

CMS Playbook: What's New and What's Next in 2018



Kim Brandt, J.D., M.A.
Principal Deputy
Administrator for Operations,
Centers for Medicare & Medicaid Services



Today's Presentation

- CMS Strategic Goals
- Patients Over Paperwork
- What We've Heard and What We're Doing
 - Taking a new approach to regulatory reform
 - Simplifying documentation requirements
 - Improving the audit process
 - Reducing EHR burden



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CMS Strategic Goals

 <p>Empower patients and doctors to make decisions about their health care</p>	 <p>Usher in a new era of state flexibility and local leadership</p>
 <p>Improve the CMS customer experience</p>	 <p>Support innovative approaches to improve quality, accessibility, and affordability</p>



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

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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

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What We Heard from Providers

CMS requirements are excessive



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New Approach To Regulatory Reform

- **Meaningful Measures Initiative:** our commitment to measuring quality without increasing burden
- Reviewing current quality measures across all programs
- Replacing lower-value process measures with higher-value outcome measures

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New Approach To Regulatory Reform (cont'd)

- CMS measures must now meet one of our designated criteria:
 - Eliminating disparities
 - Tracking to measurable outcomes and impact, not process
 - Achieving cost savings
 - Improving access for communities

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Value-Based Care and the Innovation Center

- Also looking to remove government burdens impeding a shift towards value-based care
- Reviewing comments from last year's CMMI "New Direction" Request for Information
- Plan to use CMMI to introduce competition and drive this value-based transformation

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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 will be requesting public input to further inform our efforts

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 What We Heard from Providers

Documentation requirements are complex and hard to find



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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

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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

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Looking Ahead: Documentation Requirement Lookup Service

- Long-term project to allow providers to review documentation requirements at the time of service
- For example:
 - Does my patient's insurance company have special **documentation requirements** or a **documentation template** for the item/service I'm about to order?
- Working in partnership with Standards Development Organizations, private payers and EHR vendors

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What We Heard from Providers

Providers are apprehensive of audits



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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.

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Before and After TPE Implementation

MACs:

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

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ZPICs/UPICs:

BEFORE	AFTER
Tasked with detecting/collecting overpayments in non-fraud cases	Will refer non-fraud cases to MACs for TPE

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Low Volume Appeals (LVA) Settlement Initiative

- Limited settlement agreement option for Medicare Fee-For-Service providers, physicians, and suppliers with fewer than 500 appeals pending at the Office of Medicare Hearing and Appeals (OMHA) and the Medicare Appeals Council, combined
- CMS will accept Expressions of Interest from appellants until June 8th, 2018
- For more information: go.cms.gov/LVA

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 **What We Heard from Providers**

EHRs are inefficient and burdensome 

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MyHealthEData

- Administration-wide initiative to empower patients by giving them control of their data
- Overhauling CMS programs to encourage interoperability and save time and costs
 - Meaningful Use program for hospitals
 - Quality Payment Program for clinicians
- Streamlining documentation and billing requirements for providers to allow doctors to spend more time with their patients

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Making EHRs More Interoperable

- EHRs still don't do the necessary job of making patient records easily available to providers and patients
- Working to move beyond the fax machine by:
 - Improving Provider-to-**Payer** Medical Record Exchange
 - Improving Provider-to-**Provider** Medical Record Exchange

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Addressing the Opioids Crisis

- CMS is formulating its opioid strategy to respond to the Administration's priorities and White House Commission Recommendations.
- Engaging stakeholders in listening sessions
- Identifying key focus areas:
 - Prevention
 - Treatment
 - Data

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Addressing the Opioids Crisis (cont'd)

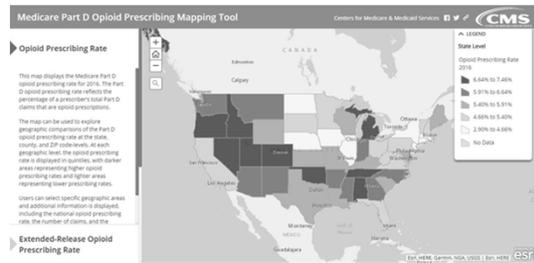
- **Healthcare Fraud Prevention Partnership (HFPP) Paper** describing best practices to address and minimize the harms of opioids
- **Stronger Medicare Policies** like the proposed rule for the Medicare lock-in program
- **State Flexibility** for states pursuing 1115 waivers focused specifically on ground-level solutions

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Part D Opioid Prescribing Mapping Tool



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Questions?

kimberly.brandt1@cms.hhs.gov