Board Fiduciary Duty to Oversee Quality: New Challenges, Rising Expectations

By Tracy E. Miller

The United States Supreme Court decision in *National Federation of Independent Business v. Sebelius* upheld the constitutionality of the individual mandate to purchase health insurance, thereby allowing continued implementation of hundreds of other provisions of the Patient Protection and Affordable Care Act (the "PPACA").[1] Although the subject of much less public attention than the individual mandate, innumerable provisions in the PPACA focus on health care quality and the redesign of health care services. These provisions have already begun to reshape the nation's health care delivery system.

Certain key initiatives to advance quality of care predated national health reform legislation. Development of new quality measures, transparency of quality reporting, and pay for performance were emerging policies at the federal and state levels a decade before enactment of the PPACA. However, the PPACA accelerated these trends, extended their reach across the continuum of care, and embedded these practices in the operation and evaluation of new care delivery models, such as accountable care organizations ("ACOs"), bundled payment arrangements, and health homes.

These fundamental changes in quality reporting, pay for performance and care delivery models have significant implications for board oversight of health care providers. In addition to its importance to mission, health care quality will have an increasing impact on financial performance, as well as strategic opportunities and risks for health care providers. While the unfolding changes in health policy and reimbursement have generated new tools for governing boards, such as comparative measures of health care quality, they have also posed new challenges and raised expectations for board oversight.

Background

Studies about the exceptionally high rate of medical errors leading to substantial injury and poor outcomes first emerged in the 1990s, culminating in a series of landmark public reports that brought patient safety to national attention.[2] Major barriers impeded quality improvement and patient safety initiatives, including the absence of comparative quality measures, the lack of transparency about quality, immature information technology systems, and notably, the absence of a compelling business case to invest in quality in a fee-for-service system.[3]

These same barriers limited the role that governing boards could play in overseeing quality. Without publicly available comparable measures of quality, boards could respond to serious events or poor survey findings, but often had little access to data that would inform a more proactive role. Moreover, the medical staff structure and regulatory oversight standards vested primary responsibility for overseeing quality in a largely independent medical staff. While boards had the authority and responsibility to grant final approval for medical credentialing, in practice, substantive evaluation of physicians occurred at the medical staff level, often with pro forma approval by boards of credentialing decisions.

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Making Quality Transparent

Beginning in 2002 with publicly reported measures of nursing home quality and subsequent establishment of Hospital Compare on the United States Department of Health and Human Services website, the Centers for Medicare and Medicaid Services ("CMS") launched a series of initiatives to promote public reporting of quality measures. The PPACA vastly expanded these initiatives, moving from voluntary reporting to financial penalties for failure to report and mandated public measures for providers across the continuum of care. Hospitals now face financial penalties for failing to report specific quality measures. Under the PPACA, financial penalties for failure to report quality measures will be phased in for hospice programs, long-term care hospitals, and physicians, among other providers, over the next three years.[4]

In addition to increasing the types of providers that report standardized public measures, the PPACA broadened the domains of quality of care that will be reported. Initial quality measures adopted by CMS focused on processes or outcomes of care for specific conditions such as acute myocardial infarction, heart failure and pneumonia. The PPACA extended public reporting and accompanying financial incentives for quality of care to serious errors captured by "never events" and measures of patient satisfaction.[5] While less standardized, programs to promote patient-centered care must also be reported to CMS as part of initiatives such as ACOs.[6]

The PPACA also seeks to strengthen the foundation for quality improvement, authorizing $75 million in funding annually through 2014 to improve the scope and reliability of quality measures, targeting specific priorities, such as measures of care management for high cost, chronically ill patients, meaningful use of information technology, and patients' experience of care.[7] Section 10322 of the PPACA will further promote public availability and analysis of quality data by making information extracted from Medicare claims data available to private entities that have the capacity to combine Medicare claims data with data from other sources to assess quality. As a result, data mining and analysis by private organizations may generate substantial additional information about quality of care related to a potentially broad spectrum of providers. Under provisions generally referred to as the Payment Sunshine Act, the PPACA also requires transparency and public reporting of payments by pharmaceutical, device, biotech, and medical supply companies to physicians and teaching hospitals for a wide array of purposes.[8] In addition to the potential impact on reputation, this data may be a powerful tool for quality and compliance oversight, enabling enforcement agencies to target investigation of unnecessary services as well as patient safety concerns.[9]

Pay for Performance

The expansion in public reporting of quality measures set the stage for federal and state initiatives to implement pay for performance in health care delivery. Since CMS launched a nationwide hospital demonstration program in 2003, it has steadily increased financial incentives tied to quality, through both penalties for poor quality and rewards for high performance. State government and private payers have followed suit, magnifying the impact of the financial incentives.

Never Events

In 2008, CMS instituted a policy of nonpayment for so-called "never events" in hospitals, serious incidents deemed preventable such as surgical site infections, falls, and stage III and IV pressure ulcers. In October 2008, New York State's Medicaid program also implemented a non-payment policy for 14 never events in hospitals. The PPACA mandated the non-payment policy for Medicaid programs nationally, barring state governments from paying for "health care-acquired conditions" identified by CMS.[10] The implementing regulations issued by CMS granted states the discretion to expand the list of health care acquired conditions as well as the provider settings where the non-payment policy would apply.[11] Under the PPACA, CMS must also study and report on applying the never events policy to long-term care, home care, and other settings.[12]

Further penalties for preventable conditions that occur in hospitals will take effect in fiscal year 2015, in accordance with Section 3008 of the PPACA. At that time, hospitals in the top quarter nationally for the number of health care-acquired conditions will face a one percent reduction in Medicare reimbursement.

Hospital Readmissions

Focusing on the high costs of hospital readmissions, the PPACA included provisions to penalize "excess" admissions at hospitals, beginning with readmissions in October 2012.[13] The Final Rule to implement the readmissions incentive, released by CMS on August 2, 2012, sets forth the methodology and payment adjustment factors that will apply.[14] Long-term care providers also have an incentive to reduce preventable hospital admissions; the United States Office of Inspector General ("OIG") identified such admissions as an enforcement priority in its 2012 Work plan.[15] In addition, it is likely that avoidable hospitalizations for short- and long-stay residents in nursing homes will be included in pay for performance incentives at both the federal and state levels, starting as early as January 1, 2013, in New York State.

Value-Based Purchasing

The PPACA made significant strides towards pay for performance based on an identified set of quality measures, or in the nomenclature of CMS, "value-based purchasing ("VBP"). First initiated on a voluntary basis for hospitals in 2003, VBP will be implemented in October 2012 for all hospitals nationally as required by Section 3001 of the PPACA. Under the VBP program, hospitals will be assessed against their performance on a baseline set of measures of clinical processes of care and patient satisfaction.[16] As structured by CMS, VBP for hospitals will be a zero sum game—CMS will generate funds for the incentive pool by reducing hospitals' base operating Diagnosis-Related Group payments by 1% in year one, increasing to 2% in year five of the incentive program. In recent reports to Congress, CMS signaled its intention to take a similar approach to VBP for long-term care providers. Specifically, in reports issued pursuant to PPACA Section 3006, CMS indicated that the VBP program for nursing homes and home care providers would redistribute funds available for reimbursement in accordance with measures of quality, hospital readmission, and patient satisfaction, starting in 2014.[17] As of 2015, CMS will reimburse physicians based on measures of quality as well as resource utilization.[18]

New Models of Care Delivery

The most ambitious provisions of the PPACA that seek to affect quality promote improved quality, reduced cost, and enhanced care coordination through new models of care delivery. Those models, encompassing ACOs, bundled care delivery initiatives, health homes, and medical homes, among others, seek to redesign the care delivery system, fostering reimbursement alterna-

tives to fee-for-service and providing financial incentives to improve quality and care coordination. Notably, the PPACA established the Center for Medicare and Medicaid Innovation ("CMMI") to fund and evaluate innovative methods of payment and care delivery, with $10 billion of funding for activities initiated from 2011 through 2019.[19]

The first shared savings model to emerge as part of federal health reform ACOs are organizations comprised of health care providers that share responsibility for the cost and quality of care for a specified group of patients in the Medicare fee-for-service program. Hospitals, physician groups, rural health centers, and federally qualified health centers are authorized to form an ACO, but providers across the continuum of care can participate in an ACO and potentially share in savings and losses.[20] While providers can chose the "one-sided" ACO model for the first three years and share savings without assuming the risk of losses, CMS has indicated that after the initial three-year term, all ACOs will be expected to assume the risk of shared losses with Medicare.[21] Many providers responded negatively to ACOs as initially conceived under proposed regulations issued by CMS. However, the final rule prompted far more support from providers and activity to form ACOs. In July 2012, CMS announced that 154 ACOs had been established. Here too, private payers have followed suit, contributing to ACOs' ability to generate enrollment and the economies of scale that may prove essential to successful implementation and cost savings.

CMS has also advanced bundled payment arrangements as a significant new approach to cost savings and quality. The PPACA requires CMS to establish a five-year pilot program by January 2013 to integrate care by hospitals, physicians, skilled nursing facilities, and other care providers immediately prior to, during, and following hospitalization.[22] In advance of the pilot program, the CMMI rolled out the Bundled Payment Initiative, offering providers four alternative models. The request for proposals for the Initiative required providers to define the conditions that would be covered, develop quality improvement projects, and propose a target for the cost of care. CMS also permitted providers to submit proposals for gain sharing to incentivize improved quality and efficiency. Studies of early bundled payment programs suggest both the long-term potential of the programs as well as the challenges and risks providers face in assigning accountability for outcomes across different providers, generating actionable data, and building programs large enough to realize savings.[23]

Seeking to improve care coordination for complex, high-cost patients with multiple chronic conditions, the PPACA provided federal funding for up to 90% of the cost for care coordination to states for Medicaid programs that develop a health home program.[24] CMS guidance to the states in establishing the program required health homes to develop extensive policies and processes to manage care, use information technology and data to improve quality, and deliver person-centered care.[25] New York State has launched its health home program, implementing the program in phases, starting with patients with multiple chronic conditions and/or a mental health condition.[26] The Department of Health has announced that the next wave of enrollment will focus on long-term care residents followed by individuals with developmental disabilities.

Heightened Focus on Poor Quality as a Compliance Risk

Federal and state regulators overseeing fraud and abuse enforcement have also raised the stakes for quality of care, pursuing poor quality as a violation of the False Claims Act ("FCA"), and requiring providers to address patient safety as part of their compliance oversight programs. Armed with data publicly reported or mined from the Medicare or Medicaid databases, the OIG and the New York State Office of Medicaid Inspector General have asserted that poor quality violates the FCA on several grounds: (i) the treatment billed for was medically unnecessary, (ii) the quality of care was so poor that the services were essentially not delivered or worthless, or (iii) the care delivered violated other federal standards related to quality such as the use of restraints. In New York State, providers with more than $500,000 annual revenue from the Medicaid program must encompass quality and credentialing in the elements of their compliance program and oversight.[27]

The 2012 OIG Work Plan also includes quality as a compliance priority for federal enforcement. The Work Plan lists specific aspects of quality among the priorities identified, including preventable hospital readmissions and quality of care delivered by post-acute care providers.[28]

Legal and Regulatory Standards for Board Oversight of Quality

In accordance with long-standing legal precedents, governing boards of non-profit organizations must meet three basic fiduciary duties: the duty of care, loyalty, and obedience to mission.[29] The duty of care requires board members to carry out their obligations to the corporation in good faith, and with the degree of care, attention, and skill that a person in a like position would reasonably believe appropriate under the circumstances. The duty of care is shaped by the business judgment rule, which affords board members broad protection.[30] In accordance with the business judgment rule, board members are not liable for decisions they make, even if the decisions later prove wrong and harmful to the corporation, if the directors acted in good faith, with the required degree of care

and a reasonable belief that the decision would serve the best interests of the organization.

As established by judicial decisions, board members can be found liable for breach of fiduciary duty for: (i) a board decision that is negligent or self-dealing, and (ii) an unconsidered failure to act in circumstances when "due attention" would have prevented the loss.[31] *In re Caremark International Inc. Derivative Litigation* enunciated the now well-accepted principle that while board members have no duty to conduct an investigation to uncover wrongdoing, they are responsible for ensuring that an adequate system exists to gather and report information to the board so that it can fulfill its fiduciary duty.[32] Hence, governing boards of health care providers have no duty to investigate in order to identify quality of care problems; board members can rely on the Chief Executive Officer and other senior executives to bring problems, including poor quality of care, to their attention. However, once notified of a concern, board members have a duty to inquire and seek corrective action, as needed.

For hospitals, the Joint Commission leadership standards and Medicare Conditions of Participation provide additional guidance about board duties relating to quality of care.[33] Under both sets of standards, the governing body is responsible for overseeing the medical staff, through approval of medical staff bylaws and structure, and credentialing standards and decisions. Joint Commission standards stress the importance of communication between the governing body, executive management and leaders of the medical staff regarding key elements of quality oversight such as performance activities, quality measures, and reports.[34]

In 2004, the OIG and the American Health Lawyers Association jointly issued a detailed statement about board duties to oversee quality (the "Joint Statement").[35] At the outset, the Joint Statement underscored the mounting focus on health care quality and concomitant heightened expectations for boards in carrying out the duty to oversee quality.[36] The core of the Joint Statement sets forth key lines of inquiry for governing boards to pursue in overseeing quality, advising boards to focus on: (i) quality goals and measures to assess those goals; (ii) accountability among key management personnel and staff to oversee quality; (iii) mechanisms to foster internal reporting on quality; (iv) coordination between the quality and compliance programs; (v) the sufficiency of information reported to the board to assess the quality improvement program; (vi) the allocation of resources for patient safety and quality improvement; (vii) the process for internal reporting of quality concerns or serious errors; and (viii) the process to identify, analyze and respond to serious adverse events. The Joint Statement also highlights the importance of board training about quality of care and assessment by the board of its own competence and activity to oversee quality.

Recent events in New York State also reflect a heightened focus on the duty of governing boards to oversee quality of care. The report of the Workgroup established by the Medicaid Redesign Team to evaluate Brooklyn's hospitals addressed the role of governing boards in overseeing quality, casting a harsh light on the boards' performance at several Brooklyn hospitals. As stated in the report,

> The boards at some of these hospitals have failed to satisfy fully their responsibilities to the organization and their communities. They have not evaluated financial and clinical performance, set strategic goals to address them, and held management accountable for achieving them.[37]

Among other recommendations, the report proposed that legislation should grant the Commissioner of Health the authority to appoint temporary operators for health care facilities that present a danger to the health or safety of their patients, and replace board members who are not fulfilling their duties to the organizations they oversee.[38] These recommendations were proposed by Governor Cuomo as part of the Executive Budget, but were not ultimately adopted.

Implications of Delivery System Change for Board Oversight

While quality has always been core to the mission of health care institutions, financial incentives from public and private payers, transparency, and the shift in care delivery models centered on care coordination have raised the stakes for governing boards and the institutions they oversee. Heightened focus on poor quality as a compliance violation and increasing use of data mining by enforcement bodies create other significant incentives for boards to oversee patient safety.

Transparency of public quality measures has direct implications for board duties to oversee quality. As discussed earlier, while governing boards have no duty to investigate to identify quality of care problems, boards must implement procedures to ensure the flow of information, and once put on notice of a quality concern, have an obligation to inquire further. In this regard, public measures of quality are an important development for board oversight, creating a public record that may trigger a board's duty to seek additional information and corrective action. Comparative, public quality measures also enable boards to assess quality in relation to peer institutions and competitors, and set affirmative goals.

Financial incentives tied to specific measures of quality or never events will have a growing impact in the wake of the PPACA. New models of care delivery—ACOs, bundled payment arrangements and health homes—also

require an effective quality program to manage patients with complex, multiple medical needs to improve coordination and drive down cost. Providers' ability to execute these models will determine the financial risks and rewards of participation, and will in turn depend on strong management skills and quality competence. In particular, providers will need the capacity to determine or participate in shared quality goals, identify measures of those goals, assign accountability for outcomes, and collect and analyze quality data in real time to change clinical behavior. As boards evaluate whether an organization should make the substantial financial investment required by these new delivery models, they will have to understand the challenges presented and the organization's capacity to adopt systems of quality improvement that can effectively change patient outcomes and reduce cost.

Qualilty performance will also shape the opportunities providers can pursue in the strategic alliances emerging in a consolidating health care marketplace. The concentration of public measures and financial incentives on certain key outcomes, including reducing hospital readmission and coordinating of care for chronically ill patients, means that providers will seek partners who can contribute to their own success. For this reason, in addition to regulators and public and private payers, other providers are a key audience for public quality measures and performance.

Meeting the Challenge: Roadmap for Board Oversight

As a result of changes in quality measurement, reporting, and incentives, a passive role for governing boards in reviewing credentialing decisions has been replaced by an emerging paradigm of a board that is more informed, more proactive, and more accountable for the quality of care. Boards can also be expected to take a data-driven approach to quality, evaluating quality based on public as well as internal performance measures.

Boards should assess their own readiness, competence, and activities to oversee quality in light of the changes under way in the health care delivery system, starting with board training to understand public measures of quality, existing and anticipated financial incentives, and the infrastructure needed for quality improvement. Significantly, studies have found that certain board actions are associated with higher performing institutions, including frequent use of quality dashboards, board training about health care quality, and a higher percentage of time at meetings devoted to quality.[39] According to one study, boards that have a committee devoted to quality are more likely to use quality dashboards, rely on quality measures to evaluate executive performance, and establish strategic goals for quality.[40]

In consultation with executive and clinical leadership, boards should consider an array of tasks to oversee quality of care in the face of mounting financial incentives and the unfolding transformation in the care delivery system, including:

- Review and evaluate a strategic plan for quality;
- Review existing and anticipated financial incentives for quality, emerging models of care delivery relevant to the organization, and regulatory priorities for quality and compliance oversight;
- Evaluate the organization's weaknesses and strengths in relation to all dimensions of quality and the organization's public profile from the perspective of regulators, payers, potential strategic partners and consumers;
- Develop priorities and goals for improvement, and establish benchmarks based on the organization's past performance, peer groups, and strategic goals;
- Require and review a concise dashboard of actionable measures of performance in relation to identified goals, including financial incentives and publicly reported measures;
- Review the organization's process to identify and address serious adverse events, develop corrective action, and report to the board of directors and to outside entities, as required;
- Seek coordination between the organization's oversight of patient safety, compliance, and conflicts of interest among executives and physicians that could give rise to patient safety or compliance concerns;
- Consider financial incentive arrangements to align physician and organizational goals for quality of care, and seek analysis of the corresponding compliance concerns that such arrangements may pose; and
- Seek review of the organization's legal infrastructure for quality (medical staff bylaws, medical director and physician contracts, and credentialing standards and procedures) to determine if these documents support a data-driven, systemic approach to quality of care.

Federal and state governments, as policymakers, payers, and regulators, have created an array of powerful new incentives for health care facilities to focus on quality of care. As a result, governing boards must now oversee quality of care not only as core to mission, but as key to the financial and strategic success of their organizations.

Endnotes

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3. Tracy Miller and Valerie Gutmann, *Changing Expectations for Board Oversight of Healthcare Quality: The Emerging Paradigm.* J of Health Sciences Law, vol. 2(4), 31-77 [hereinafter Miller and Gutmann].
4. PPACA §§ 3002, 3004.
5. *See, e.g.*, PPACA §§ 2702, 3001, 3008.
6. *See, e.g.*, 42 C.F.R. § 425.112.
7. PPACA § 3013.
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9. *See* James Sheehan, *How Payment Disclosure in Pharma and Devices Will Change Medicare/Medicaid Enforcement and Compliance* 2d Annual Summit on Disclosure (Mar. 4, 2010), available at http://www.omig.state.ny.us/data/images/stories/presentations/3-4-10_summit_on_disclosure.pdf.
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21. 42 C.F.R. § 425.600.
22. PPACA § 3023.
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26. See N.Y.S. Social Services Law § 365-1. Detailed guidance for health home applications and program requirements can be found at http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/questions_and_answers.htm.
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