

Fraud and Abuse is Alive and Well – and Coming to a Hospital Near You

Thriving Under the New MIPS and APM Requirements of MACRA

Healthcare Financial Management Association

May 22, 2017

R. Barrett Richards
Frost Brown Todd LLC

214.580.5848 (Direct)
brichards@fbtlaw.com

Fraud and Abuse Considerations 2017

- Forest Park Hospital System
- Six hospitals in six Texas cities
- Bankruptcy
- Indictments
- Press coverage on a regular basis
- Are there lessons that we can learn from their experience?

Fraud and Abuse Risks

Reach of the Government

- System did not accept Medicare or Medicaid
- Protection from Stark and Anti-Kickback Laws?
 - Texas has an “all payer” anti-kickback law
 - State jail felony
 - Insurance Fraud – criminal activity
 - Federal Employee Compensation Act – monetary compensation for medical care to civilian employees of U. S. Government
 - Federal Employees Health Benefit Program – contracts with insurance companies to pay claims on its behalf
 - Aetna, Cigna, United Healthcare – TPA for school districts and cities

Indictment

The indictment alleges:

- Payment of remuneration to induce referrals.
- Solicitation of remuneration for referrals of Medicare and Medicaid patients not served by the hospitals.
- Interstate Commerce
- Commercial Bribery (Texas statute)
- Waiver of deductibles and coinsurance amounts

Specific Allegations

- In complaining about the reduction of his remuneration for referrals from \$175,000 per month to \$125,000 per month, one defendant was quoted as writing an email stating:

We . . . “pass up 6 hospitals on our way to FP for medical conditions that could be treated locally.”

and

“How do the commissions work? I am on commission for a percentage of the surgeries that I send . . .”

Specific Allegations

- Regarding referrals to other institutions for Medicare and Medicaid patients:
- “Do we still need to chat about Medicare? I would like to get started. Just need to hammer out cost split!!”
- “What about all those Medicare leads? When can we expect to see a check for these people?”
- “I have finalized a Medicare deal with Hospital [B] for ‘\$350 per lead.’”

Monetary Effects

- Alleged to have paid approximately \$40 million in bribes and kickbacks.
- Resulted in:
 - “the victim plans and programs being billed well over half-a-billion dollars”
 - and
 - “FPMC collecting in excess of two hundred million dollars in tainted and unlawful claims”

Business Model

- Out of network
 - High remuneration
 - Sold assets based on OON cash flow
 - Went in network
 - Couldn't service obligations

Considerations for Providers under Payment for Quality Provisions of MACRA

Key Legal Aspects

Participation, Risk, Compliance, and Consolidation under:

1. the Quality Payment Program (QPP); and
2. the Merit-based Incentive Payments System (MIPS);
and
3. The Advanced Alternative Payment Model (Advanced APMs).

Major Components of QPP

1. Quality Payment Program (QPP)
 - a. Merit Based Incentive Program (MIPS)
 - b. Alternative Payment Models (APMs)
2. Repeals Sustainable Growth Rate Formula (SGR)
3. Sunsets current Medicare reporting systems:
 - a. Physician Quality Reporting System (PQRS)
 - b. Value-based Payment Modifier (VM)
 - c. Meaningful Use
4. Consolidates their functions into QPP/MIPS

Overview of MIPS effects:

- MIPS evaluates eligible clinicians with a Composite Performance Score (CPS).

<u>Weighting</u>	<u>2019</u>	<u>2020</u>	<u>2021 et seq</u>
■ Quality	60%	50%	30%
■ Resource Use (Cost)	N/A	10%	30%
■ Clinical Practice Improvement Activities	15%	15%	15%
■ Advancing Care Information (Meaningful Use)	25%	25%	25%

- Subsequent years – Resource Use weight will increase and the Quality weight will decrease

Overview - MIPS:

- Weighted scores will be based on 0 to 100 range.
- MIPS adjustment factor will be determined based on whether the clinician scored above or below the MIPS performance threshold.
- Adjustment factor applied to the clinician's Part B payments
- 2017 resulting adjustment will range from – 4% to + 4%
- Increases annually through 2022 and subsequent years when positive or negative adjustments can be as great as 9%
- Zero Sum Effect? –
 - MACRA requires budget neutrality
 - Cannot have significantly higher number of positive adjustments than negative.

Overview of Advanced APMs

- MIPS is applied to traditional fee for service payments
- Advanced APMs provide that, rather than FFS payments, clinicians can participate in APMs
- APMs include:
 - Accountable Care Organizations
 - Patient-centered Medical Homes
 - Other approved programs

Advanced APMs

- Not all APMs will meet the requirements to be Advanced APMs
- Advanced APMs must:
 - Use Certified Electronic Health Record Technology (CEHRT)
 - Provide for payment based on quality measures
 - Require clinicians to either:
 - Bear risk for monetary losses or
 - Be a Medical Home Model

Advanced APMs

- Benefits – QPs:
 - Excluded from MIPS calculations
 - Receive a lump sum incentive payment of 5% of prior year's payment for Part B covered services in 2019 through 2024
 - Beginning in 2026, receive a higher update under the physician fee schedule than non-QPs.
- Detriments ?
 - 2026 and following – higher base payment updates than MIPS participants, but bonuses are discontinued
 - Continued assumption of risk

Covers Physicians and ...

- In 2017-2020 QPP will cover **Physicians** (MD, DO, DMD, DDS) and
 1. Physician Assistants
 2. Nurse Practitioners
 3. Clinical Nurse Specialists
 4. Certified Registered Nurse Anesthetists
- Secretary given authority to include additional clinicians in 3rd payment year (2021) and subsequent years. Some discussed for the future:
 - Physical and occupational therapists, speech pathologists, audiologists, nurse midwives, clinical social workers, clinical psychologists, and dieticians

Some Physicians are Not Covered by the Program

- Physicians NOT covered:
 - Any physician in his or her first year in the Medicare program
 - Physicians with low volume
 - Low volume = Medicare charges of less than \$30,000 per year
 - Or fewer than 100 Medicare patients per year
 - Participants in Advanced Alternate Payment Models (Advanced APMs)
- CMS estimates 738,000 to 780,000 physicians billing under the PFS will be excluded in 2017

Participation Contemplated by CMS

- CMS estimates of participation in MIPS and APMs by clinicians indicate that:
 - Between 687,000 and 746,000 clinicians will be subject to MIPS for 2019
 - Between 70,000 and 120,000 eligible clinicians would become Qualifying APM Participants (QPs) through Advanced APMs in 2017
 - Relatively small percentage of clinicians will become QPs or Partial QPs in 2017

Health Information Technology

- HITECH Act (2009) provided incentives payments for professionals under the Medicare HER Incentive Program (Meaningful Use)
- MACRA ends Meaningful Use payment adjustments (for clinicians only) for CEHRT use after 2018
- CEHRT continues under MIPS – principal part of Advancing Care Information (ACI) component of score calculations.
- NPs, Pas, Clinical Nurse Specialists, and CRNAs – CEHRT certification optional in 2017

Health Information Technology

- MACRA – pushes all providers to assume some level of responsibility for actions of other providers in the treatment process – by assessing penalties and by encouraging adoption of technology
 - Use of technology is a separate performance metric under MACRA and
 - Electronic health record technology is the only practical way to capture those data required under the new payment structures for positive payment results.

How to Participate

- Individuals -Physicians may participate as an Individual
- Groups - as a Group based on tax ID number
- Virtual Groups – Solo and small practice physicians may assemble “virtual” groups of 10 or fewer Individuals.
 - Number of participants is limited by statute
 - Virtual Groups available only after 2017

Virtual Groups

- Solo and small practices may form virtual groups
- Combined reporting for MIPS
- 10 physicians or less, total in virtual group
- Does not apply to 2017
 - Does apply to 2018 and later
- \$100 million in technical assistance is available to educate and maximize participation

When to participate / Deadlines

General program timeline

- October 2016 Final Regulations
- January 1, 2017 First performance period begins
- October 2, 2017 Last possible ‘pick your pace’ 90 day performance period begins
- December 31, 2017 First performance year ends
- March 31, 2018 Final date to submit 2017 data
- January 1, 2019 First performance based payment adjustments are made based on 2017 data

Three “pick your pace” options available for 2017

1. **No Participation**: Physicians failing to participate in **2017** QPP will suffer a 4% negative “adjustment” to their **2019** payments
2. **Minimum Data Option**: Physicians who submit “some” data will not suffer the 4% negative adjustment by submitting:
 - a. One measure in the Quality Performance category; OR
 - b. One activity in the Clinical Practice Improvement category; OR
 - c. Reporting the required measures of the Advancing Care Information category.
 - d. Minimum data option physicians will not suffer negative adjustment but not eligible for positive adjustment

Partial and Full Options

3. **Some Data Option**: Physicians report more than minimum data for 90 days which will include:
 - a. more than one Quality Performance measure, or
 - b. more than one Clinical Practice Improvement activity, or
 - c. more than the required base measures in the Advancing Care Information category.

These physicians will not receive a negative adjustment and may be eligible for a small incentive payment

Full Participation Option

3. **Full Participation**: For 2017, providers will report:
 - a. All required data – across all listed categories – for at least one 90-day period and, preferably, for the full year.
 - b. CMS, “we greatly encourage MIPS eligible clinicians to meet the full year performance period” ...to... “maximize chances of positive adjustment.”

This option allows a provider to maximize the possibility and size of a potential incentive payment

What do Physicians Report?

Four MIPS categories of data to be reported:

1. Quality: choose 6 to report of 200 available measures
2. Advancing care: Pass/fail on 5 measures
3. Clinical practice improvement: 93 activities within 8 categories
4. Resource Use (Cost): For 2017, the score is calculated based on Medicare claims – no reporting

Data are required to be delivered to CMS not later than March 31, 2018.

Quality Reporting

- In general, reporting providers would report at least six quality measures. Of the six chosen, reporting of at least one outcome measure is required
- Select measures from list of available measures
 - Specialty measure sets are also available
- For groups of 16 or more clinicians, CMS also will calculate an all-cause, claims-based hospital readmission measure

Resource Use (Cost)

- CMS used statutory discretion to negate reporting of this measure in 2017 for calendar year 2019. However it will be calculated for later years
- Required data will include:
 - Total costs per capita
 - Medicare spending per beneficiary for physicians
 - Clinical condition and procedure episode cost measures from a list of 10 measures
- Cost score is the average score of all the measures that can be attributed to reporting provider

Clinical Practice Improvement Activities

- “Improvement Activities” are those anticipated to improve:
 - Patient safety
 - Care coordination
 - Patient engagement
- CMS has developed a list of 93 applicable activities
 - Full credit – participate in 4
 - Each weighted as “medium” or “high”
 - High weight activities count toward 2 of the 4

Advancing Care Information

- Revision of Meaningful Use Requirements
- Final rule contains fewer reporting requirements than Meaningful Use rule
 - Fewer reporting requirements
 - Thresholds lowered
- The idea is to encourage this category and provide incentives.

Scoring under MIPS

- MIPS “Composite Performance Score” (CPS) for each physician = 0 - 100 score
- Physicians’ payments adjusted based on whether they are above or below the average CPS
- Reporting begins in 2017
- Initial adjustment to payments first in 2019

Incentives and Penalties

- Performance threshold
- Determined annually by CMS
 - Using data from all MIPS participants
 - Participants with scores below threshold receive negative adjustments to payments
- Additional threshold of 25% of the performance threshold is determined by CMS
 - Participants below 25% threshold receive maximum negative adjustment
 - 4% first year, sliding scale up to 9% in 2022 and thereafter

Incentives and Penalties

- Budget Neutral
- No more incentive amounts can be paid than dollars saved from penalties.
- Exceptional performance bonus (2019 through 2024)
 - Excluded from budget neutrality
 - Funded from separate source
 - Annual “exceptional performance” threshold determined by CMS
 - For 2019 – the exceptional performance threshold is 70 of 100 points

Advanced Alternative Payment Models

- Excluded from MIPS reporting
- Physicians in APM can qualify for a 5% bonus incentive payment in 2019
- Avoid 4% negative payment adjustments under MIPS
- Advanced APM in 2017 must receive 25% of Medicare payments or see 20% of Medicare patients of physician through the Advanced APM entity

Three forms for APMs:

1. Innovation Center Models,
2. Shared Savings Programs, and
3. Demonstration Programs

Six initial types of APM's

1. Comprehensive Primary Care Plus
2. Next Generation ACO Model
3. ACO Shared Savings Track 2
4. ACO Shared Savings Track 3
5. Oncology Care Model
6. Comprehensive End-stage Renal Disease Care

Three statutory criteria

1. Participants must use certified electronic health record technology “CEHRT”
2. Payments must be based on Quality Measures similar to MIPS
3. Must require participants to either:
 - a. bear risk for monetary losses of more than a nominal amount or
 - b. be an expanded Medical Home Model.

Benefits of APM

- 2019 – 2024 receive a lump sum payment equal to 5% of the estimated aggregate payment amounts for Medicare Part B covered professional services for the prior year
- Exclusion from MIPS payment adjustments and reporting
- For payment years 2026 and later, an 0.75% upward payment adjustment

Participation Agreements

Each Participant must, for example:

- Commit to making the APM work
- Acquire and maintain electronic medical interface
- Make performance data available on timely basis
- Share expenses of APM operation
- Compliance with value based payment arrangement requirements (MSSP, ACO, etc)
- Compliance with Stark and Anti-Kickback
- Termination for lack of active participation

Employee Benefits Problems

- Will APM create a Controlled Group?
- Will APM create an Affiliated Service Group?
- If yes, the benefit plans need to be tested for discrimination.
- Can present a major hurdle.

Stark Law Prohibition

- Must meet an exception in 42 CFR 411.357
- Or qualify for a waiver
- Personal Services exception for physician services *to the APM*
- Fair Market Value covers Participation Agreement *APM services to physicians*
- If APM owns ancillaries, exceptions for lease or rental need to be met

Anti-Kickback Statute

- Strive for safe harbors
- Or get waivers
- Consider risk of being outside safe harbors and consider risk tolerance of participants
- Exceptions for rural and medically underserved areas

Adapt

- “Adapt or perish, now as ever, is nature’s inexorable imperative.”
- *H. G. Wells*

Thank you

R. Barrett Richards
Frost Brown Todd LLC
100 Crescent Court, Suite 350
Dallas, Texas 75201
Main: (214) 545-
Direct: (214) 580-5848
Cell: (214) 437-9002
Email: brichards@fbtlaw.com