"In one to two years, we'll likely be back on regular reporting timelines and performance assessment," Tabak says.

The benefits of the CMS reporting changes brought quick relief to hospital administrators responsible for quality data collection and management, says **Lauren Patrick**, president of Healthmonix, an analytics company in Malvern, PA, that assists healthcare organizations in delivering value-based care. The firm also is an official CMS-certified MIPS registry.

"Entire hospital staffs are being called on to address the COVID-19 pandemic. CMS's rule changes in regard to relaxing the reporting requirements are being felt immediately," she says. "Many organizations can shift focus from providing data reporting to addressing the unprecedented demands of the pandemic, without worrying about being penalized in the long run for the shift in the near-term focus. CMS should be lauded for their quick, wise response in taking this burden off the hospital quality professionals and essentially all staff in hospitals."

That immediate relief is yielding to the need for longer-term decision-making, Patrick says. Once the initial demands of the pandemic begin to wane, hospital quality professionals will need to decide longer-term whether to opt out of some of the reporting requirements or take advantage of the extended deadlines that are offered, she says.

That is true not only for current deadline changes but for any further extensions or exemptions CMS may announce, Patrick notes.

Opportunity to Assess

Any CMS changes also could be an opportunity to reassess data and reporting capabilities, using the extra time afforded by CMS to make necessary corrections, Patrick says.

"They will need to evaluate the choices in light of their internal data and the ongoing demands on their staffs. For some, this represents an opportunity to 'shore up' some of their reporting. For others, they simply may not have the resources to report," Patrick says. "We work with many providers that have their 2019 data gathered and their reporting completed, or they are just about finished. For those, it's an opportunity to perhaps audit their internal data, and improve their reporting by delaying a few weeks for resubmitting."

In particular, Patrick says quality leaders will have to carefully consider whether to take advantage of the changes for those involved in the QPP MIPS program. That will depend on the data available and potential performance numbers, she says.

"This provides an opportunity to review 2019 data and determine if they meet the minimum performance threshold to qualify for a positive payment adjustment. If their performance is below the neutral payment threshold, 30 points for 2019, then it benefits them to not report at all," she explains. "If their performance is above the 30-point threshold, and if they have the resources, they should continue to complete their 2019 submission."

For those that are not close to completing reporting and/or anticipate a low score in the program, it may be best to pass on reporting for the 2019 period, Patrick says, because CMS has removed any risk or disadvantage in not reporting.

"For those that are not complete but feel they can still achieve a high score, it's to their advantage to utilize the extra time to complete the reporting," she says. "The only potential disadvantage of not reporting is losing an incentive if a

significantly high score would have been achieved."

One concern for the QPP MIPS program is the potential lack of incentive money for high performers in the program with this change, Patrick says. This program is intended to be a budget-neutral program, which means that the incentives for high performers are funded by the penalties for low performers. "While there is a bucket of money for exceptional performance that the government provides, the amount of money available for high performers will be severely limited if no providers are penalized for not reporting," she explains. ■

SOURCES

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States Ease Licensing and Credentialing; Use Caution

Many states have lifted some restrictions on clinician licensing in response to the COVID-19 pandemic, allowing hospitals to call on more available professionals to handle the increased patient load. Although the relaxed rules are welcomed in the face of the crisis, peer review and compliance leaders should proceed with some caution.

The Federation of State Medical Boards (FSMB) is tracking the changes in licensure rules and has issued statements praising the state actions. The typical process for verifying training and licensing can take weeks. FSMB says that is not acceptable in a pandemic. FSMB is offering free access to its physician database for verification of credentials and disciplinary action for the immediate future.

Physician credentialing is controlled by state laws, but the federal government has made statements suggesting it will somehow override those statutes and require healthcare professionals to practice across state lines during the pandemic, notes **Matthew R. Fisher**, JD, partner with Mirick O'Connell in Worcester, MA. Whether the federal government has any authority to do that remains unknown.

"It might be that for Medicare purposes they can waive the requirement, saying you must be licensed in the state in which they provide the care, but if the state still requires licensure, that is a different issue," Fisher explains. "A number of states have waived that requirement in recognition that they are going to need all the help they can get. Others are not exactly waiving the requirement but saying they will get physicians licensed within a day. They're promising much more than fast-tracking a license application."

State by State Actions

The action taken by individual states varies, but all are undertaken with the intent to remove bureaucratic hurdles to putting more clinicians to work with the influx of COVID-19 patients. Pennsylvania has waived some administrative requirements. This will allow those physicians who retired in the past five years to reactivate their medical licenses at no charge.

Florida was among the first to take action, and their sweeping changes were repeated in other states. The state extended licensure renewal deadlines and allowed nursing education programs, nursing assistant training programs, and remedial courses to use supervised remote live videoconferencing for supervised clinical instruction hours required by any statute or rule.

Florida also issued waivers allowing telehealth services provided by out-of-state professionals, including physicians, nurse practitioners, licensed clinical social workers, marriage and family therapists, mental health counselors, and psychologists.

FSMB issued guidance for responding to the pandemic that included these four recommendations:

• **Eligibility.** "Physicians and physician assistants (PAs) receiving expedited licensure or reciprocity need to be duly licensed to practice medicine in at least one state

or territory and not have been subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any administrative actions such as non-payment of fees or failure to comply with continuing medical education requirements related to a license."

• **Verification.** "Physicians or PAs seeking expedited licensure or reciprocity must be employed or under an obligation to a hospital, government agency, managed care facility, placement service, or medical group or clinical practice who will perform a verification of physician's eligibility to provide care (licensure status and disciplinary history) with FSMB's Physician Data Center."

• **Duration.** "The ability to practice across state lines via emergency expedited licensure or reciprocity should be limited to the duration of the declaration of the state of emergency, including any extensions, within the state where the patient is located."

• **Documentation.** "Any provider-patient interaction, whether in person or through telemedicine, should be documented in the patient's medical record."

The FSMB provides a summary of state emergency declarations and licensing waivers, along with recommendations for license portability in pandemics, on its website at: https://bit.ly/3amhHCJ.

Still Obligated to Credential

Even in a crisis, peer review leaders must fulfill their obligations to ensure physicians are properly licensed before granting privileges, says **Kyle A. Vasquez**, JD, shareholder with Polsinelli in Chicago. "They likely have a temporary or emergency privilege category in which the process is expedited, but I'd want to make sure you validate that the physician or practitioner has an appropriate license," Vasquez says. "It is a positive step for states to remove some of the obstacles to helping these physicians best serve patients now, but that is not a message indicating that hospitals can let their guard down completely. They still have an obligation to ensure that the professionals they privilege are competent to treat patients."

Hospitals also must consider liability coverage for physicians and other practitioners coming in from another state, Vasquez says. The hospital's insurance coverage may or may not provide protection in this scenario. The only way to know for sure is to ask an insurance broker.

"Institutions that accept assistance from another state or bring in practitioners from another state should just take a moment to think about the liability considerations," Vasquez says. "Depending on how crazy things get, there are things like the Emergency Management Assistance Compact, which is a sort of mutual aid agreement among the states that lets them share resources during a crisis. It has some licensing reciprocity and liability coverage to the extent that states request assistance from another state, which is another level up from just a private practitioner going to another state to help at a particular facility."

Caution Advised

Fisher also advises quality professionals to be cautious in taking advantage of the relaxed licensing requirements. Keep in mind that providing safe, high-quality care must be the priority, even in a pandemic. Relaxing standards too much to get more hands into the fray could be a mistake. But as long as quality professionals are prudent and follow the guidelines, such as those provided by the FSMB, Fisher says the risk should be low.

"Compared to a normal scenario, I think the risk of any consequences or liability from these licensing moves actually is a little bit lower. Given the fluidity of the situation and the lack of clear instructions provided on a timely basis, you are not likely to be held responsible in a meaningful way if a mistake is made," Fisher says. "My gut feeling is that for minor noncompliance issues that may come up during this period of time, I don't think the government is going to come back after the pandemic clears and try to hammer people for trying to do the best things for patients."

However, if a mistake is left in place for some period after the pandemic, penalties and liability could result from that oversight, Fisher warns.

"A lot of hospitals are realizing that we are in a time in which they cannot get complete verification on some issues. If that means trouble in getting payment, or if they get a minor ding from it down the road, they are willing to take that risk so they can treat their patients," he says. "Even for some very conservative providers, there is an element of choosing to beg for forgiveness later because they can't wait."

The government also has made clear that reducing or waiving a copay without going through the typical analysis of financial hardship will not be seen as a kickback or beneficiary inducement, Fisher adds. Hospital leaders should watch for more developments in the

credentialing arena, even if after the initial phase of the pandemic has passed, Fisher advises.

"As this situation keeps evolving, it seems the federal and state governments are going to do what's needed to allow access to care and to make information available," he says. "While a particular action can't be predicted, it's safe to say that as the need arises, action is going to be taken. The goal of all that action is to promote access to care and, hopefully, protect the health and well-being of as many people as possible."

Aside from state and federal requirements, hospital leaders also must consider how licensing and credentialing decisions will affect requirements from The Joint Commission (TJC) or other accrediting bodies, Vasquez says. TJC posted information on its website with guidance for credentialing during a disaster. (That information is available online at: https://bit.ly/2WPLZdo.) "Making sure you are going to get paid for these services also is a key consideration. You will want to look at what your payer contracts say, how your Medicare and Medicaid enrollment is affected, looking at any federal or state Medicaid waivers that will allow payment for temporary or relocated staff," Vasquez says.

Telehealth Rules Eased

States also eased telehealth restrictions, and the Drug Enforcement Administration allowed the prescription of certain restricted medications by telehealth.

Hospitals and other healthcare organizations will be better able to serve patients and maintain quality standards through the use of telehealth services, Fisher says.

"The waivers open up access to using telehealth services at a time when healthcare organizations are struggling to provide care to all their patients, not just those directly affected by the COVID-19 virus," Fisher says.

"The visits are going to be reimbursed the same as for an in-office visit," Fisher continues. "For Medicare, you can qualify as having met all the normal requirements for payment, which usually requires the patient being there in front of you and doing certain tasks. Normally, you are allowed to do this only for established patients, but they're saying they will essentially turn a blind eye, and you can do this for new patients as well."

Polsinelli is providing an interactive map that explains the regulatory issues pertaining to telemedicine during the pandemic. That map is available online at: https://bit.ly/2WVkoHC. ■

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Telehealth Requirements Affected, DEA Allows Prescribing Narcotics

The COVID-19 pandemic prompted the Centers for Medicare & Medicaid Services (CMS) to relax some requirements related to telehealth services, expanding the types of patients and care settings that are eligible for telehealth reimbursement.

Normally, CMS allows Medicare reimbursement for telehealth services only if the beneficiary is located in a rural area and the originating site meets certain eligibility requirements.

Now, CMS is waiving the "eligible originating site" requirement for telehealth services rendered on or after March 6, 2020, and allowing telehealth services provided in all care settings, including a patient's home.

Further, the Department of Health and Human Services (HHS) stated that during the pandemic, it will not conduct audits to ensure there was a prior established relationship before the telehealth services, as is normally required.

The HHS Office for Civil Rights (OCR) also issued a notification of enforcement discretion for telehealth during the pandemic, noting that during this time, some telehealth services may not be fully compliant with the Health Insurance Portability and Accountability Act (HIPAA).

OCR said it will exercise enforcement discretion by not imposing any penalties for noncompliance with HIPAA for the good faith provision of telehealth, regardless of whether the telehealth

services were specifically related to the diagnosis and treatment of COVID-19.

OCR also indicated that providers can use certain "non-public-facing remote technologies" for telehealth services, such as Skype, Apple FaceTime, or Facebook Messenger video chat. However, they must not use "public-facing" technology like Facebook Live or TikTok.

Complete guidance on telehealth services during the pandemic is available on the CMS website at: https://go.cms.gov/2JgIg0x. The Drug Enforcement Administration stated that physicians may use telehealth to prescribe controlled substances via telemedicine without a prior in-person exam. ■

Cost Estimator Aims to Improve Patient Satisfaction

Indiana University (IU) Health in Indianapolis has built one of the most comprehensive cost estimators for patients of any hospital system, and is seeing a positive effect on its patient satisfaction scores.

The health system receives 50,000 requests a year for price estimates and can provide cost estimates for every inpatient and outpatient service at each of the system's 16 hospitals and every outpatient facility. Estimates are given by phone, in person, or online, and 95% of estimates are completed within 24 hours, says IU Health Senior Vice President and Chief Financial Officer **Jennifer Alvey**.

The cost estimator tool is patient-specific, as opposed to providing a general estimate for a type of procedure or treatment, she explains.

"We work with a patient on what types of services they need, what their physicians have said they need to do, and we work with them to capture every part of that service," she says. "If they're planning to do a hip surgery, we make sure we take into account the surgery, the physician visits, the radiology, the lab, and we put the entire cost in. We also then work through their insurance as it exists at that moment to determine their out-of-pocket costs. If necessary, we can discuss the options in terms of what they would owe up front and a payment plan."

The cost estimator tool enables the IU Health staff member to use information within the system that provides CPT codes, with the aid of a physician who works with the cost estimator group, and also provides access to the patient's insurance information. Six staff members form the team that responds to cost estimator requests. Most members have worked in case management. They provide insight into the various costs associated with different types of care.

"It's a sophisticated electronic system that facilitates this service, but it's also about 50% dependent on an individual knowing where to go look for information about this type of procedure or healthcare treatment," Alvey says. "It is not a simple, straightforward electronic system where you plug in a few bits of information and it spits out an estimate. Putting together pricing is complicated and more so when you want the patient-specific information that we provide."

IU Health compares its estimates to the final charges on its consolidated bills. Alvey says 90% of the estimates are within 5% of the estimated patient responsibility. IU Health's Net Promoter Score was 76 systemwide in 2019. Alvey says the cost estimator tool contributed to that achievement.

"It's important as a healthcare system to build toward a comprehensive billing process

where everything comes to one location. We see a lot of healthcare organizations around the country that do physician billing separate from facility without one integrated process," Alvey says. "We think of it as a patient's financial journey, and do the cost estimate well at the front. You have to do it well at the end also. You have to start there. If you can't show it all on one bill, it's hard to do the estimate up front."

Alvey also emphasizes the importance of capturing patient-specific data, particularly now that so many patients carry large deductibles. Providing general estimates of overall expenses and out-of-pocket costs can engender significant resentment when the patient's experience is different, she cautions. That can work to degrade patient satisfaction rather than enhance it.

"You also have to have the personal assistance of someone who is familiar with the healthcare system. If you just offer an electronic tool and ask patients to plug in the right information, you are not going to be able to provide an estimate that is specific enough to be useful to that person," Alvey says. "When the patient needs a CT scan, there are lots of different types with different costs. The patient is not going to know all those details. It takes that personal touch, and that's where we've put in our effort." ■

SOURCE

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Study: Hospitality More Influential Than Real Quality

As hospital quality leaders struggle to achieve even small improvements in clinical care results and hope that the effort is rewarded in patient surveys, research suggests comfort amenities like private rooms may be more effective.

That does not mean hospitals should shift focus from improving quality of care in favor of easier-to-achieve improvements in hospitality, says the lead researcher of a recent study. But it might mean the industry focus on measures like the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey is misguided, says **Cristobal Young**, PhD, assistant professor of sociology at Cornell University in Ithaca, NY.

"Improving patient satisfaction is not really about improving medical quality," Young says. "It comes down to what you mean by quality. Do you mean hotel amenities, or do you mean medical excellence? If medical excellence is still the core mission of hospitals, you probably need to set those patient satisfaction scores aside, or find ways to shift the institutional spotlight away from those satisfaction scores and focus on health and longevity scores."

Young and a colleague recently published a report casting doubt on whether clinical quality has enough influence on HCAHPS and similar measures.

"With a sample of 3,000 U.S. hospitals, we find that neither medical quality nor patient survival rates have much impact on patient satisfaction with their hospital. In contrast, patients are very sensitive to the 'room and board' aspects of care that are highly visible," the report says. "Quiet rooms have a larger impact on patient satisfaction than medical quality, and communication with nurses affects satisfaction far more than the hospital-level risk of dying. Hospitality experiences create a halo effect of patient goodwill, while medical excellence and patient safety do not."

An abstract and access to the full study is available online at this link: https://bit.ly/3btTY3H.

Young says patient satisfaction surveys can inadvertently lead patients to put more emphasis on comfort and convenience, when in fact they are not the primary focus. The survey asks them about such issues because they are easier for the patient to assess than clinical care quality. Then, the survey results incorrectly suggest that is the patient's priority, he says.

"When patients come to the hospital, they appreciate these amenities and customer service aspects, but that's not what they are there for," Young says. "I don't think any patient is going to say they came to the hospital for a good hotel experience. Hospitals are all about getting you the medical care that you need. Hospitals shouldn't be distracted from that by metrics they happen to be measuring with patients."

Nevertheless, hospitals are distracted by patient satisfaction scores. Facilities may go along with the misguided idea these scores are true measures of quality and patient

satisfaction. Perhaps leaders realize the truth and just play the game as a pragmatic way to receive the high scores that everyone wants.

"This has been a rabbit hole that a lot of people have fallen into. Hospitals are doing the things that raise patient satisfaction scores, and it makes it sound like patients are getting what they wanted," Young says. "But it's really troubling when patient satisfaction scores address not what they really value but what they can see about your hospital. Saying you raised patient satisfaction scores doesn't really mean patients are happy. It just means they're happy with what they can see."

The problem is rooted in the difficulty of showing meaningful data to patients, Young notes. It is much easier to provide amenities and ask about them than it is to explain the intricacies of morbidity, mortality, readmission rates, and similarly complex metrics. Providing only the simplest version of that information could be detrimental, Young cautions.

"I still struggle with this, because I'm not sure you want to post your mortality rates on the front door. 'Seven percent of all patients who come into this hospital die within 30 days, and we're in the 40th percentile of hospitals on this metric,'" Young says. "That's being honest with patients, but it's also pretty scary without knowing how it's calculated and what it takes into account."

No restaurant wants to post a notice saying, "We have very low rates of food poisoning," Young explains. The restaurant does not want to prompt potential customers to even think about food poisoning. Similarly, hospitals do not want to talk about a patient's chance of dying when they first enter the hospital.

"But hospitals have to be held to a higher standard. They have a fiduciary responsibility to their patients," Young notes. "They shouldn't be selling their patients a marketing campaign about high patient satisfaction scores. If they are serious about real medical quality improvement, the satisfaction scores are a real distraction."

The American Customer Satisfaction Index (ASCI), a data analysis of customer satisfaction across many industries, measures hospital satisfaction.

Most recently, the index revealed customer satisfaction with hospitals is down 5.3% from the previous year. The report says that is likely due to shifts from inpatient to outpatient settings.

Patient satisfaction with ambulatory care is steady at a score of 77 of 100 for the fourth year in a row, the report says, but patient satisfaction with hospitals was down 5.3% to 72. "As more hospital care shifts from inpatient to outpatient settings, hospitals overall suffer in customer satisfaction," the analysis says. "The most significant erosion occurs for emergency room services, retreating 8% to 67 and losing all of the gains made over the past two years. Wait times are a clear issue for emergency departments as incidences of patients leaving ERs without being seen are becoming increasingly more common."

Outpatient satisfaction scores fell 4% to 75, while inpatient care scores were up 1% to 76. (The full report is available online at the ASCI website: https://bit.ly/2JhyATd.)

Young says he is hopeful the healthcare community soon will turn its focus from satisfaction scores. "Once people come to recognize the limitations of satisfaction scores, I have no doubt that hospitals will be willing to set them aside and have an honest discussion about measuring what matters to patients," he says. "It could be a stepping stone to rethinking how we measure what happens to patients in a way that really digs down to the most fundamental things that matter to patients." ■

SOURCE

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Something Is Wrong: Good Cardiac Care Can Result in Lower Payments

Evidence showing that hospitals achieving high marks in cardiac care will not be rewarded in value-based care programs is mounting, In fact, such facilities may be penalized. The risk-adjustment models that determine payment under value-based systems do not adequately account for factors like patient mix. The result can be that hospital leaders feel like they are being punished for providing quality care. That may tempt some to game the system.

In recent research led by **Rishi Wadhera**, MD, cardiologist at Beth Israel Deaconess Medical Center and Harvard Medical School, a

higher proportion of hospitals with superior cardiac care were financially penalized under the Hospital Readmissions Reduction Program (HRRP) and the Hospital Value-Based Purchasing Program (HVBPP) compared with other hospitals.

"Our study highlights the frustration that leaders at hospitals and healthcare systems are experiencing as they roll out initiatives to improve quality of care but are getting discordant messaging from multiple organizations about how they are performing," Wadhera says. "We looked at what hospitals can control: the care they deliver within their walls. An ongoing controversy about federal value-based programs is that they really focus on measuring outcomes. But an outcome like readmissions is heavily affected by what happens outside the hospital walls."

Hospitals awarded for high-quality cardiovascular care by the American Heart Association (AHA) and American College of Cardiology (ACC) had either similar or slightly lower 30-day mortality rates than other hospitals, the study notes.

Researchers examined 3,175 hospitals participating in the HRRP and 2,781 hospitals participating in the HVBPP in fiscal year 2018. For the HRRP participants, a higher proportion of hospitals lauded by the AHA and ACC received financial penalties (85.5% vs. 78.7%).

With HVBPP hospitals, a higher proportion of the award hospitals also received penalties (51.7% vs. 41.4%). A smaller percentage of award-winning HVBPP hospitals received financial rewards under the program than others, only 48.4% for those cited for high-quality cardiac care vs. 58.6% of others.

More about the study is available at this link: https://bit.ly/39xwrNS.

The results suggest the healthcare community needs to standardize how quality cardiac care is measured and ensure that value-based programs not penalize the best performing facilities, Wadhera says.

In the meantime, hospitals need to keep doing what they do best: ensure patients receive the highest quality care, he says. Facilities should roll out quality improvement initiatives leaders think will improve outcomes for patients regardless of whether the current value-based structure will reward them.

"The evidence from these value-based programs suggest that they have not improved care, they probably disproportionately penalize our most resource-constrained hospitals, and they may be widening disparities in care," Wadhera says. "The Centers for Medicare & Medicaid Services [CMS] needs to be more responsive to evidence showing that maybe their programs are not working and maybe they are not improving care. Maybe we need to make changes based on healthcare systems' insight so that they are incentivizing the delivery of high-quality care."

Wadhera says CMS seems to be hearing the message and is realizing the programs are not working as intended when they were implemented almost 10 years ago.

"Hospitals have tried hard to improve the quality of care they deliver, but when you are being penalized every year, and you recognize that it's not because of the quality of care you're delivering but because of factors beyond your control, that's when you start to see some gaming of these measures," Wadhera says. "For the Hospital Readmission Reduction Program, it's very clear that the number of patients returning has not declined, even though the rates are going down. That's because hospitals are putting those patients in observation status and treating them more intensely in emergency rooms rather than admitting them."

Manipulating the statistics like that can produce meaningful differences in how a hospital appears to be performing in comparison to other facilities, Wadhera says. That can result in unfair comparisons and change who is penalized, he says.

"The question becomes whether outcomes like readmissions adequately reflect quality of care," Wadhera says. "The answer is probably not." ■

SOURCE

- **Rishi Wadhera**, MD, Cardiologist, Beth Israel Deaconess Medical Center, Harvard Medical School. Email: rwadhera@bidmc.harvard.edu.

CE OBJECTIVES

After completing this activity, participants will be able to:

1. Identify a particular clinical, legal, or educational issue related to quality improvement and performance outcomes;
2. Describe how clinical, legal, or educational issues related to quality improvement and performance outcomes affect nurses, healthcare workers, hospitals, or the healthcare industry in general;
3. Cite solutions to the problems associated with quality improvement and performance outcomes based on guidelines from relevant authorities and/or independent recommendations from clinicians at individual institutions.

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CE INSTRUCTIONS

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4. After successfully completing the test, your browser will be automatically directed to the activity evaluation form, which you will submit online.
5. Once the completed evaluation is received, a credit letter will be emailed to you.

CE QUESTIONS

1. **What is one of the guidelines from the Federation of State Medical Boards for credentialing physicians from another state during a pandemic emergency?**
   a. The physician or physician assistant (PA) must have a recommendation letter from three senior physicians in the home state.
   b. Physicians or PAs seeking expedited licensure or reciprocity must be employed or under an obligation to a hospital or other entity that will perform a verification of his or her eligibility to provide care.
   c. The clinician must have a minimum of five years' experience in practice after licensure in the home state.
   d. Physicians or PAs seeking expedited licensure or reciprocity must have an unblemished record at the National Practitioner Data Bank.

2. **What did the Centers for Medicare & Medicaid Services (CMS) say about data reporting for the fourth quarter of 2019 (Oct. 1 through Dec. 31, 2019)?**
   a. Reporting is optional.
   b. Reporting is mandatory.
   c. Reporting is suspended for three months, but then required.
   d. Reporting is suspended for three months, and then will be optional.

3. **According to Anna M. Timmerman, JD, what is CMS likely to do in relation to quality reporting after the COVID-19 pandemic?**
   a. If the pandemic ends shortly, she expects CMS to return to standard reporting and quality measures as quickly as they can.
   b. Regardless of the duration of the pandemic, she expects CMS to reinstate reporting and quality measures quickly.
   c. She expects CMS to extend the changes through the end of 2021.
   d. She expects CMS to survey hospitals for input before making any decision about the return to normal reporting and quality measures.

4. **What is one key to the success of Indiana University Health's cost estimator?**
   a. A small fee to patients weeds out frivolous inquiries.
   b. The estimator is entirely automated, so no staff are required to interact with patients.
   c. The tool provides a general estimate that would apply to most patients in that situation.
   d. Each estimate is specific to that patient's particular care plan, insurance, and other personal factors.