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FINAL RULE PUBLISHED CREATING A PRIOR AUTHORIZATION PROCESS FOR CERTAIN DMEPOS ITEMS (PAGE 2)

Transforming Clinical Practice Initiative Announced

Health and Human Services Secretary Sylvia M. Burwell recently announced $685 million in awards to 39 national and regional health care networks and supporting organizations to help equip more than 140,000 clinicians with the tools and support needed to improve quality of care, increase patients' access to information, and reduce costs. The Transforming Clinical Practice Initiative is one of the largest federal investments designed to support doctors and other clinicians in all 50 states through collaborative and peer-based learning networks. The award will support 29 medical group practices, regional health care systems, and regional extension centers in offering peer-to-peer support to primary and specialty physicians, nurse practitioners, physician assistants, clinical pharmacists, and their practices. These efforts include:

- Helping providers give patients better tools for communication through e-mails and other information technology applications;

- Providing dedicated coaches to help practices better manage chronic disease and offer preventive care;

- Offering real-time notification alerts for clinicians caring for high-risk patients;

- Improving screening and treatment of mental health and substance abuse across multiple care settings and increasing patient medication management education;

- Centralizing data reporting and providing technical assistance with quality improvement targets and mid-course corrections; and

- Promoting patient, provider and community engagement through advisory boards and community engagement in learning collaboratives.

In addition, 10 national organizations and health care professional associations will receive up to $27 million to:

- Align clinical practice guidelines across multiple medical specialties and disseminate those findings through well-established communications channels;

- Offer Continuing Medical Education credit to clinicians to support transformation efforts and ensure that coordinated education programs are offered to participating clinicians;

- Share best practices and provide technical assistance and coaching to their members that may be struggling with how to participate in emerging alternative payment models; and

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ACA Results in Premium Rebates

CMS has announced that consumers have received more than $2.4 billion premium rebates since 2011 because the Affordable Care Act (ACA) requires that health insurance companies spend at least 80 percent of premium dollars on health care. In 2014 alone, over 5.5 million consumers received nearly $470 million in rebates, for an average of $129 per family. Those rebates are in addition to improvements in quality and affordability savings consumers have received as the share of insurance companies in compliance with the requirements has increased.

The Medical Loss Ratio (MLR) rule, also known as the 80/20 rule, is one of the tools created through the ACA to keep costs affordable for consumers. This rule requires that issuers in the individual and small group markets spend at least 80 percent of premium dollars on health care and activities that improve the quality of health care, rather than on things like overhead. In the large group market, issuers are required to spend at least 85 percent of premium dollars in this manner. Insurance companies that fail to meet this standard owe consumers a refund in the form of lower premiums or a check.

These results show that an increasing number of consumers are in plans where they are receiving more value for their premium dollars up front because their premium rates were set to reasonably reflect insurers' spending on medical care and quality improvement activities. The number of consumers in plans that owe refunds decreased by more than one million in 2014, from approximately 6.8 in 2013 to 5.5 million in 2014.

Inside this Issue...

ACO Initiatives Announced to Improve Health Care Delivery System

CMS recently announced 121 new participants in Medicare Accountable Care Organization (ACO) initiatives designed to improve the care patients receive in the health care system and lower costs. CMS also announced that providers and hospitals have signed up to join new types of ACOs, which in addition to being paid for positive patient outcomes will also receive penalties for negative ones. With new participants in the Medicare Shared Savings Program, Next Generation ACO Model, Pioneer ACO Model, and the Comprehensive End-Stage Renal Disease (ESRD) Care Model, there will now be nearly 8.9 million beneficiaries served and a total of 477 ACOs. 64 of those ACOs are on a risk-bearing track

The Next Generation ACO Model is a new CMS Innovation Center initiative with 21 participating ACOs. Unlike other models, this model includes a prospectively (rather than retrospectively) set benchmark. The Shared Savings Program welcomed 100 new ACOs and nearly 150 renewing ACOs on January 1, 2016. In 2016, approximately 15,000 more physicians will be participating in ACOs under the program. With the new group of ACOs, CMS will have 434 ACOs, serving more than 7.7 million beneficiaries.

Thirty-nine Shared Savings Program ACOs will also participate in the ACO Investment Model (AIM). This model has a total of 41 participants, and will provide pre-paid shared savings to encourage new ACOs to form in rural and underserved areas. Additionally, the model will encourage current Shared Savings Program ACOs to transition to performance-based risk arrangement. The up-front payments distributed through the AIM support ACOs in improving infrastructure and redesigning care processes to provide beneficiaries with lower cost and higher quality health care.

Additional ACO information can be found on the following CMS webpages and accompanying factsheets:

- Next Generation ACO Model and Fact Sheet
- Shared Savings Program and Fact Sheet
- ACO Investment Model and Fact Sheet

DMEPOS: Prior Authorization Process

CMS recently issued a final rule establishing a prior authorization process for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) items that are frequently subject to unnecessary utilization. This prior authorization process will help ensure that certain DMEPOS items are provided consistent with Medicare coverage, coding, and payment rules. CMS believes the final rule will prevent unnecessary utilization while safeguarding beneficiaries' access to medically necessary care.

Under the final rule, the prior authorization process will require the same information necessary to support Medicare payment today, just earlier in the process. It will not create new clinical documentation requirements. The prior authorization process assures that all relevant coverage, coding, and clinical documentation requirements are met before the item is furnished to the beneficiary and before the claim is submitted for payment. This helps ensure that beneficiaries are not held responsible for the cost of items that are not eligible for Medicare payment. CMS believes prior authorization is an effective way to reduce or prevent questionable billing practices and improper payments for DMEPOS items. Access is preserved in this rule by having both specified timeframes for review and approval of requests, and an expedited process in cases where delays jeopardize the health of beneficiaries.

BACKGROUND

CMS has had longstanding concerns about the improper payments related to DMEPOS items. The Department of Health and Human Services' Office of the Inspector General and the U.S. Government Accountability Office have published multiple reports indicating questionable billing practices by suppliers, inappropriate Medicare payments, and questionable utilization of DMEPOS items. CMS has addressed these issues in recent years through the implementation of the DMEPOS Competitive Bidding Program, as well as heightened screening of suppliers, as authorized by the ACA.

In addition to those actions, CMS recently expanded a 3-year prior authorization demonstration program for power mobility devices (PMDs). The demonstration began in 2012 in 7 states with high incidences of fraudulent claims and improper payments. In 2014, the demonstration was expanded to 12 additional states. Based on claims processed from September 1, 2012 through August 14, 2015, monthly expenditures for the PMD codes included in the demonstration decreased from $12 million to $3 million in the original 7 demonstration states; $10 million to $2 million in the 12 additional expansion states; and $10 million to $3 million in the non-demonstration states. CMS believes the decrease in spending is due in part to national DMEPOS suppliers adjusting their billing practices nationwide (not just in the demonstration states) to comply with CMS policies based on their experiences with prior authorization in the demonstration states.

This final rule further addresses questionable utilization and improper payments by creating a prior authorization process for certain DMEPOS items beyond PMDs. The final rule implements this authority by creating: a "Master List" of items that meet specific criteria and are potentially subject to prior authorization; a "Required Prior Authorization List," a subset of items on the Master List; and a prior authorization program for the Required Prior Authorization List items.

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Revised Two-Night Midnight Rule Guidelines

CMS has revised guidelines on Reviewing Short Stay Hospital Claims for Patient Status Admissions on or After January 1, 2016. Starting October 1, 2015 Beneficiary and Family Centered Care Quality Improvement Organizations (BFCC-QIOs) began conducting initial patient status reviews of claims for inpatient admissions. Under the revised exceptions policy (CMS-1633-F), which became effective January 1, 2016, for admissions not meeting the two midnight benchmark, Part A payments may be appropriate on a case-by-case basis where the medical record supports the admitting physician's determination that the patient requires inpatient care, despite the lack of a 2 midnight expectation.

BFCC-QIOs will consider complex medical factors such as history and comorbidities, the severity of signs and symptoms, current medical needs, and the risk of an adverse event to determine whether the medical record supports the need for inpatient hospital care. Two-Midnight Short-Stay Reviews focus on educating doctors and hospitals about the Part A payment policy for inpatient admissions. Recovery auditor patient status reviews will be conducted by recovery auditors for those hospitals that have consistently high denial rates based on the BFCC-QIO Two-Midnight Short-Stay Review outcomes. Visit the Inpatient Hospital Reviews webpage for additional information regarding guidelines.

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DMEPOS: Prior Authorization Process (Cont'd)

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THE MASTER LIST

The Master List is the set of 135 DMEPOS items identified as being frequently subject to unnecessary utilization. The list contains items potentially subject to prior authorization, and are items on the DMEPOS Fee Schedule with an average purchase fee of $1,000 or greater, or an average rental fee schedule of $100 or greater, (adjusted annually for inflation) and the subject of:

- HHS Office of the Inspector General (OIG) or U.S. Government Accountability Office (GAO) reports that are national in scope and published since 2007, or

- Comprehensive Error Rate Testing Annual Medicare Fee-for-Service Improper Payment Report Durable Medical Equipment (DME and/or) Report's DMEPOS Service Specific Reports.

The list is self-updating annually such that items on the DMEPOS Fee Schedule that meet the payment threshold are added to the list when the item is the subject of an OIG or GAO report of a national scope or a future CERT DME Service Specific Report. Items will remain on the list for 10 years, but can be removed sooner if the purchase amount drops below the payment threshold. After 10 years, items can remain on the list or be added back to the list if a subsequent report identifies the item as frequently subject to unnecessary utilization.

REQUIRED PRIOR AUTHORIZATION LIST

Presence on the Master List does not automatically create a prior authorization requirement for that item. In order to balance minimizing provider and supplier burden with protecting the Medicare Trust Funds and beneficiary access, CMS will initially implement prior authorization for a subset of items on the Master List (referred to as "Required Prior Authorization List"). CMS will publish the Required Prior Authorization List in the Federal Register with 60-days' notice before implementation of prior authorization for those items.

PRIOR AUTHORIZATION PROCESS

Prior authorization will be required for those DMEPOS items on the Required Prior Authorization List. The process requires all relevant documentation to be submitted for review prior to furnishing the item to the beneficiary and submitting the claim for processing. CMS or its contractors will review the prior authorization request and provide a provisional affirmation or non-affirmation decision. A claim submitted with a provisional affirmation decision will be paid so long as all other requirements are met. A claim submitted with a non-affirmation decision or without a decision will be denied. Unlimited resubmissions of prior authorization requests are allowed.

Medicare or its review contractor will make a reasonable effort to render an initial prior authorization determination within 10 business days and will make a reasonable effort to render a resubmission prior authorization determination within 20 business days. These are maximum timeframes and will be adjusted downward for items that require less time for making a determination. An expedited review process will be available to address circumstances where applying the standard timeframe for making a prior authorization decision could seriously jeopardize the life or health of the beneficiary. The request for an expedited review must provide rationale supporting the request.

CMS will issue specific prior authorization guidance in subregulatory communications.

The final rule is currently on display at https://www.federalregister.gov/articles/2015/12/30/2015-32506/medicare-program-prior-authorization-process-for-certain-durable-medical-equipment-prosthetics.

Transforming Clinical Practices Initiative (Cont'd)

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- Provide educational materials and access to registry data information, including training on how to use the data to improve care.

A few specific examples include:

The American College of Emergency Physicians and American College of Radiology will engage clinicians, patients and families in reducing unnecessary testing. Working with member Emergency Department Physicians and Radiologists they intend to avoid over 1.1 million unnecessary diagnostic imaging tests and engage physicians in collaboratively selecting the most appropriate imaging exam, thus reducing unnecessary exposure to radiation and duplication of tests that inconvenience patients and increase costs.

The National Rural Accountable Care Consortium will assess, educate and provide on site peer-supported education and training to more than 5,500 rural providers who may wish to transition into ACOs.

The American Board of Family Medicine will work with more than 25,000 family physicians serving 50 million or more patients to help clinicians and patients navigate the changing health care system, reduce disparities in health care, and move toward a wellness-based approach to managing care.

These awards are part of a comprehensive strategy advanced by the ACA that enables new levels of coordination, continuity, and integration of care, while transitioning volume-driven systems to value-based, patient-centered, health care services.

Please visit the Transforming Clinical Practice Initiative webpage for complete details. The list of awardees is also available on the Transforming Clinical Practice Initiative Awards webpage.

Comprehensive Care for Joint Replacement Model Update

On November 16, 2015, CMS finalized the Comprehensive Care for Joint Replacement Model (CJR) after reviewing nearly 400 comments from the public on the proposed rule, and the model is set to begin on April 1, 2016. The new CJR model is designed to test bundled payment and quality measurement for an episode of care associated with lower extremity joint replacement (LEJR) procedures, including hip and knee replacements or other major leg procedures. It is designed to focus on coordinated, patient centered care and aims to improve the care experience for the growing numbers of people with Medicare who receive LEJR procedures.

Hip and knee replacements are the most common inpatient surgery for Medicare beneficiaries and can require lengthy recovery and rehabilitation periods. In 2013, there were more than 400,000 inpatient primary procedures costing more than $7 billion for hospitalizations alone. The average Medicare expenditure for surgery, hospitalization and recovery ranges from $16,500 to $33,000 across geographic areas.

The new CJR model is meant to address a currently fragmented process by focusing on coordinated, patient-centered care. Patients would benefit from their hospitals and other health care providers working together more closely to coordinate care. This could lead to better outcomes, a better experience and fewer complications such as preventable readmissions, infections or prolonged rehabilitation and recovery.

It encourages hospitals, physicians and post-acute care providers such as home health agencies and skilled nursing facilities to work together to improve quality and care coordination. This model furthers the administration's commitment to create a health care system that provides better care, spends health care dollars more wisely and makes people healthier. In this model, hospitals would be paid for the outcomes that patients want. Providers will be held accountable for the quality and cost of services they provide and would be incentivized to help patients get and stay well. Patients would continue to choose their doctor, hospital, nursing facility, home health agency and other provider, but their providers would better coordinate their care.

The CJR model will be implemented in 67 geographic areas, defined by metropolitan statistical areas (MSAs), located throughout the nation. For additional information about the model including a list of MSAs, you may visit the following CMS webpage:

https://innovation.cms.gov/initiatives/cjr.

Information Disclaimer:

The information provided in this newsletter is intended only to be general summary information to the Region III provider community. It is not intended to take the place of either the written law or regulations.

Links to Other Resources:

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Marketplace: 10 Things to Tell Your Patients