



CMS UPDATE

HCCA DENVER REGIONAL CONFERENCE

John P. Hannigan, JD, MBA, MS
Associate Regional Administrator
CMS Regions 7 & 8
Consortium for Financial Management & Fee for Service Operations
October 19, 2018

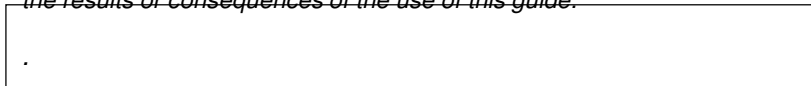
Disclaimer



This presentation was prepared as a tool to assist providers and is not intended to grant rights or impose obligations. Although every reasonable effort has been made to assure the accuracy of the information within these pages, the ultimate responsibility for the correct submission of claims and response to any remittance advice lies with the provider of services.

This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

The Centers for Medicare & Medicaid Services (CMS) employees, agents, and staff make no representation, warranty, or guarantee that this compilation of Medicare information is error-free and will bear no responsibility or liability for the results or consequences of the use of this guide.



Objectives



- CMS Strategic Goals and Priorities
- Update on Patients over Paperwork
- Summary of current CMS action to address feedback
 - Documentation Requirement Simplification
 - Targeted Probe & Educate
 - EHR Interoperability
 - Meaningful Measures Initiative
- PFS, OPFS & Burden Reduction Rules
- Discussion

3

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.

4

Challenges and Opportunities



- Nation's largest insurer
- CMS is serving more people than ever before
- National health expenditures up 4.3% in 2016, far faster growth in GDP
- Medicare Trust Fund Part A depleted in 10 years
- Medicaid second budget line item for states
- New technology largest budget item for states
- New high cost treatments & cures
- Opioid epidemic
- Aging population
- Modernizing programs to provide high quality, cost-effective care

5

PATIENTS OVER PAPERWORK

CMS.gov

Centers for Medicare & Medicaid Services

Home | About CMS | Newsroom | FAQs | Archive | Share Help Print

Learn about [your health care options](#)

Medicare

Medicaid/CHIP

Medicare-Medicaid
Coordination

Private
Insurance

Innovation
Center

Regulations &
Guidance

Research, Statistics,
Data & Systems

Outreach &
Education

Home > Patients Over Paperwork

Patients Over Paperwork

We're putting patients first by reviewing and streamlining our regulations so we can:

Reduce unnecessary burden

Increase efficiencies

Improve the beneficiary experience



<https://www.cms.gov/About-CMS/story-page/patients-over-paperwork.html>

6

PATIENTS OVER PAPERWORK



Initiative Overview

- Through Patients over Paperwork, we are moving the needle to remove regulatory obstacles that get in the way of providers spending time with patients and healthcare consumers.
- CMS is one of the top agencies for promulgating regulations within the federal government. Over the last 5 years, we have published annually, an average of 58 rules per year equating to nearly 11,000 published manuscript pages.
- While some regulations are essential to ensuring patient and provider safety and program integrity, there is a fine line between being helpful and being a hindrance.

7

PATIENTS OVER PAPERWORK



Some of CMS' Burden Reduction Initiatives include:

1. Quality and Safety Oversight Requirements
2. Electronic Health Record (EHR) Projects
3. Documentation Requirements Simplification (DRS) Initiative

<https://www.cms.gov/About-CMS/story-page/patients-over-paperwork.html>

8

PATIENTS OVER PAPERWORK

Administrator Verma's Charge:

- Simplify our requirements
- Make them easier to understand
- Get rid of requirements we no longer need
- Seek input from stakeholders
- Challenge the way we have always done things



9

Provider Feedback



What We Heard from Providers



CMS requirements
are excessive



Documentation
requirements are too
hard to find



Providers are
afraid of audits

10



CPI HOME

RESOURCES

SPOTLIGHT

EVENTS

REPORTS & GUIDANCE

REPORTING FRAUD

CENTER FOR PROGRAM INTEGRITY

PROTECTING THE MEDICARE & MEDICAID PROGRAMS FROM FRAUD, WASTE & ABUSE

RESOURCES FOR PROVIDERS

RESOURCES FOR STATES

RESOURCES FOR PARTNERS

WHO WE ARE

At the Center for Program Integrity (CPI), our mission is to detect and combat fraud, waste and abuse of the Medicare and Medicaid programs. We do this by making sure CMS is paying the right provider the right amount for services covered under our programs. We work with providers, states, and other stakeholders to support proper enrollment and accurate billing practices. Our work focuses on protecting patients while also minimizing unnecessary burden on providers.

CHECK OUT WHAT'S NEW

Stay up-to-date with the latest updates

CPI Spotlight Page

PATIENTS OVER PAPERWORK

Working to Reduce Provider Burden

<https://go.cms.gov/cpi>

WHAT WE DO

PROVIDER ENROLLMENT

MEDICAL REVIEWS & AUDITS

DATA ANALYSIS

COLLABORATION WITH STATES

OUR FOCUS IN 2018

CPI's priorities in 2018 focus on investing in data and analytics to support fraud detection and prevention efforts, reducing burdensome documentation requirements for providers, and improving communication and collaboration with all our partners.

INVESTING IN DATA AND ANALYTICS

REDUCING PROVIDER BURDEN

STRENGTHENING COMMUNICATION AND COLLABORATION

Reducing Provider Burden

@cms.hhs.gov

11

What CMS is Doing to Minimize Burden

1. Simplifying Paperwork
2. Making Required Paperwork Easier to Find
3. Improving the Audit Process
4. Making EHRs Interoperable
5. Improving Communications



Simplifying Documentation Requirements



Documentation Requirements Simplification (DRS) Initiative

We are receiving suggestions for improvements from:



Individual physicians, non-physician practitioners and supplier communications



Provider associations



CMS employees, contractors, our claims data (error rate, appeals)



Input from the larger "regulatory reform" effort currently underway

<http://go.cms.gov/SimplifyingRequirements>
ReducingProviderBurden@cms.hhs.gov

13

Documentation Requirements Simplification Examples



Example: **Signature** Requirements

Before: Our instructions were unclear and claims could be **denied** if part of the supporting medical record was **initialed** by a nurse.

After: We clarified the Program Integrity Manual. Providers ultimately responsible for the beneficiary's care still must sign the medical record. However, now we won't deny claims if a support care provider (such as a nurse documenting chemotherapy) forgets to sign part of the record.

14

Documentation Requirements Simplification Examples



Example: **Inpatient Rehabilitation Facility (IRF)** Requirements

- **Before:** Providers said that IRF claims are denied even though patients need and could benefit from an inpatient rehabilitation.
- **After:** We clarified guidance to CMS contractors, requiring them to use clinical review judgment to determine medical necessity of the intensive rehabilitation therapy program based on the individual facts and circumstances of the case, and **not based on any threshold of therapy time.**

8

15



Documentation Requirements Simplification Example



Example: **Verifying Medical Student Notes**

- Define what verification means regarding medical student documentation.
 - Teaching physicians no longer have to re-document their student's notes of services they (the physician) personally performed or re-performed.
 - The physician can verify the student's notes simply by signing them.

9

16



Making Requirements Easier to Find

The Documentation Requirement Lookup Service



Long Term Project:

- 2018:
 - ✓ Medicare FFS,
 - ✓ Some Medicare Adv plans
 - ✓ Some private payers
 - ✓ EHR vendors
- Future:
 - ✓ More Adv Plans?
 - ✓ Medicaid Plans?
 - ✓ More IT vendors



Work closely with Standards Development Organizations (SDOs):

- FHIR-based standards
- Payers build "Rules Libraries"
 - ✓ In a common format
 - ✓ With a "API" (to allow easy access)

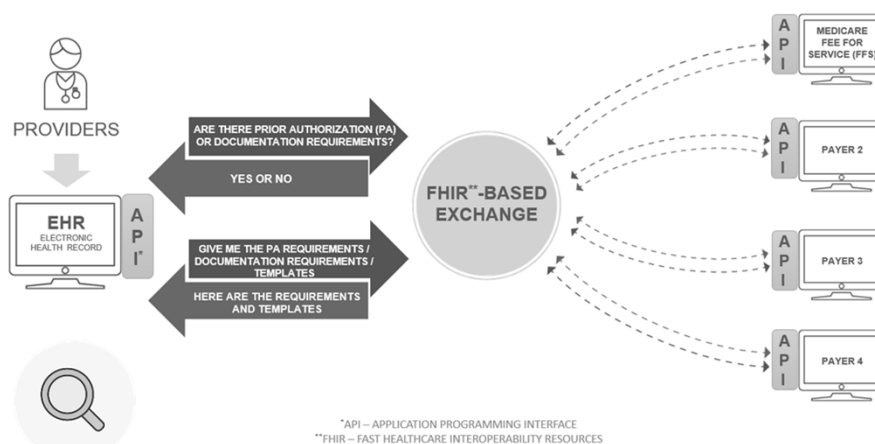


Allow providers to discover documentation requirements at the time of service:

- Right in the
 - ✓ EHR or
 - ✓ Practice management system
- Including:
 - ✓ Prior Auth required?
 - ✓ Template available?

7

Schematic



*API – APPLICATION PROGRAMMING INTERFACE
**FHIR – FAST HEALTHCARE INTEROPERABILITY RESOURCES

<https://go.cms.gov/MedicareRequirementsLookup>

Documentation: what we've heard



Medical Record Documentation Supports Patient Care

- Clear and concise medical record documentation is critical to providing patients with quality care and is required for physicians and others to receive accurate and timely payment for furnished services.
- Medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient's health history.
- Medical record documentation helps physicians and other health care professionals evaluate and plan the patient's immediate treatment and monitor the patient's health care over time.
- **Many complain that notes written to comply with coding requirements do not support patient care and keep doctors away from patients.**

19

The current state



Documenting E/M Requires Choosing the Appropriate Code

- **Currently, documentation requirements differ for each level and are based on either the 1995 or 1997 E/M documentation guidelines.**
- Billing Medicare for an Evaluation and Management (E/M) visit requires the selection of a Current Procedural Terminology (CPT) code that best represents:
 - Patient type (new v. established),
 - Setting of service (e.g. outpatient setting or inpatient setting), and
 - **Level of E/M service performed.**

*CPT codes, descriptions and other data only are copyright 2017
American Medical Association. All rights reserved. CPT is a registered
trademark of the American Medical Association (AMA).*

20

E/M Guidelines: why change?



Why Change?

- Stakeholders have said that the 1995 and 1997 Documentation Guidelines for E/M visits are clinically outdated, particularly history and exam, and may not reflect the most clinically meaningful or appropriate differences in patient complexity and care. Furthermore, the guidelines may not be reflective of changes in technology, or in particular, the way that electronic medical records have changed documentation and the patient's medical record.
- According to stakeholders, some aspects of required documentation are redundant
- Additionally, current documentation requirements may not account for changes in care delivery, such as a growing emphasis on team-based care, increases in the number of recognized chronic conditions, or increased emphasis on access to behavioral health care.

21

Proposed Changes for E/M based visits



Proposed Changes for Documentation

- Proposing a minimum documentation standard where, for Medicare PFS payment purposes for an office/outpatient based E/M visit, practitioners would only need to document the information to support a level 2 E/M visit (except when using time for documentation).

Proposed Changes for Reimbursement

- Proposing a single PFS payment rate for E/M visit levels 2-5 (physician and non-physician in office based/outpatient setting for new and established patients).

22

CMS Proposals to Streamline E/M Documentation



Summary: How to Streamline E/M Payment and Reduce Clinician Burden

- Proposing to provide practitioners choice in documentation for office/outpatient based E/M visits for Medicare PFS payment: 1) 1995 or 1997 documentation guidelines, 2) medical decision-making or 3) time.
- Proposing to expand current policy regarding history and exam, to allow practitioners to focus their documentation on **what has changed** since the last visit or on pertinent items that have not changed, rather than re-documenting information, provided they review and update the previous information.
- Proposing to allow practitioners to **review and verify** certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering it.
- Soliciting comment on how documentation guidelines for medical decision making might be changed in subsequent years.

See the Physician Fee Schedule website at:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html>



The MACs' New Review Process: "Targeted Probe & Educate (TPE)"



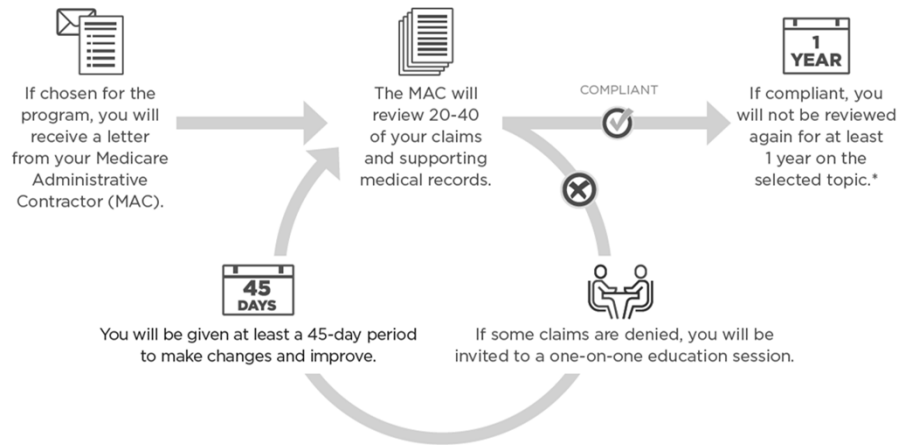
- Pilot began early 2017
- Nationwide began October 2017
- Has been well received by provider community

	Pre-TPE	TPE
# of Medical Records that can be requested	Unlimited	120 Max
1:1 Education	Not required	Required
Length of time a provider can be on MAC Review	Unlimited	3 Rounds (usually less than a year)

<http://go.cms.gov/TPE>

24

The MACs' New Review Process: "TPE"



The TPE Process

25

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

The MACs' New Review Process: "TPE"

When Medicare claims are submitted accurately, everyone benefits.



CMS's Targeted Probe and Educate (TPE) program helps providers and suppliers:

- reduce claim denials
- reduce appeals

26

The MACs' New Review Process: "TPE"

Most providers will never need TPE.

The process is only used with those who have high denial rates or unusual billing practices.

If you are chosen for the TPE program, the goal is to help you quickly improve.

Often, simple errors – such as a missing physician's signature – are to blame.



27

The MACs' New Review Process: "TPE"

What are some common claim errors?



The signature of the certifying physician was not included



Encounter notes did not support all elements of eligibility



Documentation does not meet medical necessity



Missing or incomplete initial certifications or recertification

<https://www.cms.gov/About-CMS/Components/CPI/Reducing-Burden.html>

The MACs' New Review Process: "TPE"

What if accuracy still doesn't improve?

- Most providers that have participated in the TPE process increased the accuracy of their claims.
- Any providers who fail to improve after 3 rounds of TPE will be referred to CMS for next steps.



29

Making EHRs More Interoperable



1

By improving Provider-to-Payer
Medical Record Exchange

Done:

- Revised the Electronic Submission of Medical Documentation (esMD) system to accept structured medical records (CCDA)

Doing:

- Pilot testing **Electronic Medical Documentation Requests**
- Planning to release the "Attachment Reg" (NPRM due out in 2018)
- Exploring whether Fast Healthcare Interoperability Resources (FHIR) could be helpful

2

By improving Provider-to-Provider
Medical Record Exchange

Done:

- Asked public for ideas to promote **interoperability**:
 - Comment period closed on June 25, 2018 for the IPPS RFI (CMS-1694P)

Doing:

- Working with Standards Development Organizations to develop **FHIR standards** for sending/receiving medical records
- Planning **pilot tests** with EHR vendors



Provider-to-Provider Medical Record Exchange



- Allow an ordering clinician to ELECTRONICALLY send:
 - orders, progress notes,
 - lab results,
 - discharge summary
- Allow the supplier/HHA/other provider to ELECTRONICALLY request:
 - Additional parts of the medical record
 - Signature on the Plan of Care



EHR Interoperability: Opportunities and Resources

HealthIT.gov Official Website of The Office of the National Coordinator for Health Information Technology (ONC)

TOPICS | HOW DO IT? | BLOG | NEWS | ABOUT ONC

Home > Topics > Interoperability

Interoperability

- Trusted Exchange Framework and Common Agreement
- Interoperability Roadmap
- Standards Collaboration
- Interoperability Standards Advisory
- Population Level Data Export Meeting Report
- Interoperability and Standards Reports
- About ONC Tech Lab's Interoperability in Action Webinar Series
- Advancing Interoperability with Medicaid

Interoperability

The Office of the National Coordinator for Health IT (ONC) is responsible for advancing connectivity and interoperability of health information technology (health IT).

ONC's 10 year plan for advancing interoperability is laid out in a document entitled Connecting Health and Care for the Nation: A Shared Nationwide Interoperability Roadmap version 1.0 (Roadmap) [PDF - 3.7 MB].

The Roadmap, shaped by stakeholder input and public comments, supports the vision that ONC outlined in Connecting Health and Care for the Nation: A 10 Year Vision to Achieve An Interoperable Health IT Infrastructure [PDF - 607 KB].

The collaborative efforts of stakeholders are crucial to achieving three goals:

1. the vision of a learning health system where individuals are at the center of their care and providers have a seamless ability to securely access and use health information from different sources.
2. to provide access to individuals health information, which is stored in electronic health records (EHRs), but includes information from many different sources and portrays a longitudinal picture of their health.
3. helping public health agencies and researchers rapidly learn, develop, and deliver cutting edge treatments.

<https://www.healthit.gov/topic/interoperability>

<https://www.healthit.gov/news/events/oncs-2nd-interoperability-forum>

32

Give Us Your Suggestions!



- Many CMS improvements have been suggested by clinicians, providers, facility staff, patient advocates, and other stakeholders.
- Keep the ideas coming!

**How Your
Voice Can
Be Heard**

Send suggestions and comments to:
ReducingProviderBurden@cms.hhs.gov

<https://www.cms.gov/About-CMS/story-page/patients-over-paperwork.html>



MLNConnects



Thursday, October 11, 2018

News & Announcements

New Medicare Card: Destroy the Old Card
CMS to Strengthen Oversight of Medicare's Accreditation Organizations
Participants in New Value-Based Bundled Payment Model
Medicare Diabetes Prevention Program: New Covered Service
Part A Providers: MCRF System Enhancement
Protect Your Patients from Influenza this Season

Provider Compliance

Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims — Reminder

Claims, Pricers & Codes

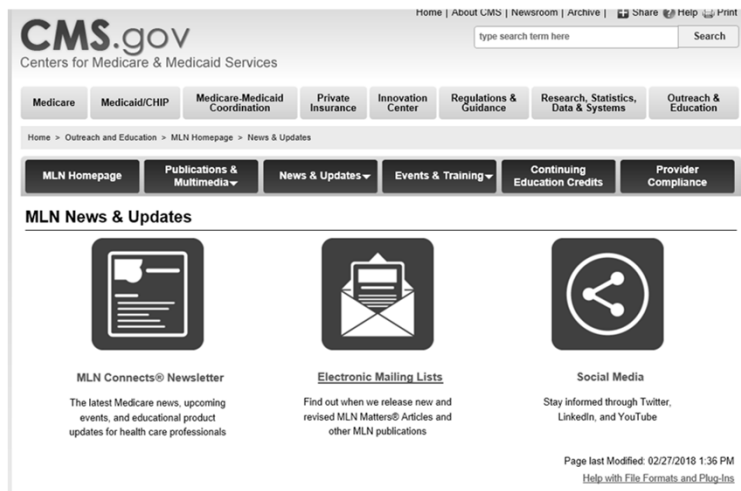
Reprocessing Claims for Diagnostic Services by Certain PTs

Upcoming Events

Submitting Your Medicare Part A
Patient Relationship Categories and Codes webcast — October 17



MLNConnects



<https://www.cms.gov/Outreach-and-Education/Outreach/FFSProvPartProg/>

35

Let's Talk About

- 2019 Physician Fee Schedule Proposed Rule (CMS-1693-P)
 - Comments closed Sep 10, 2018.
 - <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/>
 - Payment Rates under the Medicare PFS for Nonexcepted Items and Services Furnished by Nonexcepted Off Campus Provider Based Departments of a Hospital
- 2019 Medicare Hospital Outpatient Prospective Payment System (OPPS) Proposed Rule (CMS-1695-P)
 - Comments closed Sep 24, 2018.
 - <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1695-P.htm>
- Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction (CMS-3346-P)
 - Published Sep 20, 2018. Comments close Nov 19, 2018
 - <https://www.federalregister.gov/documents/2018/09/20/2018-19599/medicare-and-medicaid-programs-regulatory-provisions-to-promote-program-efficiency-transparency-and>

36

Physician Fee Schedule Proposed Rule (CMS-1693-P)

- 2019 Physician Fee Schedule Proposed Rule (CMS-1693-P)
- Discussions and proposals regarding:
 - Potentially Misvalued Codes.
 - Communication Technology-Based Services.
 - Valuation of New, Revised, and Misvalued Codes.
 - **Payment Rates under the PFS for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of a Hospital.**
 - **E/M Visits.**
 - Therapy Services.
 - Clinical Laboratory Fee Schedule.
 - Ambulance Fee Schedule— Provisions in the Bipartisan Budget Act of 2018.
 - Appropriate Use Criteria for Advanced Diagnostic Imaging Services.
 - Medicaid Promoting Interoperability Program Requirements for Eligible Professionals (EPs).
 - Medicare Shared Savings Program Quality Measures.
 - Physician Self-Referral Law.
 - CY 2019 Updates to the Quality Payment Program.
 - Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers.
 - Request for Information on Price Transparency: Improving Beneficiary Access to Provider and Supplier Charge Information.

37

OPPS Proposed Rule (CMS-1695-P)

- 2019 Medicare Hospital Outpatient Prospective Payment System (OPPS) Proposed Rule (CMS-1695-P)
 - Proposed changes to the amounts and factors used to determine the payment rates for Medicare services paid under the OPPS and those paid under the ASC payment system
 - Update and refine the requirements for the Hospital Outpatient Quality Reporting (OQR) Program and the ASC Quality Reporting (ASCQR) Program.
 - Includes three Requests for Information on
 1. promoting interoperability and electronic health care information exchange;
 2. improving beneficiary access to provider and supplier charge information; and
 3. leveraging the authority for the Competitive Acquisition Program (CAP) for Part B drugs and biologicals for a potential CMS Innovation Center model.
 - In addition, we are proposing to modify the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey measure under the Hospital Inpatient Quality Reporting (IQR) Program by removing the Communication about Pain questions.

38

OPPS Proposed Rule (CMS-1695-P)

- 2019 Medicare Hospital Outpatient Prospective Payment System (OPPS) Proposed Rule (CMS-1695-P)
 - Proposal and Comment Solicitation on Method to Control Unnecessary Increases in Volume of Outpatient Services
 - Expansion of Services at Off Campus Provider-Based Departments (PBDs) Paid under the OPPS (Section 603)
 - Proposal to Apply 340B Drug Payment Policy to Off-Campus Departments of a Hospital Paid under the Medicare Physician Fee Schedule

39

Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction (CMS-3346-P)

- Proposals to reduce regulatory burden on providers and suppliers by modifying, removing, or streamlining current regulations that we now believe are excessively burdensome.
- Three categories:
 1. Proposals that simplify and streamline processes,
 2. proposals that reduce the frequency of activities and revise timelines, and
 3. proposals that are obsolete, duplicative, or that contain unnecessary requirements, as follows.

40

Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction (CMS-3346-P)

- Critical Access Hospital (CAHs), Rural Health Centers (RHCs) and Federally Qualified Health Centers (FQHCs)
 - Hospital and CAH swing-bed providers:
 - Removing cross-references to requirements for long term care facilities that do not apply because of the short amount of time patients are in swing-beds.
 - CAHs:
 - Reducing the frequency of the requirement that CAHs perform a review of all their policies and procedures from annual to biennial, in order to allow facilities to better utilize their limited resources; and
 - Removing the duplicative requirement for CAHs to disclose the names of people with a financial interest in the CAH, as this information is also collected outside of the conditions of participation.
 - RHCs and FQHCs:
 - Reducing the frequency of review of the patient care policies from annually to every two years, in order to allow these clinics to direct their limited resources to patient care. Facilities are always permitted to conduct reviews as they deem appropriate.

41

Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction (CMS-3346-P)

- Transplant Centers
 - Updating the terminology and proposed nomenclature change used in the regulations to conform to the terminology that is widely used and understood within the transplant community
 - Removing requirements for transplant centers to re-submit clinical experience, outcomes, and other data in order to obtain Medicare approval. CMS proposes to remove this requirement in order to address unintended consequences of existing requirements
- Hospitals
 - Allowing multi-hospital systems to have unified and integrated Quality Assessment and Performance Improvement and unified infection control programs for all of its member hospitals.
 - Allowing hospitals the flexibility to establish a medical staff policy describing the circumstances under which a pre surgery/pre procedure assessment for an outpatient could be utilized, instead of a comprehensive medical history and physical examination.
 - Clarifying for psychiatric hospitals the requirement that allows for the use of non-physician practitioners or doctors of medicine/doctors of osteopathy (MD/DOs) to document progress notes of patients receiving services in psychiatric hospitals.

42

Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction (CMS-3346-P)

- Feedback Welcome!
- CMS is accepting comments until close of business November 19, 2018.
- Comments may be submitted in a variety of ways. Details about how to comment, and the proposed rule itself, is posted in the Federal Register:
<https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-19599.pdf>
- In commenting, please refer to file code CMS-3346-P. Submit your feedback:
- Electronically via <http://www.regulations.gov>
- By mail
- By express or overnight mail

Fact Sheet:

<https://www.cms.gov/newsroom/fact-sheets/medicare-and-medicaid-programs-proposed-regulatory-provisions-promote-program-efficiency-0>

Overview of Burden Reduction:

<https://downloads.cms.gov/files/MedicareBurdenReductionfinal.pdf>

43



John P. Hannigan
Centers for Medicare & Medicaid Services
Region 8, Denver

john.hannigan@cms.hhs.gov
303-844-5738

44