Our Healthcare System is Not Prepared

10,000 New Medicare Beneficiaries Every Day

The number of Americans age 85 and older will increase by 189% between now and 2050
People in Business

Her goal: Make quality health care affordable

By Norman Geode
THE DETROIT NEWS

Quality and cost are watchwords for Dea Moody-Williams. She constantly stresses both in her new job as director of program services in Michigan for the Peer Review Organization (MPRO), based in Plymouth.

The organization, sponsored by 3,000 physicians through peer review work as quality review supervisor for a peer review group in Pennsylvania as director of quality assurance for several Texas hospitals and as a review analyst for Blue Cross Blue Shield in Washington, D.C.

Manufacturing

Dow Corning Corp. in Midland announced Robert W. Grupp has been promoted to director of state affairs and government relations and made him a member of the firm's U.S. Area Operating Board. Grupp had been manager of external communications.

Advertising

New moves at D'Arcey Maxis in Bloomfield.

“What if we don’t change at all ... and something magical just happens?”
Size and Scope of CMS Responsibilities

• CMS is the largest purchaser of health care in the world

• Combined, Medicare and Medicaid pay approximately one-third of national health expenditures (approx $800B)

• CMS covers 140 million people through Medicare, Medicaid, the Children’s Health Insurance Program; or roughly 1 in every 3 Americans

• The Medicare program alone pays out over $1.5 billion in benefit payments per day

• Through various contractors, CMS processes over 1.2 billion fee-for-service claims and answers about 75 million inquiries annually

CMS Strategic Priorities for 2020
Value Based Purchasing and Transforming MIPS

Figure 1 & 4: The Updated APM Framework

| CATEGORY 1 | CATEGORY 2 | CATEGORY 3 (APPMATION || BASED ARCHITECTURE) | CATEGORY 4 | CATEGORY 5 |
|------------|------------|---------------------------------------------|------------|------------|
| Fee for Service - Indicators of Quality & Value | $ | A. Fee for Service - Indicators of Quality & Value | A. Fee for Service - Indicators of Quality & Value | A. Fee for Service - Indicators of Quality & Value |
| A. Fee for Service - Indicators of Quality & Value | $ | B. Fee for Service - Indicators of Quality & Value | B. Fee for Service - Indicators of Quality & Value | B. Fee for Service - Indicators of Quality & Value |
| B. Fee for Service - Indicators of Quality & Value | $ | C. Fee for Service - Indicators of Quality & Value | C. Fee for Service - Indicators of Quality & Value | C. Fee for Service - Indicators of Quality & Value |
| C. Fee for Service - Indicators of Quality & Value | $ | D. Fee for Service - Indicators of Quality & Value | D. Fee for Service - Indicators of Quality & Value | D. Fee for Service - Indicators of Quality & Value |
| D. Fee for Service - Indicators of Quality & Value | $ | E. Fee for Service - Indicators of Quality & Value | E. Fee for Service - Indicators of Quality & Value | E. Fee for Service - Indicators of Quality & Value |
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| N. Fee for Service - Indicators of Quality & Value | $ | O. Fee for Service - Indicators of Quality & Value | O. Fee for Service - Indicators of Quality & Value | O. Fee for Service - Indicators of Quality & Value |
| O. Fee for Service - Indicators of Quality & Value | $ | P. Fee for Service - Indicators of Quality & Value | P. Fee for Service - Indicators of Quality & Value | P. Fee for Service - Indicators of Quality & Value |
| P. Fee for Service - Indicators of Quality & Value | $ | Q. Fee for Service - Indicators of Quality & Value | Q. Fee for Service - Indicators of Quality & Value | Q. Fee for Service - Indicators of Quality & Value |
| Q. Fee for Service - Indicators of Quality & Value | $ | R. Fee for Service - Indicators of Quality & Value | R. Fee for Service - Indicators of Quality & Value | R. Fee for Service - Indicators of Quality & Value |
| R. Fee for Service - Indicators of Quality & Value | $ | S. Fee for Service - Indicators of Quality & Value | S. Fee for Service - Indicators of Quality & Value | S. Fee for Service - Indicators of Quality & Value |
| S. Fee for Service - Indicators of Quality & Value | $ | T. Fee for Service - Indicators of Quality & Value | T. Fee for Service - Indicators of Quality & Value | T. Fee for Service - Indicators of Quality & Value |
| T. Fee for Service - Indicators of Quality & Value | $ | U. Fee for Service - Indicators of Quality & Value | U. Fee for Service - Indicators of Quality & Value | U. Fee for Service - Indicators of Quality & Value |
| U. Fee for Service - Indicators of Quality & Value | $ | V. Fee for Service - Indicators of Quality & Value | V. Fee for Service - Indicators of Quality & Value | V. Fee for Service - Indicators of Quality & Value |
| V. Fee for Service - Indicators of Quality & Value | $ | W. Fee for Service - Indicators of Quality & Value | W. Fee for Service - Indicators of Quality & Value | W. Fee for Service - Indicators of Quality & Value |
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| X. Fee for Service - Indicators of Quality & Value | $ | Y. Fee for Service - Indicators of Quality & Value | Y. Fee for Service - Indicators of Quality & Value | Y. Fee for Service - Indicators of Quality & Value |

This framework represents payments from public and private payers to provider organizations (including payments between the payment and delivery arms of highly integrated health systems). It is designed to accommodate payments in multiple categories that are made by a single payer, as well as single provider organizations that receive payments in different categories—potentially from the same payer. Although payments will be classified in discrete categories, the framework captures a continuum of clinical and financial risk for provider organizations.
Goal - Accelerate the percentage of US health care payments tied to quality and value in each market segment through the adoption of shared accountability alternative payment models.

<table>
<thead>
<tr>
<th></th>
<th>Medicaid</th>
<th>Commercial</th>
<th>Medicare Advantage</th>
<th>Traditional Medicare</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>15%</td>
<td>15%</td>
<td>30%</td>
<td>30%</td>
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<tr>
<td>2022</td>
<td>25%</td>
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<td>2025</td>
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<td>100%</td>
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APM MEASUREMENT EFFORT

Commercial health plans, Managed Care Organizations (MCOs), state Medicaid agencies, Medicare Advantage (MA) plans, and Medicare voluntarily participated in a national effort to measure the use of Alternative Payment Models (APMs) as well as progress towards the LAN’s goal of tying 30% of U.S. health care payments to APMs by 2016 and 50% by 2018.

In 2018, 35.8% of U.S. health care payments, representing approximately 226.5 million Americans and 77% of the covered population, flowed through Categories 3&4 models.

In each market, Categories 3&4 payments accounted for:

- Commercial: 30.1%
- Medicare Advantage: 53.6%
- Traditional Medicare: 40.9%
- Medicaid: 23.3%
Requests for Information

Burden Topic Status

RFI Data Analysis

2,830 comment letters reviewed
3,040 mentions of burden
1,146 summarized burden topics
83% topics resolved/in progress

Burden reduction from regulatory changes alone:

5.7 Billion Dollars
40 Million Hours
...through 2021
Simplifying Documentation Requirements

• Clarified acceptable documentation for diagnostic laboratory tests.
• Allowed teaching physicians to verify student’s Evaluation and Management visit notes
• Provided an exception so that physicians acting as suppliers do not need to write orders to themselves.
• Eliminated the requirement that physicians indicate where in the medical record certification/recertification elements can be found.
• Explained that a signature and date is acceptable verification of a medical student’s documentation of an E&M visit performed by a physician
• Simplified the requirements for preliminary/verbal DMEPOS orders.
• Clarified DMEPOS written order prior to delivery date requirements.
• Clarified signature requirements

Simplifying Documentation Requirements (cont’d)

• Two-pronged solution to provide information on Medicare Fee-for-Service documentation requirements in a more clear and concise manner:

  • Provider Documentation Checklist
    • Web-based and accessible at any point in the lifetime of a claim
    • Centralize all documentation requirements in one place

  • Provider Documentation Lookup Service
    • Directly integrated into provider workflow through EHRs
    • Providers will be able to discover Medicare FFS prior authorization and documentation requirements at the time of service and within their EHR
Updating the Stark Law

• Comments received in response to an RFI posted on June 25, 2018 provided examples in which Stark Law discourages arrangements to coordinate care and improve patient experiences

• On October 17, CMS published a proposed rule to modernize and clarify regulations for the Physician Self-Referral law, also known as the Stark Law

• The comment period for the proposed rule ended December 31, 2019

• The proposed rule is one of the most significant updates to these regulations since they were implemented in 1989

• The Stark Law was enacted to prevent referrals by physicians based on their financial self-interest rather than the good of the patient

• Key Stark Law provisions operating in a primarily fee-for-service environment have not kept up with evolution towards value-based care

Updating the Stark Law (cont’d)

• The proposed rule includes:
  • Permanent exceptions to Stark Law for value-based arrangements
  • Guidance and clarifications on the law’s key requirements
  • Protection for nonabusive, beneficial arrangements between physicians and other health care providers, including for donations of cybersecurity technology
  • Requests for comment on the role of price transparency at the point of referral

• The proposal advances the CMS “Patients Over Paperwork” initiative by reducing burdens on providers who participate in value-based arrangements while protecting patients from unnecessary services and lower quality care

• The effort also contributes to the HHS Regulatory Sprint to Coordinated Care initiative
Updating the Stark Law (cont’d)

Expected Patient Impact

- **Improving Patient Care**: the proposed rule opens additional avenues to coordinate the care patient care, allowing providers to work together to ensure patients receive the highest quality of care.

- **Maintaining Patient Protections**: the proposed rule includes a carefully woven fabric of safeguards to ensure that the Stark Law continues to protect patients from unnecessary services and being steered to less convenient, lower quality, or more expensive services because of a physician’s financial self-interest.
Beneficiary Care Activities & Transitions

Common Challenges for Beneficiary Care Transitions
A New Approach to Improving Outcomes
What is the Meaningful Measures Initiative?

Launched in 2017, the purpose of the Meaningful Measures initiative is to:

• Improve outcomes for patients

• Reduce data reporting burden and costs on clinicians and other health care providers

• Focus CMS’s quality measurement and improvement efforts to better align with what is most meaningful to patients and clinicians
Meaningful Measures
Domains with Focus Areas

Promote Effective Communication & Coordination of Care
Meaningful Measure Areas
- Medication Management
- Admissions and Readmissions to Hospitals
- Transfer of Health Information and Interoperability

Promote Effective Prevention & Treatment of Chronic Disease
Meaningful Measure Areas
- Preventive Care
- Management of Chronic Conditions
- Prevention, Treatment, and Management of Mental Health
- Prevention and Treatment of Opioid and Substance Use Disorders
- Risk Adjusted Mortality

Work With Communities to Promote Best Practices of Healthy Living
Meaningful Measure Areas
- Equity of Care
- Community Engagement

Make Care Affordable
Meaningful Measure Areas
- Appropriate Use of Healthcare
- Patient-Focused Episode of Care
- Risk Adjusted Total Cost of Care

Strengthen Person & Family Engagement as Partners in their Care
Meaningful Measure Areas
- Care is Personalized and Aligned with Patient’s Goals
- End of Life Care according to Preferences
- Patient’s Experience of Care
- Functional Outcomes

Make Care Safer by Reducing Harm Caused in the Delivery of Care
Meaningful Measure Areas
- Healthcare-Associated Infections
- Preventable Healthcare Harm

Meaningful Measures
Progress to Date

- In the FY 19 Medicare Hospital IPPS and LTCH Prospective Payment System Proposed Rule, CMS eliminated a total of 19 measures that acute care hospitals are currently required to report across the 5 hospital quality and value-based purchasing programs.

- In addition, CMS removed 8 of the 16 CQMs to produce a smaller set of more meaningful measures and in alignment with the Hospital IQR Program beginning with the 2020 reporting period.

- CMS Measure Inventory:
  - 41% (180) are outcome measures
  - 10% (43) are patient-reported outcome
  - 22% (96) able to be submitted through electronic means

- Measure alignment internally
  - MA, Medicaid, Exchanges
  - Across PAC settings

- Measure alignment with states, MA plans and commercial payers
  - Core Quality Measures Collaborative
Meaningful Measures
Filling the Gaps

• Appropriate use of opioids and avoidance of harm
• Nursing home safety measures
• Interoperability and care transitions
• Appropriate use of services
• Patient-reported outcome measures

Meaningful Measures
Advancing Electronic Sources

• Developing more APIs for quality measure data submission
• Prototype the use of the FHIR standard for quality measurement
• Interoperable electronic registries – incentivizing use
• Harmonizing measures across registries
• Timely and actionable feedback to providers
• Working with CMMI on use of artificial intelligence to predict outcomes
Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, that provides two participation tracks:

**MIPS Value Pathways**

Request for Information

While there have been incremental changes to the program each year, additional long-term improvements are needed to align with CMS’ goal to develop a meaningful program for every clinician, regardless of practice size or specialty.

CMS is proposing **MIPS Value Pathways (MVPs)** to create a new participation framework beginning with the 2021 performance year. This new framework would:

- Unite and connect measures and activities across the **Quality, Cost, Promoting Interoperability**, and **Improvement Activities** performance categories of MIPS
- Incorporate a set of administrative claims-based quality measures that focus on population health/public health priorities
- Streamline MIPS reporting by limiting the number of required specialty or condition specific measures
MIPS Value Pathways

Current Structure of MIPS
- Measures
- Promoting Interoperability
- Quality
- Cost
- Improvement Activities

New MIPS Value Pathways Framework
- Closures
- Lower Reporting Burden
- Focused Participation around Pathways that are Meaningful to Clinicians or Public Health Priority

Building Pathways Framework

MIPS Value Pathways Clinicians report on values, measures, and activities based on specialty and/or outcomes within a MIPS Value Pathway measuring burden

Future State of MIPS
- Simplified
- Increased focus of the clinician
- Increased CMS Data
- Facilitates Alignment to Other Payment Models (APMs)

Fully Implemented Pathways
Continue to increase CMS-provided data and feedback to reduce reporting burden on clinicians.

MIPS Value Pathways: Diabetes Example

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MIPS Value Pathways for Diabetes

Population Health Measures: a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims, for example, the All-Cause Hospital Readmission measure.

We Need Your Feedback on:
- Pathways: What should be the structure and focus of the Pathways? What criteria should we use to select measures or activities?
- Participation: What actions are needed for small practices and multi-specialty groups? Should there be a mix of measures or activities within Pathways?
- Public Reporting: How should information be reported to patients? Should we have focused reporting at the individual clinician level?
Transparency

• Star Ratings
  o Nursing Home Compare
  o Hospital Compare
  o Physician Compare

• Price Transparency

• Quality Data Strategy
  o More rapid feedback to clinicians
  o API development for sharing quality data
  o Sharing data more broadly for research
Putting Data in the Hands of Patients
What this means for CMS

- Blue Button 2.0
  - Developer-friendly, standards-based API
  - Developer preview program – open now (over 1200 developers so far)
  - Data security is of the utmost importance

- Promoting Interoperability Program for Hospitals and Clinicians
  - Program alignment
  - Strong emphasis on interoperability and privacy/security
  - 2015 edition Certified EHR Technology

- Prevention of Information Blocking

- Star Ratings

- Interoperability Rule out for public comment
Interoperability and Patient Access Proposed Rule

- All health plans doing business in Medicare, Medicaid, and through the federal exchanges would be required to share health claims data and other important information with patients electronically.

- A patient's health information should follow a patient as they move from plan to plan, creating a longitudinal health record for the patient at their current plan.

- Publicly identify doctors, hospitals, and other providers who engage in information blocking.

- Require that all hospitals send electronic notifications to designated health care providers when their patients are admitted, discharged, or transferred from the hospital.

FIGHTING THE OPIOID EPIDEMIC
CMS Roadmap: Actions to Address the Opioid Epidemic - Overview

Scope of the problem
Key areas of focus
Successes so far
Moving forward

To review the CMS Opioids Roadmap, go to CMS.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf

CMS Work to Date

**Coverage**
CMS coverage policies now ensure some form of medication-assisted treatment across all CMS programs—Medicare, Medicaid, and Exchanges.

**Awareness**
CMS sent 24,000 letters in 2017 and 2018 to Medicare physicians to highlight that they were prescribing higher levels of opioids than their peers to incentivize safe prescribing practices.

**Tracking**
Due to safe prescribing policies, the number of Medicare beneficiaries receiving higher than recommended doses from multiple doctors declined by 40% in 2019.

**Best Practices**
CMS activated over 4,000 hospitals, 120,000 clinicians, and 5,000 outpatient settings through national quality improvement networks to rapidly generate results in reducing opioid-related events.

**Data**
CMS released data in 2017 and 2018 to show where Medicare opioid prescribing is high to help identify areas for additional interventions.

**Access**
As of June 2018, CMS approved 12 state Medicaid 1115 demonstrations to improve access to opioid use disorder treatment, including new flexibility to cover inpatient and residential treatment while ensuring quality of care.
Moving Forward

**PREVENTION**
Significant progress has been made in identifying overprescribing patterns.

**TREATMENT**
Medicare, Medicaid, and private health plans provide some coverage for pain and opioid use disorder treatments.

**DATA**
Data provides insight into doctor, pharmacy, and patient use of prescription opioids and effectiveness of treatment.

CMS can build on these efforts to further:

**PREVENTION**
1. Identify and stop overprescribing of opioids
2. Enhance diagnosis of OUD to get people the support they need earlier
3. Promote effective, non-opioid pain treatments

**TREATMENT**
1. Ensure access to treatment across CMS programs and geography
2. Give patients choices for a broader range of treatments
3. Support innovation through new models and best practices

**DATA**
1. Understand opioid use patterns across populations
2. Promote sharing of actionable data across continuum of care
3. Monitor trends to assess impact of prevention and treatment solutions

PROGRAM INTEGRITY FOCUS AREAS
Program Integrity Focus Areas

• Enrollment compliance initiatives
• Invest in data and analytics
• Strengthen collaboration with all our partners
• Medicare Advantage and Part D Efforts

Program integrity Focus Areas (cont’d)

Our recent efforts in program integrity kept

15.5 Billion Dollars

...from being lost to waste, fraud and abuse in FY17
Enrollment Compliance Initiatives

Provider Enrollment is the gateway to the Medicare and Medicaid programs and the provider’s first interaction with CMS:

- Oversees the Medicare Administrative Contractors (MACs)
- Collaborates with states to leverage Medicare provider information for Medicaid enrollments
- Oversees and develops Medicare provider enrollment and screening systems
- Analyzes and implements Medicare administrative actions such as denials, revocations and deactivations

Program Integrity Enhancements to the Provider Enrollment Process (CMS-6058-FC)

- CMS published a first-of-its-kind final rule on September 10, 2019:
  - Applies proactive methods to keep unscrupulous providers and suppliers out of Medicare and Medicaid from the outset
  - Enhances our ability to more promptly identify and act on instances of improper behavior
  - Moves CMS forward in the longstanding fight to end “pay and chase”
  - Hardens the target to criminals who would steal from our programs
  - Ensures only providers and suppliers with an unfavorable affiliation will face additional burdens

This rule brings a new era of smart, effective, proactive and risk-based tools designed to protect the integrity of these vitally important federal healthcare programs we rely on every day to care for millions of Americans
Program Integrity Enhancements to the Provider Enrollment Process (CMS-6058-FC)

This rule provides new tools to strengthen our program integrity efforts:

- **5 NEW Revocation/Denial Authorities**
  - Including affiliations-based revocation authority that allows CMS to deny providers with problematic affiliations upfront, and revoke “bad actors” with problematic affiliations already in the program

- **EXPANDED Revocation and Denial Authorities**
  - Can now revoke from Medicare if ANY Federal health care program terminates (TRICARE and VA Healthcare System)
  - Can extend revocation of one enrollment to ANY and ALL of provider or supplier’s other enrollments (used for egregious behavior)

- **Expanded Re-enrollment and Re-application Bar Provisions**
  - Blocks fraudulent or otherwise problematic providers and suppliers from re-enrolling in Medicare for up to 10 years (previously 3 years)
  - Allows for a maximum 20 year Medicare re-enrollment bar for those providers who have been revoked a second time.

Program Integrity Contractors

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

- Associations: 11%
- Federal Agencies: 8%
- State & Local: 27%
- Private Payer: 54%

112 Partners*

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

* As of October 2018

Program Integrity: Proposed Changes

- CMS continues to work to modernize the Medicare Advantage and Part D programs

- 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

- CMS extended the comment period for the RADV provision, to August 28, 2019, to give the public an opportunity to submit meaningful comments to the RADV provision proposal
Program Integrity: Proposed Changes

• Preclusion list
  - CMS made the Preclusion List available to Part D sponsors and the MA plans beginning Jan 1, 2019
  - MA and Part D plans began editing claims on April 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

Program Integrity: Medicaid Strategy

• Oversight Activities:
  - New audits of state beneficiary eligibility determinations
  - PI-focused audits of Medicaid managed care, including Medical Loss Ratio (MLR)

• 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

• Collaborate with states to ensure compliance with the Medicaid managed care final rule and implementation of PI safeguards
Final Takeaways

• CMS is committed to robust program integrity across all of our programs

• Program integrity functions help us hold the entire healthcare system accountable, protect beneficiaries from harm and safeguard taxpayer dollars

• Above all, we want to enable providers to focus on their primary mission – improving their patients’ health

Thank You!

Jean Moody-Williams, RN, MPP

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Deputy Center Director, Center for Clinical Standards and Quality

Centers for Medicare & Medicaid Services

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