CMS Update

Mary G Greene, MD, MPH, MBA
Senior Advisor, Office of the Administrator
Centers for Medicare & Medicaid Services
June 12, 2020

1

Today's Presentation

- COVID-19 Response
- Patients over Paperwork
- Interoperability & MyHealthEData
- Program Integrity

2

2

COVID-19 Response: Challenge and Goals

Challenge	Goals
• Surge of COVID-19 overwhelming local hospitals and the healthcare system • Rapid transmission of a virulent virus	• Increase telehealth • Augment health system workforce • Expand hospital and health system capacity • Give temporary relief from many paperwork, reporting, and audit requirements to focus on providing needed health care

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 two regulations to provide further flexibility to health systems

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

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)

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

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

Healthcare 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

Hospital 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

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

11

Using COVID-19 Data in 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

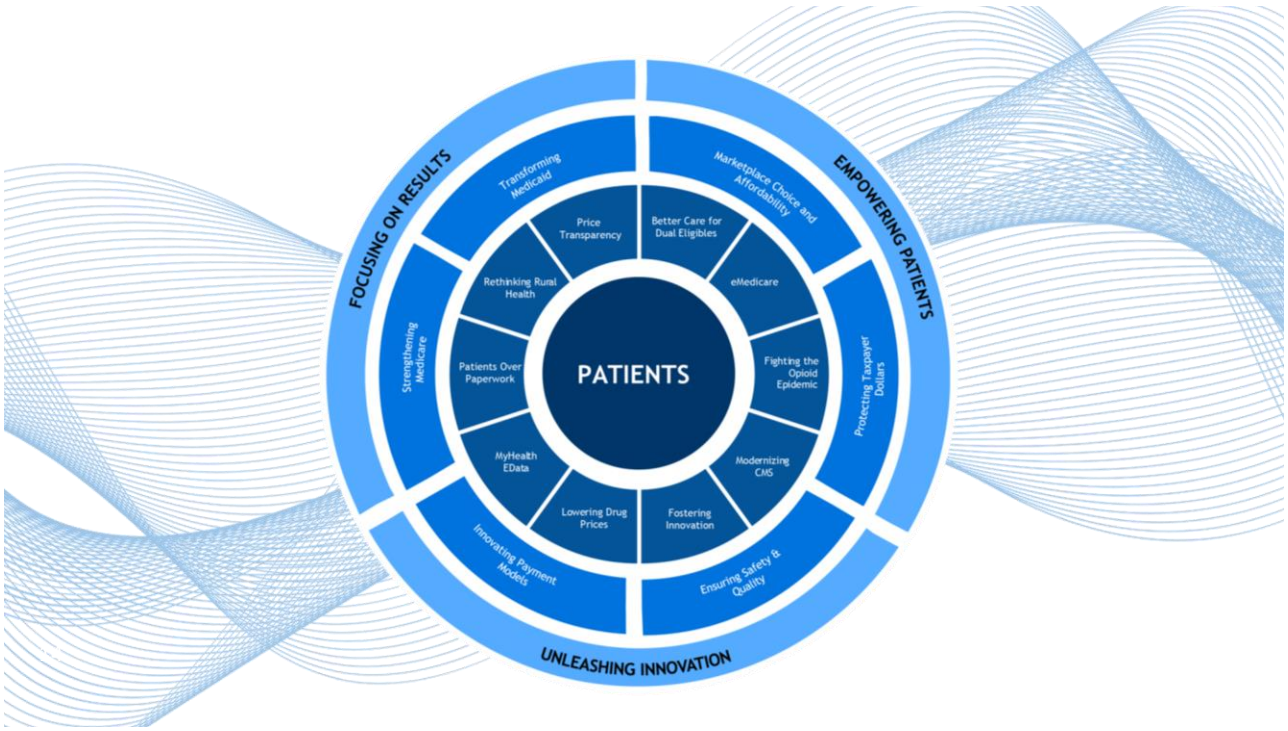
12

Using COVID-19 Data 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

13

13



14

PATIENTS OVER PAPERWORK

- Overview
- Stakeholder Engagement
- Documentation Requirements Look-up Service (DRLS)
- Prior Authorization

15

Four Major Aspirations

Overarching goal: Increase provider-patient face time and satisfaction by

- Reducing unnecessary burden
- Increasing efficiencies
- Improving beneficiary experience
- Improving clinician and provider experience

16

16

Overall Impact of Burden Reduction

6.6 billion dollars*
through regulatory changes

42 million hours*
through regulatory changes

Data elements, items, and measures cut
235 Data elements / **33** items removed (OASIS)
79 measures removed (QPP)

Highlights of this impact include:

- Roughly 220,000 hours of work saved by Skilled Nursing Facility providers due to revised Advanced Beneficiary Notice
- Teaching physicians now able to rely on and verify med student documentation for E/M
- The September, 2019 Omnibus Final Rule is estimated to save 4.4 million burden hours and $800 million, annually

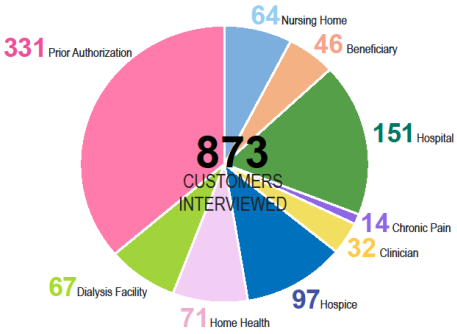
*through 2021

17

17

We use human-centered design to explore burdens and spend time at the "front line"

Patients over Paperwork On-site Engagements



199 SME INTERVIEWS
CCSQ • CM • CPI • CMCS • CMMI • OC • OHI • OMH • OFM • FCHCO • CISPS • OPOLE • HHS • NIH • CDC• ONC • SMP/SHIP • MAC • Veterans Affairs • Private Payer • Independent Consultant • Association • Vendor • Academic Institution • Health Plan • Pharmacy • Foundation • Standards Organization • Supplier

102 LISTENING SESSIONS

56 SITE VISITS & OBSERVATIONS

1,437 People
Reached via Event-in-a-Box

233 Staff
in All CMS Locations

46 States
2 Territories
in 10 Regional Locations

15,065 Data
4,249 RFI &
10,816 Stakeholder Comments

Data as of 2/13/2020

18

Our top priorities are taking shape while 2019 RFI comment analysis continues

- Prior authorization
- Beneficiaries with chronic pain
- Eligibility and enrollment for dually eligible beneficiaries
- Documentation requirements accessibility (look-up service)

INPUTS

- Total RFI Comments Reviewed: 568
- Total Unique Commenters:
  - 515 Commenters providing unique RFI responses
  - 108 Commenters providing high-volume (form letter) submissions

OUTPUTS

- Total Burden Content extracted:
  - Unique RFI Responses: 2,886 Burden Mentions
  - High Volume (Form Letter) Submissions: 707 Burden Mentions
- Stakeholder Categorization: 12 Stakeholder Types
- Burden Categorization: 17 Burden Themes

19

Among Top Burden Areas

Prior Authorization

"I hate to say it, but…prior authorization is unseating electronic health records as the top source of burden for clinicians and providers…"

- Medical community stakeholder

Documentation Requirements

"…even if you can find the instructions, there is no guarantee that it is right"

"From a physician standpoint, I want to know what I need to do while the patient is here."

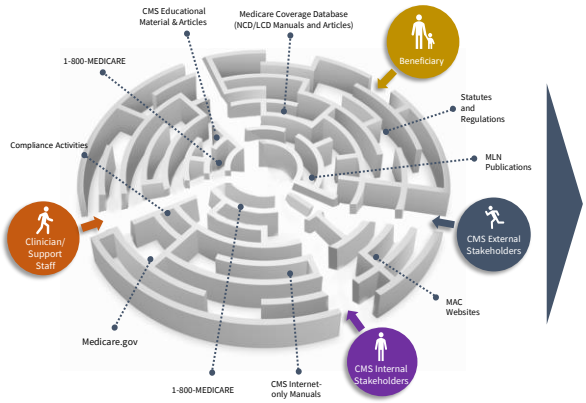
20

Most requirements are online – but today still in too many places and too hard to find

- Multiple places to get information
- Multiple files on CMS web sites
- Multiple publications
- Multiple coding instructions
- Multiple NCDs, LCDs, LCAs
- Multiple instructions on how to document

21

Information maze has unintended consequences



This contributes to:

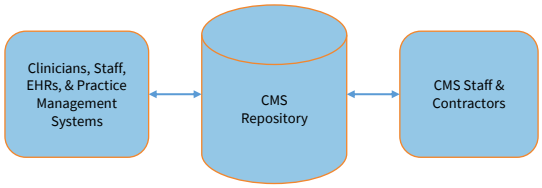
- Clinician burden / burnout
- CMS burden and rework
- Inconsistent requirements
- Delayed services to beneficiaries
- Errors in claims processing
- Increased improper payments
- Barriers to interoperability
- Customer dissatisfaction

22

Where we want to go

CMS requirements stored in a common repository that contains information that is:

- Reliable, trusted
- Right content for context, complete
- Easy to search
- Easy to understand
- Truly needed
- Available real time, directly or system-to-system, internally and externally

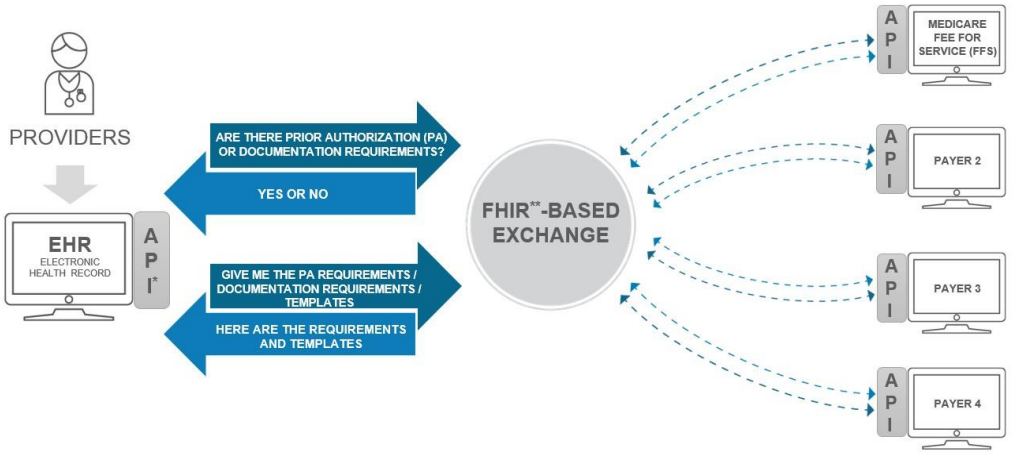


Exploring:

- *Standards*
- *Content management*
- *Governance*
- *Stakeholder needs and experience*

23

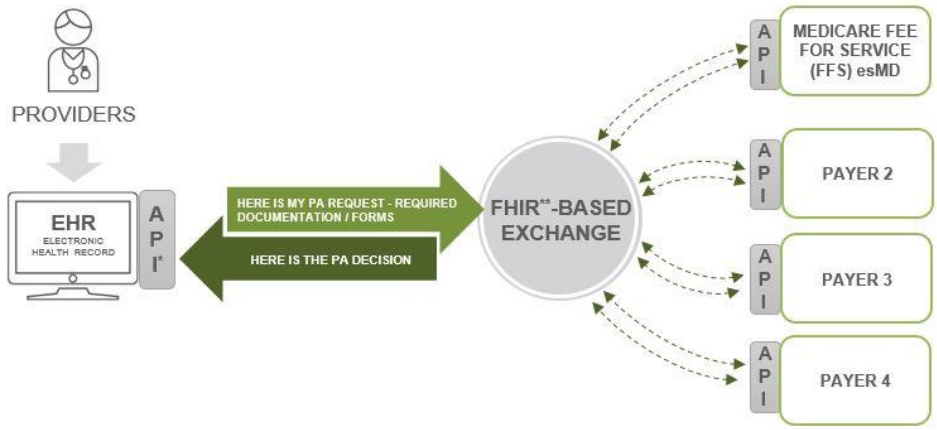
How will DRLS work for providers?



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

go.cms.gov/MedicareRequirementsLookup

How does ePrior Auth build on the DRLS?



*API – APPLICATION PROGRAMMING INTERFACE
**FHIR – FAST HEALTHCARE INTEROPERABILITY RESOURCES
***esMD – ELECTRONIC SUBMISSION OF MEDICAL DOCUMENTATION

go.cms.gov/MedicareRequirementsLookup

25

my healthe data

- Blue Button 2.0
- Interoperability and Patient Access Final Rule

26

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

27

MyHealthEData

- With Blue Button 2.0, nearly 3,400 developers are building user-friendly apps to help beneficiaries understand and access their data and 57 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)

28

Interoperability & Patient Access Final Rule

- All payers doing business in Medicare Advantage, Medicaid, CHIP and through the federal exchanges are required to share health claims data and other important information with patients electronically via a FHIR-based API
- A payer may ask third-party application developers to attest to certain privacy provisions that can help keep a patient's data private and secure
- CMS-regulated payers are required to make provider directory information publicly available via a standards-based API

29

Interoperability & Patient Access Final Rule (cont'd)

- A patient's health information should follow a patient as they move from payer to payer, 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

30

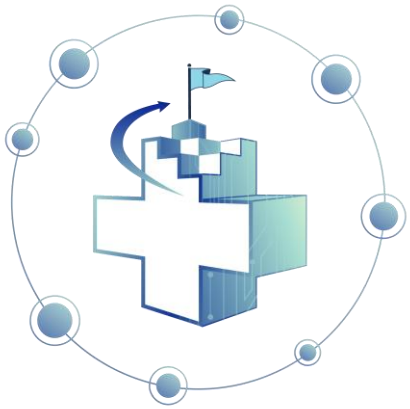
Interoperability & Patient Access Final Rule (cont'd)

- Publicly report those providers who do not have digital contact information included or updated in the National Plan and Provider Enumeration System (NPPES)
- Improve the dually eligible experience by increasing the frequency of federal-state data exchanges

31

Rule Resources

- https://www.cms.gov/Regulations-and-Guidance/Guidance/Interoperability/index
- CMSHealthInformaticsOffice@cms.hhs.gov



32

Program Integrity Focus Areas

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

PROTECTING TAXPAYER DOLLARS

33

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.

34

34

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 (MAC)
- 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

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

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.

37

Proposed Changes to MA and Part D

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, defines 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 (RADV) audits and recovery of improper payments
  - Risk Adjustment Data Validation (RADV) audits and recovery of improper payments
  - Started payment year 2014 and 2015 contract level audits in fiscal year 2019
  - Reduce the burden on audited plans while expanding the reach of the audits to more plans
  - Comments to RADV provision received by August 28, 2019 are being reviewed to inform future rule-making

38

Program Integrity: Medicaid Strategy

- Oversight Activities:
  - New audits of state beneficiary eligibility determinations
  - Audits of Medicaid managed care Medical Loss Ratio (MLR)
  - Review and assist states with the development of Payment Error Rate Measurement (PERM) Correction Action Plans (CAP) to address the state-specific drivers of improper payments
  - Provide guidance, support, and oversight to states while they conduct Medicaid Eligibility Quality Control (MEQC) pilots and establish 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

Thank you!

Mary.Greene1@cms.hhs.gov

410.786.1244