CMS Update

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Today's presentation

- COVID-19
- CMS Strategic Framework
- Patients Over Paperwork
- Updating the Physician Self-Referral Law
- Program Integrity

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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 to regulations to provide further flexibility to health systems

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COVID-19 Waivers

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

https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

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

https://www.medicaid.gov/resources-for-states/disaster-response-toolkit/coronavirus-disease-2019-covid-19/index.html

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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)

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

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COVID-19 Interim Final Rules (cont'd)

- Key elements of the second interim final rule with comment (IFC):
  - Established Medicare coverage for serology (antibody) tests
  - 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
  - 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
  - Helped hospitals increase their supply of beds to manage a surge of COVID-19 patients while maintaining stable, predictable Medicare payments

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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

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Health Care 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

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Hospitals 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

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Using COVID-19 Data

For 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
- CMS monitors Special Enrollment Period (SEP) enrollment data for Federally-facilitated Marketplace

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Using COVID-19 Data (cont'd)

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

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After the PHE

- 1135 waivers end no later than the end of the emergency period, or 60 days after the waiver was published, unless the HHS Secretary extends the waiver by notice for additional periods of up to 60 days
- CMS is reviewing waivers and flexibilities created in response to the PHE and engaging with stakeholders about their suitability for a post-PHE environment

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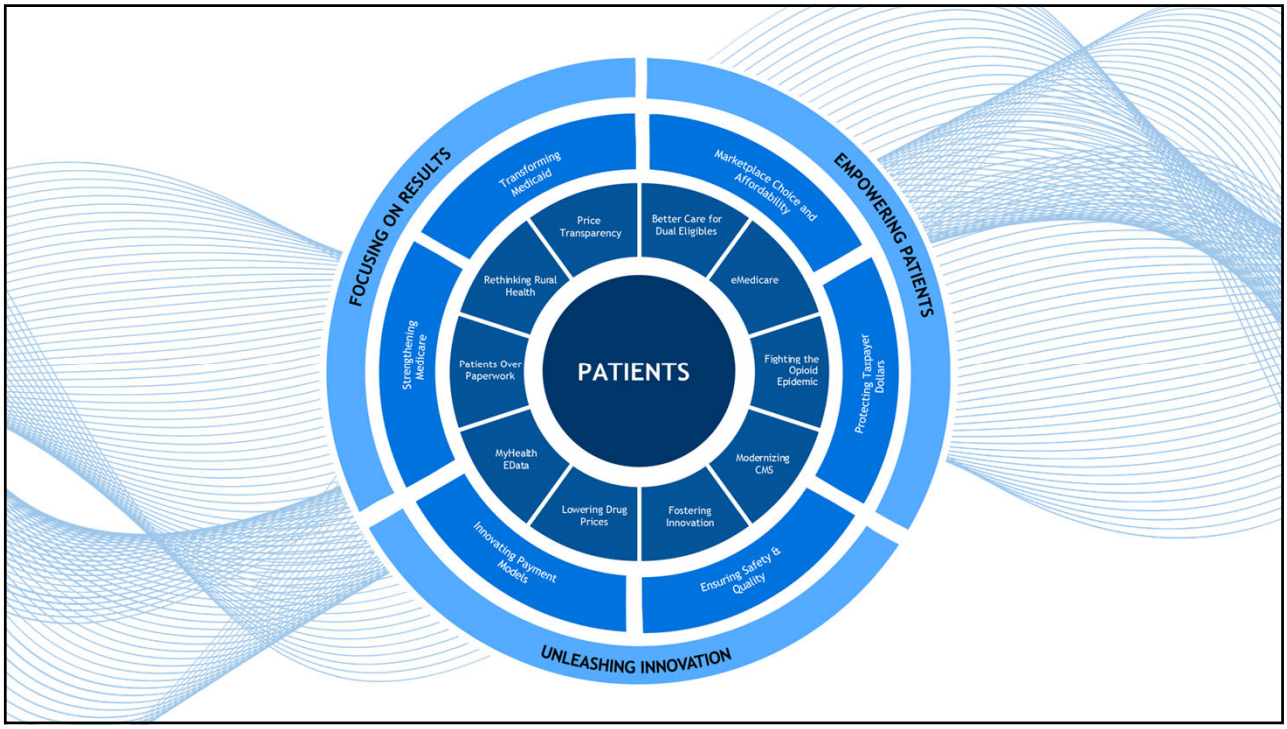

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Patients over Paperwork

PATIENTS OVER PAPERWORK

- CMS is putting patients first and empowering them to make the best decisions for themselves and their families
- Agency-wide initiative to remove regulatory obstacles and allow providers to focus on improving their patients' health
- In 2017, CMS solicited comments on specific ideas to reduce burdens through several Requests for Information (RFIs)
- As of this month, we have resolved or are actively addressing over 80% of the burden topics identified in the RFIs that are actionable for CMS

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Patients over Paperwork (cont'd)

- CMS solicited comments in June 2019 for another round of recommendations on reducing provider and beneficiary burdens
- CMS is committed to easing the burden of regulation, while maintaining our focus on integrity, quality and safety
- Issued a final rule in September 2019, combining three distinct proposed rules, that relieve burden by removing unnecessary, obsolete and excessively burdensome Medicare compliance requirements for health care facilities
- The changes will reduce the amount of time and resources that hospitals and other health care facilities have to spend on CMS-mandated compliance activities that do not improve the quality of care

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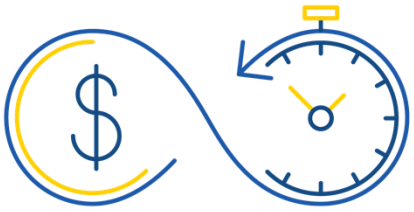
Patients over Paperwork (cont'd)



Between 2018 and 2021, CMS projects Patients over Paperwork will save:

6.6 billion dollars &
42 million hours

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Simplifying Documentation Requirements

To make it easier for providers and to 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

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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 Requirements 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*

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Updating the Physician Self-Referral Law

- Comments received in response to an RFI posted on June 25, 2018 provided examples in which Physician Self-Referral Law (PSL), also known as "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 PSL
- The comment period for the proposed rule ended on December 31, 2019
- The proposed rule is one of the most significant updates to these regulations since they were implemented in 1989
- PSL was enacted to prevent referrals by physicians based on their financial self-interest rather than the good of the patient
- Key PSL provisions operating in a primarily fee-for-service environment have not kept up with evolution towards value-based care

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Updating the Physician Self-Referral Law (cont'd)

- The proposed rule includes:
  - Permanent regulatory exceptions to Physician Self-Referral Law for value-based arrangements
  - Guidance and clarifications on the law's key requirements
  - Protection for non-abusive, 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

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Updating the Physician Self-Referral 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 Physician Self-Referral 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

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Program Integrity Focus Areas

PROTECTING TAXPAYER DOLLARS

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

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Program Integrity Focus Areas

CMS's program integrity activities, including both the prevention and recovery of improper payments, saved Medicare an estimated

$12 billion

in FY 2018.

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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

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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
  - A new re-application bar provision allows CMS to prevent a prospective provider from enrolling for up to 3 years if it provides false or misleading information on its initial enrollment application

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Prior Authorization

CMS is leading Prior Authorization (PA) and Pre-Claim Review initiatives to prevent improper payments and decrease appeals in the Medicare fee-for-service program:

- **PA of Certain DMEPOS Items**
  - Master List of items for potential prior authorization; CMS can choose items for required prior authorization
  - CMS currently requires prior auth on 40 Power Mobility Devices (PMD), 5 Pressure Reducing Support Surfaces (PRSS), and 6 high cost Lower Limb Prosthetics (LLP) (effective May 2020)
- **PA of Repetitive Scheduled Non-Emergent Ambulance Transports (Model)**
  - Currently in 8 states and Washington, D.C.
- **Home Health Review Choice Demonstration**
  - Provides flexibility, provider choice, and risk-based changes to providers who bill accurately
  - Includes HHAs in IL, OH, TX, NC, and FL that submit claims to Palmetto GBA, the Jurisdiction M MAC
- **PA of Certain Hospital Outpatient Department Services**
  - Required for 5 groups of services:
    - Blepharoplasty, Botulinum Toxin Injections, Panniculectomy, Rhinoplasty, and Vein Ablation
  - Effective July 2020

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Program Integrity: Proposed Changes

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, defined 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 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

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Program Integrity: Medicaid Strategy

- **Released the Comprehensive Medicaid Integrity Plan (CMIP) for FYs 2019-2023, which describes CMS' 5-year plan to protect taxpayer dollars by combatting fraud, waste, and abuse in Medicaid and the Children's Health Insurance Program (CHIP)**
- **The CMIP includes several oversight activities, such as:**
  - Continued audits of state beneficiary eligibility determinations
  - Continued audits of Medicaid managed care Medical Loss Ratio (MLR)
  - Review and assist states with the development of Payment Error Rate Measurement (PERM) Corrective Actions Plans (CAPs) to address the state-specific drivers of improper payments
  - Provide guidance, support, and oversight for states' Medicaid Eligibility Quality Control (MEQC) pilots and 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
- **Also released the first MLR audit report for California that identified several areas for improvement, such as documentation requirements to support MLR calculations**

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Thank you!

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