

# HEALTHCARE COMPLIANCE NEWSLETTER

Issue 12, Winter 2017

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*This newsletter is prepared by the Office of Compliance and is intended to provide you with current information about healthcare compliance and HIPAA privacy issues. For additional information, to view past newsletters, or to provide comments about this or any future issues of this newsletter, please contact the Office of Compliance at (213) 740-8258 or at [compliance@usc.edu](mailto:compliance@usc.edu).*

*The USC Help & Hotline can be used by all faculty,*

## One Year Later: The Yates Memo, False Claims Act and Director & Executive Liability

On September 19 and 27, 2016, the US Department of Justice announced two False Claims Act settlements that required corporate executives to make substantial monetary payments to resolve their liability.

In the first, North American Health Care Inc. (NAHC) and two individuals (its chairman of the board and a senior vice president of reimbursement) agreed to settle potential False Claims Act liability for a total of \$30 million.

The second settlement involves the former CEO of Tuomey Healthcare, who, a year after the \$72.4 million corporate FCA resolution and two years after his departure from Tuomey as CEO, is now settling his own liability for \$1 million, has been required to release any indemnification claims he may have had against the company, and has agreed to a four-year period of exclusion from participating in federal health care programs.

Coinciding with the Tuomey CEO settlement announcement, Bill Baer, Principal Deputy Associate Attorney General of the US Department of Justice (DOJ), gave a speech in Chicago discussing company cooperation and "individual accountability" in the context of federal civil enforcement.

This new guidance, as well as the two settlements, come a little over a year after DOJ Deputy Attorney General, Sally Yates, issued what is now known as the "Yates Memo," which sets forth guidance to be used by DOJ civil and criminal attorneys "in any investigation of corporate misconduct" in order to "hold to account the individuals responsible for illegal corporate conduct." Since then, corporate resolutions like these have been watched for telltale signs of whether the Yates Memo is really changing the way federal enforcement does business. Given the timing of the speech and the settlements, and the high level of the officers involved, that change may be here.

Read the full article [here](#).

## CMS Releases Final Rule Implementing MACRA with 2017 Resources

On Friday, October 14, the Centers for Medicare and Medicaid Services (CMS) released the much anticipated Final Rule with comment period implementing the Medicare Access and CHIP Reauthorization Act (MACRA). The Final Rule establishes a new program, the Quality Payment Program (QPP) with two tracks for eligible clinicians being paid under Medicare fee-for-service. The first performance year for both tracks of the QPP will be 2017, for payment adjustments in 2019. The final rule provides further flexibilities from the [proposed rule](#) in order to help clinicians transition into the new payment system.

### Transition Year - 2017

CMS refers to the first performance year, 2017, as a transition year, providing choices to eligible clinicians to participate in ways appropriate for their practice. The Pick Your Pace provision allows for four ways of

*staff, and students to report suspected violations of an applicable law, regulation, or university policy confidentially and without fear of retribution. The Help & Hotline can also be used to ask questions about applicable laws, regulations, and university policies that may impact your job duties.*

*The USC Help & Hotline is staffed 24 hours a day, 365 days a year: (213) 740-2500 or file on the [web](#) and enter **UOSC** as the access code.*

participating in 2017 in order to avoid a negative payment adjustment. Non-reporting in 2017 will lead to an automatic negative adjustment of 4 percent in 2019.

**Option 1:** Test the program. By reporting one measure each in the quality and improvement activity categories or reporting the measures in the advancing care information category, clinicians can avoid a negative adjustment in 2019.

**Option 2:** Partially report. By reporting one measure in each performance category for a full 90 days in 2017, clinicians can avoid a negative adjustment and have the opportunity to possibly receive a small positive adjustment in 2019.

**Option 3:** Fully report. By reporting fully for 90 days to a full year, a clinician can earn a moderate positive payment adjustment and may be eligible for additional payment adjustments as exceptional performers.

**Option 4:** Participate in an Advanced Alternative Payment Model (AAPM). Those receiving 25% of Medicare payments or seeing 20% of Medicare patients through an AAPM in 2017, can earn a 5% incentive payment in 2019.

### **Merit-Based Incentive Payment System (MIPS)**

Track 1 in the QPP, the Merit-Based Incentive Payment System (MIPS) combines the current Physician Quality Reporting System (PQRS), Value Modifier (VM), and EHR Meaningful Use (MU) programs into one reporting system for eligible clinicians to report and receive positive, negative, or neutral adjustments based on their performance in four categories (Quality, Resource Use, Advancing Care Information, and Improvement Activities).

In the Final Rule, CMS indicated it will not include performance in the Resource Use category for 2017. The remaining categories will have the following performance weighting for 2017:

- Quality (60%)
- Advancing Care Information (25%)
- Improvement Activities (15%)

CMS has also lowered the required amount of measures in each category. Quality will include 6 measures, Advancing Care Information will include 5 measures, and eligible clinicians can perform a maximum of 4 activities to receive the highest score. The benchmarks for the measures will be released prior to January 1, 2017.

### **Outlook**

The final rule is effective January 1, 2017 and CMS will accept comments on the Final Rule for the next 60 days. The release of other final payment rules, such as the Physician Fee Schedule, in the coming weeks may also include changes to correspond with the QPP implementation, particularly with the implementation of new payment models. CMS intends for QPP to evolve and expand as implementation continues in future years. Beyond 2017, CMS suggests that it will likely continue to propose other transition options in the future in response to stakeholder concerns.

### **Resources**

Along with the Final Rule, CMS has rolled out many helpful resources for providers to understand and prepare for QPP in 2017:

[Final Rule](#)

[Executive Summary](#)

[Quality Payment Program Website](#)

[Quality Payment Program Fact Sheet](#)

[Small Practice Fact Sheet](#)

[Alternative Payment Models in the Quality Payment Program](#)

## Cooperation with Compliance Investigations

Every USC employee shares the university's responsibility to comply with laws and regulations governing a variety of activities, including but not limited to research, healthcare, privacy and security, employment practices, environmental health and safety, financial aid, athletics and conflict of interest. This policy outlines the responsibilities of all USC employees with regard to investigations, monitoring reviews, and recommendations of the USC Office of Compliance (OOC) and other departments charged with conducting compliance-related reviews and investigations.

Neither the university nor any employee may retaliate, or threaten or attempt to retaliate, against anyone for making a report or assisting in an investigation or monitoring review under this policy.

Find the full policy here:

<http://policy.usc.edu/cooperation-with-compliance-investigations/>

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## First Telehealth FCA Case Comes Down Over MD Billing; Beware Related Risks

Connecticut psychiatrist Anton Fry and his Danbury-based mental health practice, CPC Associates, Inc., agreed to pay \$36,704 to resolve allegations that they billed Medicare for services provided over the phone from Jan. 1, 2008, to June 1, 2015, the U.S. Attorney's Office for the District of Connecticut said July 27. Fry allegedly didn't meet the patients or treat them in person, and the services didn't qualify as telehealth.

Medicare covers 37 services delivered by telehealth, including emergency department or initial inpatient telehealth consultations, office or other outpatient visits and individual psychotherapy when they are provided in a rural area, which includes counties outside of Metropolitan Statistical Areas (MSAs) or in health professional shortage areas either outside of an MSA or in a rural census tract. Telehealth services have to be delivered in an "originating site," such as hospitals and physician practices; skyping from home doesn't cut it. "Distant-site" providers deliver telehealth services and bill Medicare using CPT codes.

Providers also must use face-to-face, interactive audio and video telecommunications systems that enable real-time communication between the distant-site provider and the patient at the originating site.

"The patients treated over the phone by Dr. Fry and CPC Associates were not located in rural health professional shortage areas and Dr. Fry and CPC Associates did not use interactive audio and video communications," the U.S. attorney's office says. "They simply treated certain Medicare patients by phone."

Telehealth services fall into two buckets: (1) asynchronous monitoring, which is real-time, face-to-face communication, and includes telepsychology and monitoring of patients with cardiac conditions and continuous positive airway pressure (CPAP) machines for sleep apnea; and (2) "store and forward," which refers to information that is gathered and forwarded to providers for review, such as radiology images. The American Medical Association's CPT advisory panel is looking to add codes for telehealth, and reimbursement probably will follow, but for now, the technology has outpaced regulations. And because the amount at issue was relatively small, this could signal an increasing focus on providers engaging in telemedicine services.

Read the press release here:

<https://www.justice.gov/usao-ct/pr/danbury-physician-and-mental-health-practice-pay-36000-settle-false-claims-act>

## Government Recoveries for Past Fiscal Year

The Department of Justice obtained more than \$4.7 billion in settlements and judgments from civil cases involving fraud and false claims against the government in fiscal year 2016 ending Sept. 30, Principal Deputy Assistant Attorney General Benjamin C. Mizer, head of the Justice Department's Civil Division, announced on December 14, 2016. This is the third highest annual recovery in False Claims Act history, bringing the fiscal year average to nearly \$4 billion since fiscal year 2009, and the total recovery during that period to \$31.3 billion.

"Congress amended the False Claims Act 30 years ago to give the government a more effective tool against false and fraudulent claims against federal programs," said Mizer. "An astonishing 60 percent of those recoveries were obtained in the last eight years. The beneficiaries of these efforts include veterans, the elderly, and low-income families who are insured by federal health care programs; families and students who are able to afford homes and go to college thanks to federally insured loans; and all of us who are protected by the government's investment in national security and defense. In short, Americans across the country are healthier, enjoy a better quality of life, and are safer because of our continuing success in protecting taxpayer funds from misuse."

Read the full press releases here:

<https://www.justice.gov/opa/pr/justice-department-recovers-over-47-billion-false-claims-act-cases-fiscal-year-2016>

<https://www.justice.gov/opa/pr/justice-department-collects-more-153-billion-civil-and-criminal-cases-fiscal-year-2016>