CMS Update

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Today's Presentation

- Patients over Paperwork
- Updating the Stark Law
- Interoperability & MyHealthEData
- Opioids
- Program Integrity

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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:

5.7 Billion Dollars

&

40 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 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*

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 ends 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

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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.

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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

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MyHealthEData (cont'd)

- With Blue Button 2.0, **over 2,400** developers are building user-friendly apps to help beneficiaries understand and access their data and **54** 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)
- Developing a prototype Medicare Documentation Requirements Lookup Service using a FHIR-based API

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MyHealthEData (cont'd)

- On June 30, the White House hosted the second Blue Button Developers Conference to bring developers and technology executives together to share ideas on enhancing patient access to their health data and using data to drive improvements in care
- CMS launched the "Data at the Point of Care" Pilot to empower clinicians by providing them with the claims data they need to deliver high quality care to Medicare beneficiaries

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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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CMS Opioid Strategy

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Addressing the Opioids Crisis

- CMS's **Opioid Roadmap** is a three-pronged approach to combating the opioid epidemic focusing on:
  - **prevention** of new cases of opioid use disorder (OUD);
  - **treatment** of patients who have already become dependent on or addicted to opioids; and
  - utilization of **data** from across the country to target prevention and treatment activities
- CMS recently released a summary of our efforts to date to implement the Support Act

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Addressing the Opioids Crisis (cont'd)

- Stronger Medicare prescription opioid policies started January 1, 2019 – 7-day acute pain fill limits, care coordination, and pharmacy/provider lock-in program
- State Flexibility to pursue a full continuum of opioid use disorder care using 1115 demonstrations. 27 states so far.
- Promoting payment system innovation through new models: InCK and MOM.

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Addressing the Opioids Crisis (cont'd)

- Encouraging telehealth in Medicare for the treatment of substance use disorder by eliminating originating site requirements and allowing several services to be furnished by telehealth
- Guidance to states allowing them to end Medicaid restrictions on covered SUD treatment for pregnant and postpartum women
- Requiring coverage of mental health and substance use disorder treatment in CHIP plans
- Publication of Substance Use Disorder data book using T-MSIS data

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Addressing the Opioids Crisis (cont'd)

- Work started on other key provisions:
  - Demonstration program to test bundled payment for medication assisted treatment
  - Guidance to states on federal reimbursement options for SUD treatment services delivered via telehealth

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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
- Enhance Medicaid oversight

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Program integrity Focus Areas (cont'd)

Our recent efforts in program integrity kept Medicare program integrity kept

15.5 Billion Dollars

…from being lost to waste, fraud and abuse in FY17

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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.

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Comparative Billing Reports (CBRs)

Compare an individual provider's billing and/or prescribing practices for a specific billing code, policy group, or service with the billing and/or prescribing practices of that provider's peers in the same state and/or specialty, and national averages

- Topics selected based on annual improper payment data, OIG reports, and other internal CMS data sources
- Provide insight into Medicare policy and regional billing trends to increase provider utilization awareness
- Non-enforcement strategy helps moderate extreme billing and improve quality
- Drive down unnecessary spending and helped educate providers on proper coding

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Comparative Billing Reports (CBRs) (cont'd)

Results:

- Provided a record number of CBRs to over 56,000 Medicare providers across 14 different Medicare service areas in 2019 (40% increase from 2018)
- $63.8 million in total claims payment savings on Emergency Department Services and 11% decline in services when comparing 2017 to 2019
- $33.9 million in total claims payments savings on opioids when comparing 2018 to 2019

For more information visit Comparative Billing Reports (https://cbr.cbrpepper.org/)

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Program Integrity Contractors

MAC	Medicare Administrative 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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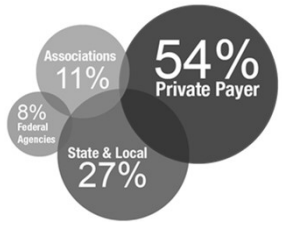
Healthcare Fraud Prevention Partnership (HFPP)

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

Make-up of the Partnership



* As of October 2018

112 Partners*

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

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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

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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

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The Future of Program Integrity / Using Advanced Technology in Program Integrity

- CMS released two RFIs on October 21, 2019 and followed up with three listening sessions and a national webinar
- CMS gathered information to:
  - Better align program integrity initiatives with the changing health care environment and adopt new and innovative technologies
  - Collaborate with states to ensure compliance with the Medicaid managed care final rule and implementation of PI safeguards

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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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