Quality Measure Validation Audit Resource

Prepared by Wilems Resource Group, LLC.

WILEMS resource group

November 16, 2017

Table of Contents

Introduction

The Medicare Shared Savings Program Final Rule Section 425.316 (c) stipulates that in order for the Centers for Medicare and Medicaid Services (CMS) to identify ACOs that are not meeting the quality performance standards, CMS will review an ACO's submission of quality measurement data.

This Quality Measure Validation Audit Resource is designed to provide guidance to ACOs as they work to ensure their organization is prepared to successfully respond to an audit request. This Resource is not intended to be a comprehensive solution to every Quality Measure Validation Audit, as the individual circumstances of each ACO, its quality processes, and the Samples identified by CMS can raise specific issues, concerns, and opportunities. Nor does this Resource establish an attorney/client privilege or relationship between NAACOS, Wilems Resource Group and any ACO Participant, Provider or Supplier. However, this Resource will give an ACO the tools necessary to prepare for, and successfully respond to, a CMS Quality Measure Validation Audit.

Quality Measure Validation Audit Process

The Quality Measure Validation (QMV) Audit measures the accuracy of the ACO's reporting during the quality reporting process. It does **not** measure whether the ACO is meeting the quality standards. As an example, when CMS reviews the flu shot measure during this audit, the question is not whether the flu shot was received, but whether or not the ACO accurately reporting whether the flu shot was received. If the ACO reports that a flu shot was **not** received, and the QMV Audit shows the flu shot **was** given, the ACO will fail that record. This is true even though the ACO reported a lower quality standard than was actually achieved for this Medicare Fee-For-Service Beneficiary (beneficiary).

For purposes of discussion, we break the QMV Audit down into two phases: (1) Documentation Request and (2) Record Review.

Phase 1: Documentation Request

CMS provides each ACO with a sample list of Beneficiaries for each measure being audited. The exact number of Beneficiaries sampled will vary as CMS requests the number of records necessary to reach a 90 percent confidence interval that the audited sample is representative of the ACOs quality reporting performance. CMS has provided guidance stating that they did not anticpate this number exceeing 50 records per audited measure. The initial sample list provided by CMS also includes the answers provided by the ACO during the quality reporting process. The ACO is then allowed 2-3 weeks to provide the medical records supporting each quality measure response reported.

Phase 2: Record Review

The ACO is required to submit documentation for each of the Beneficiaries selected by CMS for each measure. In previous iterations of the QMV Audit provess, the CMS auditor will randomly select eight (8) of the 30 samples under each measure. However, recent updates to the Physician Fee Schedule Final Rule has changed this, and CMS will now review documentation for all samples and provide an overall match rate across all measures. The ACO will pass the audit if their match rate is 80% or higher.

Consequences and Follow-Up

If the ACO fails the audit the overall quality score for the ACO will be adjusted, absent unusual circumstances, proportionally to the audit performance. CMS will calculate an ACO's audit-adjusted quality score to provide for a one percent reduction to the ACO's overall quality score for each percentage point difference between the ACO's audit match rate and the 80 percent match rate. This adjusted quality score may impact the ACO's ability to receive any shared savings.

In most cases CMS will work with the ACO to identify issues and implement Corrective Action Plans (CAPS), as appropriate. This CAP should provide sufficient detail to reassure CMS that the ACO has corrected any issues of noncompliance. CAPS are discussed in detail in the Corrective Actions and Follow-Up Section of this Resource.

In extreme cases, based on the nature and severity of the noncompliance, CMS may forgo the issuance of the warning letter or CAP and immediately terminate the ACO's participation agreement. An ACO that exhibits a pattern of inaccurate or incomplete reporting of the performance measures, may also be terminated.

Audit Preparedness

Although the possible consequences of a failed QMV Audit are daunting, with a little foresight, ACOs can easily prepare for the QMV Audit. This preparation will help ensure the ACO can respond to a QMV Audit Notice successfully and within the time allotted by CMS.

Prior to Quality Measure Reporting

The key to success during the Quality Measure Reporting process, is to ensure that all ACO Participants, Provider/Suppliers and quality related staff are trained on the specific requirements of each quality measure.

Provider/Suppliers

The ACO should ensure that Provider/Suppliers understand each element and best practices for documentation such that the ACO can get credit for the quality of service being provided. Most providers are meeting quality of care requirements, though not all of them are documenting each element in a manner sufficient for the ACO to report it within the requirements of the Shared Savings Program.

Quality Related Staff

Quality Related Staff are those individuals who work with providers to provide care to Beneficiaries, or assist the ACO in the Quality Measure Reporting process. These individuals should be trained on each element necessary to be present in the chart

before the ACO can report the quality measure as having been met for the Beneficiary. Quality Related Staff also needs to be trained on the type of documentation that can be used for reporting. For example, the ACO cannot use claims data alone to report on the self-reported measures. This understanding is crucial to the ACO's ability to respond successfully to the QMV Audit, as the reported response must be able to be validated within the medical record for audit purposes.

Quality Measure Reporting

It is important for ACOs to keep the potential for a QMV Audit in mind during the Quality Measure Reporting process. A few extra steps during the initial reporting process can save enormous amounts of time during the audit, and can help ensure the ability of the ACO to respond successfully.

Document Retention

When pulling medical records during the initial reporting process, the ACO should highlight the information used to make the quality measure determination being reported. For example, a reviewer would highlight in the medical record the flu shot response (ex: Yes), date flu shot was given (ex: September 9, 2017), and where it was administered (ex: Walgreens). This documentation can then be retained by the ACO following the submission, allowing the ACO to respond to an audit request without having to access the medical records a second time. The ACO should also be sure to save a PDF of the submission completed during the initial reporting process. This PDF can be used by the ACO in completing an internal review and assist in identifying issues prior to a CMS audit.

Quality Assurance Review

Many ACOs find the initial Quality Measure Reporting process to be more time consuming than anticipated. As a result, there tends to be a scramble to complete the process just before the deadline. This last minute scramble precludes the ability of the ACO to complete a quality review of the documentation being pulled and the data being entered into the Quality Reporting tool. However, this Quality Assurance (QA) review is vital to preventing human error in data entry. The QA review can also identify areas of

confusion related to quality measure requirements prior to submission. Early identification of these concerns can provide an opportunity for correction prior to submission – and before an audit notice is ever received.

After Quality Measure Reporting

If an ACO is not selected for a QMV Audit in a given year, leadership should consider completing a mock audit. This audit can help an ACO identify concerns and correct those issues prior to the quality reporting period in the next performance year. It is recommended that the ACO perform a mock audit on a sample of Beneficiaries for each measure. This mock audit can be accomplished in phases, with a few measures being reviewed each quarter throughout a performance year. Or the ACO can opt to focus resources and only review those measures where there seems to be the most confusion. It is important to remember that this mock audit is not intended to identify how the ACO is doing in relation to the quality metrics. The audit should focus on the ability of the ACO to accurately report quality related standards.

Surviving the QMV Audit

Once the QMV Audit Notice is received from CMS, the ACO will only have two to three weeks to respond. The tight timeline and the sheer number of records to review can be overwhelming. The first step in managing the successful audit response is to identify key individuals and available resources. The following individuals should be included in the audit project plan:

- Audit Owner: this individual may be in Compliance or Operations, but should not be the individual who was responsible for the initial Quality Measure Reporting Process. The Audit Owner should have project management experience. Quality Measure Reporting experience is less vital, but may be beneficial.
- Business Owner: this is the individual who was ultimately responsible for oversight and management of the initial Quality Measure Reporting Process.

- Quality Measure Reporting Staff: these individuals will actually pull documentation related to each sample, and are likely the same individuals who pulled medical records during the initial Quality Measure Reporting process.
- Quality Assurance Team: these individuals complete the QA Review of the documentation pulled in response to the QMV audit. Ideally, these individuals were not involved in the initial Quality Measure Reporting process, though this may be difficult to accomplish in practice.
- Technical Support: this is a key IT Contact who can be available throughout the audit for resolution of technical issues, such as remote access concerns, or difficulty in uploading files to CMS.

Data Collection & Review

It can be tempting to start at the top of the sample list provided by CMS, and work your way down. However, this can create significant delays through bottlenecks in the QA Review process and make it difficult for the ACO to meet the tight deadline for the QMV Audit. It is best for the ACO to use the 80/20 Rule, whereby you work to get the easy 80 percent as quickly as possible and start putting that documentation through the QA Review process while you work to locate the more difficult information. If the ACO used the documentation recommendation found in the Quality Measure Reporting section of this Resource, then pulling documentation for these samples should be relatively painless.

As soon as documentation has been collected, the QA Review can begin. QA Review can be completed as records are found, or completed once all records have been located for an entire measure. The ACO should consider which option makes the most sense based on the availability of individuals with sufficient expertise to complete the review. Either way, the QA Review should focus on ensuring the documentation pulled, and highlighted, is sufficient to support the answer provided during the initial Quality Measure Reporting process. If completed timely, this review can provide the ACO an opportunity to perform additional clean-up on the documentation before submission, and

allows for early identification of opportunities for improvement in the Quality Measure Reporting process.

If the QA Review identifies deficiencies, or mismatches, in any of the records, the Quality Measure Reporting Staff can go back to the medical record to search for additional information which may correct the concern. For example, if the ACO reported that the beneficiary received a mammogram; the record may state that the Beneficiary was sent for a mammogram but not include information on the results of that mammogram. The Quality Measure Reporting Staff can go back into the medical record and search for documentation showing the result of the mammogram to meet the required elements for this measure, and match the initial reporting.

The ACO should then use this QA Review to determine an internal score across all measures, and document areas where mismatches were found and unable to be corrected.

Crafting the Audit Submission

It is important to package the documentation concisely and coherently. The QMV Audit Notice will contain detailed instructions on how to package and submit the documentation requested. However, the ACO may find it is necessary to include additional information for some Beneficiaries. As an example, a common error identified during review of initial Quality Measure Reporting is reporting on the incorrect Beneficiary. Often Beneficiaries have a common name, and occasionally an ACO will report on the wrong individual with the same name. In these instances, the ACO should include a short memorandum explaining the error and provide documentation to support the information provided during the initial reporting process. The ACO could pull documentation for both the correct Beneficiary, even though it was not used in the initial reporting process, as well as the medical record for the wrong Beneficiary that was used during Quality Measure Reporting to support the original answer provided.

Corrective Actions and Follow-Up

If the ACO used a formal QA Review process during the document collection phase of the audit, then as soon as the audit response has been submitted to CMS, the ACO can begin work to implement process improvements.

Internal Review & Corrective Actions

The Audit Owner and the ACO's Compliance Officer (if not the same individual), should work with the Business Owner to document any identified opportunities for improvement, and implement internal CAPs as necessary. It is important to note that internal CAPs are not disciplinary tools, and should not be viewed as such. Internal CAPs are simply tools to document the methods by which the ACO is working to improve processes and ensure that any issues of non-compliance do not recur. Any effective internal CAP should:

- Identify the root cause of the identified issue: This could be as simple as human error, but the two most common root causes related to Quality Measure Reporting are issues with training related to quality measure requirements, and issues related to technology and reporting mechanisms.
- Offer solutions based on the root case: The solutions should be directly related to the root cause of the error, and should be measurable and specific. As an example, if the ACO fails two measures as a result of inadequate training, then the ACO should work to include additional information related to those two quality measures in the quality training program.
- Include an ongoing monitoring plan: The internal CAP should include a plan for ensuring that the recommended corrective actions are effective. In the training example above, the ACO should also consider completing additional monitoring of medical records throughout the year to ensure

that the training was effective in changing the documentation behaviors of the ACO's providers.

Responding to the CMS Audit Report

Hopefully, by the time your ACO receives the CMS Audit Report, you will already be working through any identified deficiencies through the use of internal CAPs identified above. These CAPs will provide the basis of your response to the CMS Audit Report, and allow the ACO to respond quickly. The ACO should review the CMS Audit Report and highlight:

- Opportunities for improvement based on identified deficiencies: pull internal CAPs and documentation created as a result of the ACO's internal QA Review.
- Areas of disagreement or concern. CMS will set up a call to discuss your audit results. This is a great time to seek clarification on audit results or point out discrepancies between the CMS findings and the ACO's internal QA Review.

Once this is complete, the ACO should draft a response to the CMS Audit Report which addresses each finding and/or deficiency noted by CMS. The ACO should have documented internal CAPs, and ongoing monitoring to support the effectiveness of those plans. This will go a long way in reassuring CMS that the ACO is acting in good faith and is working to ensure complete and accurate reporting in the next performance year. The ACO should work to ensure the drafted response is demonstrative of the ACO's focus on ensuring compliance and improving the quality of care provided to ACO Beneficiaries.