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Improve Quality and Reimbursement

Quality reporting is a significant opportunity for your organization.

page 7

The Stark Law

A proactive approach to audit and compliance.

page 14

Mature InformatŠn Risk Management Programs

Prevent avoidable data breaches with multidisciplinary teamwork.

page 18

Auditing Hazardous Waste Management Activities

Mitigate risks and raise compliance awareness now.

page 28

Improve Quality and Reimbursement

Quality reporting is a significant opportunity for your organization

By Eric Lowy, CIA, and Divya Moolchandani, MHA, CHC

Quality reporting has far-reaching business, financial and reputational implications and should connect with the strategy of an organization. An internal audit of quality reporting reviews the systems, processes and internal controls that are in place to collect, validate, submit and monitor measures required for reliable reporting of data. In addition to strengthening controls and reliability of reporting, these reviews can identify efficiencies, improve internal performance, reduce manual intervention and increase financial performance and recognition.

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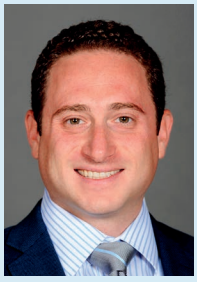

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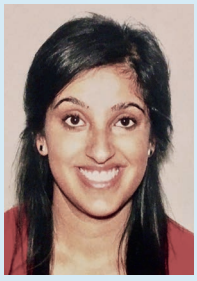


Healthcare quality measures are increasingly used by CMS, commercial payers, federal and state regulatory agencies, and the public to evaluate the effectiveness of an organization's patient care delivery. Quality reporting is also an increasingly important factor in determining reimbursement incentives and penalties, which are part of the shift from volume to value.

The volume of metrics and various reporting structures for quality are complex; a typical health system may report over 500 measures to several registries. Additionally, quality reporting is now an essential requirement for providers participating in the Quality Payment Program created by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Performance based on these measures can impact an organization's ability to obtain incentive reimbursement for higher quality services, as well as its effectiveness in promoting its brand and reputation.

As healthcare reimbursement evolves from volume-based fee-for-service payments into value-based reimbursement programs, quality reporting will be the gateway between clinical care and financial reimbursement. Similar to financial reporting, several key assertions need to be met to help ensure the reliability of quality reporting. Accordingly, internal control over quality reporting (ICOQR) could be the Sarbanes-Oxley of healthcare internal audit, since key processes underlying quality reporting will need to be routinely evaluated.

In addition to strengthening controls and reliability of reporting, ICOQR can identify efficiencies, improve internal performance, reduce manual intervention and increase financial performance and recognition.

Initial risk assessment

When designing an audit of a quality reporting program, the landscape of quality measures may be overwhelming in terms of volume and complexity. Therefore, a high-level risk assessment should be considered in order to build an inventory of registries, measures and owners of the measures. This may require meeting with various leaders to identify the variety of stakeholders and obtain registry submissions and results for review.

An initial risk assessment will allow auditors to gain an understanding of the relevant registries and measures, stakeholders, core processes and potential risk areas to audit. Such an inventory is critical in assessing the end-to-end processes underlying quality reporting.

There are specific steps to perform during this initial risk assessment.

- Evaluate and review:
  - Registries and measures, for financial implications
  - Alignment with strategic initiatives
  - Information from prior internal audits
- Define a scope that is realistic for the first year, after giving consideration to the volume of registries, measures, stakeholders and related EHR and reporting systems.
- Tailor the objective of the audit based on the top risks identified in your risk assessment that are inherent throughout the quality reporting process.

Top ICOQR risk areas

Quality reporting processes vary across organizations, but there are five common risk areas where controls could break down across various subprocesses, functional areas and systems:

- Roles and responsibilities
- Data integrity
- System interface
- Collection and submission
- Monitoring

Roles and responsibilities

The impact of quality reporting is evolving quickly and is dependent on an organization's portfolio of conditions, treatments and service lines. As such, many provider organizations tend to have decentralized oversight of measures or submissions. Accordingly, some organizations may find it difficult to initially identify process ownership, as governance and oversight may be in early stages of maturity or not formally defined.

Newly developed reporting processes, quality reporting systems, IT infrastructure and the role of IT personnel in quality reporting may also be areas of increased risk. Maintaining department and individual accountability over quality measures and registries may improve the effectiveness and accuracy of data collection and corrective action follow-up.

> *Beginning with a top-down perspective, consider the roles of the Board, committees, subcommittees, and workgroups when identifying roles, responsibilities and owners of measures/registries*.

Data integrity

Assessing data integrity involves reviewing the points where it is entered, and where it is used to measure quality. An audit of quality reporting focuses on the controls in place for collecting and reporting data, rather than assessing whether quality care was provided. For example, patient registration may be a key risk area, as incorrect patient intake data or the complexity of 68,000 different ICD (International Classification of Diseases) codes may affect quality case identification.

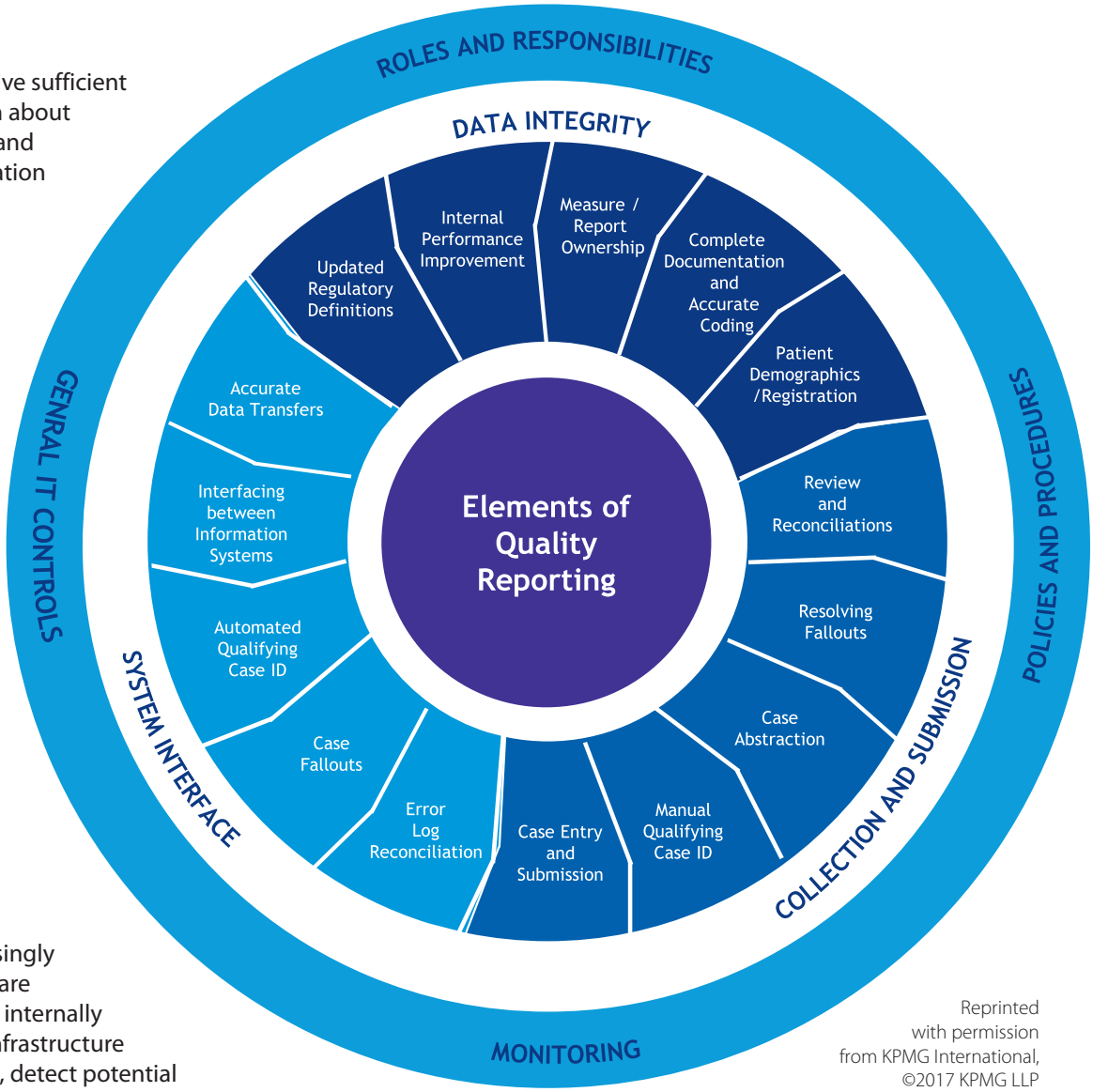
Provider documentation is also a point of data entry for quality reporting. Clinicians may not understand how to phrase quality language, or might copy and paste documentation across charts, creating unreliable documentation notes. Lack of controls for coders and Clinical Documentation Integrity (CDI) staff is also a risk for data integrity, since this is where cases are flagged by procedure and diagnosis codes.

Quality measure definitions are often complicated and have ever-evolving definitions and exceptions. CDI and

The purpose of auditing quality reporting is to review controls to help ensure the reliability of quality data reported both externally and internally by provider organizations.

coding staff may not receive sufficient counseling and education about quality-related language and coding to identify information that must be reported. Reviewing data collection points may provide valuable opportunities to train and educate providers, coders and quality reporting staff about specific quality language and regulatory changes, and foster an organizational culture of quality.

Identify process owners at data integrity points to document the quality-related controls that are in place across the data gathering process.



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System interface

As the quality-related processes become increasingly significant, organizations are relying on third party and internally developed systems and infrastructure to identify adverse events, detect potential cases for investigation and calculate numerators/denominators for measures. Detective controls are necessary to help ensure the accuracy and completeness of quality reporting interfaces from electronic health records (EHRs) to the reporting system, manual spreadsheets, summary reports and/or registries.

The system may not accurately flag case-related quality measures, or the error logs that are generated between interfaces may not be resolved sufficiently through the various data integrity checks.

Additionally, the report writing and programming within these systems to capture quality measures and information may not filter quality cases in accordance with measure definitions, and therefore needs to be thoroughly tested. Review of system interfaces may lead to more efficient processes for data collection and reporting. Systems may also have capabilities to help identify root causes of common errors (e.g., specific clinicians or coders making errors).

Consider the collaboration between IT staff and clinical personnel to resolve kick-outs, case fall-outs, error logs, case surveillance, and/or measure reporting, as these processes may be complicated. Processes performed by third parties should also be evaluated, such as review of Service Organization Control reports (i.e., SOC reports).

Measure collection and reporting

Without controls to verify data collection, there is a risk that the number of quality cases or measure calculations may not be completely or accurately collected and reported, resulting in financial, administrative and/or reputational implications for your organization.

Manual identification of cases may result in error rates and misidentification of quality cases if information is not communicated clearly and efficiently. As quality cases are received and reviewed, there may be errors caused by data

entry, insufficient detective controls of difficult quality cases, lack of tracking of quality cases to be submitted, incorrect interpretation of measure definitions and/or unresolved case fall-outs.

Prior to submission of final, aggregated data to the registry, which is typically quarterly, there are also a number of risks to consider.

Cases need to be given final review across data collection points to help ensure the correct numbers of cases are being submitted in numerators and denominators. Cases crossing reporting periods may be incorrect or collection of aggregated data over the quarter could be untimely. Additional issues may arise in reporting due to lack of confirmation that data was received by the registry and/or unresolved errors in submission.

Review of high-risk cases may help identify root causes of errors for quality improvement.

Identifying opportunities for increased efficiencies for data collection, flagging of quality cases, submission/review of cases, and surveillance to track and report flagged cases may improve data reliability and free up key clinical resources.

> *Document the calculation and submission processes for each registry you are evaluating in your audit in order to identify areas for testing and obtain assurance over accurate data being reported.*

Monitoring

Regular monitoring of accurate and complete quality performance data is a catalyst to ongoing performance improvement. Dashboards, benchmarking, trend analysis and other reporting should be utilized to evaluate performance and oversee corrective action plans. Additionally, review of high-risk cases may help identify root causes of errors for quality improvement.

Monitoring should be occurring at the various levels of the organization such as in departments, workgroups, committees and Board-level reporting. These groups may be tasked with educating clinical and/or coding staff about documentation and coding improvements and updates to regulatory definitions of quality measures as they change. Oversight and monitoring activities, including a defined schedule, periodic dashboard reporting and root cause analysis of issues provides governance and ongoing surveillance, and facilitates transparent process improvement.

> *Review the mission, purpose and actions of the relevant monitoring groups that are in place to assess governance and determine the feedback loops that contribute to quality improvement.*

Better ICOQR practices for organizations

Commonly observed better practices for ICOQR include:

1. Accountability and ownership of registry reporting
2. Performance improvement through monitoring controls and dashboards
3. Existence of a clear channels of communication
4. Updated processes based on measure definition or regulatory changes
5. Cross-training and periodic education of quality staff
6. Maintenance of quality or departmental policies and procedures
7. Automation of data surveillance and reporting
8. Periodic auditing of cases for quality improvement

Conclusion

Quality reporting is quickly becoming as relevant to healthcare providers as financial reporting. This reporting will have a growing impact on an organization's bottom line as risk-based payments continue to increase. Payers and providers are moving toward population health management, which is a data-driven approach toward improving the quality and efficiency of health systems. Therefore, elements of ICOQR should be included on annual audit plans of internal audit departments for the foreseeable future.

Quality reporting is a significant opportunity for healthcare internal auditors to improve quality and financial performance in their organization. An effective way to begin this process is to conduct an initial risk assessment and create an inventory of reporting metrics, registries, and owners.

Rather than extensive, random audits of historical quality scores, focus on a comprehensive and independent evaluation of the design and effectiveness of internal controls. These should cover the five common risk areas (i.e., roles and responsibilities, data integrity, system interface, collection and reporting, and monitoring controls). Align the registries and measures evaluated in the audit to strategic goals of the organization to help provide assurance over quality data and potentially offer specific insights into opportunities for performance improvement.

Internal audit can be used to drive results, such as productivity gains, cost savings, improved brand reputation, and, most importantly, to improve quality of care and patient health. **NP**