Today’s Presentation

• COVID-19 Response
• Patients over Paperwork
• Interoperability & MyHealthEData
• Program Integrity
COVID-19 Response: Challenge and Goals

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Goals</th>
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<tbody>
<tr>
<td>• Surge of COVID-19 overwhelming local hospitals and the healthcare system</td>
<td>• Increase telehealth</td>
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<td>• Rapid transmission of a virulent virus</td>
<td>• Augment health system workforce</td>
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<td>• Expand hospital and health system capacity</td>
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<td>• Give temporary relief from many paperwork, reporting, and audit requirements to focus on providing needed health care</td>
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COVID-19 Public Health Emergency

• President’s declaration of a public health emergency (PHE) on March 13 empowered HHS to authorize CMS to provide unprecedented flexibility for certain Medicare, Medicaid, and CHIP program requirements

• Blanket waivers allow providers to not have to apply for individual waivers under section 1135 of the Social Security Act

• 1135 waivers apply to federal requirements only, not those established by states, and are retroactive to March 1, 2020

• CMS also issued two regulations to provide further flexibility to health systems
COVID-19 Waivers

Total Number of Medicare Blanket Waivers: **Over 130**


Total Number of State 1135, 1115, Disaster SPA, and IT Funding Request Approvals: **Over 150**


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**Telehealth**

- CMS is expanding access to health care services via telehealth to ensure continuity of care and reduce risk of transmission
- Starting March 6, Medicare can pay for telemedicine services from a broad range of providers
- Three main types of services: telehealth visits, virtual check-ins, e-visits
- 135 new CPT codes added to the Medicare telehealth services list and 89 of those are authorized to be furnished via audio-only devices
- Expanded benefit available to beneficiaries in all areas (not just rural)
COVID-19 Interim Final Rules

• CMS provided relief to a wide and unprecedented range of regulatory requirements to maximize the health system’s preparedness in weeks when normally, rulemaking takes at least a year

• Key elements of the first interim final rule with comment (IFC):
  o Provided many provider types flexibility to use telecommunications technology to visit and monitor Medicare beneficiaries
  o New payments for laboratories to collect specimens from homebound patients and inpatients (not in a hospital) for COVID-19 testing
  o Expansion of Part B ambulance coverage for the transport of patients to all facility destinations, such as community mental health centers and FQHCs

COVID-19 Interim Final Rules (cont’d)

• Key elements of the second interim final rule with comment (IFC):
  o Established Medicare coverage for serology (antibody) tests
  o Established separate payment to hospital outpatient departments and physician practices to collect lab samples. Medicare will also pay pharmacies who are enrolled as labs to perform tests for beneficiaries.
  o Further expanded access to telehealth services available for Medicare beneficiaries, including by lifting restrictions on the type of clinical practitioners that can furnish telehealth services
  o Helped hospitals increase their supply of beds to manage a surge of COVID-19 patients while maintaining stable, predictable Medicare payments
Healthcare Workforce Augmentation

• CMS cut red tape so health professionals can spend more time with patients and practice to the fullest extent of their licensure and training
• More nursing home clinicians can now perform certain medical exams for Medicare patients
• Occupational therapists from home health agencies can perform initial assessments on certain homebound patients
• Teaching physicians can provide supervision to medical residents using audio-visual technology

Hospital Without Walls

• CMS took numerous actions to allow hospitals to expand capacity and operate spaces more fluidly to keep COVID-positive and COVID-negative patients separated
• Steps include: allowing non-hospital space to be temporarily used, waiving distance and bed requirements for CAH hospitals
• CMS waived enforcement of part of EMTALA to permit off-site screening locations for potentially COVID-positive patients
• CMS announced flexibilities to relax paperwork and reporting requirements
Provider Enrollment and Burden Relief

• In order to sufficiently expand provider capacity, CMS waived certain Medicare Fee-For-Service paperwork, reporting, and audit requirements

• New toll-free hotlines for providers and suppliers to work with MACs to quickly navigate enrollment process

• CMS allowed Medicare-enrolled providers to practice across state lines more easily

Using COVID-19 Data in Operations

• CMS is using administrative claims and encounter data to track the utilization of healthcare services related to COVID-19 in the Medicare and Medicaid programs and monitor the effects of the outbreak on program utilization

• CMS is also collaborating with CDC to collect and release nursing home COVID-19 cases and deaths to improve public health responses and inform the public
Using COVID-19 Data for Program Integrity

- CMS is in the process of analyzing the COVID-19 waivers and flexibilities to identify program integrity risks and develop monitoring strategies.
- CMS is collaborating with stakeholders to inform beneficiaries about scams and potentially fraudulent activities.
Four Major Aspirations

Overarching goal: Increase provider-patient face time and satisfaction by

- Reducing unnecessary burden
- Increasing efficiencies
- Improving beneficiary experience
- Improving clinician and provider experience
Overall Impact of Burden Reduction

- **$6.6 billion dollars** through regulatory changes
- **42 million hours** through regulatory changes
- **235 Data elements / 33 items removed (OASIS)**
- **79 measures removed (QPP)**

Highlights of this impact include:
- Roughly 220,000 hours of work saved by skilled nursing facility providers due to revised advanced beneficiary notice.
- Teaching physicians now able to rely on and verify med student documentation for E/M.
- The September, 2019 Omnibus Final Rule is estimated to save 4.4 million burden hours and $650 million, annually.

We use human-centered design to explore burdens and spend time at the “front line”
Our top priorities are taking shape while 2019 RFI comment analysis continues

**INPUTS**
- Total RFI Comments Reviewed: 568
- Total Unique Commenters:
  - 515 Commenters providing unique RFI responses
  - 108 Commenters providing high-volume (form letter) submissions

**OUTPUTS**
- Total Burden Content extracted:
  - Unique RFI Responses: 2,886 Burden Mentions
  - High Volume (Form Letter) Submissions: 707 Burden Mentions
- Stakeholder Categorization: 12 Stakeholder Types
- Burden Categorization: 17 Burden Themes

### Among Top Burden Areas

**Prior Authorization**

“I hate to say it, but…prior authorization is unseating electronic health records as the top source of burden for clinicians and providers…”

- Medical community stakeholder

**Documentation Requirements**

“…even if you can find the instructions, there is no guarantee that it is right”

“From a physician standpoint, I want to know what I need to do while the patient is here.”
Most requirements are online – but today still in too many places and too hard to find

- Multiple places to get information
- Multiple files on CMS web sites
- Multiple publications
- Multiple coding instructions
- Multiple NCDs, LCDs, LCAs
- Multiple instructions on how to document

Information maze has unintended consequences

This contributes to:

- Clinician burden / burnout
- CMS burden and rework
- Inconsistent requirements
- Delayed services to beneficiaries
- Errors in claims processing
- Increased improper payments
- Barriers to interoperability
- Customer dissatisfaction
Where we want to go

CMS requirements stored in a common repository that contains information that is:

- Reliable, trusted
- Right content for context, complete
- Easy to search
- Easy to understand
- Truly needed
- Available real time, directly or system-to-system, internally and externally

Exploring:
- Standards
- Content management
- Governance
- Stakeholder needs and experience

How will DRLS work for providers?

go.cms.gov/MedicareRequirementsLookup
How does ePrior Auth build on the DRLS?

- Blue Button 2.0
- Interoperability and Patient Access Final Rule
MyHealthEData

• Administration-wide initiative to unleash data to empower patients by giving them control of their healthcare information and allowing it to follow them throughout their healthcare journey

• CMS is taking steps to ensure patients have unencumbered access to their health information, in a format that is practical, useable and easily shared

• Seamless data sharing will increase efficiency and patient safety while reducing cost

MyHealthEData

• With Blue Button 2.0, nearly 3,400 developers are building user-friendly apps to help beneficiaries understand and access their data and 57 organizations with applications in production

• Learn more: developers and beneficiaries

• Overhaul of Meaningful Use program and requirement for clinicians and hospitals to adopt the 2015 edition of certified EHR technology (CEHRT)
Interoperability & Patient Access Final Rule

• All payers doing business in Medicare Advantage, Medicaid, CHIP and through the federal exchanges are required to share health claims data and other important information with patients electronically via a FHIR-based API

• A payer may ask third-party application developers to attest to certain privacy provisions that can help keep a patient’s data private and secure

• CMS-regulated payers are required to make provider directory information publicly available via a standards-based API

Interoperability & Patient Access Final Rule (cont’d)

• A patient’s health information should follow a patient as they move from payer to payer, 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
Interoperability & Patient Access Final Rule (cont’d)

- Publicly report those providers who do not have digital contact information included or updated in the National Plan and Provider Enumeration System (NPPES)
- Improve the dually eligible experience by increasing the frequency of federal-state data exchanges

Rule Resources

- CMSHealthInformaticsOffice@cms.hhs.gov
Program Integrity Focus Areas

- Enrollment compliance initiatives
- Medicare Advantage & Part D efforts
- Enhance Medicaid oversight

CMS’s program integrity activities, including both the prevention and recovery of improper payments, saved Medicare an estimated $12 billion in FY 2018.
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 (MAC)
- 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

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
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.

Proposed Changes to MA and Part D

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

- Strengthening collaboration and oversight of Part C and D programs through the implementation of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (the SUPPORT Act)
- Addressing overutilization of opioid prescribing through outreach and education
  - CMS sent 600+ letters in January 2020 to prescribers of concurrent opioid and benzodiazepine medications comparing them to their peers, defines as those within the same specialty and State
  - This effort is included under SUPPORT Act, Sec. 6065 and is part of our data driven efforts to combat the nation’s opioid crisis
- Risk Adjustment Data Validation (RADV) audits and recovery of improper payments
  - Started payment year 2014 and 2015 contract level audits in fiscal year 2019
  - Reduce the burden on audited plans while expanding the reach of the audits to more plans
  - Comments to RADV provision received by August 28, 2019 are being reviewed to inform future rule-making
Program Integrity: Medicaid Strategy

- **Oversight Activities:**
  - New audits of state beneficiary eligibility determinations
  - Audits of Medicaid managed care Medical Loss Ratio (MLR)
  - Review and assist states with the development of Payment Error Rate Measurement (PERM) Correction Action Plans (CAP) to address the state-specific drivers of improper payments
  - Provide guidance, support, and oversight to states while they conduct Medicaid Eligibility Quality Control (MEQC) pilots and establish CAPs
- **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**

Thank you!

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