Centers for Medicare & Medicaid Services Update

Healthcare Enforcement Compliance Institute

October 31, 2017

Kim Brandt, J.D., M.A.
Principal Deputy Administrator for Operations, Centers for Medicare & Medicaid Services

Today's presentation

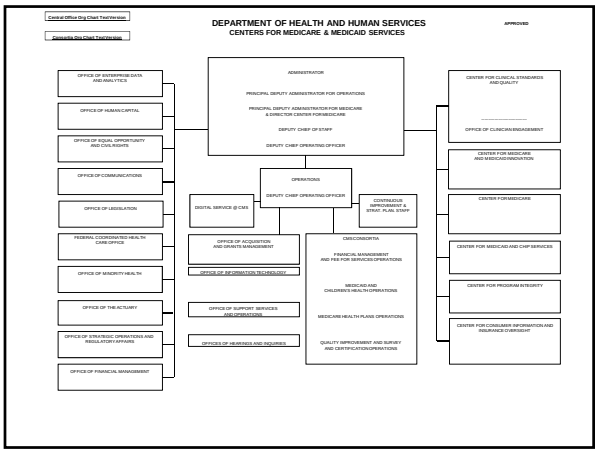
- CMS overview – organizational structure, strategic goals and general principals
- Medicare Appeals
- Documentation/medical review
- Regulatory Reform/provider burden
- Contractors (RACs, MACs and UPICs)

2

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

3



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

5

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*

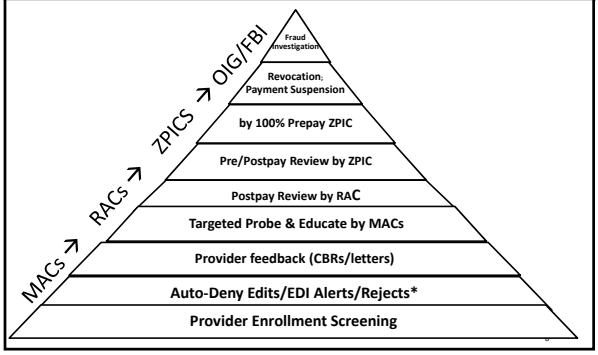
6

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

7

Who Performs Reviews



8

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

9

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

10

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

11

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

12

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

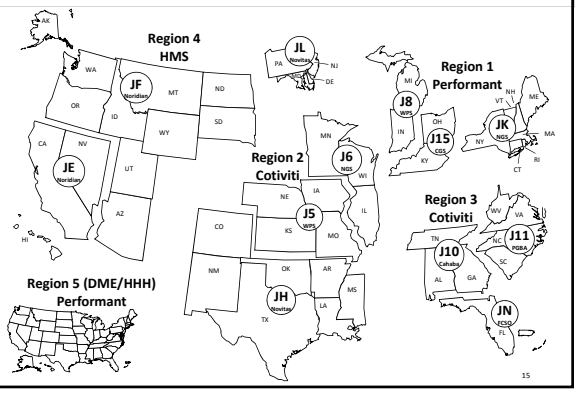
13

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

14

New Recovery Audit Contractors (RACs)



15

RAC Documentation Request Limits
Physician/Non-physician

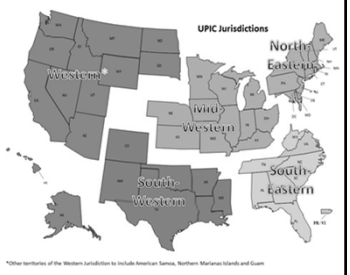
- Physician/Non-physician (Part B) Practitioner Documentation Request Limits have not changed since February 2011
- Still based on:
  - TIN and first three digits of ZIP code (physical locations)
  - Number of individual rendering practitioners in group
    - 1 - 5 practitioners: 10 records per 45 days
    - 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

See details at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/PhyADR.pdf

16

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



17

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

18

Questions??

- Kimberly.brandt1@cms.hhs.gov
  410/786-3151

19