

# CMS Update

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## Today's Presentation

- Patients over Paperwork
- Interoperability & MyHealthEData
  - Opioids
  - Program Integrity

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## Patients over Paperwork

- CMS is putting patients first and empowering them to make the best decisions for themselves and their families
- Agency-wide initiative to remove regulatory obstacles and allow providers to focus on improving their patients' health
- In 2017, CMS solicited comments on specific ideas to reduce burdens through several Requests for Information (RFIs)
- As of this month, we have resolved or are actively addressing over **58%** of the **1,146** burden topics identified in the RFIs



## Patients over Paperwork (cont'd)

- CMS is committed to easing the burden of regulation, while maintaining our focus on integrity, quality and safety
- In September 2018, CMS issued a proposed rule to relieve burden by removing unnecessary, obsolete and excessively burdensome Medicare compliance requirements for health care facilities
- Proposed changes will reduce the amount of time and resources that health care facilities have to spend on CMS-mandated compliance activities that do not improve the quality of care



## Patients over Paperwork (cont'd)

Between 2018 and 2021, CMS projects Patients over Paperwork will save:

5.7  
Billion  
Dollars

&

40  
Million  
Hours



## Simplifying Documentation Requirements

- To make it easier for providers and to reduce improper payments and appeals, we are working to:
  - Eliminate sub-regulatory documentation requirements that are no longer needed
  - Simplify remaining sub-regulatory documentation requirements



## Simplifying Documentation Requirements (cont'd)

- Two-pronged solution to provide information on Medicare Fee-for-Service documentation requirements in a more clear and concise manner:

- **Provider Documentation Checklist**

- Web-based and accessible at any point in the lifetime of a claim
- Centralize all documentation requirements in one place

- **Provider Documentation Lookup Service**

- Directly integrated into provider workflow through EHRs
- Providers will be able to discover Medicare FFS prior authorization and documentation requirements at the *time of service* and *within their EHR*



## Updating the Stark Law

- Stark was a primary theme of comments submitted in response to our Request for Information on burden reduction
- CMS is working on an update to our Stark regulations to be issued later this year
- This is a key component of the **HHS Regulatory Sprint to Coordinated Care** to remove barriers and help providers deliver the best team-based care



## MyHealthEData

- Administration-wide initiative to unleash data to empower patients by giving them control of their healthcare information and allowing it to follow them throughout their healthcare journey
- CMS is taking steps to ensure patients have unencumbered access to their health information, in a format that is practical, useable and easily shared
- Seamless data sharing will increase efficiency and patient safety while reducing cost



## MyHealthEData (cont'd)

- With Blue Button 2.0, **over 1500** developers are building user-friendly apps to help seniors understand and access their data
  - Learn more: [developers](#) and [beneficiaries](#)
- Overhaul of Meaningful Use program and requirement for clinicians and hospitals to adopt the 2015 edition of certified EHR technology (CEHRT)
- Developing a prototype Medicare Documentation Requirements Lookup Service using a FHIR-based API



## Interoperability and Patient Access Proposed Rule

- All health plans doing business in Medicare, Medicaid, and through the federal exchanges must share health claims data and other important information with patients electronically
- Claims data should follow a patient as they move from plan to plan, allowing a single access point for patients and sharing critical information for plans
  - Publicly identify doctors, hospitals, and other providers who engage in information blocking
  - Require that all hospitals send electronic notifications to designated health care providers when their patients are admitted, discharged, or transferred from the hospital



## CMS Opioid Strategy

As one of the largest payers of healthcare services, CMS has a key role in addressing the opioid epidemic and is focused on three key areas:



### PREVENTION

Manage pain using a safe and effective range of treatment options that rely less on prescription opioids



### TREATMENT

Expand access to treatment for opioid use disorder



### DATA

Use data to target prevention and treatment efforts and to identify fraud and abuse



## Addressing the Opioids Crisis

- CMS is implementing its opioid strategy to respond to the Administration's priorities, the White House Commission Recommendations, and the newly enacted opioid law
- Continuing to consider feedback from stakeholders in listening sessions
- On June 11, 2018 CMS released the [CMS Opioid Roadmap](#) on our three-pronged approach to combating the opioid epidemic focusing on:
  - **prevention** of new cases of opioid use disorder (OUD);
  - **treatment** of patients who have already become dependent on or addicted to opioids; and
  - utilization of **data** from across the country to target prevention and treatment activities



## Addressing the Opioids Crisis (cont'd)

- **Stronger Medicare prescription opioid policies** started January 1, 2019 – 7-day acute pain fill limits, care coordination, and pharmacy/provider lock-in program
- **State Flexibility** for states pursuing 1115 demonstrations focused specifically on ground-level solutions
- **Promoting payment system innovation** through new demonstrations and models

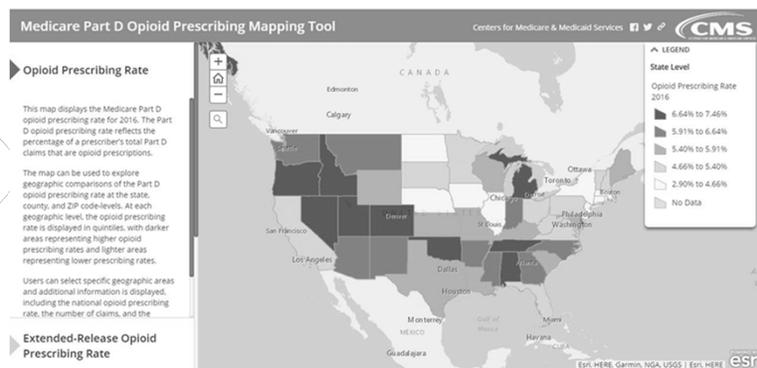


## Addressing the Opioids Crisis (cont'd)

- Key provisions of the **SUPPORT Act** enacted October 24, 2018
  - Cover services provided by Opioid Treatment Programs (OTPs), including methadone
  - Permit a Prescription Drug Plan sponsor to suspend payments if there is a credible allegation of fraud
  - Expand IMD coverage for mothers and beneficiaries with SUD
  - Demonstration program to test bundled payment for medication assisted treatment
  - Expand “sunshine” efforts to additional health professionals, such as physician assistants



## Opioid Prescribing Mapping Tool – Part D & Medicaid



## Program Integrity Focus Areas

- Enrollment compliance initiatives
- Invest in data and analytics to support fraud detection and prevention efforts and recover improper payments
- Strengthen collaboration with all our partners
- Medicare Advantage and Part D Efforts
- Enhance Medicaid oversight



## Program integrity Focus Areas (cont'd)

Our recent efforts in program integrity kept Medicare program integrity kept

**5.7  
Billion  
Dollars**

...from being lost to waste, fraud and abuse in FY17



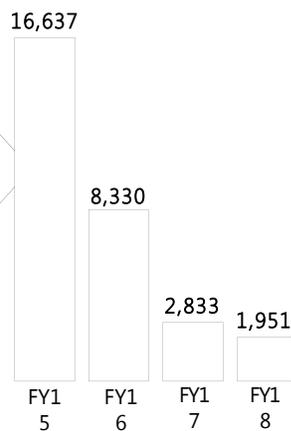
## Enrollment Compliance Initiatives

- CMS has increased compliance initiatives to reduce revocations based on technical-grounds when appropriate
- Increased focus on more egregious offenses like cases involving false or misleading disclosures, abusive billing, or abusive prescribing
- The revalidation process has helped the provider community to maintain compliance with Medicare program requirements, thus decreasing revocations



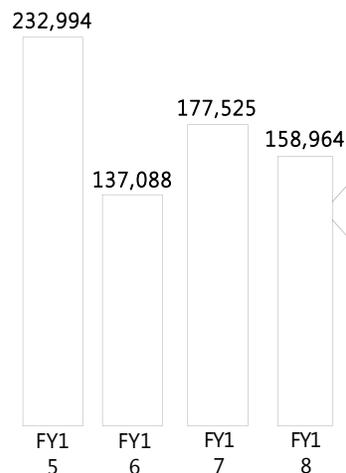
**2.2 MILLION** TOTAL ENROLLMENTS

### Revocations



**88 %** DECLINE in Revocations (Unique Enrollments) Since FY15

### Deactivations



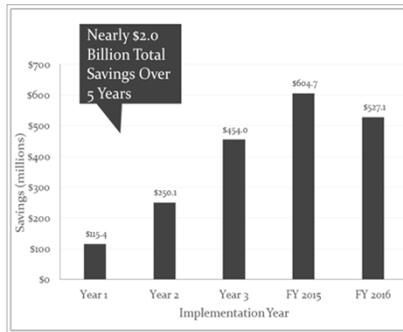
**32 %** DECLINE in Deactivations (Unique Enrollments) Since FY15



## Program Integrity - Fraud Prevention System (FPS)

FPS is a state-of-the-art predictive analytics system that is part of CMS's comprehensive Program Integrity strategy.

- Identify leads for early intervention by MAC/UPIC/LE
- Identify bad actors/MCC
- Deny claims not supported by Medicare Policy



## Program Integrity Contractors

<b>MAC</b>	<b>Medicare Administrative Contractors (Targeted Probe &amp; Educate)</b>	To <b>prevent future</b> improper payments (pre-payment) - Targeted Probe & Educate (TPE)
<b>RAC</b>	Medicare FFS Recovery Auditors	To <b>detect and correct past</b> improper payments (post-payment)
<b>UPIC</b>	Unified Program Integrity Contractors	To identify <b>potential fraud/ Improper payments</b>
<b>MEDIC</b>	Medicare Drug Integrity Contractor	To identify <b>fraud and improper payments Part C &amp; D</b>
<b>MPIC</b>	Marketplace Program Integrity Contractors	To identify <b>fraud</b> in the Marketplace <b>Exchange</b>



## RAC Program Enhancements

- RACs must have CMS approval before doing reviews
- Each RAC is required to post all CMS-approved review topics, for their respective region, to their website to notify providers

Issue Number	Issue	Review Type	Claim Type	Review and Claim Status	Date Approved	Details
0001	Complete Inpatient Hospital MS-DRG Category	Complete	Inpatient Hospital	2 - all applicable states	01/23/2017	Details
0002	Complete Medical Necessity Social Reauthorization	Complete	Inpatient, Outpatient, ASC, Physician	2 - all applicable states	01/23/2017	Details
0003	Admitted Registration/Continued Stay (MS-DRG 1-4)	Automated	Outpatient Hospital	2 - all applicable states	01/26/2017	Details
0007	Zedonic Acid Daily (Greater than or equal to 2)	Automated	Outpatient Hospital	2 - all applicable states	01/26/2017	Details

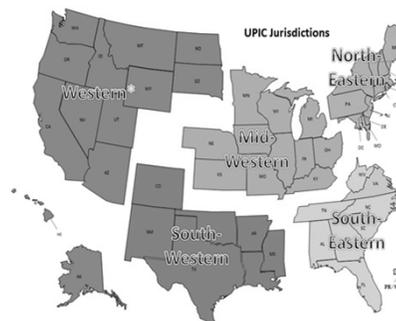
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## Program Integrity: Unified Program Integrity Contractors (UPICs)

Goal: To identify fraud and improper payments

- Integrate audit and investigation program integrity functions across Medicare and Medicaid
- Strengthen coordination of Federal and State program integrity efforts
- Refer fraud to law enforcement



\*Other territories of the Western Jurisdiction to include American Samoa, Northern Marianas Islands and Guam

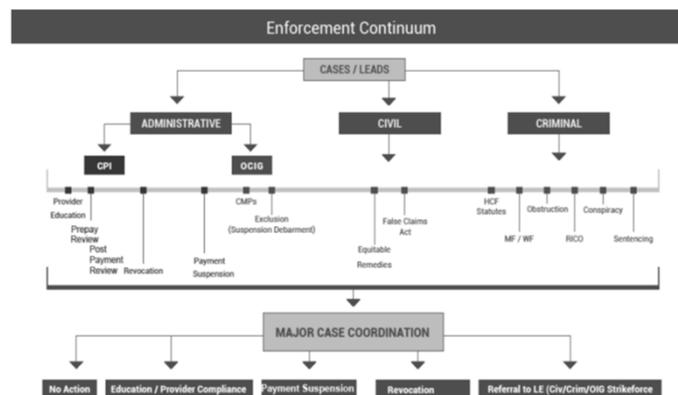


## Program Integrity: Prior Authorization

- Implement demonstration programs to establish prior authorization process for certain services to ensure services are provided efficiently and consistent with the law
- Support our efforts to curb unnecessary utilization of care and ensure quality of care
- Administered in ways to minimize burden and allow providers and beneficiaries to know earlier in the process whether Medicare will likely pay for a service



## Strengthen Collaboration with Partners



## Healthcare Fraud Prevention Partnership (HFPP)

Voluntary, public-private partnership between the federal government, state and local agencies, law enforcement, private health insurance plans, employer organizations, and healthcare anti-fraud associations to identify and reduce fraud, waste, and abuse across the healthcare sector

### Make-up of the Partnership



\* As of October 2018

### 112 Partners\*

9 Federal Agencies  
12 Associations  
30 State/Local Partners  
61 Private



## Program Integrity: Proposed Changes

- CMS continues to work to modernize the Medicare Advantage and Part D programs
- Risk Adjustment Data Validation audits and recovery of improper payments
  - Start payment year 2014 and 2015 contract level audit this fiscal year
  - Reduce the burden on audited plans while expanding the reach of the audits to more plans
- CMS extended the comment period for the RADV provision, to April 30, 2019, to give the public an opportunity to submit meaningful comments to the RADV provision proposal



## Program Integrity: Proposed Changes

- Preclusion list

- CMS will make the Preclusion List available to Part D sponsors and the MA plans beginning Jan 1, 2019
- MA and Part D plans began editing claims on April 1, 2019

### Medicare Advantage (Part C)



- Opted out providers cannot receive Medicare payment for services furnished to Medicare beneficiaries under FFS or a MA plan



- MA plans will deny enrollment and prevent payment for a health care item or service if the individual/entity is on the Preclusion List

### Prescriber (Part D)



- Pharmacy will deny prescriptions at point of sale if the provider is on the Preclusion List



## Program Integrity: Medicaid Strategy

- Oversight Activities:

- PI-focused audits of Medicaid managed care, including Medical Loss Ratio (MLR)
- PI-focused audits of state improper claiming of the federal match
- Conduct new audits of state beneficiary eligibility determinations

- Collaborate with states to ensure compliance with the Medicaid managed care final rule and implementation of PI safeguards

- Optimize PI use of T-MSIS data, conduct data analytics pilots with states, and improve state access to data sources that are useful for PI



## Final Takeaways

- CMS is committed to robust program integrity across all of our programs
- Program integrity functions help us hold the entire healthcare system accountable, protect beneficiaries from harm and safeguard taxpayer dollars
- Above all, we want to enable providers to focus on their primary mission – improving their patients' health

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Thank You!

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