Movers & Shakers:

What's New in Health Care Liability, Accountability and Employability

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LIABILITY

Yates Memo + False Claims Acts =
Renewed Emphasis on Your Organization's Compliance Program

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The Yates Memo = Game Changer

- Focus on **individual accountability** in federal civil and criminal investigations
- Cooperation credit depends on corporations disclosing all relevant facts, including individuals responsible for decisions/misconduct
- Focus on individuals in civil & criminal investigations
- Cooperation between attorneys handling civil & criminal investigations
- No release of individual liability in corporate settlements
- No corporate settlement without plan for resolving individual cases
- Individual's ability to pay should not influence decision whether to investigate or prosecute

Federal FCA Overview

- Liability for knowingly submitting a false claim (e.g., claims made during period of Stark or AKS non-compliance)
  - With knowledge of falsity or acting in deliberate ignorance or reckless disregard of the truth related to a claim
    - e.g., billing for services not provided
  - "Reverse" false claims – where a person knowingly avoids paying money owed to the government
    - e.g., failure to return an overpayment can trigger FCA liability

Alaska's New False Claims Act – SB 74

- Prohibits providers and recipients from **knowingly**…
  - Submitting, authorizing or causing to be submitted a false or fraudulent **claim** for Medicaid payment
  - Making, using or causing a false record or statement to get paid
  - Using a false record or statement to conceal, avoid, increase or decrease an **obligation** to repay money/return property
- This may be Alaska's "perfect storm"

  for health care!

Duty to Identify/Repay Overpayments

- Biennial review or audit using statistically valid sample of submitted claims
- Identified overpayments must be reported to DHSS "not later than 10 business days after identification" with proposal for repayment
  - DHSS must approve repayment plan: lump sum, payment plan or offset
- <u>Self-identified repayments are not subject to interest or penalties</u>

Compliance Best Practices = Best Defense

- OIG elements for an effective compliance program:
  1. Written standards of conduct, policies and procedures that promote a commitment to compliance
  2. Chief compliance officer and compliance committee charged with the responsibility for the compliance program with direct report to the CEO and the Boa
  3. Regular effective education and training programs for all affected employees
  4. Complaint process/whistleblower protections

Compliance Program (continued)

5. Internal response system with disciplinary action for violation of policies, statutes, regulations or FHCP requirements
6. Audits/compliance monitoring systems
7. Investigation and remediation of identified systemic problems; non-employment or retention of sanctioned individuals

Write it…follow it…update it!

ACCOUNTABILITY

Preparing for MIPS: Getting Started
&
Coming to Anchorage (maybe): AMI and CABG EPMs

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Preparing for MIPS: Getting Started

- First and foremost, cut through the MIPS clutter and hype
- Focus on the goal: Earning the best possible comprehensive performance score ("CPS") for your physician group's "MIPS eligible clinicians"
  - "MECs" = physicians, physician assistants, nurse practitioners, clinical nurse specialists and CRNAs
- The CY 2017 CPS calculated for your physician group's MECs will determine their CY 2019 MIPS payment adjustment

MIPS/Getting Started (continued)

- The CPS calculated for a MEC is used to determine the "MIPS payment adjustment" for the clinician
- MIPS payment adjustment: An upward payment adjustment, no payment adjustment or a downward payment adjustment, as appropriate, to the amount otherwise paid under Part B for the items and services furnished by a MEC during a "MIPS payment year"
- The first MIPS payment year: CY 2019 (based on data from CY 2017)

MIPS/Getting Started (continued)

- A MEC's payment adjustment: Based on his/her CPS compared to the CPSs of all other MECS in the country
- It's a race to the top: The bottom 50% of CPS scores (no matter how good the scores may be) receive a negative adjustment; the top 50% of scores receive no adjustment or a positive adjustment
- CY 2019 MIPS payment adjustments (including Method II CAHs): -4% to +4% (in exceptional cases, up to +22% (rare))
  - Percentages grow each CY (by CY 2022 and beyond, -9% to +9% . . . in exceptional cases, up to +37% (rare))

MIPS Performance Category Weights for CPSs for the 2017 Performance Period	Individual MIPS Eligible Clinicians ("MECs") in Physician Groups Not Participating in a MIPS APM*	MECs in Physician Groups Participating in a Medicare Shared Savings ACO	MECs in Physician Groups Participating in a Next Generation Model ACO	MECs in Physician Groups Participating in "Other" MIPS APMs
Quality	50%	50%	50%	not scored
Resource Use	10%	not scored	not scored	not scored
Advancing Care Information	25%	30%	30%	75%
Clinical Practice Improvement Activity	15%	20%	20%	25%

*MIPS APMs (MIPS alternative payment models): (1) Medicare Shared Savings Program; (2) Next Generation ACO Model; (3) Oncology Care Model; (4) Comprehensive Primary Care Plus Program; and (5) Comprehensive ESRD Program.

2017 Scoring Methodologies for Individual MIPS Eligible Clinicians ("MECs")	Individual Scoring within Physician Group Not Participating in a MIPS APM*	Group Scoring of Physician Group Not Participating in a MIPS APM
Quality	Individual quality performance data is reported and scored for each MEC in the group. A MEC's quality score = 50% of his/her CPS.	Individual quality performance data for all MECs in the group are reported in the aggregate and scored as a group. The quality score = 50% of physician group's CPS.
Resource Use	Individual resource use performance data (obtained by CMS from administrative claims data) is scored for each MEC in the group. A MEC's resource use score = 10% of his/her CPS.	Individual resource use performance data for all IMECs in the group (obtained by CMS from administrative claims data) are aggregated and scored as a group. The resource use score = 10% of physician group's CPS.
Advancing Care Information ("ACI")	Individual ACI performance data is reported and scored for each IMEC in the group. A MEC's ACI score = 25% of his/her CPS.	Individual ACI performance data for all IMECs in the group are reported in the aggregate and scored as a group. The ACI score = 25% of physician group's CPS.
Clinical Practice Improvement Activity ("CPIA")	Individual CPIA performance data is reported and scored for each IMEC in the group. A MEC's CPIA score = 15% of his/her CPS.	Individual CPIA performance data for all IMECs in the group are reported in the aggregate and scored as a group. The CPIA score = 15% of physician group's CPS.
Application of CPS for 2019 MIPS Payment Adjustment	The individual CPS calculated for a MEC will be used to determine the MEC's 2019 MIPS payment adjustment, if any.	The "group" CPS is applied to each IMEC in the group, regardless of what an IMEC's individual CPS would have been, and will be used to determine each IMEC's 2019 MIPS payment adjustment, if any.

*MIPS APMs (MIPS alternative payment models): (1) Medicare Shared Savings Program; (2) Next Generation ACO Model; (3) Oncology Care Model; (4) Comprehensive Primary Care Plus Program; and (5) Comprehensive ESRD Program.

2017 Scoring Methodologies for Individual MIPS Eligible Clinicians ("MECs")	Scoring MECs in a Physician Group Participating in a Medicare Shared Savings Program ("MSSP") ACO	Scoring MECs in a Physician Group Participating in a Next Generation ACO	Scoring MECs in Physician Groups Participating in "Other" MIPS APMs
Quality	The MSSP ACO (i.e., the entity that contracts with CMS) reports its quality performance data to MIPS using the CMS Web Interface through the same process that it uses to report performance data to the MSSP. The data will be reported only once but will be used for both MIPS and the MSSP. The ACO's MIPS quality score = 50% of the ACO's "group" CPS.	The Next Gen ACO (i.e., the entity that contracts with CMS) reports its quality performance data to MIPS using the CMS Web Interface through the same process that it uses under the Next Gen Model. The data will be reported only once but will be used for both MIPS and the Next Gen Model. The ACO's MIPS quality score = 50% of the ACO's "group" CPS.	Not Scored
Resource Use	Not Scored	Not Scored	Not Scored
Advancing Care Information ("ACI")	Each ACO participant TIN reports its MECs' ACI performance data as a group, outside of the ACO reporting process. The group scores from all of the ACO participant TINs are aggregated, weighted, and averaged to yield a single ACI score. The weights used for each TIN are the number of MECs in that TIN. This ACI score = 30% of the ACO's "group" CPS.	Individual performance data are reported and scored for all MECs identified as part of the ACO. All the individual scores are aggregated and averaged to yield a single ACI score. This ACI score = 30% of the ACO's "group" CPS.	Individual performance data are reported and scored for all MECs identified as part of the APM entity (i.e., the entity that contracts with CMS). All the individual scores are aggregated and averaged to yield a single ACI score. This ACI score = 75% of the APM entity's "group" CPS.
Clinical Practice Improvement Activity ("CPIA")	Same reporting/scoring process as described above for ACI. The CPIA score = 20% of the ACO's "group" CPS.	Same reporting/scoring process as described above for ACI. The CPIA score = 20% of the ACO's "group" CPS.	Same reporting/scoring process as described above for ACI. The CPIA score = 25% of the APM entity's "group" CPS.
Application of CPS for 2019 MIPS Payment Adjustment	The ACO's "group" CPS is applied to each MEC identified as part of the ACO as of December 31, 2017, regardless of what a MEC's individual CPS would have been, and will be used to determine each MEC's 2019 MIPS payment adjustment, if any.	The ACO's "group" CPS is applied to each MEC identified as part of the ACO as of December 31, 2017, regardless of what a MEC's individual CPS would have been, and will be used to determine each MEC's 2019 MIPS payment adjustment, if any.	The APM entity's "group" CPS is applied to each MEC identified as part of the APM entity as of December 31, 2017, regardless of what a MEC's individual CPS would have been, and will be used to determine each MEC's 2019 MIPS payment adjustment, if any.

AMI & CABG EPMs

- August 2, 2016: CMS publishes proposed rule that would establish in 98 selected MSAs (Anchorage in the list of 248 possible MSAs):
  - An acute myocardial infarction ("AMI") episode payment model
  - A coronary artery bypass graft ("CABG") episode payment model
- EPMs = bundled payment initiatives (proposed 5 performance years: July 1, 2017 through December 31, 2021)
- Mandatory for acute care hospitals in the selected 98 MSAs

AMI & CABG EPMs (continued)

- EPM episode initiated by an admission to a hospital for an "anchor hospitalization" paid under EPM-specific MS-DRGs under the IPPS
- Episode includes the anchor hospitalization and a 90-day period after discharge from the anchor hospital and all related services covered under Medicare Parts A and B during the episode
- CMS would set episode target prices annually based on a blend of hospital-specific and regional historical spending data (gradual shift to only regional spending data). . . the hospital is ultimately responsible for any gains or losses, regardless of other providers involved in the episode
  - Only upside (no risk) first year; risk sharing begins second year
- *Care redesign, gain/risk sharing with other episode providers*

EMPLOYABILITY

Corrective Actions for Employed Physicians

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Multiple Standards

- Employment and Labor Laws
- State Licensure (Hospital, Professional)
- Accreditation
- Conditions of Participation and Federal Regulations
- Medical Staff Bylaws (including Rules & Regulations)
- For clinics and hospitals under jurisdiction

  of Native sovereign nations, application of those

  nations' laws and exemptions

Steps to Consider

FIRST: Are patients at risk? Is immediate action required?

1. Who is the employer?
2. Which standards apply?
   - Clinical vs. personnel issues
   - Both types of issues combined
3. Applicable policies
   - Clinical issue
   - Non-clinical issue

Steps to Consider (continued)

4. Licensure issues
   – Hospital
   – Professional
5. Reporting?
   – State licensing authority
   – National Practitioner Databank
6. Payor contract requirements (including government, private, grants)

Steps to Consider (continued)

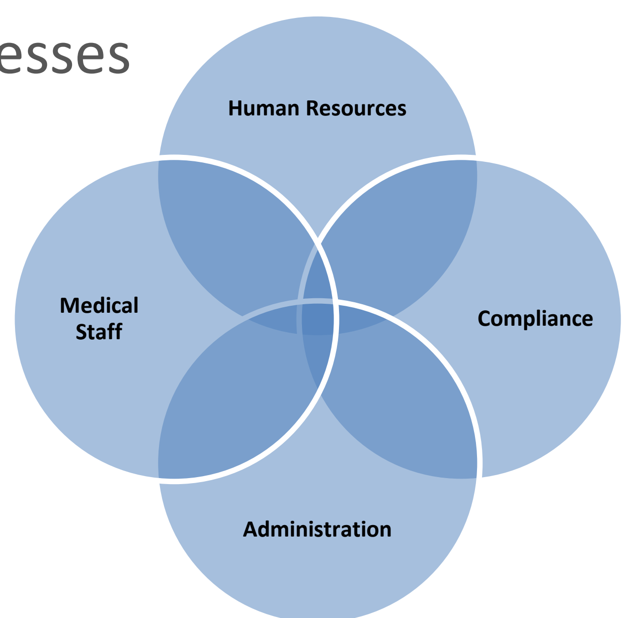
7. Is the physician a member of a bargaining unit?
8. How do we gather relevant facts?
   - Who investigates?
     - Employment investigation vs. Bylaws process
     - Attorney/Client Privilege
     - Peer Review Privilege
   - Who receives/reviews the investigative report?
   - Who determines action to be taken?

Keep in Mind

1. Retaliation and whistleblower considerations?
2. Insurance coverage?
3. PHI protections?

Recommendations

- Add communication recommendations to compliance plan
- Remember confidentiality for all processes
- When considering an issue in your own area, "check the box" for possible other areas
- Establish appropriate policies and procedures and follow them



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