



mln listening session

A MEDICARE LEARNING NETWORK® (MLN) EVENT

Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics

Monday, August 12, 2019

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Acronyms in this Presentation

- APM Alternative Payment Models
- CMS Centers for Medicare & Medicaid Services
- CPT Current Procedural Technology
- CY Calendar Year
- E/M Evaluation and Management
- GAF Geographic Adjustment Factor
- HCPCS Healthcare Common Procedure Coding System
- MAT Medication Assisted Treatment
- MDM Medical Decision Making
- MLN Medicare Learning Network
- MIPS Merit-based Incentive Payment System
- MSPB Medicare Spending Per Beneficiary measure



Acronyms in this Presentation

- MVP MIPS Value Pathways
- OTP Opioid Treatment Program
- OUD Opioid Use Disorder
- PFS Physician Fee Schedule
- QCDR Quality Clinical Data Registry
- QPP Quality Payment Program
- RUC RVS Update Committee
- RVU Relative Value Unit
- SAMHSA Substances Abuse and Mental Health Services Administration
- TIN Tax Identification Number
- TPCC Total Per Capita Costs for All Attributed Beneficiaries measure



Agenda

- **Opening Remarks**
- **Evaluation and Management (E/M) Payments**
 - Feedback Session
- **Quality Payment Program Improvements**
 - Feedback Session
- **New Opioid Treatment Program Benefit**
 - Feedback Session



When & Where to Submit Comments

- See the [proposed rule](#) for information on submitting formal comments by September 27, 2019.
- Proposed rule includes proposed changes not reviewed in this presentation so please refer to proposed rule for complete information
- Feedback during presentation not considered as formal comments; please submit comments in writing using formal process
- See proposed rule for information on submitting comments by close of 60-day comment period on September 27 (When commenting refer to file code CMS-1715-P)
- Instructions for submitting comments can be found in proposed rule; FAX transmissions will not be accepted
- You must officially submit your comments in one of following ways:
 - electronically through Regulations.gov
 - by regular mail
 - by express or overnight mail
 - by hand or courier



Opening Remarks

Administrator Seema Verma



E/M Payments

Ann Marshall
Emily Yoder



Medical Record Documentation Supports Patient Care

- Clear and concise medical record documentation is critical to providing patients with quality care and is necessary for physicians and others to receive accurate and timely payment for furnished services.
- Medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient's health history.
- Medical record documentation helps physicians and other health care professionals evaluate and plan the patient's immediate treatment and monitor the patient's health care over time.
- Many complain that notes written to comply with coding requirements do not support patient care and keep doctors away from patients.



Levels of E/M Visits and PFS Payment

- Physicians and other practitioners paid under the PFS bill for office/outpatient E/M visits using a set of CPT codes that distinguish visits based on level of complexity, site of service, and whether the patient is new or established.
- The three key components when selecting the appropriate code to bill are **history**, **examination**, and **medical decision making (MDM)**. For visits that consist predominantly of counseling and/or coordination of care, time can be used as the key or controlling factor determining visit level.
- There are currently five levels of E/M office/outpatient visits (reported using CPT codes 99201-99215). Payment increases with each level.



Choosing the Appropriate Code and Providing Supporting Documentation

- For coding and billing the PFS, in the past practitioners have used either the 1995 or 1997 E/M documentation guidelines. These are very similar to a parallel set of guidelines that are longstanding in the CPT codebook.
- These guidelines specify medical record information within each of the three components that serves as support for billing a given visit level.
- Stakeholders have said that the E/M documentation guidelines, and the code set itself are clinically outdated and may not reflect the most clinically meaningful or appropriate differences in patient complexity and care. Documentation has proliferated to support visit level in a way that bloats the medical record and prevents ready access to the most important information for patient care.



Policies for E/M Office/Outpatient Visits Finalized in the CY 2019 Final Rule for CY 2021

- In the CY 2019 PFS Final Rule, CMS finalized payment, coding, and documentation changes for E/M office/outpatient visits to be implemented in CY 2021, specifically:
 - Single blended rate for levels 2 through 4 (one for established and one for new patients), maintaining separate payment rates for levels 1 and 5;
 - Add-on G codes for level 2 through 4 visits that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care;
 - An “extended visit” add-on G code (GPRO1) for level 2 through 4 visits to account for the additional resources required when practitioners spend additional time with these patients. Existing prolonged service codes will be used with level 5.



Policies for E/M Office/Outpatient Visits Finalized in the CY 2019 Final Rule for CY 2021

- For level 2 through 5 visits, choice to document using the current framework, MDM or time:
 - When time is used to document, practitioners will document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary (typical CPT time for code reported, plus any extended/prolonged time).
 - When using current framework or MDM to document, for level 2 through 4 visits CMS will only require the supporting documentation currently associated with level 2 visits (as a corollary to the blended payment).
 - Current MDM guidelines will apply when using MDM to select visit level.



Proposed Policies for 2021

- Following the finalization of these policies, key stakeholders, including the American Medical Association (AMA) engaged CMS in ongoing dialogue.
- The AMA/CPT has developed a similar alternative approach that we are proposing to largely adopt for the PFS effective January 1, 2021 because we believe it reflects CMS' goals of reducing documentation burden, is more in line with the current practice of medicine, and will more likely adopted by other payers. This approach is detailed in full on the AMA website at <https://www.ama-assn.org/cpt-evaluation-and-management>.
- CPT has redefined the office/outpatient E/M visit code set—We are proposing to adopt CPT's revisions to the office/outpatient E/M code descriptors (including deletion of CPT code 99201) and assign separate payment rates to each of the codes as revised.



Proposed Policies for 2021

- There would be choice of time or MDM to select code level.
- MDM – We are proposing to adopt the new interpretive guidelines by CPT for levels of MDM.
- History/Exam – History and exam would no longer be used to select visit level; instead, there would be a medically appropriate history and exam.
- Time
 - We would adopt the new times in the code descriptors that include all practitioner time the day of the visit
 - We would adopt the new CPT code for prolonged services (CPT 99xxx) in lieu of GPRO1 (the extended service code) and CPT codes 99358, 99359 (prolonged non-face-to-face). We are seeking input on policies related to CPT codes 99358, 99359.



Proposed Changes to the Office/Outpatient E/M Code Valuation for CY 2021

- The AMA RUC reviewed and made valuation recommendations for all codes in the office/outpatient E/M code family and an add-on code for prolonged service time, based on a robust survey of around 50 specialty societies.
- The RUC recommended values increase payment for office/outpatient E/M services.
- We are proposing to accept the RUC-recommended values for all of these codes, effective January 1, 2021.



Proposed Payment for Office/Outpatient Based E/M Visits

Level	Current Payment* (new patient)	Approximate Payment Rates Finalized in 2019 for CY 2021	Proposed Payment**
1	\$45	\$44	N/A
2	\$76		\$77
3	\$110	\$135	\$119
4	\$167		\$177
5	\$211	\$211	\$232

Level	Current Payment* (established patient)	Approximate Payment Rates Finalized in 2019 for 2021	Proposed Payment**
1	\$22	\$24	\$24
2	\$45		\$60
3	\$74	\$93	\$96
4	\$109		\$136
5	\$148	\$148	\$190

* Current Payment for CY 2019

**Proposed Payment based on the CY2020 proposed relative value units and the CY2019 payment rate

- We are also proposing a new prolonged services code for additional time spent with patients beyond the level 5 visit. We are proposing a payment rate of approximately \$35.
- We are also proposing to consolidate the two add-on HCPCS G codes we finalized last year for primary care and certain non-procedural specialty care into a single code describing the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition. The proposed payment rate for this services is approximately \$17.



Add-on Codes for Certain Types of Visits

- In the CY 2019 PFS Final Rule we finalized two HCPCS add-on G-codes describing additional resources associated with primary care and certain types of non-procedural specialty visits, for CY 2021.
- However, we understand from previous comments and ongoing engagement with stakeholders that the add-on code(s) should be easy to understand and report for purposes of medical documentation and billing.
- We also want to maintain clarity that the add-on code is not intended to reflect a difference in payment by specialty, but rather recognition of a different per visit resource cost based on the kinds of care practitioners provide, regardless of Medicare enrollment specialty.
- We are therefore proposing a single add-on code that describes ongoing primary care and/or ongoing medical care related to a single, serious, or complex chronic condition billable with every office/outpatient E/M visit meeting these criteria.



Feedback Session



Quality Payment Program

Molly MacHarris
Corey Henderson



Merit-based Incentive Payment System (MIPS) Proposals for 2020

Performance Categories – High-Level Proposed Changes:

- **Quality:** Remove low-bar, standard of care, process measures, focus on high-priority outcome measures, and add new specialty sets; increase sample to 70% for data completeness; introduce a benchmarking policy for 2022 payment year.
- **Cost:** Add 10 episode-based measures and revise current global measures' attribution methodologies (TPCC and MSPB Clinician).
- **Improvement Activities:** Addition of 2 new Improvement Activities, modification of 7 existing Improvement Activities, removal of 15 existing Improvement Activities; new requirement for Improvement Activity credit for groups (**at least 50%** of MIPS eligible clinicians participate).
- **Promoting Interoperability:** New reweighting standards for hospital-based MIPS eligible clinicians in groups; revised the Query of Prescription Drug Monitoring Program (PDMP) measure and removed the Verify Opioid Treatment Agreement measure in alignment with the Medicare PI program for eligible hospitals and CAHs.



MIPS Proposals for 2020

Performance Category Weights:

Performance Category	Performance Category Weights Year 3 (2019)	Proposed Weights Year 4 (2020)	Proposed Weights Year 5 (2021)	Proposed Weights Year 6 (2022)
 Quality	45%	40%	35%	30%
 Cost	15%	20%	25%	30%
 Improvement Activities	15%	15%	15%	15%
 Promoting Interoperability	25%	25%	25%	25%



MIPS Proposals for 2020

Payment Thresholds:

Performance Period	Performance Threshold	Exceptional Performance Bonus	Payment Adjustment*
Year 1 (2017)	3 points	70 points	Up to +4%
Year 2 (2018)	15 points	70 points	Up to +5%
Year 3 (2019)	30 points	75 points	Up to +7%
Year 4 (2020) Proposed	45 points	80 points	Up to +9%
Year 5 (2021) Proposed	60 points	85 points	Up to +9%

*Payment adjustment (and exceptional performer bonus) is based on comparing final score to performance threshold and additional performance threshold for exceptional performance. To ensure budget neutrality, positive MIPS payment adjustment factors are likely to be increased or decreased by an amount called a “scaling factor.” The amount of the scaling factor depends on the distribution of final scores across all MIPS eligible clinicians.



MIPS Proposals for 2020

Third-Party Intermediaries:

CMS is focused on improved partnerships with third parties to help reduce the clinician reporting burden. CMS is proposing that QCDRs and Qualified Registries must:

- Support the **Quality, Improvement Activities, and Promoting Interoperability** performance categories;
- Provide enhanced performance feedback; and
- Deliver quality improvement services.

Additional Proposed Changes:

- Definition of hospital-based clinicians
- Final score reweighting policy due to data integrity concerns
- Targeted reviews requests to be submitted within 60 days of the MIPS payment adjustment



Advanced Alternative Payment Models (APMs) Proposals for 2020

MIPS APM Quality Reporting Credit:

- MIPS eligible clinicians participating in APMs will be allowed the option to report for the MIPS Quality performance category to offer flexibility and improve meaningful measurement.
- Proposed **MIPS APM Quality Reporting Credit** for APM participants in Other MIPS APMs where quality scoring through the APM is not technically feasible, including:
 - A credit equal to 50% percent of the MIPS Quality performance category weight
 - Quality reporting exceptions

Additional Proposed Changes:

- Partial QPs only excluded from MIPS in the TIN through which they received Partial QP status
- Introducing the use of the average marginal risk rate



MIPS Proposals for 2021 and Beyond

MIPS Value Pathways

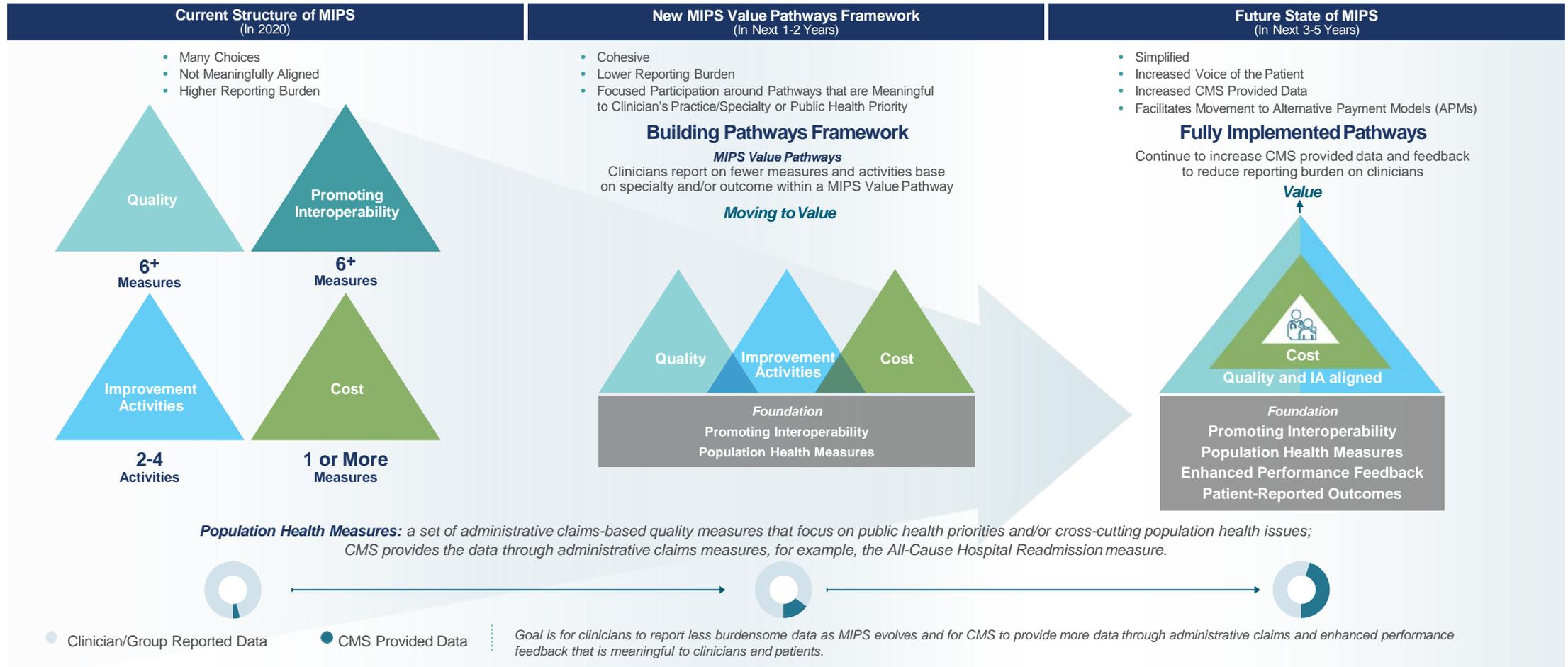
CMS is proposing **MIPS Value Pathways (MVPs)** to create a new participation framework beginning with the 2021 performance year. This new framework would:

- Unite and connect measures and activities across the **Quality, Cost, Promoting Interoperability, and Improvement Activities** performance categories of MIPS
- Incorporate a set of administrative claims-based quality measures that focus on population health/public health priorities
- Streamline MIPS reporting by limiting the number of required specialty or condition specific measures

CMS encourages the health care community to review the Transforming MIPS: MIPS Value Pathways Request for Information (RFI) and our [illustrative diagram](#) and submit formal comments. We look forward to working with you to establish this new framework.



MIPS Value Pathways



We Need Your Feedback on:

Pathways:

What should be the structure and focus of the Pathways?
What criteria should we use to select measures and activities?

Participation:

What policies are needed for small practices and multi-specialty practices?
Should there be a choice of measures and activities within Pathways?

Public Reporting:

How should information be reported to patients?
Should we move toward reporting at the individual clinician level?



MIPS Value Pathways: Surgical Example

Current Structure of MIPS (In 2020)	New MIPS Value Pathways Framework (In Next 1-2 Years)	Future State of MIPS (In Next 3-5 Years)
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MIPS moving towards value; focusing participation on specific meaningful measures/activities or public health priorities; facilitating movement to Advanced APM track

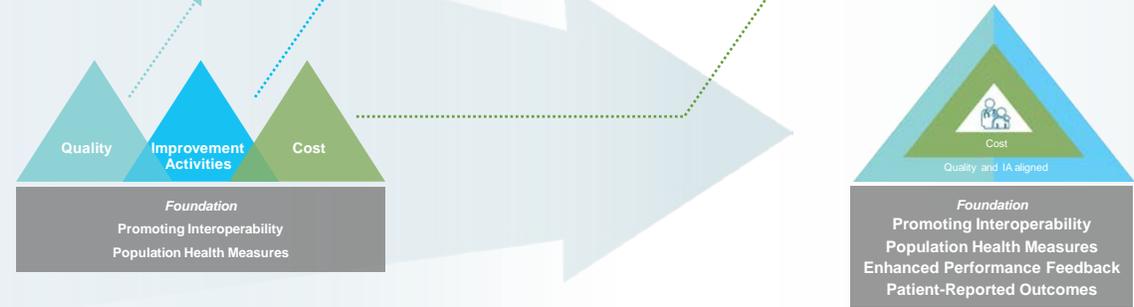
 <p>Surgeon chooses from same set of measures as all other clinicians, regardless of specialty or practice area</p>	 <p>Surgeon reports same "foundation" of PI and population health measures as all other clinicians but now has a MIPS Value Pathway with surgical measures and activities aligned with specialty</p>	 <p>Surgeon reports on same foundation of measures with patient-reported outcomes also included</p>
 <p>Four performance categories feel like four different programs</p>	 <p>Surgeon reports on fewer measures overall in a pathway that is meaningful to their practice</p>	 <p>Performance category measures in Surgical Pathway are more meaningful to the practice</p>
 <p>Reporting burden higher and population health not addressed</p>	 <p>CMS provides more data; reporting burden on surgeon reduced</p>	 <p>CMS provides even more data (e.g. comparative analytics) using claims data and surgeon's reporting burden even further reduced</p>



MIPS Value Pathways for Surgeons

QUALITY MEASURES Unplanned Reoperation within the 30-Day Postoperative Period (Quality ID: 355) Surgical Site Infection (SSI) (Quality ID: 357) Patient-Centered Surgical Risk Assessment and Communication (Quality ID: 358)	IMPROVEMENT ACTIVITIES Use of Patient Safety Tools (IA_PSPA_8) Implementing the Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop (IA_CC_1) OR Completion of an Accredited Safety or Quality Improvement Program (IA_PSPA_28)	COST MEASURES Medicare Spending Per Beneficiary (MSPB_1) Revascularization for Lower Extremity Chronic Critical Limb Ischemia (COST_CCLI_1) Knee Arthroplasty (COST_KA_1)
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*Measures and activities selected for illustrative purposes and are subject to change.



Population Health Measures: a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.

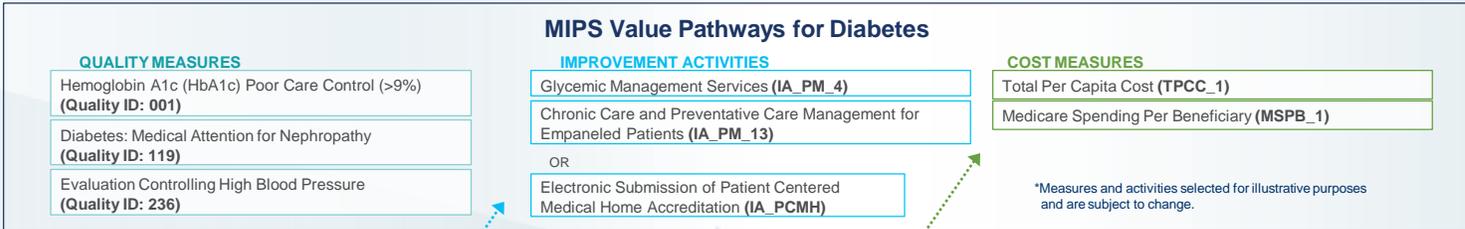


MIPS Value Pathways: Diabetes Example

Current Structure of MIPS (In 2020)	New MIPS Value Pathways Framework (In Next 1-2 Years)	Future State of MIPS (In Next 3-5 Years)
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MIPS moving towards value; focusing participation on specific meaningful measures/activities or public health priorities; facilitating movement to Advanced APM track

 <p>Endocrinologist chooses from same set of measures as all other clinicians, regardless of specialty or practice area</p>	 <p>Endocrinologist reports same "foundation" of PI and population health measures as all other clinicians but now has a MIPS Value Pathway with measures and activities that focus on diabetes prevention and treatment</p>	 <p>Endocrinologist reports on same foundation of measures with patient-reported outcomes also included</p>
 <p>Four performance categories feel like four different programs</p>	 <p>Endocrinologist reports on fewer measures overall in a pathway that is meaningful to their practice</p>	 <p>Performance category measures in endocrinologist's Diabetes Pathway are more meaningful to their practice</p>
 <p>Reporting burden higher and population health not addressed</p>	 <p>CMS provides more data; reporting burden on endocrinologist reduced</p>	 <p>CMS provides even more data (e.g. comparative analytics) using claims data and endocrinologist's reporting burden even further reduced</p>



Population Health Measures: a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.



Feedback Session



Opioid Treatment Programs

Lindsey Baldwin
Pierre Yong



Overview

Expanding access to treatment for Opioid Use Disorder is one of CMS' key areas of focus in addressing the opioid epidemic.

The following presentation includes a discussion of proposed policies to implement coverage of a new Medicare Part B benefit for Opioid Treatment Programs (OTPs).



The SUPPORT for Patients and Communities Act

Section 2005 of the SUPPORT Act establishes a new Medicare Part B benefit for opioid use disorder (OUD) treatment services furnished by OTPs on or after January 1, 2020.

The statute allows implementation “through one or more bundles based on the type of medication provided (such as buprenorphine, methadone, naltrexone, or a new innovative drug), the frequency of services, the scope of services furnished, characteristics of the individuals furnished such services, or other factors as the Secretary determine[s] appropriate.”



Background

- Currently, the Substance Abuse and Mental Health Services Administrations (SAMHSA) certifies about 1,700 OTPs nationwide.
- They are located predominately in urban areas, tend to be free-standing facilities, and provide medication-assisted treatment (MAT) in addition to a range of other services. SAMHSA defines MAT as the use of medication in combination with behavioral health services to provide an individualized approach to the treatment of substance use disorder, including OUD (42 CFR 8.2).
- The payor mix for OTPs currently includes Medicaid, private payors, TRICARE, as well as individual pay patients.
- Medicare currently covers office-based opioid treatment with buprenorphine and naltrexone but has historically not covered OTPs, which are the only entities authorized to use methadone for the treatment of OUD. Coverage of OTPs is a new benefit that we anticipate will expand access to care.



OTP Proposals in the Proposed Rule

- OTP means an entity that is an opioid treatment program (as defined in section 8.2 of title 42 of the Code of Federal Regulations, or any successor regulation) that—
 - Is enrolled in Medicare;
 - Has in effect a certification by the Substance Abuse and Mental Health Services Administration (SAMHSA);
 - Is accredited by an accrediting body approved by SAMHSA; and
 - Meets such additional conditions as the Secretary may find necessary to ensure—
 - (i) the health and safety of individuals being furnished services under such program; and
 - (ii) the effective and efficient furnishing of such services.



OTP Proposals in the Proposed Rule

The statute specifies that OUD treatment services provided by OTPs will include the following:

- FDA-approved opioid agonist and antagonist treatment medications,
- The dispensing and administration of such medications (if applicable),
- Substance use disorder counseling,
- Individual and group therapy,
- Toxicology testing,
- And other items and services that the Secretary determines are appropriate.



OTP Proposals: Coding and Payment

- We are proposing to adopt a coding structure for OUD treatment services that varies by the medication administered.
- To operationalize this approach, we are proposing to establish G codes for weekly bundles describing treatment with:
 - Methadone,
 - Oral buprenorphine, injectable buprenorphine, buprenorphine implants (insertion, removal, and insertion/removal),
 - Extended-release injectable naltrexone,
 - Medication not otherwise specified, and
 - A non-drug bundle



OTP Proposals

Partial Episodes

To provide more accurate payment to OTPs in cases where a beneficiary is not able to or chooses not to receive all items and services described in their treatment plan or in which the OTP is unable to furnish services, for example, in the case of a natural disaster, we are proposing to establish separate payment rates for partial episodes that correspond with each of the full weekly bundles.

Intensity Add-on

We are proposing to adjust the bundled payment rates through the use of an add-on code in order to account for instances in which effective treatment requires additional counseling or group or individual therapy to be furnished for a particular patient that substantially exceeds the amount specified in the patient's individualized treatment plan.

Telecommunications

We are proposing to allow OTPs to furnish the substance use counseling, individual therapy, and group therapy included in the bundle via two-way interactive audio-video communication technology, as clinically appropriate, in order to increase access to care for beneficiaries.



OTP Proposals: Payment

- The proposed codes describing OTP treatment services are assigned flat dollar payment amounts (these services are not assigned RVUs)
- Each bundled payment is composed of:
 - **Drug component**
 - We are proposing to use the typical or average maintenance dose to determine the drug costs for each of the proposed bundles
 - We are proposing to use the payment methodology in section 1847A of the Act, which is based on Average Sales Price, to set the payment rates for the “incident to” drugs and ASP-based payment to set the payment rates for the oral product categories when we receive manufacturers’ voluntarily-submitted ASP data for these drugs
 - **Non-drug component**
 - The non-drug component includes payment for counseling, therapy, toxicology testing, and drug dispensing and administration (as applicable)
 - The non-drug component was priced based on a crosswalk to the non-drug portion of TRICARE’s weekly bundled rate for methadone
- See Table 15 in the CY2020 [proposed rule](#) for the proposed payment rates



OTP Proposals: Beneficiary Copayment

- We are proposing to set the copayment at zero for a time-limited duration (for example, for the duration of the national opioid crisis), as we believe this would minimize barriers to patient access to OUD treatment services.
- Setting the copayment at zero also ensures Medicare-enrolled OTP providers receive the full Medicare payment amount for Medicare beneficiaries if secondary payers are not available or do not pay the copayment, especially for those dually eligible for Medicare and Medicaid.
- We intend to continue to monitor the opioid crisis in order to determine at what point in the future a copayment may be imposed. At such a time we deem appropriate, we would institute cost sharing through future notice and comment rulemaking.
- The Part B deductible would apply for OUD treatment services, as mandated for all Part B services by section 1833(b) of the Act.



OTP Proposals: Locality Adjustments

- **Drug component:** Because our proposed approaches for pricing the MAT drugs included in the bundles all reflect national pricing, and because there is no geographic adjustment factor applied to the payment of Part B drugs under the ASP methodology, we do not believe that it is necessary to adjust the drug component of the bundled payment rates for OTP services based upon geographic locality.
- **Non-drug component:** Unlike the national pricing of drugs, the cost for the services included in the non-drug component of the OTP bundled payment for OUD treatments are not constant across all geographic localities. In order to account for the differential costs of OUD treatment services across the country, we are proposing to adjust the non-drug component of the bundled payment rates using an approach similar to the established methodology used to geographically adjust payments under the PFS based upon the location where the service is furnished. In order to apply a single adjustment, we are proposing to use the Geographic Adjustment Factor (GAF) to adjust the payment for the non-drug component of the OTP bundled payment to reflect the costs of furnishing the non-drug component of OUD treatment services in each of the PFS localities.



OTP Proposals: Annual Updates

To fulfill the statutory requirement to provide an update each year to the OTP bundled payment rates, we are proposing to apply a blended annual update, comprised of distinct updates for the drug and non-drug components of the bundled payment rates, to account for the differing rate of growth in the prices of drugs relative to other services.

- **Drug component:** We are proposing to update the payment for the drug component based upon the changes in drug costs reported under the pricing mechanism used to establish the pricing of the drug component of the applicable bundled payment rate.
- **Non-drug component:** We are proposing to update the non-drug component of the bundled payment for OUD treatment services based upon the Medicare Economic Index (MEI).



OTP Enrollment

In order to enroll with Medicare, OTPs must be certified by SAMHSA and accredited by a SAMHSA-approved accrediting body.

For more information on the accreditation process, visit SAMHSA's [Certification of Opioid Treatment Programs \(OTPs\)](#) webpage.



OTP Enrollment Proposals

Enroll using the CMS Form-855B

- Pay the application fee (CY 2019, \$586)
- Submit fingerprints for all 5% or greater owners, including partners
- Undergo an observational site visit at the OTP practice location
- Report all 'ordering/prescribing' and 'dispensing' practitioners on the supplemental attachment form specific to OTPs



Feedback Session



Resources

- [E/M Webpage](#)
- [Quality Payment Program Website](#)
- [OTP Webpage](#)
- [SUPPORT for Patients and Communities Act](#)
- [CMS Roadmap: Fighting the Opioid Crisis](#)



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