Improving Compliance while Reducing Provider Burden: CMS Medicare Claim Review Programs

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Today's Presentation

- CMS Overview – Strategic Goals and General Principles
- Medicare Audits and Appeals
- Documentation/Medical Review
- Regulatory Reform/Provider Burden
- Contractors (RACs, MACs and UPICs)
- Addressing the Opioids Crisis

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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

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New Administration CMS Strategic Goals

Empower patients and doctors to make decisions about their health care

Usher in a new era of state flexibility and local leadership

Support innovative approaches to improve quality, accessibility, and affordability

Improve the CMS customer experience

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CPI Objectives from CMS Strategic Goals

CPI's program integrity objectives flow from CMS' strategic goals:

Empower patients and doctors to make decisions about their health care	Balance program integrity initiatives aimed to protect beneficiaries and the Trust Fund while minimizing provider burden
Usher in a new era of state flexibility and local leadership	Share best practices with states and increase flexibility in program integrity approaches while improving accountability in Medicaid programs
Support innovative approaches to improve quality, accessibility, and affordability	Integrate, analyze, and share data to inform decision making
Improve the CMS customer experience	Clarify and simplify program requirements through collaboration, transparency, outreach, and education

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Medicare Audits and Appeals

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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

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Investigations and Audits

CPI develops a risk-based and targeted regional and national investigation/audit approach which are operationalized by the UPICs:

- National investigative priorities (2018): Home Health, Hospice, Laboratory Services.
  - In-house data analysis through FPS and other means identify targets before fieldwork is initiated in order to reduce potential burden.
  - Fieldwork is often conducted with assistance from the appropriate UPIC or ZPIC and, if the scheme and investigative strategy is proven, it is rolled out to UPICs and ZPICs for implementation.
- Provides oversight of CMS program integrity contractors (UPICs and ZPICs for Medicare Parts A and B and National Benefit Integrity Medicare Drug Integrity Contractor [NBI MEDIC] for Medicare Parts C and D).
- Partners across CMS components to provide program integrity oversight of Medicare Advantage and Prescription Drug Plans
- Has approval authority for all Medicare payment suspensions
- Serves as CMS' liaison with law enforcement on investigative activities

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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
  - PREVENT future appeals
    - **Escalation/De-escalation Initiative,** targeting interventions to improve adherence to program requirements (see slides 12-13)
    - **Regulation Reform** and **Documentation Requirements Simplification** to clarify, simplify and potentially reduce requirements (see slide 16)

**OMHA is the third level of appeals*

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Documentation/Medical Review

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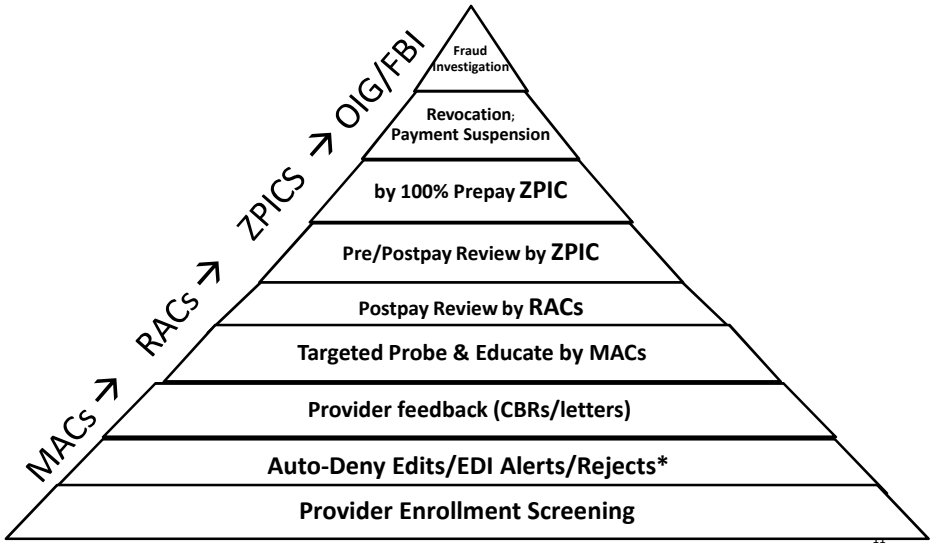
Who Performs Reviews



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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

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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

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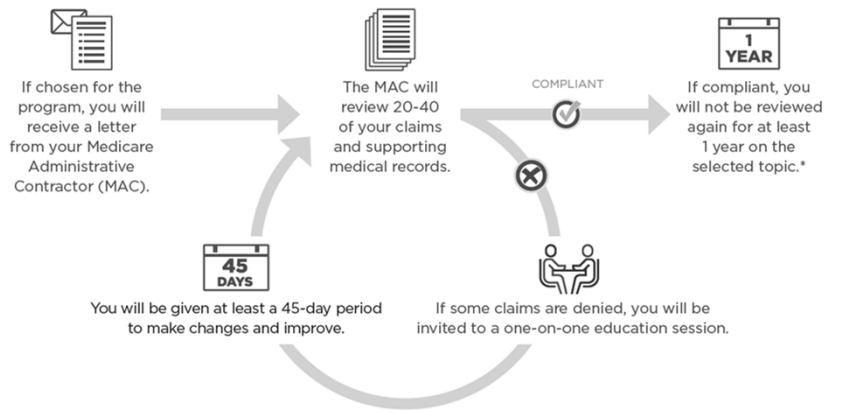
Targeted Probe and Educate (TPE) Program



*MACs may conduct additional review if significant changes in provider billing are detected.

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Regulatory Reform/Provider Burden

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Regulation Reform and Documentation Requirement Simplification

- Last year, CMS included language in its draft payment regulations soliciting ideas from the public about regulatory requirements that need to be revised or removed
  - We have gotten 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

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Patients over Paperwork

- We are moving the needle to remove regulatory obstacles that get in the way of providers spending time with patients
- CMS is already taking significant steps to evaluate and streamline our regulations with the goal of:
  - **reducing unnecessary burden**
  - **increasing efficiencies**
  - **improving the customer experience**
- In addition to the Requests for Information published in many of our 2017 regulations, we are establishing customer-centered workgroups focusing first on clinicians, beneficiaries, and institutional providers (with similar groups for plans, states and suppliers to follow)

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Patients over Paperwork (cont'd)

- Some of CMS' specific goals are to:
  - Increase the number of customers – clinicians, institutional providers, health plans, etc. – engaged through direct and indirect outreach;
  - Decrease the hours and dollars clinicians and providers spend on CMS-mandated compliance
  - Increase the proportion of tasks that CMS customers can do in a completely digital way

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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

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Contractors (MACs, RACs and UPICs)

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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

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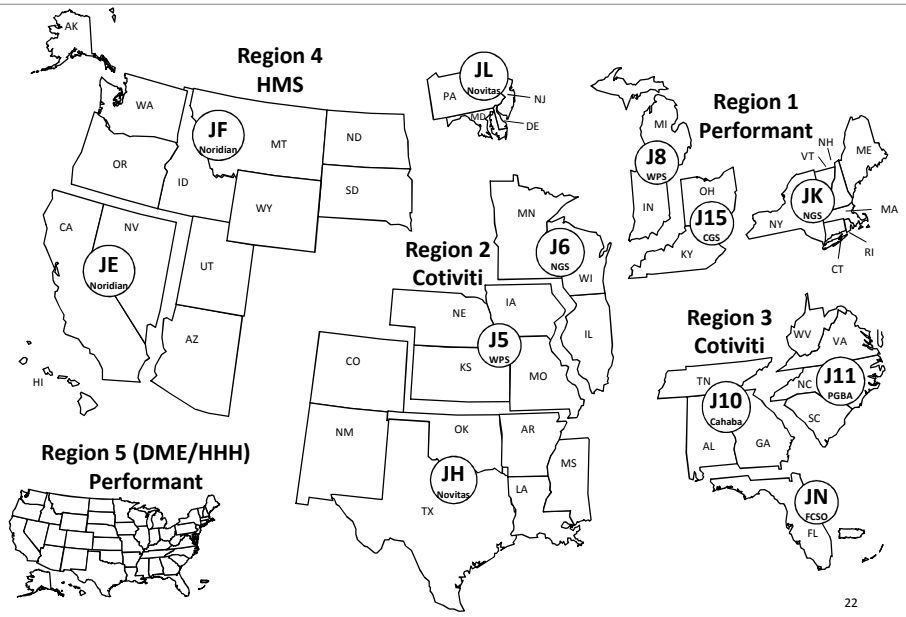
New Recovery Audit Contractors (RACs)



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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

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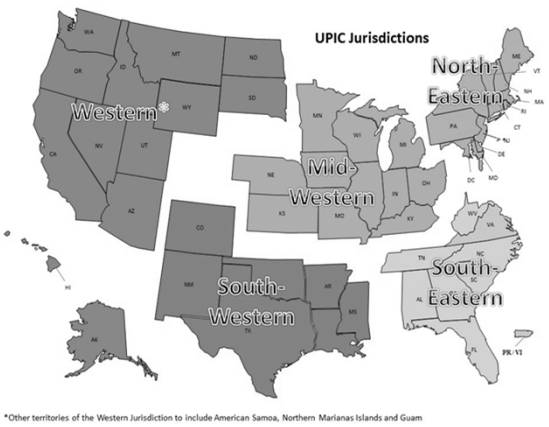
Unified Program Integrity Contractor

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



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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 – currently under protest

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Addressing the Opioids Crisis

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Addressing the Opioids Crisis

CMS is revising and updating its opioid response to this Administration's priorities and White House Commission Recommendations. Initial steps include:

- **Engaging stakeholders in listening sessions:** CMS held a number of listening sessions with providers, insurance companies, drug manufacturers and other stakeholders to solicit input on best practices and joint approaches to addressing the opioids crisis
- **Incorporating opioids-related measures in Medicare's Quality Payment Program (QPP):** Medicare's QPP has opioid-specific measures and clinical improvement activities for clinicians to select, providing them an opportunity to earn a bonus payment based on the quality of the care they provide

Addressing the Opioids Crisis (cont'd)

- **Displaying Opioid Drug Mapping Tool:** An interactive Opioid Drug Mapping Tool identifies communities where intervention is most needed by showing comparisons of the number and percentage of Medicare Part D opioid prescriptions filled at state, county, and zip code levels
- **Healthcare Fraud Prevention Partnership (HFPP) Paper:** Published a white paper describing best practices by a variety of healthcare payers to address and minimize the harms of opioids while ensuring access to medically-necessary therapies and reducing fraud, waste, and abuse
- **Medicare lock-in program**
  CMS is working on a proposed rule for the Medicare lock-in program required under the 2016 Comprehensive Addiction and Recovery Act – public comment closed on January 16, 2018.

Questions??

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