Centers for Medicare & Medicaid Services Update

Healthcare Enforcement Compliance Institute

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Today’s presentation

• CMS overview – organizational structure, strategic goals and general principals
• Medicare Appeals
• Documentation/medical review
• Regulatory Reform/provider burden
• Contractors (RACs, MACs and UPICs)
Introduction

• Providers are the heart and soul of medical care
  – Drive the care, innovate on improvements
  – Juggle competing demands: High throughput, efficiency, and quality for the most straightforward to most complicated patients

• Medicare is huge and complex
  – 7300 hospitals
  – 1.5 million physicians
  – Over 4 million claims PER DAY!

• Estimated 11% of all Medicare Fee-For-Service (FFS) claim payments are improper
  – Translates into approximately $41 Billion per year in improper payments

• Medicare has to be efficient in enabling care and paying for care
  – Timelines for payments
  – Safeguards to ensure payments are proper

• Vast majority of providers go out there every day to do the right thing, and even do heroic things
  – Sometimes providers do not meet some Medicare requirements and need help getting back on track
  – A small subset of providers (and people or organizations who pretend to be providers) put our beneficiaries and taxpayer money at risk, increasing administrative burden on the rest of providers as a consequence
**CMS Strategic Goals**

- Empowering patients and doctors to make decisions about their healthcare
- Increasing state flexibility and local leadership
- Developing innovative approaches to improving quality, accessibility and affordability, and
- Improving the CMS customer experience

**Medicare Appeals**

- Appeals for denials of claims payments are themselves burdensome for both providers and CMS
- While Office of Medicare Hearings and Appeals (OMHA)* is processing a record number of Medicare appeals, they continue to receive more requests for hearings than our ALJs can adjudicate in a timely manner
- This is what CMS is doing to address the challenge:
  - **DECREASE** the CURRENT backlog of appeals
    - Settlement Conference Facilitation, piloting an alternative dispute resolution process at the third level of appeal
    - Telephone Discussion Demonstration with DME Suppliers, doing what
  - **PREVENT** future appeals
    - Escalation/De-escalation Initiative, targeting interventions to improve adherence to program requirements (see slides 6-7)
    - Regulation Reform and Documentation Requirements Simplification to clarify, simplify and potentially reduce requirements (see slide 8)

*OMHA is the third level of appeals
CMS’ Goals

• Our job is to:
  – Help providers adhere to the rules when they need help
  – Identify that small subset of providers that should be exited out of the program
    • It’s that subset of abusive and fraudulent people/organizations that drive the creation of
      more rules which get applied to everyone

• We are working to get better at differentiating:
  – The vast majority of “good guys and gals”
  – From the few nefarious ones

• We must focus our actions on those few “bad guys and gals” and relieve some of
  the requirements burden on the rest

• Today I will tell you about:
  – Some of the things we are doing to get there
  – How you can help

Who Performs Reviews

- Fraud Investigation
- Revocation, Payment Suspension
- Pre/Postpay Review by ZPIC
- Postpay Review by RAC
- Targeted Probe & Educate by MACs
- Provider feedback (CBRs/letters)
- Auto-Deny Edits/EDI Alerts/Rejects*
- Provider Enrollment Screening
### BEFORE
**Escalate/De-Escalate Initiative**

- **MACs**
  - Could request/review an **unlimited number** of medical records (within their budget)
  - After reviews are completed, would send **vague denial codes**
  - Could keep a provider on review for a given topic for **years/decades**

- **ZPICs/UPICs**
  - Tasked with detecting potential fraud
  - Were also tasked with detecting/collecting overpayments in non-fraud cases

### AFTER full implementation of Escalate/De-Escalate Initiative

- **MACs**
  - May only request/review an **20-40** medical records per provider per topic
  - After 20-40 reviews are completed
    - Must send **detailed denial reasons**
    - Must offer **1:1 educational call** to discuss the denial reasons
    - Must **wait 45 days** ("improvement period")
  - May repeat for up to 3 rounds; then must **STOP reviews and refer** (or "escalate") the provider for stronger corrective action
  - This process is called "Targeted Probe & Educate" or TPE
  - TPE is in place in 4 MACs now; will be in all 19 MACs by November 2017

- **ZPICs/UPICs**
  - Will refer non-fraud cases to MACs for TPE ("de-escalate")
  - Beginning November 2017
Regulation Reform and Documentation Requirement Simplification

- This spring/summer, CMS included in its draft payment regulations language soliciting ideas from the public about regulatory requirements that need to be revised or removed
  - We are getting lots of suggestions!
  - CMS staff are busy reviewing them

- CMS has also recently undertaken an effort to revise/remove unclear or unnecessary sub-regulatory guidance

- CMS is planning a Provider Documentation Manual that will put all coverage and payment documentation requirements IN ONE PLACE

Listening Sessions and Provider Conferences

- CMS holds Open Door Forum calls for physicians and other provider types throughout the year

- CMS currently holds:
  - Quarterly in-person provider enrollment focus groups
  - Semi-annual in-person provider enrollment conferences

- CMS is planning:
  - Quarterly in-person provider compliance focus groups
  - Semi-annual in-person provider compliance conferences
Provider Burden Research

**Purpose:** To explore challenges perceived by Medicare providers in meeting CMS programmatic and policy requirements

- Recruitment of primary care physicians, specialists and administrative staff
- Focus groups and interviews are being conducted across the country from August 23 to September 13
- Group discussion includes interactions with CMS, understanding and transparency around requirements, knowledge of resources, areas needing improvement
- Results will be used to identify and prioritize areas for burden reduction

Enhancing MAC/RAC Provider Portals

- **In the past:** Significant variation in features available on MAC/RAC Portals
- **New:** All MAC/RAC Provider Portals will be required to offer the following features:
  - Documentation upload
  - Secure messaging
  - More information about the status of reviews
- **Enhancements will begin this fall**
**RAC Documentation Request Limits**  
**Physician/Non-physician**

- Physician/Non-physician (Part B) Practitioner Documentation Request Limits have not changed since February 2011

- Still based on:
  - TIN and first three digits of ZIP code (physical locations)
  - Number of individual rendering practitioners in group
    - 1 - 5 practitioners: 10 records per 45 days
    - 6 - 24 practitioners: 25 records per 45 days
    - 25 - 49 practitioners: 40 records per 45 days
    - 50 or more practitioners: 50 records per 45 days

Unified Program Integrity Contractor

• The purpose of the UPIC is to:
  – Coordinate provider investigations across Medicare and Medicaid;
  – Improve collaboration with States by providing a mutually beneficial service; and
  – Increase contractor accountability through coordinated oversight

Current Status of UPICs

• Midwestern Jurisdiction – awarded to AdvanceMed Corporation
• Northeastern Jurisdiction – awarded to SafeGuard Services, LLC
• Western Jurisdiction - currently under protest
• Southeastern Jurisdiction – currently under protest
• Southwestern Jurisdiction – scheduled to be awarded by the end of FY2017
Questions?

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