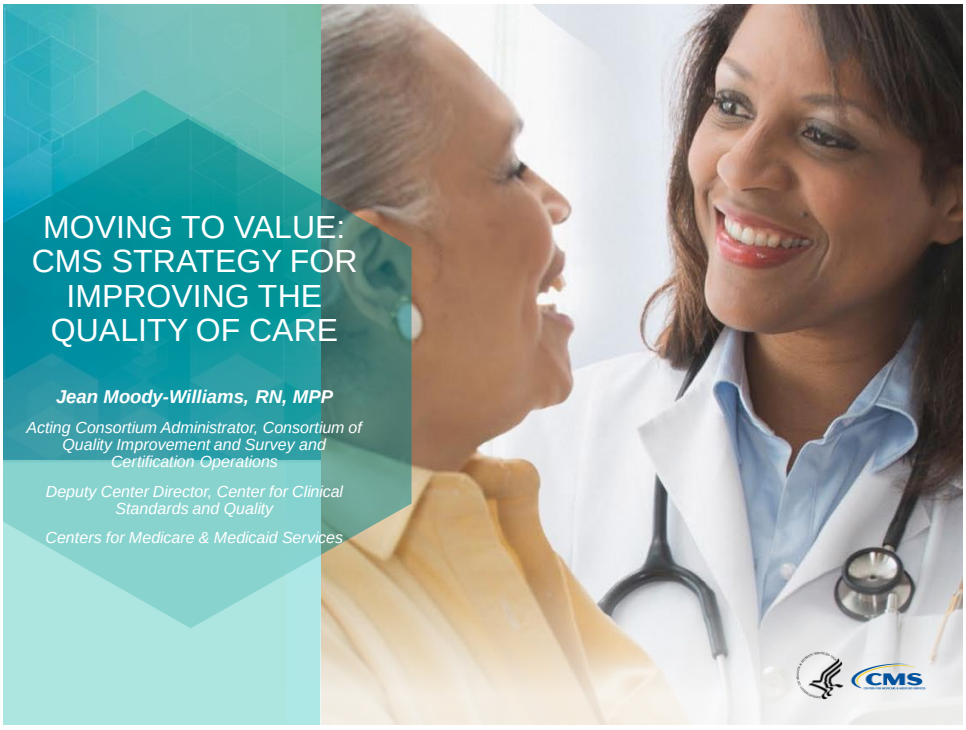


## Our Healthcare System is Not Prepared

**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 Goode**
THE DETROIT NEWS

Quality and cost are watchwords for Jean 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.

Moody-Williams

The organization, sponsored by 3,000 physicians through-

been in 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 promoted **Robert W. Grupp** 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.

Grupp

**Advertising**

New moves at **D'Arcy Masius** [illegible]/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

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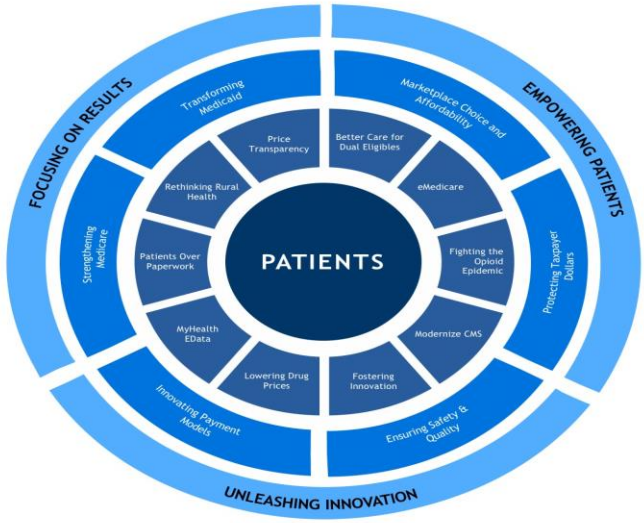
## CMS Strategic Priorities for 2020

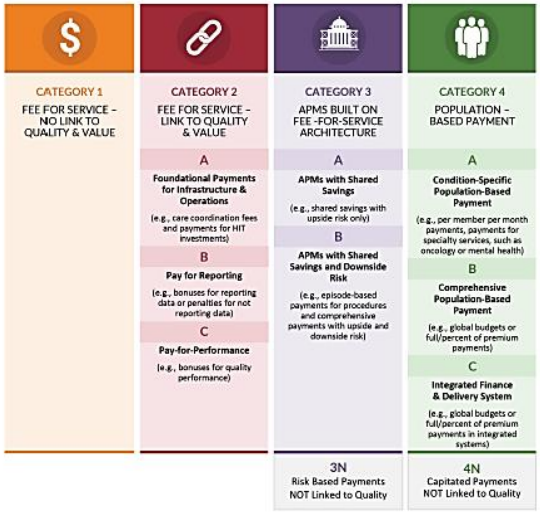



6

# Value Based Purchasing and Transforming MIPS



Figure 1 & 4: The Updated APM Framework




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.

HCP LAN
Health Care Payment Learning & Action Network

**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.**

| | Medicaid | Commercial | Medicare Advantage | Traditional Medicare |
|---|---|---|---|---|
| 2020 | 15% | 15% | 30% | 30% |
| 2022 | 25% | 25% | 50% | 50% |
| 2025 | 50% | 50% | 100% | 100% |

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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:


*Representativeness of covered lives: Commercial - 61%; Medicare Advantage - 67%; Traditional Medicare - 100%; Medicaid - 51%*



HCPLAN
Health Care Payment Learning & Action Network

# PATIENTS OVER PAPERWORK

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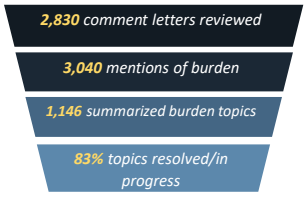
PATIENTS OVER PAPERWORK

## Requests for Information

**RFI Data Analysis**




**Burden Topic Status**


Burden reduction from regulatory changes alone….

5.7 Billion Dollars

40 Million Hours

…through 2021

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## 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**

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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 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 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)

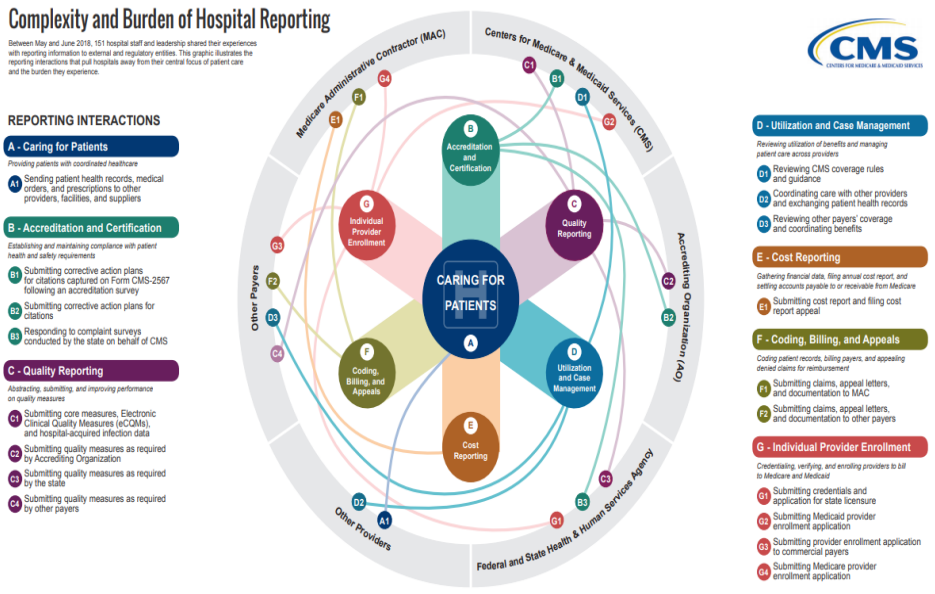
- The proposed rule includes:
  - Permanent exceptions to Stark Law for value-based arrangements
  - Guidance and clarifications on the law's key requirements
  - Protection for nonabusive, beneficial arrangements between physicians and other health care providers, including for donations of cybersecurity 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)

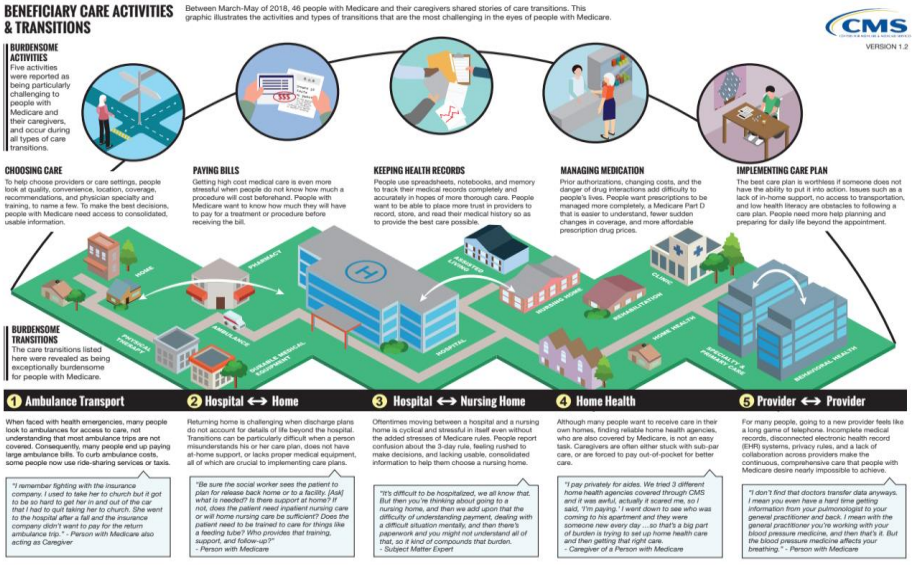
**Expected Patient Impact**

- **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.

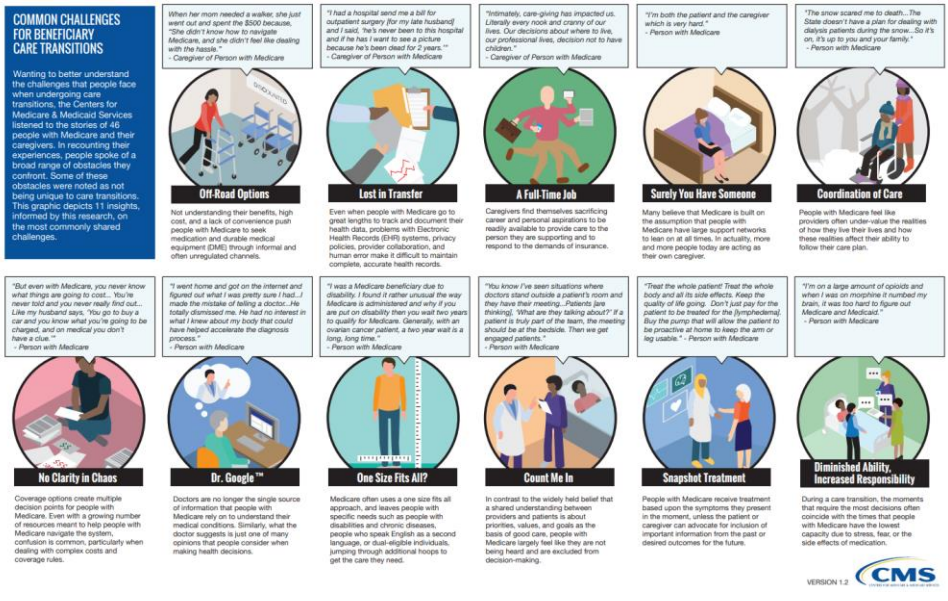
CMS 10



## Beneficiary Care Activities & Transitions




## Common Challenges for Beneficiary Care Transitions



# MEANINGFUL MEASURES

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## 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

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## 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

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## 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

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## 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

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## 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

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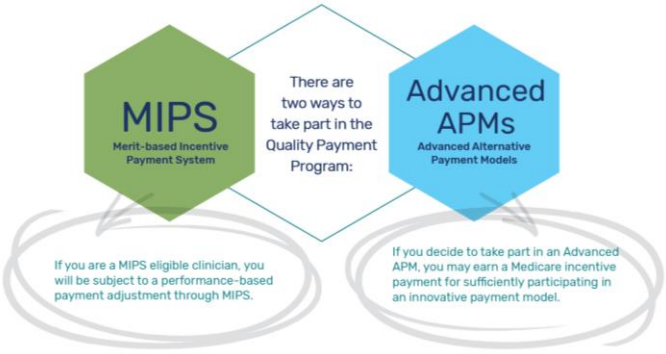
## Quality Payment Program

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:

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## 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

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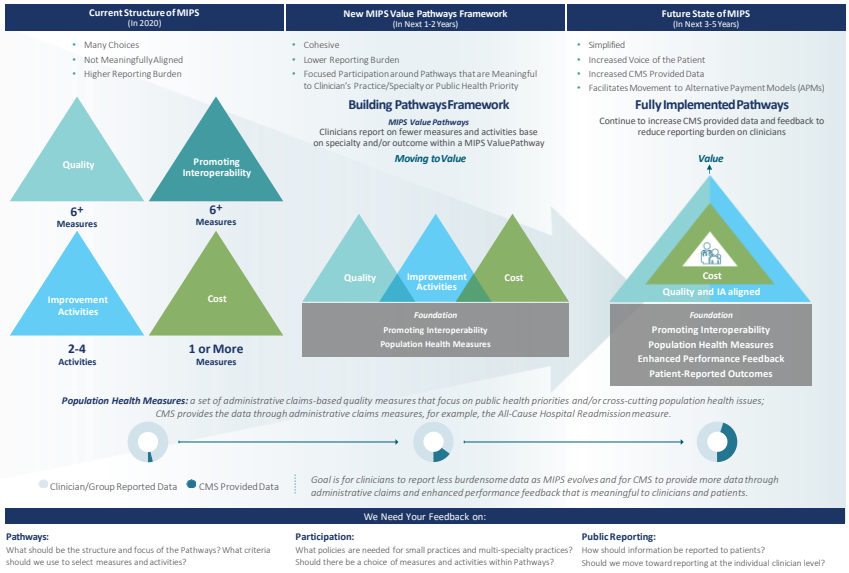
# MIPS Value Pathways

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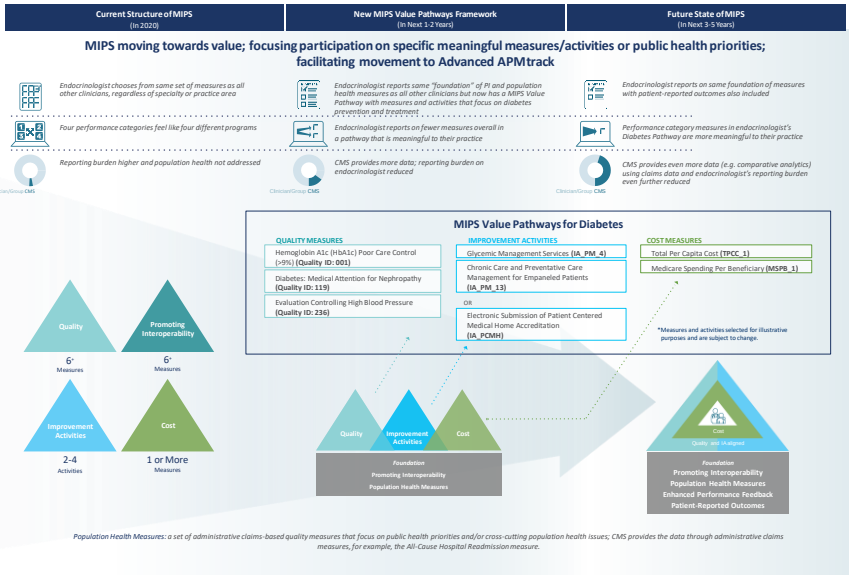
# MIPS Value Pathways: Diabetes Example

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## Transparency

- Star Ratings
  - Nursing Home Compare
  - Hospital Compare
  - Physician Compare
- Price Transparency
- Quality Data Strategy
  - More rapid feedback to clinicians
  - API development for sharing quality data
  - Sharing data more broadly for research

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## My HealthEData


CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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## 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

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## 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

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## FIGHTING THE OPIOID EPIDEMIC

36

## CMS Roadmap: Actions to Address the Opioid Epidemic - Overview

CMS Roadmap
TO ADDRESS THE **OPIOID EPIDEMIC**

- 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

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## 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.

**DATA**

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

**TRACKING**

Due to safe prescribing policies, the number of Medicare beneficiaries receiving higher than recommended doses from multiple doctors **declined by 40% in 2017.**

**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.

**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.

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## 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:**

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

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

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

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## PROGRAM INTEGRITY FOCUS AREAS

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# 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

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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.

CMS 25

# Program Integrity Contractors

| | | |
|---|---|---|
| MAC | Medicare Administrative Contractors (Targeted Probe & Educate) | To **prevent future** improper payments (pre-payment) - Targeted Probe & Educate (TPE) |
| RAC | Medicare FFS Recovery Auditors | To **detect and correct past** improper payments (post-payment) |
| UPIC | Unified Program Integrity Contractors | To identify **potential fraud/ Improper payments** |
| MEDIC | Medicare Drug Integrity Contractor | To identify **fraud** and **improper payments Part C & D** |
| MPIC | Marketplace Program Integrity Contractors | To identify **fraud** in the Marketplace **Exchange** |

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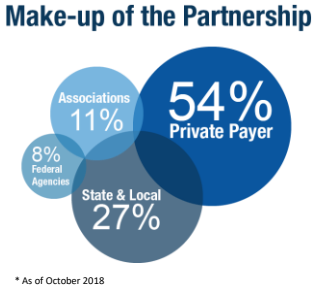
# Healthcare Fraud Prevention Partnership (HFPP)

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




* As of October 2018

**112 Partners***

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



# 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

CMS 49

# 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

CMS 50

# 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

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## Thank You!

**Jean Moody-Williams, RN, MPP**

*Acting Consortium Administrator, Consortium of Quality Improvement and Survey and Certification Operations*

*Deputy Center Director, Center for Clinical Standards and Quality*

*Centers for Medicare & Medicaid Services*

Jean.MoodyWilliams@cms.hhs.gov

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