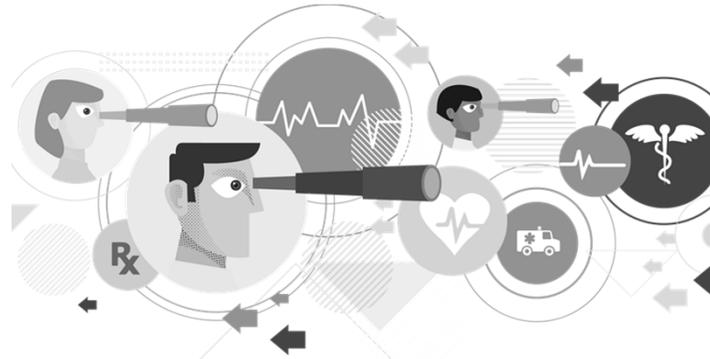


CMS Update: Program Integrity & Opioid Epidemic



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Today's Presentation

- Patients Over Paperwork
- Addressing the Opioid Epidemic
- Program Integrity

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Patients over Paperwork

- Agency-wide initiative to remove regulatory obstacles that get in the way of providers spending time with patients
- In 2017, CMS solicited comments on specific ideas to reduce burdens through several Requests for Information

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What We Heard from Providers



CMS requirements are excessive



Documentation requirements are complex and hard to find



Providers are apprehensive of audits



EHRs are inefficient and burdensome

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What We Heard from Providers

CMS requirements are excessive



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New Approach To Regulatory Reform

- CMS is committed to easing the burden of regulation, while ensuring we maintain a 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

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Re-evaluating Our Approach to Stark

- Stark was a primary theme of comments submitted in response to our Request for Information on burden reduction
- CMS reviewed all comments and convened a workgroup that included partners from OIG and Department of Justice
- Issued a Request for Information June 20, 2018 with comments due August 24, 2018
- CMS is reviewing the comments submitted and developing a proposed rule
- 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

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What We Heard from Providers

Documentation requirements are complex and hard to find



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Simplifying Documentation Requirements

- To make it easier for providers and 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
- Continue to solicit stakeholder suggestions for improvements

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Centralizing Documentation Requirements

- Developing a Provider Documentation Manual to centralize all coverage and payment documentation requirements in one place
- It will reference and allow providers to easily find other online resources
- Providers will have the opportunity to review chapter drafts and provide comments

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What We Heard from Providers

Providers are apprehensive of audits



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Targeted Probe and Educate (TPE)



The objective is to make sure **providers are educated** on documentation requirements so that **mistakes can be easily fixed** in future claims.

- Providers have more opportunities for 1:1 education.

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Before and After TPE Implementation

MACs:

BEFORE	AFTER
Could request/review an unlimited number of medical records	Can review 20-40 medical records per provider per topic
Would send vague denial codes after completing reviews	Must send detailed denial reasons and offer 1:1 education call to discuss
Could keep a provider on review for a given topic for years	Must STOP reviews and refer provider for stronger corrective action after 3 rounds

ZPICs/UPICs:

BEFORE	AFTER
Tasked with detecting/collecting overpayments in non-fraud cases	Will refer non-fraud cases to MACs for TPE

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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

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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 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

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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 waivers focused specifically on ground-level solutions
- **Promoting payment system innovation** through new demonstrations and models

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Addressing the Opioids Crisis (cont'd)

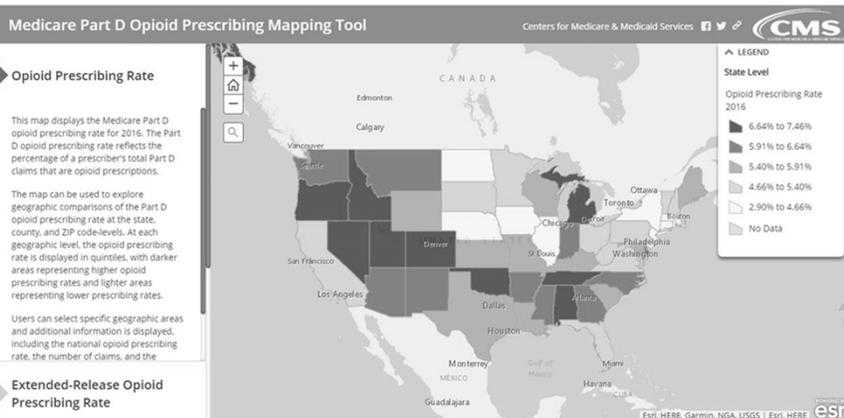
- **Key provisions of the SUPPORT Act enacted October 24, 2018**

- 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

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Part D Opioid Prescribing Mapping Tool



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Program Integrity Focus Areas

- 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

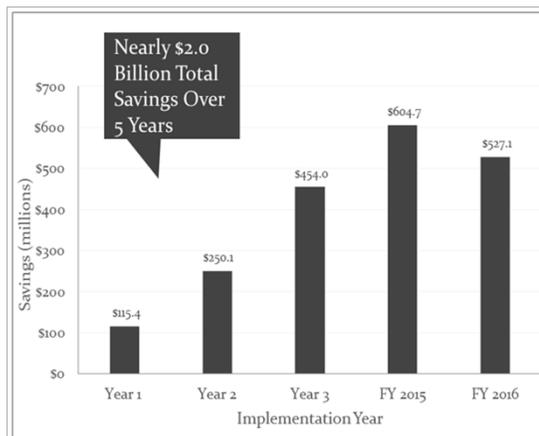
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Program Integrity - Fraud Prevention System (FPS)

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



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Program Integrity Contractors

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

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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

Cotiviti Healthcare

CMS Approved Audit Issues

Provide Portal Login

THIS LIST INCLUDES ALL CMS APPROVED AUDIT ISSUES. Cotiviti RAC Approved Issues as of 04/27/2017 (PDF Version)

Cotiviti RAC Approved Issues as of 04/27/2017 (Excel Version)

Search visible issue name

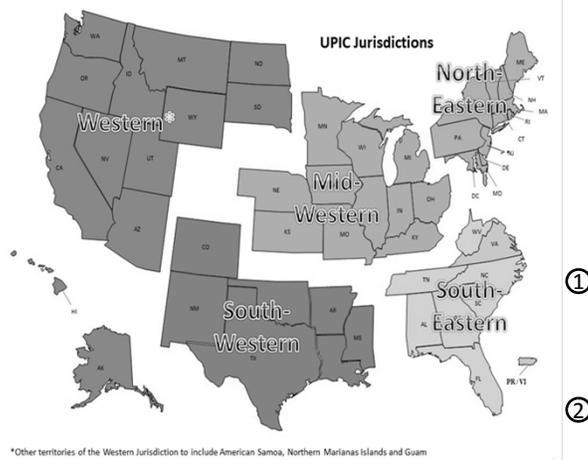
Issue Number - Year	Review Type	Claim Type	Region and States	Date Approved	Details
0001 - Complex Inpatient Hospital MS-DRG Coding Validation	Complex	Inpatient Hospital	2 - all applicable states	01/23/2017	Details
0003 - Complex Medical Necessity Sacral Neuromodulation	Complex	Inpatient, Outpatient, ASC, Physician	2 - all applicable states	01/23/2017	Details
0006 - Automated Repackenson (Leukeran) Billed With Units > 4	Automated	Outpatient Hospital	2 - all applicable states	01/29/2017	Details
0007 - Zidronic Acid Units > [greater than or equal to] 5	Automated	Outpatient Hospital	2 - all applicable states	01/29/2017	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

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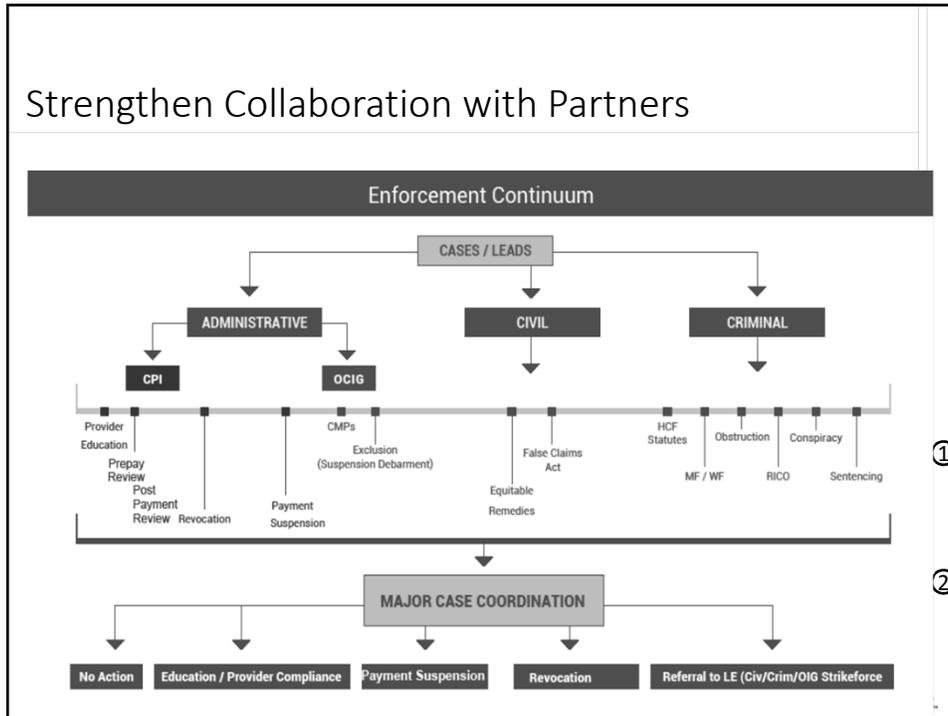
Program Integrity: Prior Authorization

- 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

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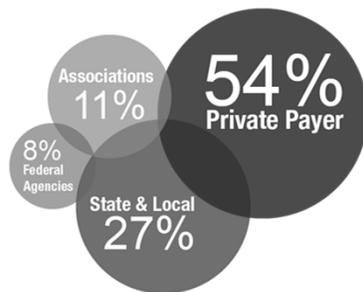
Strengthen Collaboration with Partners



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



112 Partners*

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

* As of October 2018



Program Integrity: Medicare Advantage & Part D

- CMS continues to work to modernize the Medicare Advantage and Part D programs
- On November 1, 2018 CMS published a proposed rule Policy and Technical Changes to Medicare Advantage and Part D Programs (CMS-4185-P)
- Comments were due December 31, 2018
- On December 20, 2018 CMS announced a 120-day extension, to April 30, 2019, for public comments for the RADV provision in the proposed rule

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Program Integrity: Proposed Changes

- 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.
 - As noted above, 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
 - CMS is hosting an industry wide Medicare Advantage RADV training on January 29, 2019

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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.

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

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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

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Final Take Aways

- CMS is committed to robust program integrity across all of our programs
- Balancing that with provider burden and educating them on complying with our program requirements
- Ensuring the integrity of our programs is one of our top goals

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Thank You!

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