



# Making a Down Payment on Health Reform

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CMS Region IX

**HFMA Northern California Chapter's  
Legislative Seminar**

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# The American Recovery and Reinvestment Act



- **CMS covers medical care for almost 100 million seniors, people with disabilities, and children, through Medicare, Medicaid and the Children’s Health Insurance Program (CHIP). This includes approximately 1.9 million American Indians and Alaska Natives covered by these programs and who get their care through the Indian Health Service.**
- **The Recovery Act signed into law by President Barack Obama on February 17, 2009 will ensure that health care—currently one-sixth of the nation’s gross domestic product—will continue to support the economy.**

# Accelerating Adoption of Health IT Systems to Modernize the Health Care System



- **The new law gives CMS a major role in supporting economic growth in the health sector with the investment in 21st Century health information technology. CMS will be able to devote new Medicare and Medicaid resources to encourage hospitals and physicians' offices to connect electronically. Among them:**
  - Expanded incentives for doctors, hospitals, and other eligible professionals, to adopt EHR technology beginning in 2011.
  - In Medicaid, incentives to encourage providers to adopt and use certified EHRs.
  - CMS and other agencies within HHS also will manage new funds devoted to health IT, including supporting a nationwide health IT information exchange; expanding the pool of providers encouraged to adopt EHRs; and, promoting interoperability in clinical data registries.

# Protecting Health Care Coverage for Millions of Americans During This Recession



- **ARRA provides an additional \$268 million in payments to states for hospitals serving a disproportionate share of low-income patients.**
- **The new law extends the *Transitional Medical Assistance (TMA)* program, which covers people who are transitioning back into the workforce. With the extension until December 31, 2010, low-income families determined eligible for TMA will now be able to count on Medicaid coverage temporarily even if their new incomes mean they earn too much to qualify. The bill also gives States the option to relax TMA eligibility requirements and extend the initial period of eligibility for a full year.**

## Continued...



- **ARRA would also extend the Qualifying Individual (QI) program, which helps cover the cost of Medicare part B premiums for people who are having trouble paying them. The QI program would be extended through December 31, 2010.**
- **Already, \$15 billion in new ARRA funds are being distributed to help states cover the costs of their Medicaid programs.**

# Providing Evidence-Based Prevention to Americans



- **The bill will provide \$1 billion for proven clinical preventive services and community-based prevention programs. Because more than half of Americans—156 million—go without the flu vaccine every year, this plan makes a significant investment in immunizations to remove the cost barrier. Further, given that 1 in 3 adults and almost one-quarter of Medicare beneficiaries have a chronic disease, this plan tackles obesity, smoking and other health risks by expanding prevention programs that operate in communities across the nation.**

# Strengthening the Health Workforce



- **The President believes that a strong health workforce, including doctors, nurses, community health workers and public health practitioners, are the lynchpin to an effective health care system. The bill provides \$500 million to support programs like the National Health Services Corps which place providers in underserved communities. Further, it will fund existing workforce programs (Title VII and VIII) which are critical for the education and training of the next generation of doctors and nurses.**

# National Institute of Health



- **The bill invests \$10 billion in the National Institutes of Health. This funding will end the backlog of valid research projects that have been on hold due to inadequate budgets. According to Research America, this investment could create 70,000 jobs and stimulate the economy of every state because 90 percent of NIH funding is distributed to colleges, universities and research institutions across the country.**

# Comparative Effectiveness Research



- **The bill invests \$1.1 billion in comparative effectiveness research. This provides patients and providers with better information on the relative merits of different treatment options.**

# Health and Human Services IT Security



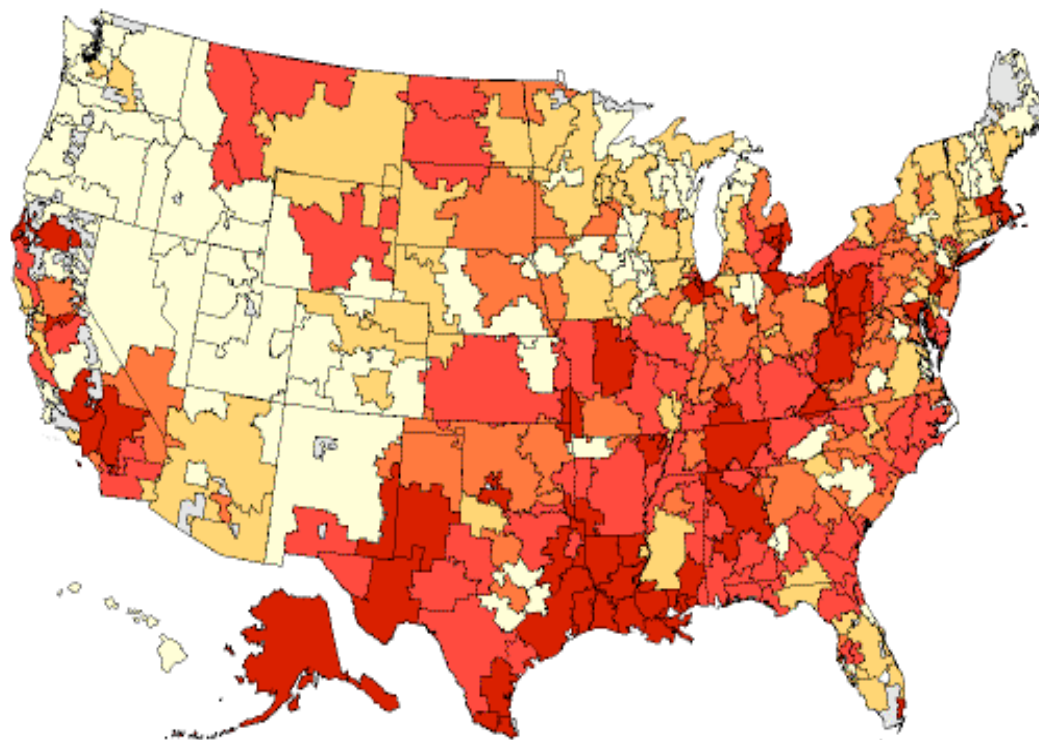
- **The bill provides \$50 million to the Department of Health and Human Services for information technology security.**

# Value Based Purchasing



- **Transform Medicare from a passive payer to an active purchaser of higher quality, more efficient health care**
- **Tools:**
  - Measurement
  - Payment incentives
  - Public reporting
  - Conditions of participation
  - Coverage policy
  - QIO program
- **Initiatives:**
  - Pay for reporting
  - Pay for performance
  - Gainsharing
  - Competitive bidding
  - Bundled payment
  - Coverage decisions
  - Direct provider support

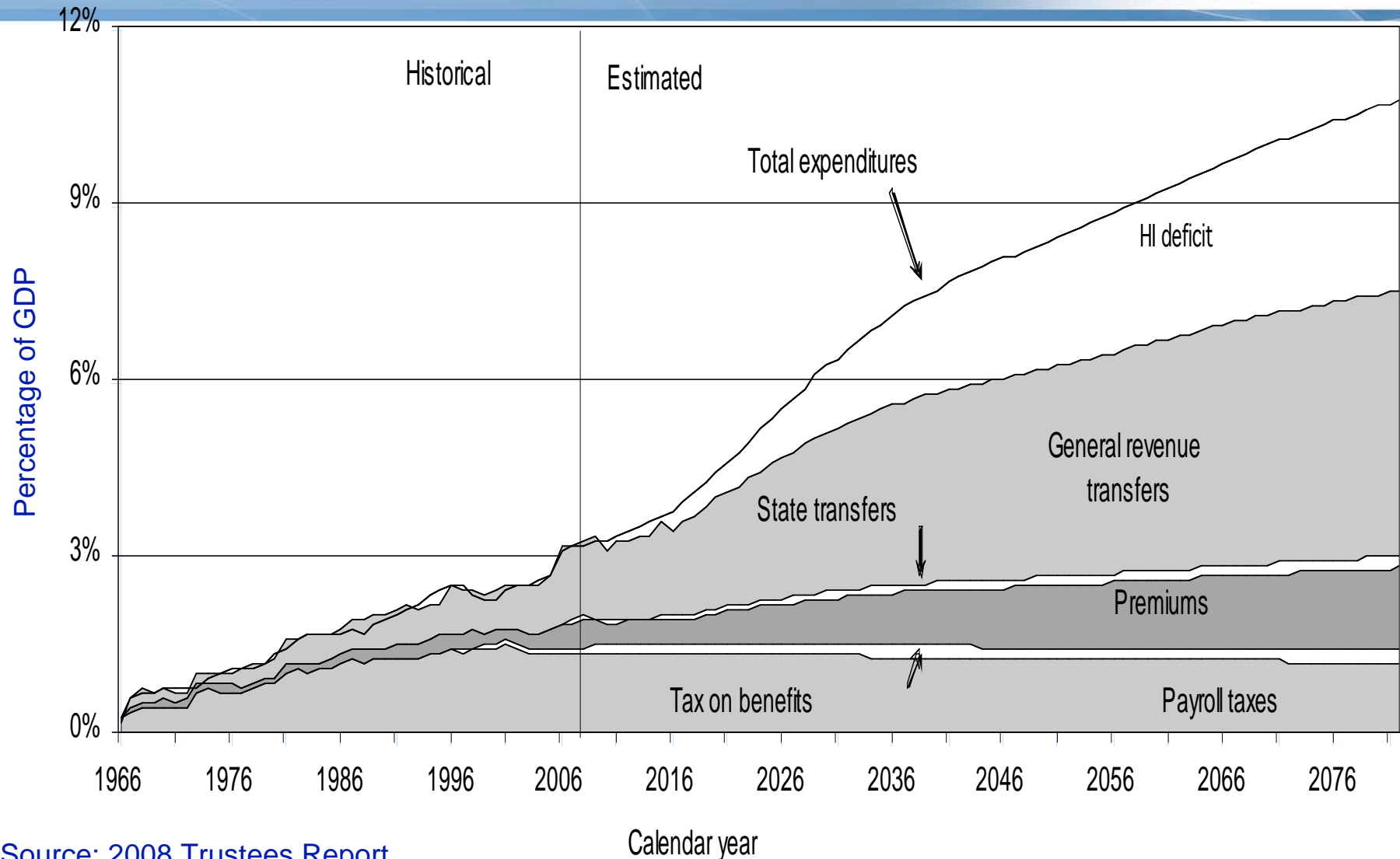
# Practice Variation



**Map 2.5. Inpatient Hospital Services per Medicare Enrollee by Hospital Referral Region (1995)**

- \$2516 to 3723 (61)
- 2321 to < 2516 (60)
- 2117 to < 2321 (61)
- 1893 to < 2117 (62)
- 1483 to < 1893 (62)
- Not Populated

# Medicare Will Strain the Federal Budget



Source: 2008 Trustees Report

# VBP Demonstrations and Pilots



- **Physician Group Practice Demonstration**
- **Medicare Care Management Performance Demonstration**
- **Nursing Home Value-based Purchasing Demonstration**
- **Home Health Pay for Performance Demonstration**
- **Premier Hospital Quality Incentive Demonstration**

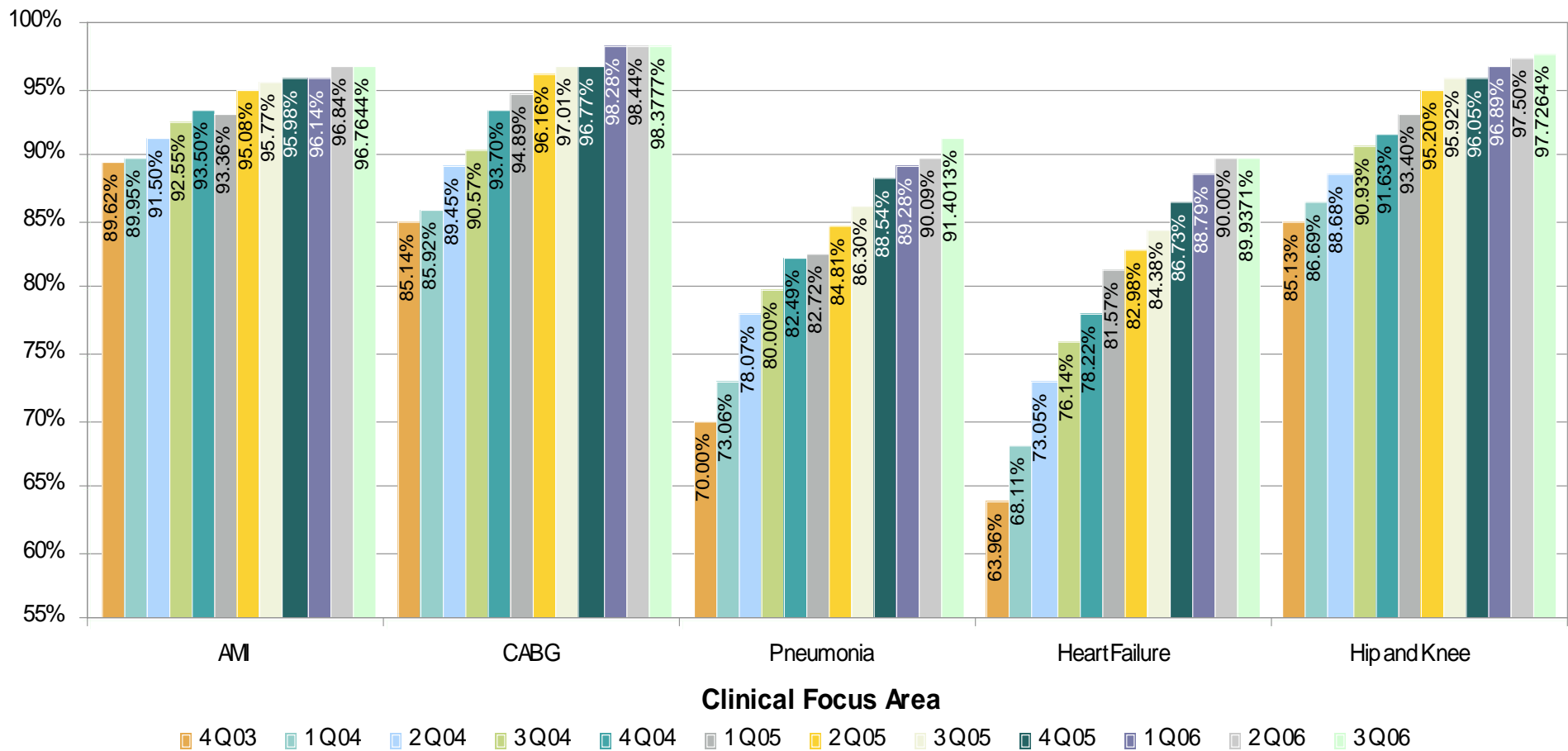
# Premier Hospital Quality Incentive Demonstration



## CMS/Premier HQID Project Participants Composite Quality Score:

Trend of Quarterly Median (5th Decile) by Clinical Focus Area

October 1, 2003 - September 30, 2006 (Year 1 and Year 2 Final Data, and Yr 3 Preliminary)






# Value Based Purchasing Initiatives



## Hospital-Acquired Conditions

# Statute: CMS must select conditions that are:



-  **High cost, high volume, or both**
-  **Assigned to a higher paying DRG when present as a secondary diagnosis**
-  **Reasonably preventable through the application of evidence-based guidelines**

# Addressing “Never Events”



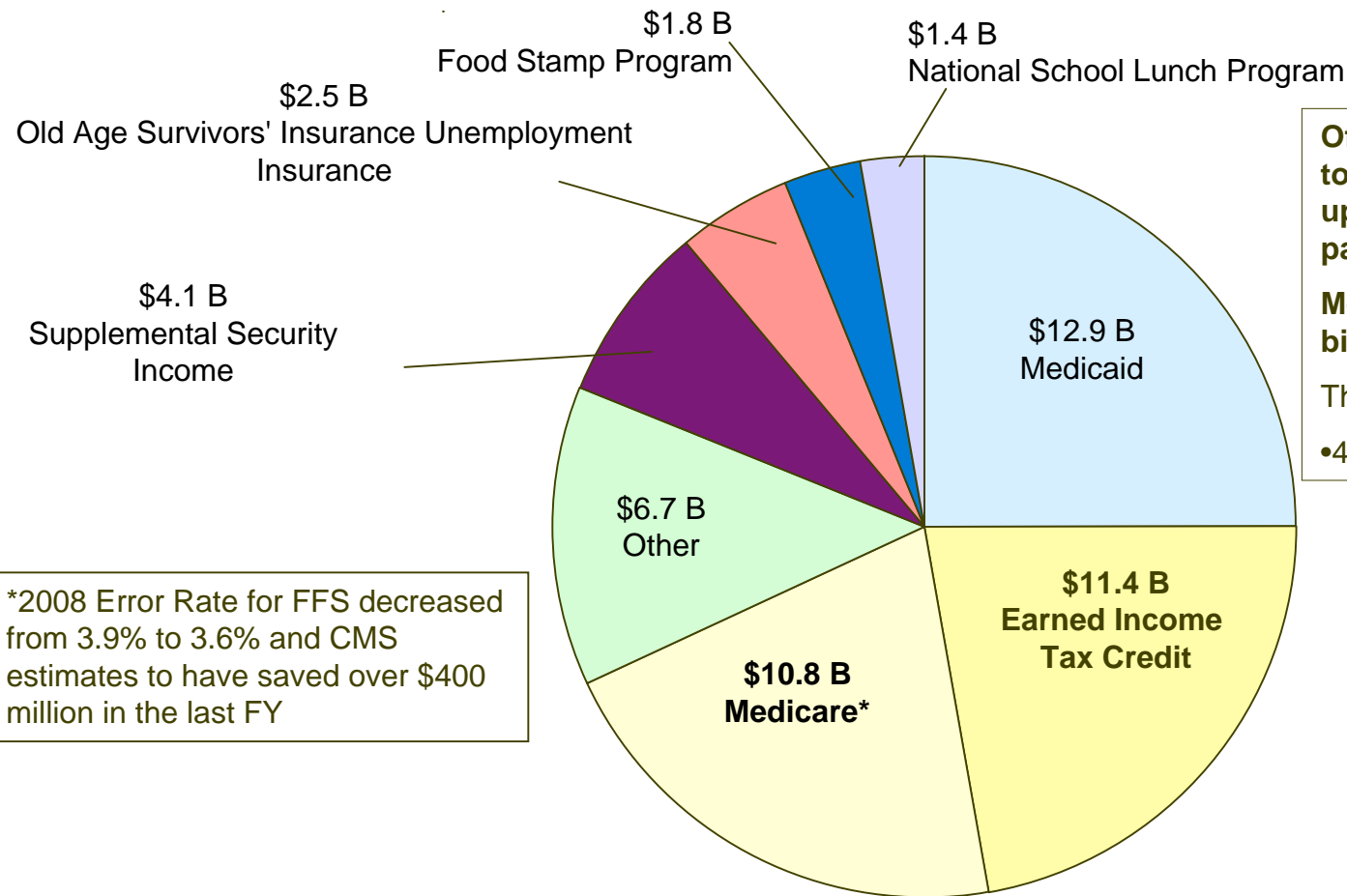
**“...when a Medicare beneficiary requires a particular surgical or other invasive procedure to treat a particular medical condition and the practitioner erroneously performs a different procedure, Medicare will not cover that particular surgical or other invasive procedure because it is not a reasonable and necessary treatment for the Medicare beneficiary’s particular medical condition.”**

Decision Memo for WRONG SURGERY Performed on a Patient (CAG-00401N), issued January 15, 2009

# Recovery Audit Contractors (RACs) and Medicare

# Why do we have RACs?

## Top 8 Federal Programs with Improper Payments 2007



\*2008 Error Rate for FFS decreased from 3.9% to 3.6% and CMS estimates to have saved over \$400 million in the last FY

Of all agencies that reported to OMB in 2007, these 8 make up 88% of the improper payments.

Medicare receives over 1.2 billion claims per year.

This equates to:

- 4.5 million claims per work day

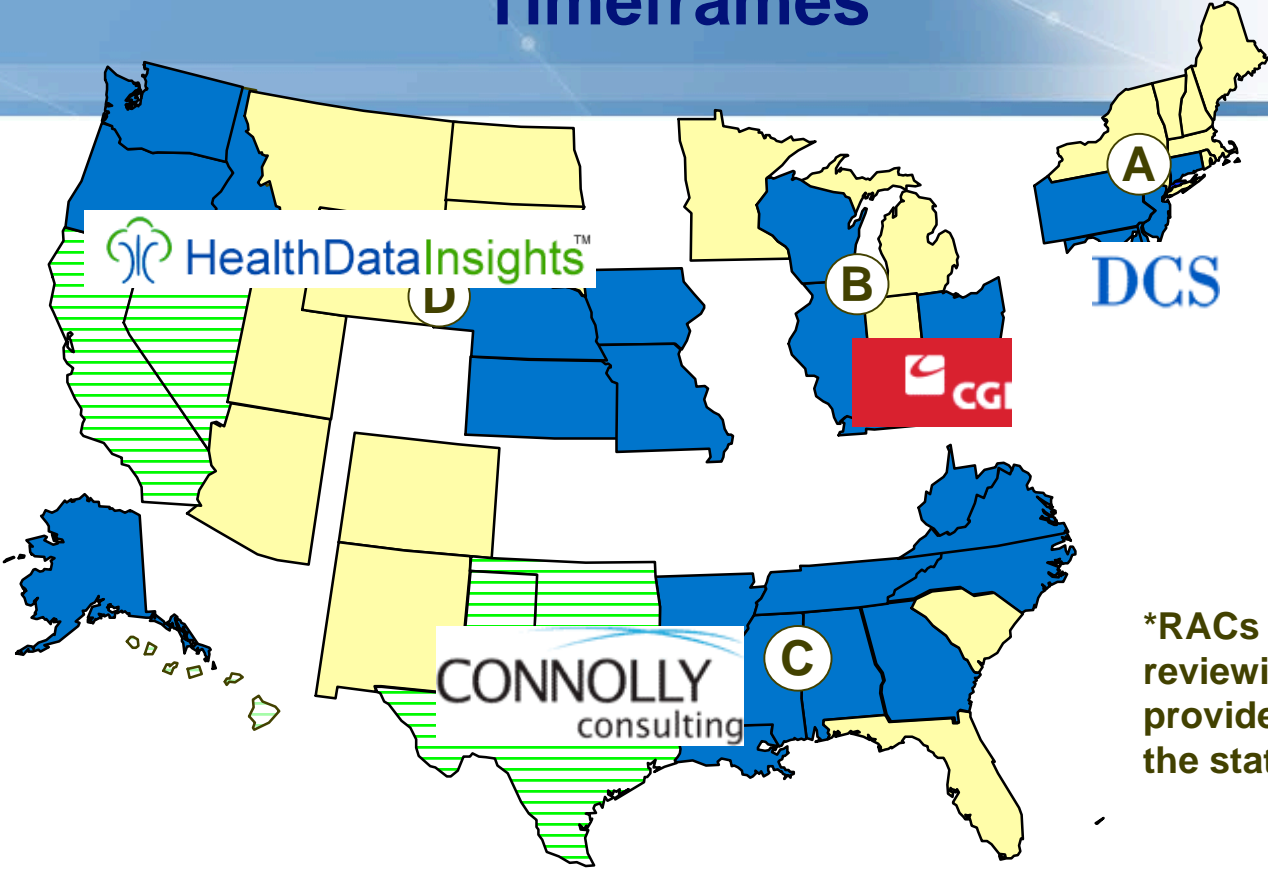
# What is a RAC?

## The RAC Program Mission



- **The RACs detect and correct past improper payments so that CMS and Carriers, FIs, and MACs can implement actions that will prevent future improper payments**
  - **Providers** can avoid submitting claims that do not comply with Medicare rules
  - **CMS** can lower its error rate
  - **Taxpayers** and future Medicare beneficiaries are protected

# Timeframes



\*RACs may not begin reviewing until there is provider outreach in the state

Claims Available for Analysis	Provider Outreach	Earliest Correspondence
March 1, 2009	March 1, 2009	March 1, 2009
March 1, 2009	March 1, 2009	March 1, 2009
August 1, 2009	August 1, 2009	August 1, 2009

# RAC Legislation



- **Medicare Modernization Act, Section 306**
  - Required the 3-year RAC demonstration
- **Tax Relief and Healthcare Act of 2006, Section 302**
  - Requires a permanent and nationwide RAC program by January 1, 2010
- **Both of these statutes gave CMS the authority to pay the RACs on a contingency fee basis**

# What does a RAC do?

## RAC Review Process



- **RACs review claims on a post-payment basis**
- **RACs use the same Medicare policies as Carriers, FIs and MACs**
  - NCDs, LCDs, CMS Manuals
- **Two types of review:**
  - Automated (no medical record needed)
  - Complex (medical record required)
- **RACs will not be able to review claims paid prior to October 1, 2007**
  - RACs will be able to look back three years from the date the claim was paid
- **RACs are required to employ a staff consisting of nurses or therapists, certified coders, and a physician CMD**

## RAC Program's Three Keys to Success



- **Minimize Provider Burden**
- **Ensure Accuracy**
- **Maximize Transparency**

# Minimize Provider Burden



- **Limit the RAC “look back period” to three years**
  - Maximum look back date is October 1, 2007
- **RACs will accept imaged medical records on CD/DVD**
- **Limit the number of medical record requests**

# Summary of Medical Record Limits (for FY 2009)



- **Inpatient Hospital, IRF, SNF, Hospice**
  - 10% of the average monthly Medicare claims (max 200) per 45 days per NPI
  
- **Other Part A Billers (HH)**
  - 1% of the average monthly Medicare episodes of care (max 200) per 45 days per NPI

# Summary of Medical Record Limits (for FY 2009)



- **Continued...**
  - Physicians (including podiatrists, chiropractors)
    - Sole Practitioner: 10 medical records per 45 days per NPI
    - Partnership 2-5 individuals: 20 medical records per 45 days per NPI
    - Group 6-15 individuals: 30 medical records per 45 days per NPI
    - Large Group 16+ individuals: 50 medical records per 45 days per NPI
  - Other Part B Billers (DME, Lab, Outpatient hospitals)
    - 1% of the average monthly Medicare services (max 200) per NPI per 45 days

# Medical Record Limit Example



## ■ Outpatient Hospital

- 360,000 Medicare paid services in 2007
- Divided by 12 = average 30,000 Medicare paid services per month
- $\times .01 = 300$
- Limit = 200 records/45 days (hit the max)

# Ensure Accuracy



- **Each RAC employs:**
  - Certified coders
  - Nurses and/or Therapists
  - A physician CMD
- **CMS' New Issue Review Board provides greater oversight**
- **RAC Validation Contractor provides annual accuracy scores for each RAC**
- **If a RAC loses at any level of appeal, the RAC must return the contingency fee**

# Maximize Transparency



- **New issues are posted to the web**
- **Vulnerabilities are posted to the web**
- **RAC claim status website (2010)**
- **Detailed review results letter following all complex reviews**

# What can providers do to get ready?



- Know where previous improper payments have been found
- Know if you are submitting claims with improper payments
- Prepare to respond to RAC medical record requests

# Know Where Previous Improper Payments Have Been Found



- **Look to see what improper payments were found by the RACs:**
  - Demonstration findings: [www.cms.hhs.gov/rac](http://www.cms.hhs.gov/rac)
  - Permanent RAC findings: will be listed on the RACs' websites
  
- **Look to see what improper payments have been found in OIG and CERT reports**
  - OIG reports: [www.oig.hhs.gov/reports.html](http://www.oig.hhs.gov/reports.html)
  - CERT reports: [www.cms.hhs.gov/cert](http://www.cms.hhs.gov/cert)

# Know if you are submitting claims with improper payments



- **Conduct an internal assessment to identify if you are in compliance with Medicare rules**
- **Identify corrective actions to implement for compliance**

# Prepare to Respond to RAC Medical Record Requests



- **Tell your RAC the precise address and contact person they should use when sending Medical Record Request Letters**
  - Call RAC
  - No later 1/1/2010: use RAC websites
- **When necessary, check on the status of your medical record (Did the RAC receive it?)**
  - Call RAC
  - No later 1/1/2010: use RAC websites

Who will be in charge of responding to RAC Medical Record requests?

What address will we use?

Who will be in charge of tracking our RAC Medical Record requests?

# Appeal When Necessary



- **The appeal process for RAC denials is the same as the appeal process for Carrier/FI/MAC denials**
- **Do not confuse the “RAC Discussion Period” with the Appeals process**
  - If you disagree with the RAC determination...
    - ❖ Do not stop with sending a discussion letter
    - ❖ File an appeal before the 120<sup>th</sup> day after the Demand letter

Who will be in charge of deciding whether to appeal a RAC denial?

How will we keep track of what we want to appeal, what we have appealed, what our overturn rate is, etc.?

# Learn from Your Past Experiences



- **Keep track of denied claims**
- **Look for patterns**
- **Determine what corrective actions you need to take to avoid improper payments**

Who will be in charge of tracking our RAC denials, looking for patterns?

How will we avoid making similar improper payment claims in the future?

# Contacts and Resources



- **RAC Website:** [www.cms.hhs.gov/RAC](http://www.cms.hhs.gov/RAC)
- **RAC Email:** [RAC@cms.hhs.gov](mailto:RAC@cms.hhs.gov)

# RAC Contacts at CMS



RAC	CMS Contact Person	Phone
<b>A</b> 	<b>Ebony Brandon</b>	<b>410-786-1585</b>
<b>B</b> 	<b>Scott Wakefield</b>	<b>410-786-4301</b>
<b>C</b> 	<b>Amy Reese</b>	<b>410-786-8627</b>
<b>D</b> 	<b>Kathleen Wallace</b>	<b>410-786-1534</b>

# Stay Informed- Region IX Stakeholder Call



- **Every 3rd Thursday of the month, 2-3pm PST**
- **Next call, July 16th, 2009 at 2 PM PST.**
- **Toll Free: 1-888-452-0273**
- **Pass Code: Stakeholder Call**
- **Leader: David Saÿen**
- **Register for “CMS Region IX Stakeholder” listserv for notification and details about calls, please contact: [nicole.lockey@cms.hhs.gov](mailto:nicole.lockey@cms.hhs.gov)**

**Thank you!**



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