CMS Representative Discusses 2018 Goals and Initiatives at HCCA Atlanta Regional Conference

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On January 26, 2018, the Health Care Compliance Association (HCCA) held its annual Regional Conference in Atlanta, Georgia. The conference was well attended by compliance officers and counsel from all across the Southeast.

The conference kicked off with an engaging presentation by Kim Brandt, J.D., M.A., Principal Deputy Administrator for Operations for the Centers for Medicare and Medicaid Services (CMS). Ms. Brandt's presentation covered strategic goals for CMS in 2018, provided an overview of new Medicare auditors and audit focus areas, and touched on the current administration's push for regulatory reform to reduce provider burden. Below are some key takeaways from her insightful presentation.

CMS Goals for 2018

Ms. Brandt outlined CMS's four strategic goals for 2018 and provided helpful details about how CMS plans to achieve them:

1. **Empowering patients and doctors to make decisions about their health care.** CMS's focus in this category will be on "liberating data" and getting as much information as possible to beneficiaries and providers to increase access to better treatments and to improve patients' ability to manage their own care. With reference to an initiative to increase access to health data via mobile applications, Ms. Brandt's insights aligned with the strategic discussions at the recent inaugural HITAC meeting (for an overview of those presentations, click here). Ms. Brandt recognized that Medicaid members are more "digital" than ever, and noted that CMS is beginning to recognize these technology skills in its communications.
2. **Ushering in a new era of state flexibility and local leadership.** CMS's focus in this area will be on Medicaid issues—what Ms. Brandt referred to as the "forgotten M" of CMS. CMS will be focused on increasing flexibility with Medicaid waivers and sharing more information on which State innovations are going well.
3. **Improving the CMS customer experience.** CMS's approach here will be to make the agency "more customer-service friendly." Initiatives aimed at achieving this goal include developing additional educational materials, like MedLearn Matters and video blog postings, and working to make information easier to find. In line with this objective, watch for a program integrity documentation manual that will consolidate various forms in one location.
4. **Supporting innovative approaches to improve quality, accessibility, and affordability.** The big focus for CMS in this area will be on transforming from a fee for services model to reflect new payment models. The Center for Medicare and Medicaid Innovation has been active in this area for some time, but a particular focus for 2018 will be on the opioid crisis. For example, working to identify ways to better treat addiction and to better the physician/hospital alignment for care coordination.

In addition to the specific strategic objectives discussed above, as part of the push by the Trump Administration to reduce regulatory burden on providers, CMS is seeking guidance from the provider community on what regulatory burdens are pulling them away from patient care.

Audits and Appeals

Balanced Approach to Enforcement. According to Ms. Brandt, an estimated 11% of all Medicare Fee-For-Service claim payments are improper, which translates into approximately $41 Billion per year in improper payments. CMS will therefore continue to focus on and promote its program integrity efforts in 2018. CMS will concentrate on Home Health, Lab, and Hospice providers in particular based on the high error rates and billing irregularities seen by CMS in these industries. However, of particular interest for providers may be Ms. Brandt's statement that CMS will be striving to balance its program integrity work with maintaining flexibility for providers to "do what they need to do."

Increasing Focus on Education. Ms. Brandt discussed this important shift in focus from what she referred to as the old "gotcha" mentality. Instead, CMS is trying to get better at differentiating between the "good guys and the bad guys," meaning those providers who just need more education from the few nefarious providers. To do that, CMS will be offering more education to providers and making sure they understand the rules first before getting Program Integrity involved. If, however, providers continue to bill incorrectly after these education efforts, CMS will make referrals to Program Integrity as needed.

Consolidation of Functions to UPICs. Ms. Brandt discussed the consolidation of certain functions to Unified Program Integrity Contractors (UPICs). As described on CMS's website:

> The Unified Program Integrity Contractors (UPICs) perform fraud, waste, and abuse detection, deterrence and prevention activities for Medicare and Medicaid claims processed in the United States. Specifically, the UPIC's [sic] perform integrity related activities associated with Medicare Parts A, B, Durable Medical Equipment (DME), Home Health and Hospice (HH+H), Medicaid, and the Medicare-Medicaid data match program (Medi-Medi). The UPIC contracts operate in five (5) separate geographical jurisdictions in the United States and combine and integrate functions previously performed by the Zone Program Integrity Contractor (ZPIC), Program Safeguard Contractor (PSC) and Medicaid Integrity Contractor (MIC) contracts.[1]

According to Ms. Brandt, UPICs should not be working cases unless they are "truly fraudulent"; in other words, UIPCs should send most cases back to the Medicare Administrative Contractors (MACs) for provider education. CMS is currently in the process of awarding contracts for UPICs.

Addressing Delays in Appeals Processing. CMS is also taking more action to reduce delays in Medicare appeals with a two-pronged approach. First, CMS is working to reduce the existing backlog by implementing various new strategies, such as offering and engaging in more settlement agreements. Second, CMS is working to prevent future appeals through efforts such as:

- **The Escalate/De-escalate Initiative and the Targeted Probe and Educate Program.** MACs may now request only 20-40 medical records per provider per topic, in contrast to the unlimited records they could request before. After review, they are required to send detailed denial reasons, offer a one-on-one educational call to discuss the denial reasons, and must wait for a 45 day "improvement period" before they can audit the same provider again.

- **Regulatory reform.** Ms. Brandt noted that regulatory reform to reduce provider burden is approximately number three on a list of top five priorities for CMS Administrator Seema Verma. Last year, CMS solicited public input on which regulatory requirements should be revised or removed and is in the process of reviewing them. In addition, CMS has recently undertaken an effort to revise or remove unclear or unnecessary sub-regulatory guidance. Collectively, these efforts are aimed at reducing unnecessary burden, increasing efficiencies, and improving the customer experience.

- **Simplifying documentation requirements.** Dubbing the efforts "Patients over Paperwork," Ms. Brandt discussed ways in which CMS intends to remove regulatory obstacles that get in the way of providers spending time

1 Centers for Medicare and Medicaid Services, *Review Contractor Directory - Interactive Map*, https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/ (last accessed Feb. 8, 2018).

with patients. She shared some of CMS's specific goals in this area:

- Increase the number of customers (clinicians, institutional providers, health plans, etc.) engaged through direct and indirect outreach;
- Decrease the hours and dollars clinicians and providers spend on CMS-mandated compliance; and
- Increase the proportion of tasks that CMS customers can do in a completely digital way.

Addressing the Opioid Crisis

CMS is currently revising and updating its opioid response to reflect the current Administration's priorities and recommendations for the crisis. Current activities include engaging stakeholders in listening sessions and incorporating opioid-related measures in Medicare's Quality Payment Program. CMS has created an "Opioid Drug Mapping Tool" which identifies communities where intervention is most needed by showing the number and percentage of Medicare Part D opioid prescriptions filled at the state, county and zip code levels. In essence, the Map allows one to see "hot spots" for Medicare opioid prescriptions. Notably, the data lags by a few years, but CMS is looking at ways to update the information faster.

Conclusion

Ms. Brandt shared many exciting updates and insights into CMS's goals and initiatives for 2018. Providers should stay alert for updates from CMS this year, by participating in CMS-hosted listening sessions, subscribing to CMS listservs, and keeping attune for announcements. From regulatory reform to the publication of consolidated resources, Ms. Brandt's presentation suggested that CMS's approach in 2018 will be a more provider-friendly one, with a customer focus aimed at reducing provider burden and improving patient care.

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