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
  – 7,500 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 bend the rules or organizations who pretend to be providers but are not
  – Translates into taxpayer money at risk, including 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 CMS Suppliers, doing what
  - PREVENT future appeals
  - Escalation/De-escalation Initiative, targeting interventions to improve adherence to
    - 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**

- 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/collection overpayments in non-fraud cases

**BEFORE**

**Escalate/De-Escalate Initiative**
**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 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

New Recovery Audit Contractors (RACs)
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

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??

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