The CMS Quality Payment Program

POTENTIAL FOR IMPROPER PAYMENTS

2019 HCCA Healthcare Enforcement Compliance Conference

Michael Stearns, MD, CPC, CFPC, CRC
Principal and CEO
Apollo HIT, LLC

Raul G. Ordonez III
Senior Director, Compliance
Office of Compliance and Ethics
Jackson Health System

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Part I. Quality Payment Program Overview

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CMS Quality Payment Program (QPP)

2019 is year 3 of the QPP

Two QPP tracks:

- The Merit-based Payment Incentive System (MIPS)
- Advanced Alternative Payment Models (APMs)

Impact:

- ≈800,000 clinicians in the MIPS
- ≈180,000 - 200,000 clinicians in Advanced APMs

MIPS Basics

Mandatory Program for all eligible clinicians

Clinicians and groups received a score between 0 and 100 points

Score determines payment adjustments in the corresponding payment year

Medicare Bart B Payment adjustments will reach: -9% to +9%

MIPS Scores Based on Performance in Four Categories

Quality	Up to 6 quality measures
Promoting Interoperability	Electronic health record (EHR) measures
Improvement Activities	Attest to meeting the requirements for 1-4 improvement activities
Cost	10 cost measures (2019 performance year)

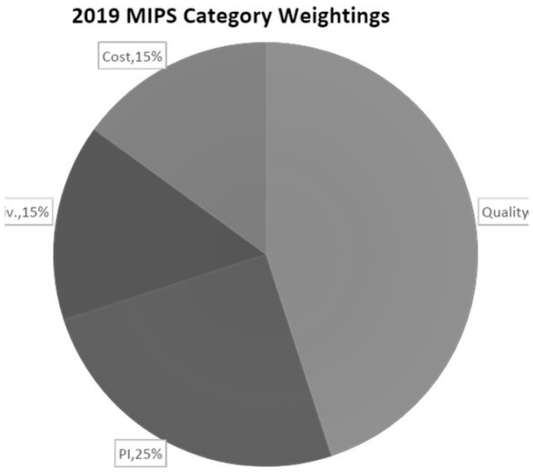
Changes to MIPS Performance Category Weightings in 2019

Quality: 45%

Promoting Interoperability: 25%

Cost: 15%

Improvement Activities: 15%



MIPS Eligible Clinician (EC) Types In 2019

2017-2018	ADDITIONAL EC TYPES IN 2019
Physicians	Physical therapists
Physician assistants	Occupation therapists
Nurse practitioners	Qualified speech-language pathologists
Clinical nurse specialists	Qualified audiologists
Certified nurse anesthetists	Clinical psychologists
	Registered dieticians/nutrition professionals

Performance Thresholds in 2019

30 points for the 2019 performance year

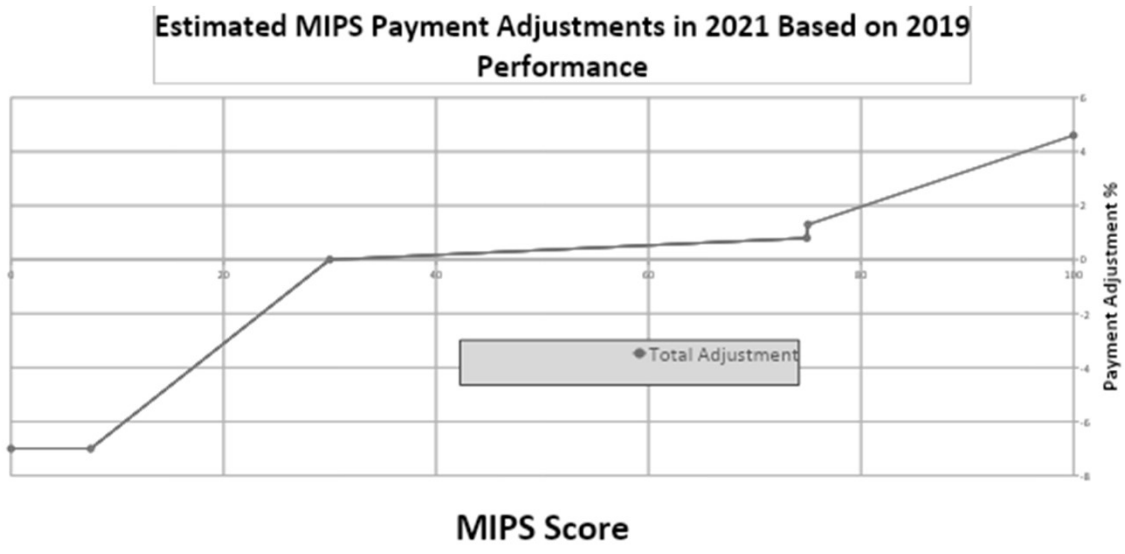
- >30 points: positive adjustment
- =30 points: neutral adjustment
- <30 points: negative adjustment

Threshold values established by CMS for first 5 years of program

Exceptional Performance Payment

$500,000,000 annual fund for exceptional MIPS performance
- Funded for the first 6 years of the QPP

Practices must achieve the "additional" payment threshold
- 75 points in 2019
- Maximum of 10% (additional payment adjustment)



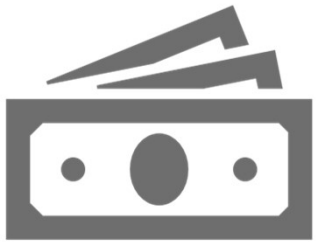
Maximum Positive Payment Adjustments

"3X" multiplier may be applied to positive payment adjustments

- Assumes adequate funds are available

Theoretical maximum positive payment adjustments per year:

- 31% for payment year 2021
- 37% for payment years 2022-2024
- 27% for payment years 2025 and beyond



Advanced Alternative Payment Models (APMs)

2019 Medicare Advanced APMs

- Bundled Payments for Care Improvement Advanced Model (BPCI Advanced)
- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Medicare Accountable Care Organization (ACO) Track 1+ Model
- Next Generation ACO Model
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3
- Oncology Care Model (OCM) - Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1- CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)

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Advanced APM Basics

Qualifying Advanced APM Participants (QPs)

Based on reaching payment or patient volume thresholds

QPs:

Receive a 5% lump sum bonus

Excluded from the MIPS

Advanced APMs must have greater than nominal shared risk

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Section II. QPP: Fraud, Waste and Abuse Vulnerabilities

Quality Performance Reporting

Performance on clinical quality measures common to all QPP programs

Assess performance through ratios:

- E.g., the percentage of patients with a history of tobacco use that received cessation intervention

Quality measures have detailed specifications

- Include numerator and denominator criteria, and may include exceptions and exclusions, CPT/HCPCS codes, ICD-10-CM codes, medications

Quality Measure Benchmarks

Most quality measures have benchmarks
- Majority of benchmarks significantly elevated
- Creates pressure on clinicians/organizations to achieve "perfect scores"

MIPS Measure #134 "Screening for Depression and Follow-Up Plan"

Average	Decile_3	Decile_4	Decile_5	Decile_6	Decile_7	Decile_8	Decile_9	Decile_10
67.7	17.11 - 45.64	45.65 - 73.81	73.82 - 90.05	90.06 - 98.49	98.50 - 99.99	--	--	100

Quality Measure Reporting: Potential Compliance Challenges

False documentation "allowing" the clinician to:
- Achieve performance met or meet a requirement for an exception/exclusion

Retrospective actions that may result in noncompliance
- Quality data can be captured from clinical records retrospectively
- Alterations could be made to medical records to increase quality performance

Data aggregation from all sites of care – burdensome requirement
- Quality performance data
- Promoting interoperability performance data

Quality Measure Data Capture and Reporting (2)

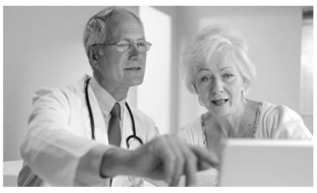
Potential compliance challenges:

- EHR tools/templates
  - Default content that addresses measure
  - Ease of use settings for data capture
    - E.g., check a box stating an activity was performed ("Weight-loss counseling provided")
- Manipulate quality data after export
  - Some third parties have encouraged "cherry-picking" of data to be submitted

Promoting Interoperability – Compliance Challenges (1)

E-Prescribing

- Failure to aggregate all prescriptions written during the performance period



Provide Patient Access Measure

- Measure is worth 40% of the score in the PI category
- Patients that refuse access:
  - Counted if provided with instructions
  - Potential for practices to add these patients to numerator without offering access
- Must meet the requirement that information is shared within patient within 4 business days

Promoting Interoperability – Compliance Challenges (2)

Sending Health Information Measure

- Measure requires that clinicians export and securely send an electronic Summary of Care Document for referrals or transitions of care

Specification document does not include some key guidance

- As per CMS QPP support team:
  - Receiving clinician must be using an EHR that can import an electronic version of the Summary of Care document
  - Sending the patient back to see a provider they have seen previously counts as a "referral"
- Difficult for practices and auditors to interpret…

Promoting Interoperability – Compliance Challenges (3)

Receiving and Incorporating Health Information Measure

- Requires clinician to import and reconcile an electronic Summary of Care record for referred patients, patients undergoing a transition of care, and for patients "never previously encountered" by the clinician
  - "Never previously encountered" may be difficult for practices to track and to audit
    - E.g., patient seen in follow-up by PA shortly after being seen by MD
- Only encounters where the Summary of Care record has been "received" count towards the denominator
  - Difficult for providers to track and potentially for auditors to review
    - E.g., Summary of Care record sent via a secure third-party email application

Promoting Interoperability – Compliance Challenges (4)

Hardship Exceptions

- Practices may apply through attestation for a hardship exception
  - If approved PI category is reweighted to zero points
- Hardship exceptions available for:
  - Small groups that experience significant barriers to meeting the PI category requirements
  - Decertified EHR technology
  - Insufficient Internet connectivity
  - Extreme and uncontrollable circumstances, (e.g., natural disasters)
  - Lack of availability of Certified EHR Technology

Promoting Interoperability – Compliance Challenges (5)

Hardship Exception Vulnerabilities

- Attestation only
- Practice must provide documentation, but only if they are audited

Small practice exception does not specify that the practice needs to have faced significant barriers

- "On behalf of the clinician(s) listed in this application, I am requesting this hardship exception and attest that the clinician(s) was(were) participating in a small practice"

Clarification provided in Final Rule(s) and CMS PI FAQ document

- Practice must be facing substantial barriers to meeting PI requirements

Improvement Activity Compliance Challenges

MIPS Program only

Reporting is through attestation only

Potential Focus Areas of Audit

- False attestation that improvement activity requirements were completed
- Failure to have supporting documentation that activities were performed
- Failure to meet the specific requirements outlined in the improvement activity specification

Cost Category Performance

Risk adjustment common to all QPP models

- Models used similar to Medicare Advantage
- Hierarchical Condition Category (HCC) coding
  - Based on a subset of ICD-10-CM codes that fall into HCC code "buckets"
  - HCC codes have assigned risk adjustment coefficient values
  - HCC codes summated to determine the overall "Risk Adjustment Factor" (RAF) score

Cost Performance in the QPP

Performance based on risk adjusted encounters
- CMS HCC coding/RAF score model

Potential for Compliance Challenges:
- Overreporting diagnoses not supported by:
  - The clinical scenario (e.g., sepsis reported when clinical criteria have not been met)
  - Clinician documentation
- Shifting diagnoses towards conditions with higher levels of risk adjustment

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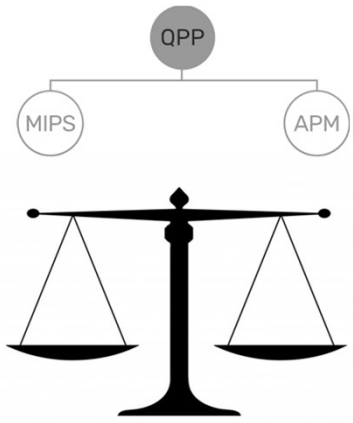
Part III:
Prospects of Regulatory Enforcement in Quality Payment Program



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Government Commentary

"If CMS Does not develop and implement a comprehensive QPP Program integrity plan, the program will be at greater risk of fraud and improper payments."

DHHS OIG Follow-up Review: CMS's Management of the Quality Payment Program

December 2017

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Government Commentary cont'd

"On the basis of our sample results, we estimated that CMS inappropriately paid $729,424,395 in incentive payments to EP's who did not meet meaningful use requirements."

DHHS OIG: 'Medicare Paid Hundreds of Millions in Electronic Health Record Incentive Payments That Did not Comply with Federal Requ

June 2017

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Meaningful Use-Performing Interoperability

-Provider Enforcement

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United States v. White

- 2012
- Shelby Regional Medical Center
- Manually inputting data from paper records to EHR
- User Attestations
- 2014: CFO sentenced to 23 months in prison and $4 million in restitution

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United States ex rel. Moore v. 21st Century Oncology, LLC

- Self-disclosure
- Falsifying data, fabricating utilization reports, and superimposing vendor logo
- 2017: $26 million settlement

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United States ex rel. Awad et al. v. Coffey Health System

- Hospital System
- 2011-2016
- Chief Information Officer/Compliance Officer
- Security Risk Analysis
- Manual capture of reported data
- 2019: $250,000 Settlement

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United States ex rel. Sheldon v. Kettering Health Network

- HIPAA breaches
- Failure to Run Requested Reports from EHR
- FCA Violation for Meaningful Use Payments?
- 2016: U.S. Court of Appeals affirmed dismissal for failure to state a claim

United States ex rel. Misch v. Memorial Hospital of South Bend, Inc., et al.,

- Attorney Relators
- Meaningful Use Stage 1: Core Measure 11
- Providing Patients with EHR within three (3) business days
- False Claims?
- Voluntarily Dismissed

United States ex. Rel. Lewis v. Community Health Systems

- Relators-IT Managers of EHR System
- Poorly integrated functionality
- Causing information to be entered multiple times
- Failing to issue warning upon medication duplication
- 2019: DOJ has yet to intervene; investigation still open

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EHR Vendor Liability

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U.S. ex rel. Delaney v. eClinicalWorks LLC

- eClinicalWorks
- Failure to Document and Track Medications/Lab Results
- Eprescribe Measure
- 2017: $155 million settlement

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U.S. v. Greenway Health, LLC

- 2011-2017
- Office of the National Coordinator for Health Information Technology (*ONC*) Health IT *Certification* Program
- "test scripts"
- Clinical Summaries Calculation
- 2019: $57.25 million settlement

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EHR Vendor Liability cont'd

- Liability for Providers?
- Vendor Agreements?
- Attestations?

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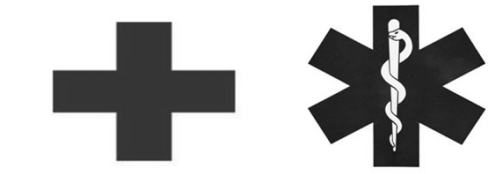
Quality Measures



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United States of America ex. rel. Megan Duffy v. Lawrence Mem. Hosp

- Inpatient/Outpatient Quality Reporting Programs
- Hospital Value-Based Purchasing Program
- Chest-pain Patients "Arrival Time" in ED
- *Escobar* and "Materiality" Standard
- Must prove inaccurate reporting would impact government payment?

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Medicare Advantage Risk Scores

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Sutter Health

- Inaccurate Diagnoses
- Hierarchical Condition Codes ("HCC's")
- Lack of Supporting Documentation
- Lack of Training and Auditing/Monitoring Program
- Still ongoing
- 2019: $30 million settlement in related case *United States ex rel. Ormsby v. Sutter Health, et al* for MAO

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United States ex rel. David Nutter, M.D., and David Nutter, M.D., individually, v. Sherif F. Khalil, M.D., Beaver Medical group, L.P., The Beaver Medical Clinic, Inc., Epic Management, L.P., and Epic Management, Inc.

- Beaver Medical Group L.P.
- Diagnoses Codes not Supported by medical record
- Inflated Payments
- August 2019: $5 million settlement

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United States ex rel. Swoben v. Secure Horizons, et al

- Davita/Healthcare Partners
- Incorrect Diagnoses Codes/Inflated Payments
- "One-way" Chart Reviews
- Improper directives regarding coding for spinal condition
- 2018: $270 Million Settlement

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Part IV: Compliance Tips

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Maintaining Audit Readiness

-Maintain a QPP Handbook
-Include Measure definition
-Explain organization's interpretation
-Include screenshots of system functionality
-Archive any patient records relied upon
-Archive any guidance received from government agencies

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Mitigating Risk

- Policies and Procedures
- Internal/External Auditing
- Connecting with those managing the program
- Training and Education
- QPP Committee

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Questions???

Presenter Contact Information:

Michael Stearns: Michael@ApolloHIT.com

Raul G Ordonez III: Raul.Ordonez@jhsmiami.org