Today’s Presentation

• Patients Over Paperwork

• Addressing the Opioid Epidemic

• Program Integrity
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

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
What We Heard from Providers

CMS requirements are excessive

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
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

What We Heard from Providers

Documentation requirements are complex and hard to find
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

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
What We Heard from Providers

Providers are apprehensive of audits

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.
Before and After TPE Implementation

**MACs:**

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

<table>
<thead>
<tr>
<th>BEFORE</th>
<th>AFTER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tasked with detecting/collecting overpayments in non-fraud cases</td>
<td>Will <strong>refer</strong> non-fraud cases to MACs for TPE</td>
</tr>
</tbody>
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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
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

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
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

**Part D Opioid Prescribing Mapping Tool**

This map displays the Medicare Part D opioid prescribing rate for 2016. The Part D opioid prescribing rate reflects the percentage of a prescriber’s total Part D claims that are opioid prescriptions.
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

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

Nearly $2.0 Billion Total Savings Over 5 Years

<table>
<thead>
<tr>
<th>Year</th>
<th>Savings (millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$477.4</td>
</tr>
<tr>
<td>2</td>
<td>$539.1</td>
</tr>
<tr>
<td>3</td>
<td>$254.8</td>
</tr>
<tr>
<td>FY 2015</td>
<td>$604.7</td>
</tr>
<tr>
<td>FY 2016</td>
<td>$777.1</td>
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Program Integrity Contractors

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

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

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

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
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)  Prescriber (Part D)

  • 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
  • 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 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

Thank You!

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