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

Part I.
Quality Payment Program Overview
**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

- Physicians
- Physician assistants
- Nurse practitioners
- Clinical nurse specialists
- Certified nurse anesthetists

ADDITIONAL EC TYPES IN 2019

- Physical therapists
- Occupation therapists
- Qualified speech-language pathologists
- Qualified audiologists
- 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)

Qualifying Advanced APM Participants (QPs)

- Based on reaching payment or patient volume thresholds
- Receive a 5% lump sum bonus
- Excluded from the MIPS

Advanced APM Basics

- Advanced APMs must have greater than nominal shared risk
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”

<p>| MIPS Measure #134 “Screening for Depression and Follow-Up Plan” |
|------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|------------------|</p>
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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

Part III:
Prospects of Regulatory Enforcement in Quality Payment Program
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

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
Meaningful Use-Performing Interoperability

- Provider Enforcement

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
**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

**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
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

EHR Vendor Liability
**U.S. ex rel. Delaney v. eClinicalWorks LLC**

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

**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
EHR Vendor Liability cont’d

• Liability for Providers?

• Vendor Agreements?

• Attestations?

Quality Measures

- 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?

Medicare Advantage Risk Scores

[Icons: Emoticon, Gauge, Dollar Sign]
Sutter Health

- Inaccurate Diagnoses
- Hierarchical Condition Codes ("HCC’s")
- Lack of Supporting Documentation
- Lack of Training and Auditing/Monitoring Program
- Still ongoing


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

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

Part IV: Compliance Tips
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

Mitigating Risk

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

Presenter Contact Information:
Michael Stearns: Michael@ApolloHIT.com
Raul G Ordonez III: Raul.Ordonez@jhsmiami.org