U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Centers for Medicare & Medicaid Services

Spring Edition
Atlanta Regional Office

The Pulse of CMS

"A quarterly regional publication for health care professionals"
Serving Alabama, North Carolina, South Carolina, Florida, Georgia, Kentucky, Mississippi and Tennessee.

HEATH CARE FRAUD AND ABUSE CONTROL HIGH LIGHTED

Health Care Fraud and Abuse Control Program

The Affordable Care Act has helped the government fight fraud, strengthen health insurance programs, protect consumers, and save taxpayer dollars. The Obama Administration is committed to reducing fraud, waste, and abuse across the government. Since 2010, the U.S. Department of Health & Human Services (DHHS), Office of Inspector General (HHS OIG), CMS, and the U.S. Department of Justice (DOJ) have been using powerful, new anti-fraud tools to protect Medicare and Medicaid by shifting beyond a "pay and chase" approach toward fraud prevention. Through the groundbreaking Healthcare Fraud Prevention Partnership, stronger relationships have been built between the government and private sector to help protect all consumers.

These focused efforts are successful. In Fiscal Year (FY) 2014, the government recovered $3.3 billion as a result of health care fraud judgments, settlements and additional administrative impositions in health care fraud cases and proceedings. Since its inception in 1997, the Health Care Fraud and Abuse Control (HCFAC) Program has returned more than $27.8 billion to the Medicare Trust Funds. The HCFAC program has returned $7.70 for each dollar invested.

.

The Health Care Fraud Prevention and Enforcement Action Team (HEAT), a joint initiative between HHS, OIG, and DOJ, has played a critical role in the fight against health care fraud. A key component of HEAT is the Medicare Fraud Strike Force .These are interagency task force teams comprised of OIG and DOJ analysts, investigators, and prosecutors who target emerging or migrating fraud schemes, including fraud by criminals masquerading as health care providers or suppliers.

Since 2007, the Medicare Fraud Strike Force has charged over 2,100 individuals involved in more than $6.5 billion in fraud. Many of these charges have resulted from coordinated, multi-district national takedowns. Since 2010, the Medicare Fraud Strike Force has conducted seven national takedowns, resulting in charging nearly 700 people with a total of more than $2.2 billion in fraud, including a 90-person, $260 million takedown in six cities in May 2014. The Medicare Fraud Strike Force has a current conviction rate of approximately 95 percent. The average term of incarceration for individuals charged by the Medicare Fraud Strike Force exceeds 4 years.

Another powerful tool in the effort to combat health care fraud is the federal False Claims Act. In 2014, the Justice Department obtained $2.3 billion in settlements and judgments from civil cases involving fraud and false claims against federal health care programs such as Medicare and Medicaid. Since January 2009, the Justice Department has recovered more than $15.2 billion in cases involving health care fraud. These amounts reflect federal losses only. In many of these cases, the department was instrumental in recovering additional billions of dollars for state health care programs.

.

Continued on Page 3

Inside this Issue:

Update on the Status of Provisions

The negative 21% payment rate adjustment under current law for the Medicare Physician Fee Schedule is scheduled to take effect on April 1, 2015. CMS is taking steps to limit the impact on Medicare providers and beneficiaries by holding claims for a short period of time beginning on April 1, 2015. Holding claims for a short period of time allows CMS to implement any subsequent Congressional action while minimizing claims reprocessing and disruption of physician cash flow in the event of legislation addressing the 21% payment reduction. Under current law, electronic claims are not paid sooner than 14 calendar days (29 days for paper claims) after the date of receipt. As we stated in our recent email to physicians, CMS will provide more information about next steps by April 11, 2015.

In addition to the Medicare Physician Fee Schedule adjustment, other provisions affecting providers will also expire by April 1, including exceptions to the outpatient therapy caps, add-on payments for ambulance services, payments for low volume hospitals, and payments for Medicare dependent hospitals. These provisions include:

Exceptions process for Medicare Part B outpatient therapy caps—These caps are the annual per beneficiary cap amounts for occupational therapy and for physical therapy and speech-language pathology services combined, determined for each calendar year. Based on current law, exceptions to the therapy caps, which are allowed for reasonable and necessary therapy services above the caps, will be considered only for dates of service through March 31, 2015.

Continued on Page 4

Proposed Rule to Support Nationwide Operability

HHS, CMS, and the Office of the National Coordinator for Health Information Technology (ONC) recently announced the release of the Stage 3 notice of proposed rulemaking for the Medicare and Medicaid Electronic Health Records (EHRs) Incentive Programs, and the2015 Edition Health IT Certification Criteria, which will be used to improve the way electronic health information is shared and ultimately improve the way care is delivered and experienced. Together, these proposed rules will give providers additional flexibility, make the program simpler, drive interoperability among electronic health records, and increase the focus on patient outcomes to improve care.

The Meaningful Use Stage 3 proposed rule issued by CMS specifies new criteria that eligible professionals, eligible hospitals, and Critical Access Hospitals (CAHs) must meet to qualify for Medicaid EHR incentive payments. The rule also proposes criteria that providers must meet to avoid Medicare payment adjustments based on program performance beginning in payment year 2018. The rule gives more flexibility and simplifies requirements for providers by focusing on advanced use of electronic health records and eliminating requirements that are no longer relevant. The 2015 Edition Health IT Certification Criteria proposed rule aligns with the path toward interoperability. The proposed rule builds on past editions of adopted health IT certification criteria, and includes new and updated IT functionality and provisions that support the EHR Incentive Programs care improvement, cost reduction, and patient safety across the health system.

For more information, please visit the websites listed below:

- Stage 3 Proposed Rule: Comment period ends on May 29, 2015
- 2015 Edition Proposed Rule: Comment period ends on May 29, 2015
- Draft 2015 Edition Certification Test Procedures: Comment period ends on June 30, 2015
- Blog: CMS intends to modify requirements for Meaningful Use
- EHR Incentive Program website
- Health IT Regulations website

Advancing Care for People with Medicare and Medicaid

The Federal Coordinated Health Care Office (Medicare-Medicaid Coordination Office) serves people who are enrolled in both Medicare and Medicaid, Medicare-Medicaid enrollees, also known as dual eligibles. Our goal is to make sure Medicare-Medicaid enrollees have full access to seamless, high quality health care and to make the system as cost-effective as possible.

The Medicare-Medicaid Coordination Office works with the Medicaid and Medicare programs, across federal agencies, states and stakeholders to align and coordinate benefits between the two programs effectively and efficiently. We partner with states to develop new care models and improve the way Medicare-Medicaid enrollees receive health care. The Medicare-Medicaid Coordination Office was established pursuant to Section 2602 of the Affordable Care Act. The goals of the Office are:

1. Providing dual eligible individuals full access to the benefits to which such individuals are entitled to under the Medicare and Medicaid programs,

2. Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs,

3. Improving the quality of health care and long-term services for dual eligible individuals,

4. Increasing dual eligible individuals' understanding of and satisfaction with coverage under the Medicare and Medicaid programs,

5. Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs,

6. Improving care continuity and ensuring safe and effective care transitions for dual eligible individuals,

7. Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers, and

8. Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs,

Do you have questions or comments? Please share your ideas for improving the care experience for Medicare-Medicaid enrollees by emailing us at MedicareMedicaidCoordination@cms.hhs.gov .

You may also sign up for regular email updates by visiting this link

Please note – Our General Information website contains information if you have questions regarding a bill, applying for Medicaid, and how to obtain assistance with your health care costs or billing a beneficiary

Provider Outreach Staff:

Sabrina Teferi
Phone: (404) 562-7251

E-mail your questions and comments to us at: PartABInquiriesRO4@cms.hhs.gov

Additional free subscriptions to The Pulse can be obtained by registering on our list-serv at: http://list.nih.gov

Atlanta Regional Office:

Region IV
Division of Financial Management & Fee-For-Service Operations
Sam Nunn Atlanta Federal Center
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303-8909

Phone: 404-562-7347 e-Fax: 443-380-8924
Email: sabrina.teferi@cms.hhs.gov

CMS Announces Special Enrollment Period

CMS recently announced a Special Enrollment Period (SEP) for individuals and families who did not have health coverage in 2014 and are subject to the fee or "shared responsibility payment" when they file their 2014 taxes in states, which use the Federally-facilitated Marketplaces (FFM). This special enrollment period will allow those individuals and families who were unaware or didn't understand the implications of this new requirement to enroll in 2015 health insurance coverage through the FFM.

For those who were unaware or didn't understand the implications of the fee for not enrolling in coverage, CMS will provide consumers with an opportunity to purchase health insurance coverage from March 15 to April 30. If consumers do not purchase coverage for 2015 during this special enrollment period, they may have to pay a fee when they file their 2015 income taxes. Those eligible for this special enrollment period live in states with a Federally-facilitated Marketplace and:

- Currently are not enrolled in coverage through the FFM for 2015,
- Attest that when they filed their 2014 tax return they paid the fee for not having health coverage in 2014, and
- Attest that they first became aware of, or understood the implications of, the Shared Responsibility Payment after the end of open enrollment (February 15, 2015) in connection with preparing their 2014 taxes.

The SEP began on March 15, 2015 and will end at 11:59 pm E.S.T. on April 30, 2015. If a consumer enrolls in coverage on or before the 15th of the month, coverage will be effective on the first day of the following month. This year's tax season is the first time individuals and families will be asked to provide basic information regarding their health coverage on their tax returns. Individuals who could not afford coverage or met other conditions may be eligible to receive an exemption for 2014. To help consumers who did not have insurance last year determine if they qualify for an exemption, CMS also launched a health coverage tax exemption tool today on HealthCare.gov and CuidadodeSalud.gov.

Continued on Page 4

Health Care Fraud and Abuse Control Program (cont'd)

Continued from Page 1

In 2014, the DOJ obtained $2.3 billion in settlements and judgments from civil cases involving fraud and false claims against federal health care programs such as Medicare and Medicaid. Since January 2009, the Justice Department has recovered more than $15.2 billion in cases involving health care fraud. These amounts reflect federal losses only. In many of these cases, the department was instrumental in recovering additional billions of dollars for state health care programs.

Other steps the administration has taken to fight fraud include:

Health Care Fraud Prevention Partnership: The Obama Administration has joined with private insurers, states, and associations in the Health Care Fraud Prevention Partnership (HFPP) to prevent health care fraud on a national scale. From 2013 through 2014, HFPP completed early "proof-of-concept" studies that enabled partners, including DOJ, HHS-OIG, FBI, and CMS, states, private plans, and associations to take substantive actions, such as payment system edits, revocations, and payment suspensions to stop fraudulent payments and improve the government's collective forces against waste, abuse, and fraud.

State-of-the-Art Fraud Detection Technology: HCFAC funding also supported HHS OIG's continued enhancement of data analysis capabilities for detecting health care fraud, including tools that allow for complex data analysis. HHS OIG continues to use data analysis, predictive analytics, trend evaluation, and modeling approaches to better analyze and target oversight of HHS programs. Analysis teams use data to examine Medicare claims for known fraud patterns, identify suspected fraud trends, and calculate ratios of allowed services as compared to national averages.

Enhanced Provider Screening and Enrollment Requirements: Provider enrollment is the gateway to billing the Medicare program, and CMS implemented new critical safeguards in efforts to better screen providers enrolling in the Medicare program. The Affordable Care Act required CMS to revalidate all existing 1.5 million Medicare suppliers and providers under new risk-based screening requirements. CMS will have requested revalidations by March 2015. As a result of revalidation and other proactive initiatives, CMS deactivated more than 470,000 enrollments and revoked nearly 28,000 enrollments to prevent certain providers from re-enrolling and billing the Medicare program. A provider with deactivated billing privileges can reactivate at any time, and a revoked provider is barred from re-entry into Medicare for a period ranging from 1 to 3 years.

Coverage to Care Initiative

Thanks to the Affordable Care Act, more than 14 million Americans, many for the first time now have quality health insurance through the Marketplace, Medicaid and CHIP. It's important for the newly insured to fully understand when, where, and how to use their new coverage to get the right care, at the right time, in the right place to stay healthy.

This is why CMS has launched a new nationwide initiative called Coverage to Care (C2C). This initiative designed to help consumers understand their new coverage and help them get primary care and the preventive services that are right for them so they can live long, healthy lives.

The *C2C* website provides patients, healthcare providers, and stakeholders with information and resources regarding the program.

Millions of Americans now have the security and peace of mind that comes from having quality health insurance. However, to fully enjoy its benefits, they need to understand their new coverage, and how to use it appropriately to get the care and preventive services that are right for them. C2C *is* designed to do that, and help the newly insured take the first steps to living a long and healthy life.

ACA Initiative Builds on Success of ACOs

HHS recently announced a new initiative from the CMS Innovation Center: the Next Generation Accountable Care Organization (ACO) Model of payment and care delivery. ACOs in the Next Generation ACO Model will take on greater performance risk than ACOs in current models, while also potentially sharing in a greater portion of savings. To support increased risk sharing, ACOs will have a stable, predictable benchmark and flexible payment options that support ACO investments in care improvement infrastructure that provides high quality care to patients.

The new ACO model encourages greater coordination and closer care relationships between ACO providers and beneficiaries. ACOs will have a number of tools available to enhance the management of care for their beneficiaries. These tools include rewards to beneficiaries for receiving their care from physicians and professionals participating in their ACOs, coverage of skilled nursing care without prior hospitalization, and modifications to expand the coverage of telehealth and post-discharge home services to support coordinated care at home. CMS will accept ACOs into the Next Generation ACO Model through two rounds of applications in 2015 and 2016, with participation expected to last up to five years.

More information is available on the following websites:

- Fact Sheet
- Blog: Building on the Success of the ACO Model
- FAQs
- Next Generation ACO Model web page

Updated on the Status of Provisions (cont'd)

Continued from Page 1

Add-on Payments for Ambulance Services—Currently Medicare provides for an increase in the ambulance fee schedule amounts (both base rate and mileage) for covered ground ambulance transports that originate in rural areas by three percent and covered ground ambulance transports that originate in urban areas by two percent. In addition, currently Medicare provides for an increase of 22.6 percent in the base rate of the ambulance fee schedule amount for covered ground ambulance transports that originate in rural areas designated as super rural. These provisions expire as of April 1, 2015.

Payments for Low-Volume Hospitals and Medicare Dependent Hospitals —The Affordable Care Act and subsequent legislation made temporary changes to the low-volume hospital payment adjustment for hospitals that meet certain discharge and mileage criteria. The Medicare Dependent Hospital program also provides enhanced payment to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. These temporary changes to the low-volume hospital adjustment and the Medicare Dependent Hospital provision expire on April 1, 2015.

Recovery Auditor Inpatient Hospital Status Reviews—CMS will continue to prohibit Recovery Auditor inpatient hospital patient status reviews for dates of admission occurring between October 1, 2013 and April 30, 2015. In addition, CMS will continue the Inpatient Probe and Educate process through April 30, 2015.

CMS must take steps to implement the negative update and the expiration of the other provisions noted above. Providers should remember that claims for services furnished on or before March 31, 2015 are not affected by the payment cut and will be processed and paid under normal time frames. We are working to limit any impact to Medicare providers and beneficiaries as much as possible.

Special Enrollment Period (cont'd)

Continued from Page 3

Most taxpayers will only need to check a box when they file their taxes to indicate that they had health coverage in 2014 through their employer, Medicare, Medicaid, veterans care or other qualified health coverage that qualifies as "minimum essential coverage." The remaining taxpayers will take different steps. It is expected that 10 to 20 percent of taxpayers who were uninsured for all or part of 2014 will qualify for an exemption from the requirement to have coverage. A much smaller fraction of taxpayers, an estimated 2 to 4 percent, will pay a fee because they made a choice to not obtain coverage and are not eligible for an exemption.

Americans who do not qualify for an exemption and went without health coverage in 2014 will have to pay a fee ($95 per adult or 1 percent of their income, whichever is greater) when they file their taxes this year. The fee increases to $325 per adult or 2% of income for 2015. Individuals taking advantage of this special enrollment period will still owe a fee for the months they were uninsured and did not receive an exemption in 2014 and 2015.

The Administration is committed to providing the information and tools tax filers need to understand the new requirements. Part of this outreach effort involves coordinating efforts with nonprofit organizations and tax preparers who provide resources to consumers and offer on the ground support. If consumers have questions about their taxes, need to download forms, or want to learn more about the fee for not having insurance, they can find information and resources on the HealthCare.gov or IRS websites. Consumers can also call the Marketplace Call Center at 1-800-318-2596.

Consumers seeking to take advantage of the special enrollment period can find out if they are eligible by visiting the HealthCare.gov website. Consumers can find local help at Localhelp.healthcare.gov or call the Federally-facilitated Marketplace Call Center at 1-800-318-2596. TTY users should call 1-855-889-4325. Assistance is available in 150 languages. The call is free.