Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

WEST FLORIDA ACO, LLC, GENERALLY REPORTED COMPLETE AND ACCURATE DATA ON QUALITY MEASURES THROUGH THE CMS WEB PORTAL, BUT THERE WERE A FEW REPORTING DEFICIENCIES THAT DID NOT AFFECT THE OVERALL QUALITY PERFORMANCE SCORE

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Office of Inspector General

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Report in Brief
Date: August 2019
Report No. A-09-18-03003

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

West Florida ACO, LLC, Generally Reported Complete and Accurate Data on Quality Measures Through the CMS Web Portal, but There Were a Few Reporting Deficiencies That Did Not Affect the Overall Quality Performance Score

Why OIG Did This Review

The Affordable Care Act established the Medicare Shared Savings Program (MSSP). Accountable Care Organizations (ACOs) in the MSSP may be eligible to receive shared savings payments from the Centers for Medicare & Medicaid Services (CMS) if they reduce healthcare costs and satisfy the quality performance standard for their assigned beneficiaries. As part of the standard, ACOs must report to CMS complete and accurate data on all ***quality measures***. For performance year (PY) 2016, ACOs reported more than half of the quality measures using the designated CMS web portal. If the reported data were not complete and accurate, the shared savings payments could have been affected. This vulnerability led us to select two ACOs that had consistently received shared savings payments in order to perform an initial risk assessment of ACOs' reporting of data on quality measures through the CMS web portal. This report covers one of those ACOs.

Our objective was to determine whether West Florida ACO, LLC (West Florida) complied with applicable Federal requirements when reporting data on quality measures through the CMS web portal.

How OIG Did This Review

We limited our review to West Florida's data on nine quality measures reported through the CMS web portal for PY 2016. We reviewed a stratified random sample of 240 beneficiary-measures.

What OIG Found

For 227 of the 240 sampled beneficiary-measures, West Florida complied with applicable Federal requirements by reporting complete and accurate data on quality measures through the CMS web portal. However, for the remaining 13 sampled beneficiary-measures, West Florida did not comply with requirements. Specifically, the medical records did not support that the beneficiaries (1) should have been either included in or removed from the ***measure population*** based on the ***exclusion criteria*** or (2) satisfied the ***conditions of the quality measures***. Further, the medical records did not support the reported ***measurement values*** or the reported ***"Patient Reason" exception***. Instead, the records supported (1) different measurement values that would have still satisfied the conditions of the quality measure or (2) a ***"Medical Reason" exception*** that would have still removed the beneficiary from the measure population.

These reporting deficiencies, which did not affect West Florida's overall quality performance score, occurred because according to West Florida officials, the ACO participant staff (1) made clerical errors when entering the data and (2) presumed that the beneficiaries did not have an active diagnosis of depression and did not realize that the beneficiaries should have been removed for meeting the exclusion criteria for the depression screening measure. In addition, according to these officials, physicians find it difficult to distinguish between the two exception reasons and, based on a physician's interpretation, either the "Patient Reason" exception or the "Medical Reason" exception may apply.

What OIG Recommends and West Florida Comments

We recommend that West Florida (1) ensure that it accurately reports all data on quality measures through the CMS web portal and (2) clarify with CMS its understanding of the exclusion criteria for a beneficiary to be removed from the measure population and the difference between the "Patient Reason" exception and the "Medical Reason" exception.

West Florida concurred with our findings and described actions that it planned to take to address our recommendations.

The full report can be found at https://oig.hhs.gov/oas/reports/region9/91803003.asp.

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INTRODUCTION

WHY WE DID THIS REVIEW

The Patient Protection and Affordable Care Act (ACA)[1] established the Medicare Shared Savings Program (MSSP) to facilitate coordination and cooperation among healthcare providers and suppliers to improve quality of care for Medicare beneficiaries and reduce healthcare costs. Eligible providers and suppliers may voluntarily participate in the MSSP by creating or joining an Accountable Care Organization (ACO).[2] ACOs may be eligible to receive shared savings payments from the Centers for Medicare & Medicaid Services (CMS) if they reduce healthcare costs and satisfy the quality performance standard (MSSP standard) for their assigned beneficiaries. ACOs may also be liable for any shared losses if they fail to reduce healthcare costs.

As part of the MSSP standard, ACOs are required to report to CMS complete and accurate data on all quality measures through three submission methods, one of which is the designated CMS web portal (called the Group Practice Reporting Option Web Interface). CMS uses these measures to assess the quality of care furnished by an ACO and to determine the ACO's overall quality performance score, which is used to calculate the ACO's shared savings payments or, if applicable, the amount of shared losses. For performance year (PY)[3] 2016, ACOs reported data on more than half of the quality measures using CMS's web portal. (For example, these data included whether beneficiaries had received required vaccinations.) If the reported data were not complete and accurate, the shared savings payments could have been affected. This vulnerability led us to review whether ACOs reported complete and accurate data on these quality measures through the CMS web portal to support the shared savings payments.

To perform an initial assessment of the risk of ACOs reporting incomplete or inaccurate data on quality measures through the CMS web portal, we selected two ACOs from those that had consistently received shared savings payments since they began participating in the MSSP. This report covers one of those ACOs, West Florida ACO, LLC (West Florida). This review is part of the Office of Inspector General's (OIG's) body of work examining various aspects of ACOs under the MSSP.[4] Appendix C contains a glossary of terms used in this report.

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[1] P.L. No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010).

[2] ACOs are groups of doctors, hospitals, and other providers that come together to give coordinated high-quality care to Medicare beneficiaries, to ensure that beneficiaries get the right care at the right time while avoiding unnecessary duplication of services and preventing medical errors.

[3] A PY is generally a 12-month period beginning on January 1 of each year during an ACO's agreement period in the MSSP.

[4] We plan to issue a separate report on the results of our review of the other ACO. See Appendix B for a list of related OIG reports.

OBJECTIVE

Our objective was to determine whether West Florida complied with applicable Federal requirements when reporting data on quality measures through the CMS web portal.

BACKGROUND

Medicare Fee-for-Service

CMS administers Medicare's fee-for-service program, which provides hospital and supplementary medical insurance to eligible beneficiaries. Under the program, Medicare reimburses providers and suppliers for services and specific items that they provide to Medicare beneficiaries. Medicare's fee-for-service reimbursement method tends to reward providers and suppliers for the volume of services delivered rather than the quality of those services. In addition, delivery of care is often fragmented because of insufficient incentives to coordinate care and improve quality.

Medicare Shared Savings Program and Accountable Care Organizations

The ACA required CMS to establish the MSSP to facilitate coordination and cooperation among healthcare providers and suppliers to improve quality of care for Medicare fee-for-service beneficiaries and reduce healthcare costs (ACA § 3022). Eligible providers and suppliers may voluntarily participate in the MSSP by creating or joining an ACO. (These providers and suppliers are referred to as "ACO participants.")

For each PY, CMS assigns Medicare fee-for-service beneficiaries to an ACO.[5] Medicare continues to pay ACO participants under the fee-for-service program. ACOs may be eligible to receive shared savings payments if they reduce healthcare costs and satisfy the MSSP standard for their assigned beneficiaries. ACOs may also be liable for any shared losses if they fail to reduce healthcare costs.

An ACO participates in the MSSP for an agreement period of at least 3 PYs. During this period, an ACO may choose to participate by (1) sharing in potential savings while not being liable for shared losses (track 1) or (2) sharing in potential savings while also being liable for shared losses (tracks 2 and 3).[6]

[5] Starting in PY 2018, a beneficiary can be assigned to an ACO based on the primary care practitioner (e.g., primary care physicians and certain specialists) that the beneficiary selects.

[6] For agreement periods beginning on July 1, 2019, and in subsequent years, an ACO participates in the MSSP for an agreement period of at least 5 PYs. During this period, an ACO may participate by (1) sharing in potential savings while gradually becoming liable for shared losses (BASIC track) or (2) sharing in higher levels of potential savings and shared losses (ENHANCED track).

For PYs 2013 through 2016, Medicare made a total of about $2 billion in shared savings payments to ACOs. In particular, for PY 2016, 134 of 432[7] ACOs received approximately $701 million of these payments.

Quality Measures and Methods of Reporting

In addition to reducing healthcare costs, ACOs must meet the MSSP standard to be eligible to receive shared savings payments. As part of the standard, ACOs are required to report to CMS complete and accurate data on all quality measures (42 CFR § 425.502(a)) for each PY. CMS establishes quality measures to assess the quality of care furnished by ACOs (42 CFR § 425.500(a)). ACOs must submit data on quality measures according to the method of submission established by CMS (42 CFR § 425.500(c)). Further, CMS publishes guidance for ACOs to use when reporting data on quality measures for each PY.

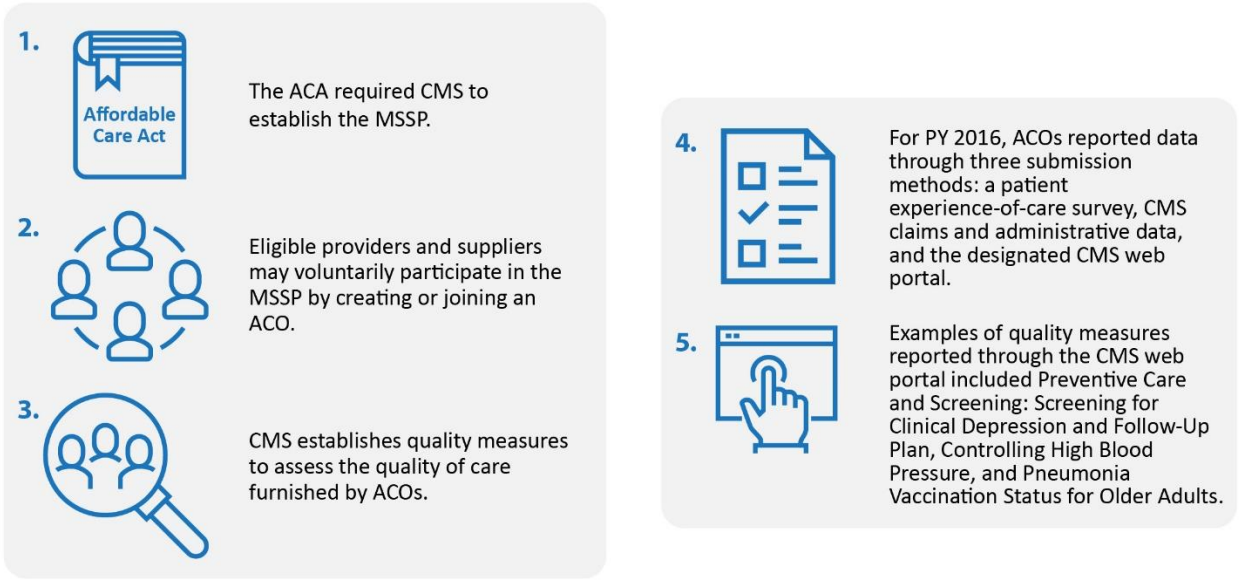
For PY 2016, CMS measured quality of care using 34 nationally recognized quality measures,[8] focusing on areas such as preventive care and high-cost chronic conditions. ACOs reported data on these quality measures through 3 submission methods: (1) a patient experience-of-care survey (8 measures), (2) claims and administrative data (8 measures), and (3) the designated CMS web portal (18 measures). Examples of quality measures reported through the CMS web portal were Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan (depression screening) and Controlling High Blood Pressure.

Figure 1 on the following page explains how CMS and ACOs work together to report data on quality measures.

[7] Four ACOs were liable for shared losses, and 294 ACOs were neither eligible to receive shared savings payments nor liable for shared losses because they generally did not reduce healthcare costs or chose to participate in track 1.

[8] These measures have generally been tested, validated, and clinically accepted by a nationally recognized, multistakeholder, consensus-based entity, such as the National Quality Forum.

Figure 1: How CMS and Accountable Care Organizations Work Together To Report Data on Quality Measures



Quality Measures Reported Through the CMS Web Portal

As part of the MSSP standard, CMS required ACOs to report complete and accurate data on 18 of the 34 quality measures through the CMS web portal for PY 2016. CMS provided a random sample of an ACO's assigned beneficiaries through the CMS web portal by distributing the sampled beneficiaries across the 18 measures.[9] CMS required an ACO to report data on (1) a minimum of 248 beneficiaries for each measure (minimum reporting requirement) or (2) all beneficiaries if fewer than 248 were available for the measure.

CMS published guidance for ACOs to use when reporting data for the 18 quality measures using the beneficiaries' medical records.

An ACO was required to perform three steps when reporting data on quality measures:

- **Step 1:** The ACO confirmed whether each beneficiary should have been included in the sample.

- **Step 2:** The ACO determined whether each beneficiary should have been included in the measure population for each quality measure.[10]

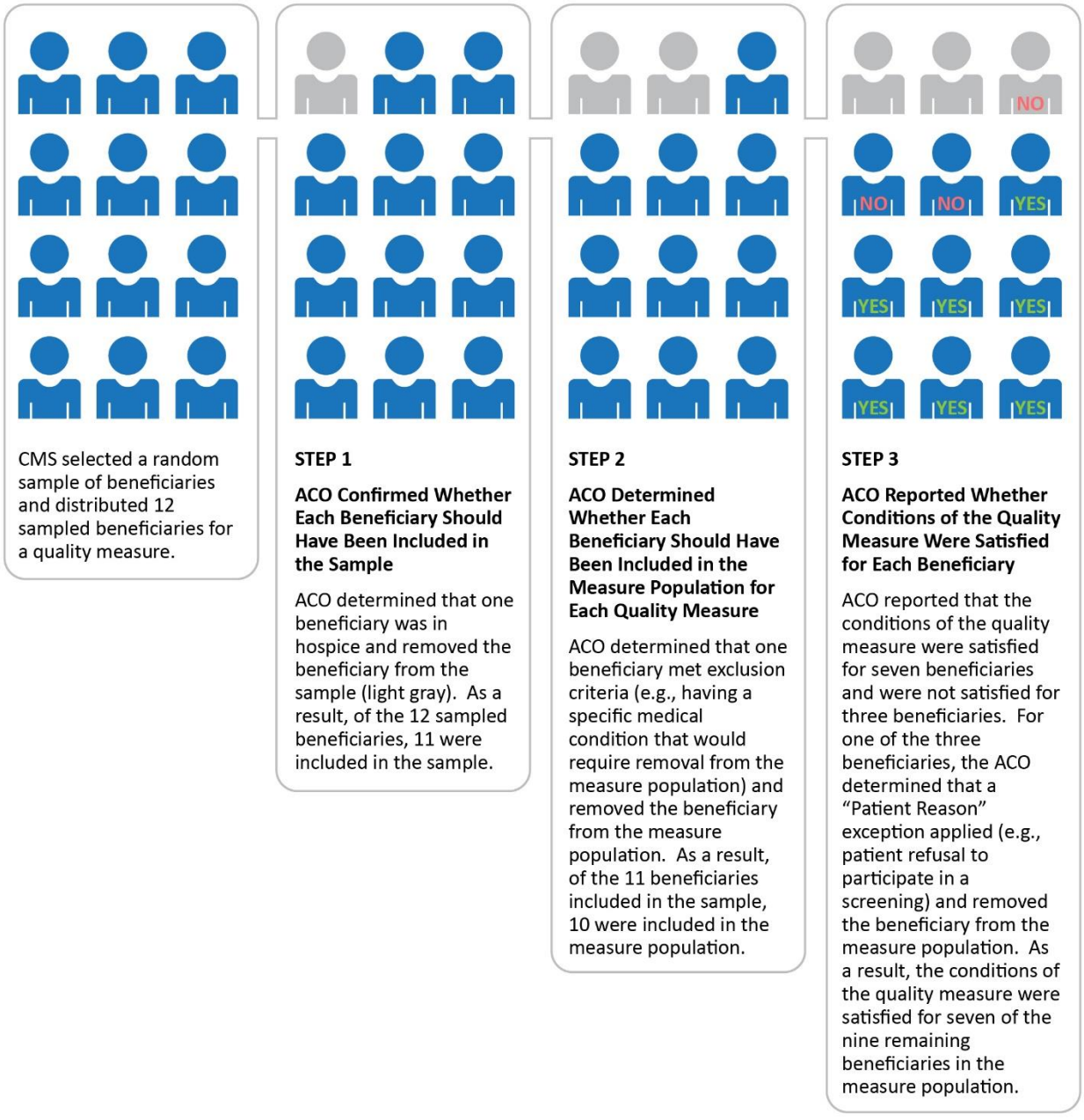
[9] For PY 2016, all but 1 measure had a sample size of up to 616 beneficiaries, and 1 measure had a sample size of up to 750 beneficiaries.

[10] The measure population represented beneficiaries (from the sample that CMS selected and provided) for whom CMS measured the quality of care furnished by the ACO through the use of quality measures.

- **Step 3:** The ACO reported whether conditions of the quality measure were satisfied for each beneficiary.

See Appendix D for details on these steps, which uses as an example the depression-screening quality measure for PY 2016. Figure 2 illustrates the steps that an ACO followed and examples of possible outcomes when reporting data on a quality measure. (The number of beneficiaries shown in Figure 2 is for illustrative purposes only.)

Figure 2: Steps Followed and Examples of Possible Outcomes When an Accountable Care Organization Reported Data on a Quality Measure



Calculation of the Overall Quality Performance Score for Shared Savings Payments

To calculate an ACO's overall quality performance score, CMS used the data on 18 quality measures that ACOs reported through the CMS web portal in combination with the remaining 16 measures from the patient experience-of-care survey and the claims and administrative data. (For example, CMS used the result (7 of the 9 beneficiaries (78 percent)) in step 3 of Figure 2 as part of calculating the score.) This score was used to calculate the shared savings payments or, if applicable, the amount of shared losses. If an ACO reported inaccurate data on quality measures for any of the 18 measures reported through the CMS web portal (e.g., the ACO improperly reported that a beneficiary satisfied the conditions of a quality measure), the overall quality performance score and ultimately the shared savings payment or, if applicable, the amount of shared losses could have been affected.

CMS's Validation Audits of Quality Measures

CMS may choose to perform Quality Measure Validation Audits to verify that ACOs are reporting complete and accurate data on quality measures through the CMS web portal. During these audits, a CMS contractor reviews beneficiaries' medical record documentation to determine whether it adequately supports (matches) the data that the ACO previously reported on quality measures. The audit includes calculating a match rate, which is the number of matches (i.e., the number of audited records that were adequately supported by medical record documentation) divided by the number of total audited records, multiplied by 100. The results of the audit may be used to adjust an ACO's overall quality performance score and ultimately the shared savings payment or, if applicable, the amount of shared losses.

According to Federal requirements, if CMS had chosen to perform an audit for PY 2016 and an ACO's match rate had been less than 90 percent, CMS could have adjusted the ACO's overall quality performance score by multiplying the ACO's original overall quality performance score by its match rate.[11] For example, if an ACO's original overall quality performance score had been 80 percent and the ACO's match rate had been 85 percent, the ACO's adjusted overall quality performance score would have been 68 percent (80 percent multiplied by 85 percent). CMS could have used the adjusted score to determine the amount of savings the ACO would have shared or, if applicable, the amount of losses it would have owed. CMS could have also required the ACO to submit a corrective action plan for approval.

For PY 2016, CMS opted not to perform these audits because of proposed changes in Federal regulations, which would have affected the audits. Instead, CMS analyzed ACOs' data on quality measures and issued warning letters or placed ACOs on corrective action plans for identified data anomalies.

[11] Specific to PY 2016, if an ACO's match rate had been less than 90 percent and there had been unusual circumstances, CMS would have retained discretion not to adjust the ACO's overall quality performance score. Further, if the match rate had been equal to or greater than 90 percent, CMS would not have adjusted the ACO's overall quality performance score. In subsequent years, CMS revised this methodology.

West Florida ACO, LLC

West Florida is an ACO located in Trinity, Florida. It was one of the first 27 ACOs that CMS accepted to participate in the MSSP and, as of January 1, 2016, was in its second agreement period in the program. For PY 2016, West Florida had 57 ACO participants and 14,893 assigned beneficiaries. It had an overall quality performance score of 99.34 percent and received $6,602,831 in shared savings payments.

West Florida used a third-party software package (a data-reporting program) as a tool for reporting data on quality measures through the CMS web portal. Specifically, West Florida received from CMS a sample of beneficiaries via the web portal and uploaded the sample to the data-reporting program. The ACO participants individually reported data on quality measures using the data-reporting program for their beneficiaries. West Florida reviewed the data for completeness before uploading and submitting the data through the CMS web portal.

West Florida provided education and guidance, including the *2016 ACO Quality Measures Quick Reference Guide*, to its ACO participants on reporting and documenting each quality measure.

HOW WE CONDUCTED THIS REVIEW

We limited our review to West Florida's data on nine quality measures reported through the CMS web portal for PY 2016.[12] We selected these quality measures because CMS had identified them as subject to its planned Quality Measure Validation Audits for PY 2016, which CMS later opted not to perform. Our review covered 4,095 lines of reported data. Each line contained information about one beneficiary for one quality measure (beneficiary-measure). We reviewed a stratified random sample of 240 beneficiary-measures. We provided medical records to an independent medical review contractor for 120 sampled beneficiary-measures. We reviewed the medical records for the remaining 120 sampled beneficiary-measures because evaluating these measures did not require medical expertise.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

[12] The nine quality measures were (1) Falls: Screening for Future Fall Risk, (2) Pneumonia Vaccination Status for Older Adults, (3) Preventive Care and Screening: Body Mass Index Screening and Follow-Up Plan, (4) Preventive Care and Screening: Tobacco Use: Screening and Cessation, (5) Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan, (6) Colorectal Cancer Screening, (7) Diabetes: Hemoglobin A1c Poor Control, (8) Diabetes: Eye Exam, and (9) Controlling High Blood Pressure.

FINDINGS

West Florida generally complied with applicable Federal requirements when reporting data on quality measures through the CMS web portal, but we found a few reporting deficiencies that did not affect the overall quality performance score. For 227 of the 240 sampled beneficiary-measures, West Florida complied with requirements by reporting complete and accurate data. However, for the remaining 13 sampled beneficiary-measures, West Florida did not comply with requirements. Specifically, we found the following deficiencies (listed in order of the steps the ACO was required to perform when reporting data on quality measures):

- For three sampled beneficiary-measures, the medical records did not support that the beneficiaries should have been included in the measure population (two sampled beneficiary-measures) or that a beneficiary should have been removed from the measure population (one sampled beneficiary-measure) based on the exclusion criteria.

- For seven sampled beneficiary-measures, the medical records did not support that the beneficiaries satisfied the conditions of the quality measures.

- For three sampled beneficiary-measures, the medical records did not support the reported measurement values (two sampled beneficiary-measures) or the reported exception reason (one sampled beneficiary-measure) for the beneficiaries. Instead, the records supported (1) different measurement values that would have still satisfied the conditions of the quality measure or (2) a different exception reason that would have still removed the beneficiary from the measure population.

These reporting deficiencies occurred because according to West Florida officials, the ACO participant staff (1) made clerical errors when entering the data and (2) presumed that the beneficiaries did not have an active diagnosis of depression and did not realize that the beneficiaries should have been removed for meeting the exclusion criteria for the depression screening measure. In addition, according to these officials, physicians find it difficult to distinguish between the two exception reasons and, based on a physician's interpretation, either the "Patient Reason" exception (i.e., patient refusal to participate in a required screening) or the "Medical Reason" exception (i.e., patient's low functional capacity) may apply.

These deficiencies did not affect West Florida's overall quality performance score because West Florida's calculated match rate was greater than 90 percent.[13]

[13] West Florida's match rate was 95 percent: (227 sampled beneficiary-measures that matched the medical record documentation/240 sampled beneficiary-measures) × 100. If CMS had performed a Quality Measure Validation Audit for PY 2016 and the calculated match rate had been equal to or greater than 90 percent, West Florida's overall quality performance score would not have been adjusted.

FEDERAL REQUIREMENTS

As part of the MSSP standard, ACOs are required to report to CMS complete and accurate data on all quality measures (42 CFR § 425.502(a)).[14] Further, CMS published quality measure specifications,[15] a web portal user guide,[16] and other guidance[17] to instruct ACOs on how to report data on quality measures related to (1) the exclusion criteria for a beneficiary to be removed from a measure population; (2) the conditions that a beneficiary must satisfy for a measure; (3) measurement values used to determine whether a beneficiary satisfied the conditions of a measure; and (4) exception reasons for a beneficiary who did not satisfy the conditions of a measure.

A FEW BENEFICIARIES' MEDICAL RECORDS DID NOT SUPPORT WEST FLORIDA'S REPORTED DATA ON QUALITY MEASURES

For 13 sampled beneficiary-measures, the beneficiaries' medical records did not support West Florida's reported data on quality measures.

Medical Records Did Not Support Inclusion of Beneficiaries in or Removal of a Beneficiary From the Measure Population

CMS instructed ACOs to remove beneficiaries from the measure population for depression screening if they met the exclusion criteria, which is an active diagnosis of depression or bipolar disorder.

For three sampled beneficiary-measures, the medical records did not support that the beneficiaries should have been included in the measure population or that a beneficiary should have been removed from the measure population:

- For two sampled beneficiary-measures, West Florida included the beneficiaries in the measure population for depression screening and reported data on quality measures for them. However, the medical records for the beneficiaries did not support their inclusion in the measure population because they met the exclusion criteria. Specifically, the two

[14] We did not evaluate whether West Florida met the remaining part of the MSSP standard under 42 CFR § 425.502(a).

[15] CMS, *2016 Group Practice Reporting Option (GPRO) Web Interface Narrative Measure Specifications, Version 7.0*, December 18, 2015.

[16] CMS, *Physician Quality Reporting System (PQRS) Program Year 2016/Group Practice Reporting Option (GPRO) Web Interface User Guide, Version 1.0,* December 15, 2016. Accessed at https://qnpapp.qualitynet.org/cs/pqrs/documents/gpro/GPROWebHelp/index.htm on August 1, 2019.

[17] Other CMS guidance included the following: *2016 GPRO Web Interface Quality Reporting Questions & Answers*, November 21, 2016; *2016 Group Practice Reporting Option (GPRO) Web Interface Supporting Documents; and 2016 Web Interface Measures Performance Rate Algorithms.*

beneficiaries should have been removed from the measure population because they had an active diagnosis of depression and were already being treated for depression.

- For one sampled beneficiary-measure, West Florida reported that the beneficiary met the exclusion criteria for removal from the measure population for depression screening. However, the medical records did not support that the beneficiary met the exclusion criteria for removal. Specifically, the beneficiary should have been included in the measure population because the records did not support a diagnosis of depression or bipolar disorder.

Medical Records Did Not Support That Beneficiaries Satisfied the Conditions of Quality Measures

CMS instructed ACOs to report whether conditions of a quality measure were satisfied for each beneficiary, such as whether the beneficiary was screened for a future fall risk during PY 2016.

For seven sampled beneficiary-measures, the medical records did not support that the conditions of a quality measure were satisfied for each beneficiary. Specifically, the medical records did not support that the beneficiaries had the required exam, screening, vaccination, or followup plan for the following quality measures: (1) Diabetes: Eye Exam (three sampled beneficiary-measures), (2) Falls: Screening for Future Fall Risk (two sampled beneficiary-measures), (3) Pneumonia Vaccination Status for Older Adults (one sampled beneficiary-measure), and (4) Preventive Care and Screening: Body Mass Index Screening and Follow-Up Plan (one sampled beneficiary-measure).

Medical Records Did Not Support the Reported Measurement Values or the Reported Exception Reason

CMS instructed ACOs to report the date and value of a beneficiary's most recent blood-pressure reading in PY 2016 for the Controlling High Blood Pressure measure. CMS also instructed ACOs to report the applicable exception reason for the depression screening measure.

For three sampled beneficiary-measures, the medical records did not support the reported measurement values (two sampled beneficiary-measures) or the reported exception reason (one sampled beneficiary-measure) for the beneficiaries. Instead, the records supported (1) different measurement values that would have still satisfied the conditions of the quality measure or (2) a different exception reason that would have still removed the beneficiary from the measure population:

- For two sampled beneficiary-measures, West Florida reported measurement values for the beneficiaries to satisfy the conditions of the Controlling High Blood Pressure measure. However, the medical records did not support these values. For example, for one beneficiary, West Florida reported on December 22, 2016, a blood-pressure reading

of 132/76. However, the medical records showed a reading of 136/78 on December 5, 2016, which was the most recent blood-pressure reading in PY 2016.[18]

- For one sampled beneficiary-measure, West Florida reported that the beneficiary did not satisfy the conditions of the depression screening measure and applied the "Patient Reason" exception to remove the beneficiary from the measure population. However, the medical records did not support the "Patient Reason" exception (i.e., the records did not show that the beneficiary refused the depression screening). Instead, the medical records supported the "Medical Reason" exception (i.e., the records showed that the beneficiary had a low functional capacity).[19]

CONCLUSION

West Florida generally complied with applicable Federal requirements when reporting data on quality measures through the CMS web portal, but we found a few reporting deficiencies that did not affect the overall quality performance score. For 227 of the 240 sampled beneficiary-measures, West Florida complied with applicable Federal requirements. However, for the remaining 13 sampled beneficiary-measures, West Florida did not comply with requirements.

These deficiencies occurred because according to West Florida officials, the ACO participant staff (1) made clerical errors when entering the data and (2) presumed that the beneficiaries did not have an active diagnosis of depression and did not realize that the beneficiaries should have been removed for meeting the exclusion criteria for the depression screening measure. In addition, according to these officials, physicians find it difficult to distinguish between the two exception reasons and, based on a physician's interpretation, either the "Patient Reason" exception (i.e., patient refusal to participate in a required screening) or the "Medical Reason" exception (i.e., patient's low functional capacity) may apply.

These deficiencies did not affect West Florida's overall quality performance score because West Florida's calculated match rate was greater than 90 percent.[20]

[18] When we requested supporting medical records for these two sampled beneficiary-measures, West Florida clarified that it had reported the wrong measurement values and provided supporting medical records for different measurement values, which should have been reported. These measurement values would still have satisfied the conditions of the quality measure.

[19] The beneficiary would still have been removed from the measure population because an exception reason applied.

[20] See footnote 13.

RECOMMENDATIONS

We recommend that West Florida ACO, LLC:

- ensure that it accurately reports all data on quality measures through the CMS web portal and

- clarify with CMS its understanding of (1) the exclusion criteria for a beneficiary to be removed from the measure population and (2) the difference between the "Patient Reason" exception and the "Medical Reason" exception.

WEST FLORIDA COMMENTS

In written comments on our draft report, West Florida concurred with our findings and described actions that it planned to take to address our recommendations. West Florida's comments appear in their entirety as Appendix E.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We limited our review to West Florida's data on nine quality measures reported through the CMS web portal for PY 2016.[21] We selected these quality measures because CMS had identified them as subject to its planned Quality Measure Validation Audits for PY 2016, which CMS later opted not to perform. Our review covered 4,095 lines of reported data. Each line contained information about one beneficiary for one quality measure (beneficiary-measure). We reviewed a stratified random sample of 240 beneficiary-measures.

We provided medical records to an independent medical review contractor for 120 sampled beneficiary-measures. We reviewed the medical records for the remaining 120 sampled beneficiary-measures because evaluating these measures did not require medical expertise.

We limited our review of internal controls to those applicable to our objective. Specifically, we gained an understanding of West Florida's policies and procedures for reporting data on quality measures through the CMS web portal and maintaining beneficiary medical records to support the reported data.

We conducted our audit from August 2017 through September 2018, which included fieldwork performed at West Florida in Trinity, Florida, and at three selected ACO participants' offices in Hernando and Pasco Counties in Florida.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- met with CMS officials and contractors to gain an understanding of (1) the ACOs' process for reporting data on quality measures through the CMS web portal and (2) CMS's Quality Measure Validation Audits;

- held discussions with West Florida officials to obtain an understanding of West Florida's process for reporting data on quality measures, including uploading and submitting data through the CMS web portal;

[21] The nine quality measures were (1) Falls: Screening for Future Fall Risk, (2) Pneumonia Vaccination Status for Older Adults, (3) Preventive Care and Screening: Body Mass Index Screening and Follow-Up Plan, (4) Preventive Care and Screening: Tobacco Use: Screening and Cessation, (5) Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan, (6) Colorectal Cancer Screening, (7) Diabetes: Hemoglobin A1c Poor Control, (8) Diabetes: Eye Exam, and (9) Controlling High Blood Pressure.

- performed walk-throughs at 3 West Florida ACO participants' offices to obtain an understanding of the participants' process for reporting data on quality measures using West Florida's data-reporting program;

- obtained from CMS the web portal data for West Florida for quality measures reported for PY 2016;

- created a sampling frame of 4,095 lines of reported data, with each line containing information about 1 beneficiary for 1 quality measure (beneficiary-measure);

- selected a stratified random sample of 240 beneficiary-measures, consisting of 30 beneficiary-measures from each of the following 8 strata:

    - stratum 1—Falls: Screening for Future Fall Risk,

    - stratum 2—Pneumonia Vaccination Status for Older Adults,

    - stratum 3—Preventive Care and Screening: Body Mass Index Screening and Follow-Up Plan,

    - stratum 4—Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention,

    - stratum 5—Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan,

    - stratum 6—Colorectal Cancer Screening,

    - stratum 7—Diabetes Composite (consisting of two individual measures containing the same sample population of beneficiaries, Diabetes: Hemoglobin A1c Poor Control and Diabetes: Eye Exam), and

    - stratum 8—Controlling High Blood Pressure;

- obtained medical records from West Florida as support for the sampled beneficiary-measures;

- provided medical records to an independent medical review contractor, which determined whether 120 sampled beneficiary-measures from strata 5, 6, 7, and 8 were reported completely and accurately;

- reviewed the medical review contractor's results;

- reviewed the medical records for the 120 remaining sampled beneficiary-measures from strata 1 through 4;

- calculated a match rate[22] for West Florida; and

- discussed the results of our review with West Florida officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[22] Diabetes Composite was considered one stratum when calculating the match rate.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
ACOs' Strategies for Transitioning to Value-Based Care: Lessons From the Medicare Shared Savings Program	OEI-02-15-00451	7/19/2019
Using Health IT for Care Coordination: Insights From Six Medicare Accountable Care Organizations	OEI-01-16-00180	5/17/2019
CMS Ensured That Medicare Shared Savings Program Beneficiaries Were Properly Assigned: Beneficiaries Were Assigned to Only One Accountable Care Organization and Were Not Assigned to Other Shared Savings Programs	A-09-17-03010	10/19/2017
Medicare Shared Savings Program Accountable Care Organizations Have Shown Potential for Reducing Spending and Improving Quality	OEI-02-15-00450	8/28/2017

APPENDIX C: GLOSSARY OF TERMS[23]

Accountable Care Organization participant: An eligible provider or supplier (or a group of providers or suppliers) that voluntarily participates in the MSSP.

Assigned beneficiaries: Medicare beneficiaries who were assigned to an ACO for the performance year based on (1) where the beneficiaries received their highest Medicare allowed amount for primary care services or (2) their selection of a primary care practitioner.

Conditions of a quality measure: Required outcomes or processes (e.g., screening for future fall risk) for beneficiaries who were included in a measure population.

Exception reason: A reason that would allow removal of a beneficiary from a measure population if the conditions of a quality measure were not satisfied, e.g., the "Patient Reason" exception (refusal to participate in a required screening) and the "Medical Reason" exception (low functional capacity).

Exclusion criteria: A medical condition or a situation that would require removal of a beneficiary from a measure population before reporting whether the conditions of a quality measure were satisfied for a beneficiary (e.g., having an active diagnosis of depression that would require removal of a beneficiary from the measure population for depression screening).

Group Practice Reporting Option Web Interface: A secure internet-based application made available by CMS for registered users to report data on quality measures (the CMS web portal).

Match rate: The number of audited records that were adequately supported by medical record documentation divided by the number of total audited records, multiplied by 100.

Measurement values: Specific values (e.g., a beneficiary's blood pressure reading on a given date) used to determine whether certain conditions were satisfied for a beneficiary.

Measure population: Beneficiaries (from the sample that CMS provided) for whom CMS measured the quality of care furnished by the ACO through the use of quality measures.

Measure-specific criteria: The requirements a beneficiary must meet to be included in a measure population.

Overall quality performance score: A value that is based on reported data on quality measures and is used to calculate the shared savings payments or the amount of shared losses.

Quality measure: A standardized method of assessing the quality of care furnished by ACOs.

[23] The terms and definitions in this glossary are for the purposes of this report only and may not be the same terms and definitions used in Federal regulations and CMS guidance.

APPENDIX D: STEPS FOR REPORTING DATA ON QUALITY MEASURES

This appendix describes the three steps an ACO was required to perform and uses the depression-screening measure for PY 2016 as an example.

Example of a Quality Measure Reported Through the CMS Web Portal

Depression is associated with increased healthcare costs as well as higher rates of many chronic medical conditions. Depression screening measured whether a beneficiary was screened during a visit date in PY 2016 using an age-appropriate standardized depression screening tool (e.g., a PHQ-9 questionnaire), and if the result of the screening was positive, whether a followup plan was documented on the date of the screening.

Step 1: ACO Confirmed Whether Each Beneficiary Should Have Been Included in the Sample

An ACO confirmed whether each beneficiary should have been included in the overall sample by (1) determining whether it could find the beneficiary's medical records[24] and (2) confirming that the beneficiary was not in hospice, had not moved out of the country, was not deceased, and was not enrolled in a health maintenance organization. Any beneficiary who was not confirmed for inclusion was removed from the overall sample.[25]

Step 2: ACO Determined Whether Each Beneficiary Should Have Been Included in the Measure Population for Each Quality Measure

For beneficiaries who were confirmed to be included in the overall sample, an ACO determined whether the beneficiaries should have been included in the measure population for each quality measure. The measure population consisted of beneficiaries from the sample for whom CMS measured the quality of care furnished by ACOs through the use of quality measures. Each measure population consisted of beneficiaries who (1) met measure-specific criteria, such as age, gender, and diagnosis; and (2) did not meet certain exclusion criteria, such as having a specific medical condition that would require removal of a beneficiary from the measure population.[26]

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[24] According to CMS guidance, the ACO should report that it could not find the medical record only if there was an inability to locate and access the beneficiary's medical record after a concerted effort was made. For example, an ACO may not have been able to find or access beneficiary medical records if a flood destroyed them.

[25] If a beneficiary was removed from the overall sample, the beneficiary was also removed from all measures into which the beneficiary had been distributed in the CMS web portal. In this case, the ACO was required to replace the removed beneficiary with an additional beneficiary for each measure (if available) and report data on the additional beneficiary to meet the minimum reporting requirement.

[26] If a beneficiary was removed from an individual measure population, the ACO was required to replace the removed beneficiary with an additional beneficiary for the measure (if available) and report data on the additional beneficiary to meet the minimum reporting requirement. Not all quality measures had exclusion criteria.

Examples of Measure Specific and Exclusion Criteria

To have been included in the depression-screening measure population, a beneficiary should have been at least 12 years old at the beginning of PY 2016, with at least one visit during PY 2016 (i.e., the beneficiary met the measure-specific criteria). In addition, the beneficiary should not have had an active diagnosis of depression or bipolar disorder (i.e., the beneficiary did not meet the exclusion criteria).

Step 3: ACO Reported Whether Conditions of the Quality Measure Were Satisfied for Each Beneficiary

For beneficiaries who were included in each measure population, an ACO reported through the CMS web portal whether certain conditions were satisfied for each beneficiary. Each quality measure had a set of specific conditions, such as whether the beneficiary was appropriately screened and whether the required tool was used to perform the screening. For certain quality measures, ACOs also reported specific measurement values (e.g., a beneficiary's blood pressure reading on a given date), which were used to determine whether certain conditions were satisfied for a beneficiary.

Example of Satisfying the Conditions of a Quality Measure

To satisfy the conditions of the depression screening measure, a beneficiary who was included in the measure population should have been screened for depression during a visit in PY 2016 using an age-appropriate, standardized screening tool (e.g., a PHQ-9 questionnaire), and if the result of the beneficiary's depression screening was positive, a followup plan should have been documented on the date of the screening.

For beneficiaries who did not satisfy the conditions of a quality measure, an ACO determined whether a specific exception reason applied for removal. Specific exception reasons included a "Patient Reason" exception (e.g., refusal to participate in a required screening) and a "Medical Reason" exception (e.g., allergies to a required vaccine). (Not all quality measures had exception reasons.) If a beneficiary did not satisfy the conditions of a quality measure but an exception reason applied, the beneficiary was removed from the measure population.

Examples of Exception Reasons

If a beneficiary was not screened for depression, the beneficiary could still have been removed from the measure population if any of the following exception reasons applied: the beneficiary refused to participate (i.e., "Patient Reason" exception) or the beneficiary required immediate medical attention or was in a situation where his or her functional capacity would have affected the results of the depression screening (i.e., "Medical Reason" exception).

APPENDIX E: WEST FLORIDA COMMENTS

Report Number: A-09-18-03003

Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

Dear Lori A. Ahlstrand,

West Florida ACO LLC would like to thank the OIG audit team for all of their hard work and assistance throughout the audit process. It was a pleasure working with them and we appreciated all of their efforts in ensuring a smooth audit process. We have reviewed the recommendations listed in the report and concur with their findings.

West Florida ACO will continue to make its best efforts to report quality measures accurately through the CMS portal.

We will notify CMS about and request:

I. not including the beneficiaries in the sample if CMS already had data of the exclusions, and
II. that in many cases, the "patient reason" and "medical reason" can overlap and that any of these two exceptions need to be considered equivalents.

Sincerely,

Jayadeva Chowdappa

Jayadeva Chowdappa, MD
CEO

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