



mln call

A MEDICARE LEARNING NETWORK® (MLN) EVENT

Physician Fee Schedule and OPPS/ASC Final Rules

November 6, 2019



Acronyms in this Presentation

- **AMA** – American Medical Association
- **APM** – Alternative Payment Model
- **ASC** – Ambulatory Surgical Center
- **ASP** – Average Sales Price
- **CCM** – Chronic Care Management
- **CPT** – Current Procedural Terminology
- **E/M** – Evaluation and Management
- **FDA** – Food and Drug Administration
- **HCPCS** – Healthcare Common Procedure Coding System
- **IPO** – Inpatient Only
- **MA** – Medicare Advantage
- **MAT** – Medication-Assisted Treatment
- **MIPS** – Merit-based Incentive Payment System
- **MSPB** – Medicare Spending Per Beneficiary
- **MVPs** – MIPS Value Pathways
- **OPPS** – Outpatient Prospective Payment System
- **OTP** – Opioid Treatment Program
- **ODD** – Opioid Use Disorder
- **PA** – Physician Assistant
- **PFS** – Physician Fee Schedule
- **QCDR** – Quality Clinical Data Registry
- **QP** – Qualifying Participant
- **RUC** – Relative Value Scale Update Committee
- **SAMHSA** – Substance Abuse and Mental Health Services Administration
- **TPCC** – Total Per Capita Cost



Agenda

- Opening Remarks
- CY 2020 Physician Fee Schedule (PFS)
 - PFS Payment and Physician Assistant (PA) Supervision Policy Updates
 - Quality Payment Program
 - Opioid Treatment Programs
- CY 2020 Outpatient Prospective Payment System (OPPS)/Ambulatory Surgical Center (ASC)



Opening Remarks

Administrator Seema Verma



CY 2020 PFS



PFS Payment and PA Supervision Policy Updates

Christiane Labonte
Emily Yoder



Policies for E/M Office/Outpatient Visits Finalized for CY 2021

- We are largely aligning our Evaluation and Management (E/M) coding with changes laid out by the American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel for office/outpatient E/M visits, which:
 - Retain 5 levels of coding for established patients, reduce the number of levels to 4 for office/outpatient E/M visits for new patients, and revise the code definitions
 - Revise the times and medical decision making guidelines for all of the codes and requires performance of history and exam only as medically appropriate
 - Allow clinicians to choose the E/M visit level based on either medical decision making or time
- Visit the AMA [CPT E/M](#) webpage for more details
- We believe this approach reflects CMS' goals of reducing documentation burden



Policies for Office/Outpatient E/M Visits Finalized for CY 2021

- We are adopting the Relative Value Scale Update Committee (RUC) recommended values for the office/outpatient E/M visit codes and the new add-on CPT code for prolonged service time. The AMA RUC-recommended values will increase payment for office/outpatient E/M visits.
- We are also consolidating and increasing payment for the Medicare-specific add-on code for office/outpatient E/M visits for primary care and 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. This is not intended to reflect a difference in payment by enrollment specialty, but rather a better recognition of differences between kinds of visits.
- We are not adopting changes to the global surgery codes, as we continue to evaluate data about post-operative visits.



Approximate Payments for Office/Outpatient Based E/M Visits

Level	Current Payment* (new patient)	Approximate Finalized Payment**	Current Payment* (established patient)	Approximate Finalized Payment**
1	\$45	N/A	\$22	\$24
2	\$76	\$77	\$45	\$60
3	\$110	\$119	\$74	\$96
4	\$167	\$177	\$109	\$136
5	\$211	\$232	\$148	\$190

* Current Payment for CY 2019

** Finalized Payment based on the CY 2020 finalized relative value units and the CY 2019 payment rate
CY 2021 Payments may change based on CY 2021 rulemaking

- The new prolonged services code will have a payment of approximately \$22
- The HCPCS G-code add-on for primary care or medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition will have a payment of approximately \$15



Physician Supervision Requirements for PAs

- We are modifying our regulation on physician supervision for PA professional services to give PAs greater flexibility to practice more broadly in the current health care system in accordance with state law and state scope of practice rules in the state in which the PA professional services are furnished.
- Accordingly, a PA must furnish professional services in accordance with any state laws or state scope of practice rules that describe the required practice relationship between physicians and PAs, including explicit supervisory or collaborative practice requirements that describe a form of supervision for purposes of section 1861(s)(2)(K)(i) of the Act.
- In the absence of any state rules for physician supervision of PA services, we are finalizing a revision to the current supervision requirement to clarify that physician supervision is a process in which a PA has a working relationship with one or more physicians to supervise the delivery of their health care services.



Care Management Services

- For CY 2020, we are finalizing our proposal to increase payment for transitional care management, which is a care management service provided to beneficiaries after discharge from an inpatient stay or certain outpatient stays.
- We are creating a Medicare-specific code for additional time spent beyond the initial 20 minutes of non-complex Chronic Care Management (CCM) services, which is a service provided to beneficiaries with multiple chronic conditions over a calendar month. We also refined several aspects of CCM care planning.
- Recognizing that clinicians across all specialties manage the care of beneficiaries with chronic conditions, we are also creating new coding for principal care management services for patients with only a single serious and high-risk chronic condition.



Quality Payment Program

Molly MacHarris
Brittany LaCouture



Policies for 2021 and Beyond: MIPS Value Pathways

- CMS is committed to the transformation of the Merit-based Incentive Payment System (MIPS) through the **MIPS Value Pathways (MVPs)**, a new participation framework beginning in the 2021 performance year. This new framework will:
 - Remove barriers to Alternative Payment Model (APM) participation
 - Move away from siloed activities and towards an aligned set of measure options more relevant to a clinician's scope of practice that is meaningful to patient care
 - Promote value by focusing on **Quality** and **Cost** measures and **Improvement Activities** built on a foundation of population health measures calculated from administrative claims-based quality measures and **Promoting Interoperability** concepts
 - Further reduce reporting burden
 - Keep the patient at the center of our work
- After consideration of the comments submitted to the MVPs Request for Information, CMS is finalizing a modified proposal to define MVPs as a subset of measures and activities established through rulemaking. CMS is committed to working with stakeholders to develop this new framework, as well as develop additional ways to reduce burden in the MIPS program.

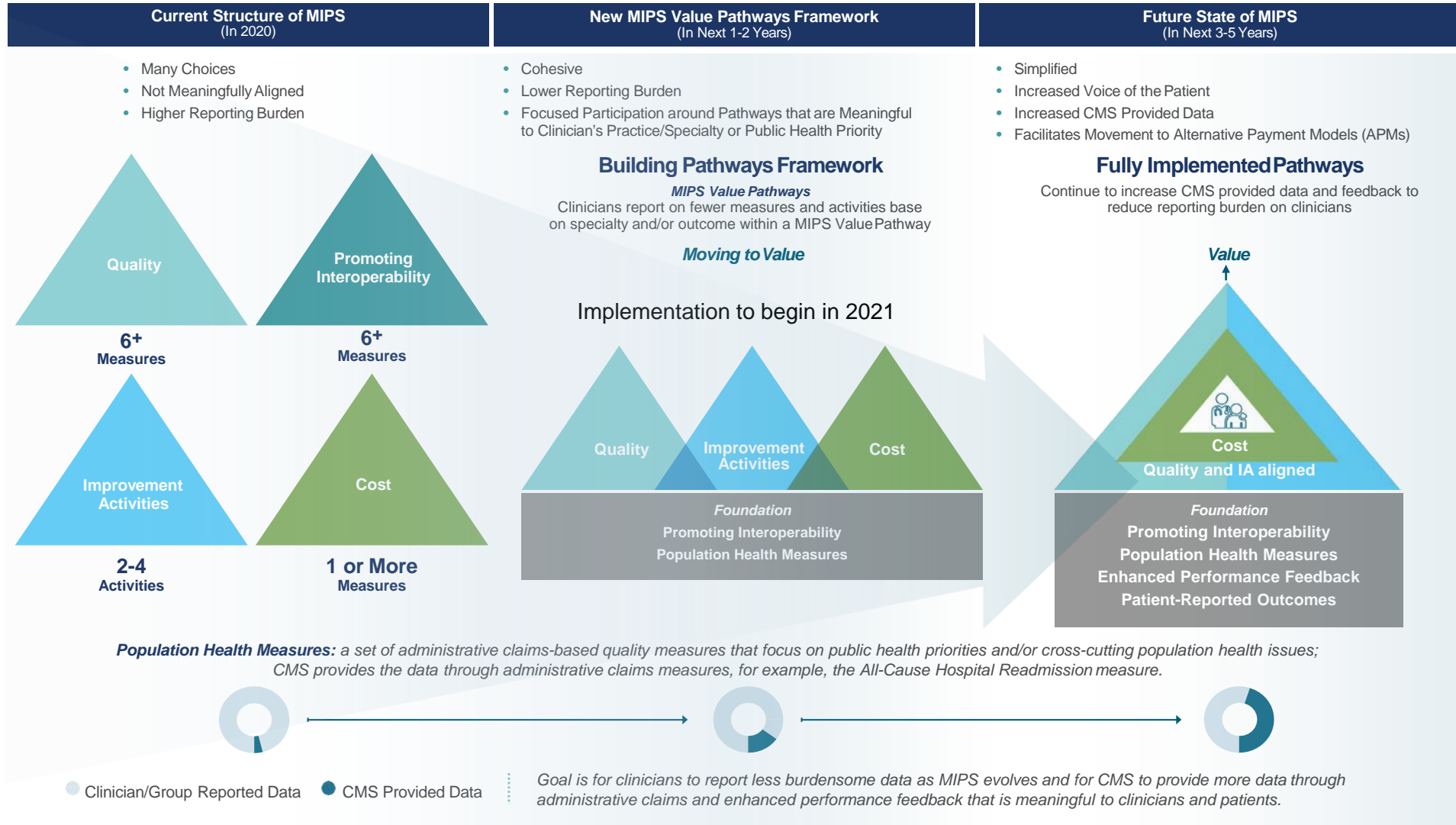


New MVPs Resources

- [MVPs](#) webpage
- [MIPS Value Pathways: The Future of MIPS](#) video












MIPS Value Pathways



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

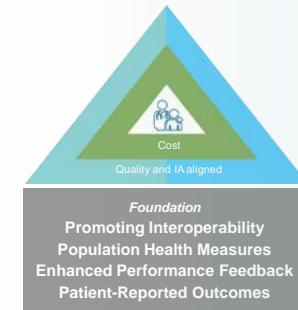
 <p>Surgeon chooses from same set of measures as all other clinicians, regardless of specialty or practice area</p>	 <p>Surgeon reports same "foundation" of PI and population health measures as all other clinicians but now has a MIPS Value Pathway with surgical measures and activities aligned with specialty</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.

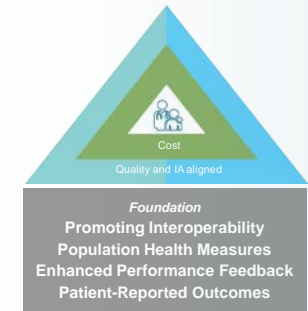
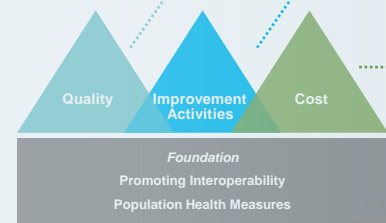
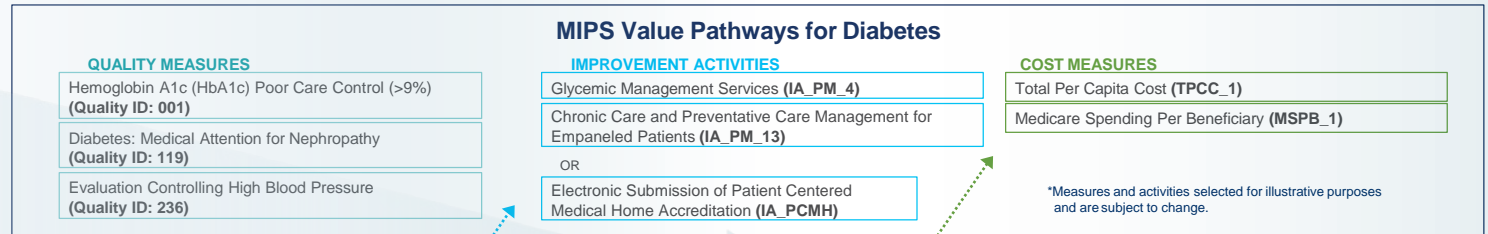


MIPS Value Pathways: Diabetes Example

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.







Final Rule 2020: MIPS Performance Categories – High Level Changes

- **Quality:** Increase the data completeness threshold to 70%; continue to remove low-bar, standard of care process measures; address benchmarking for certain measures to avoid potentially incentivizing inappropriate treatment; focus on high-priority outcome measures; and add new specialty sets
- **Cost:** Add 10 new episode-based measures to continue expanding access to this performance category; revise the existing Medicare Spending Per Beneficiary Clinician (MSPB Clinician) and Total Per Capita Cost (TPCC) measures
- **Improvement Activities:** Increase the participation threshold for group reporting from a single clinician to 50% of the clinicians in the practice; update the Improvement Activity Inventory and establish criteria for removal in the future; and conclude the CMS Study on Factors Associated with Reporting Quality Measures
- **Promoting Interoperability:** Keep the Query of Prescription Drug Monitoring Program measure as an optional measure; remove the Verify Opioid Treatment Agreement measure; and reduce the threshold for a group to be considered hospital-based



2020 Final Rule: MIPS

Performance Category Weights – No changes from 2019

Performance Category	Performance Category Weights	Performance Category Weights
	2019	2020
 Quality	45%	45%
 Cost	15%	15%
 Improvement Activities	15%	15%
 Promoting Interoperability	25%	25%



2020 Final Rule: MIPS

Performance Thresholds:

Performance Period	Performance Threshold	Exceptional Performance Bonus	Payment Adjustment*
2017	3 points	70 points	Up to +4%
2018	15 points	70 points	Up to +5%
2019	30 points	75 points	Up to +7%
2020	45 points	85 points	Up to +9%
2021	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.



2020 Final Rule: MIPS

Third-Party Intermediaries:

- CMS is focused on improving partnerships with third parties to help reduce clinician reporting burden.
- Beginning with the 2020 performance period, Qualified Clinical Data Registries (QCDRs) are required to work together to harmonize similar measures.
- Beginning with the 2021 performance period, third-party intermediaries are required to consolidate services by:
 - Providing continuity of service to their participants
 - Supporting all MIPS performance categories that require data submission
 - Providing enhanced performance feedback and allowing clinicians to view their performance on a given measure in comparison to others
 - Requiring that QCDR measures be fully developed and tested prior to self-nomination

Additional Changes:

- Final score reweighting policy finalized to address data integrity concerns
- Targeted review requests must be submitted within 60 days of the release of the MIPS payment adjustment factor(s) with performance feedback



2020 Final Rule: APMs

MIPS APM Scoring Standard:

- MIPS eligible clinicians participating in APMs will report for the MIPS Quality performance category through MIPS at the Entity, taxpayer identification number, or individual level to offer flexibility and improve meaningful measurement
- A 50% **MIPS APM Quality Reporting Credit** will be for APM participants in MIPS APMs that do not require reporting through MIPS

Additional Changes:

- Updating the definition of average marginal risk rate



Opioid Treatment Programs

Lindsey Baldwin



Background

- [CMS Roadmap: Fighting the Opioid Crisis](#)
- Section 2005 of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act ([SUPPORT Act](#)) established a new Medicare Part B benefit for Opioid Use Disorder (OUD) treatment services, including medications for Medication-Assisted Treatment (MAT), furnished by Opioid Treatment Programs (OTPs)
- CMS is implementing this benefit beginning January 1, 2020, as required by the SUPPORT Act



Finalized Policies

- Definition of OUD treatment services, which includes:
 - Food and Drug Administration (FDA) - approved opioid agonist and antagonist treatment medications
 - The dispensing and administering of such medications (if applicable)
 - Substance use counseling
 - Individual and group therapy
 - Toxicology testing which includes both presumptive and definitive testing
 - Intake activities
 - Periodic assessments
- Allow counseling and therapy services described in the bundled payments, to be furnished via two-way interactive audio-video communication technology as clinically appropriate



Finalized Policies (cont'd)

- Bundled payment rates for OTPs based on the medication administered for episodes of care for a period of one week in duration:
 - Based on a drug and non-drug component.
 - Stratified into several codes to account for differences in beneficiaries' clinical needs, including add-on codes for intake activities, periodic assessments, and take-home doses of medication.
 - See Table 15 in the CY 2020 final rule for the payment rates. Rates for the non-drug component will be adjusted by geographic locality and will be updated on an annual basis.
- Zero beneficiary copayment for 2020



Finalized Policies (cont'd)

- Substance Abuse and Mental Health Services Administration (SAMHSA) certification is required as part of the enrollment policy and process for OTPs:
 - OTPs that have been fully and continuously certified by SAMHSA since October 23, 2018, will be assigned to the “moderate risk” level of categorical screening
 - OTPs that have not been fully and continuously certified by SAMHSA since that date will be assigned to the “high risk” screening level



Key Changes from the Proposed Rule

Among other changes, CMS is amending the proposed policy as follows:

- For the drug component of the OTP bundle, we finalized a payment of ASP+0 percent, when available. For methadone, we will use TRICARE pricing when ASP is not reported. For oral buprenorphine, we are finalizing using National Average Drug Acquisition Cost pricing when ASP is not reported.
- For the non-drug component of the OTP bundle, we are finalizing a higher payment rate than what was included in the proposed rule. This higher payment rate will better align with Medicare payment amounts for similar services in other settings and with many Medicaid rates, instead of cross-walking payment to rates paid by TRICARE, as proposed.



Key Changes from the Proposed Rule (cont'd)

- In addition to the items and services specified by the statute for CMS to include in bundle, CMS is also finalizing additional payments for intake and periodic assessment activities, which OTPs are required to provide under SAMHSA regulations. We are also finalizing add-on payments for additional counseling and therapy services and take-home supplies of methadone and oral buprenorphine.
- CMS did not finalize the proposed partial episodes policy. CMS has thus updated the threshold for billing the weekly episode to the delivery of at least one service in the bundle (from either the drug or non-drug component).
- CMS adjusted the screening protocols for OTPs that have been fully and continuously certified by SAMHSA since October 23, 2018. These OTPs will be assigned to the “moderate-risk” level of categorical screening and will not need to submit fingerprints. OTPs that have not been fully and continuously certified by SAMHSA since October 23, 2018, have been assigned to the high-risk screening level. CMS will expedite the enrollment process to ensure that OTP enrollment is not delayed.



For Dually Eligible Beneficiaries

- Along with creating the OTP benefit, the SUPPORT Act also mandates all states cover OTP in their Medicaid programs effective October 2020, subject to an exception process as defined by the Secretary.
- Starting January 1, 2020, Medicare will be the primary payer for OTP services for dually eligible beneficiaries (those enrolled in both Medicare and Medicaid) who currently get OTP services through Medicaid. Briefly, Medicaid:
 - Must pay for services delivered to these beneficiaries by OTP providers who are not yet enrolled in Medicare but are enrolled in Medicaid, to the extent the service is covered in the state plan
 - Will later recoup the Medicaid payments made to the OTP, back to the effective date of the OTP's Medicare enrollment, and the OTP will then bill Medicare for those services
- OTP providers should enroll in Medicare now to be able to bill for services starting January 1, 2020.

Visit the [Medicaid](#) OTP webpage for more information.



Medicare Advantage / Duals

- Medicare Advantage (MA) plans must furnish enrollees access to the OTP benefit as good or better than what is available to beneficiaries in Original Medicare through providers that are certified by SAMHSA.
- MA plans may furnish access to the OTP by directly contracting with OTPs or by allowing enrollees to access services from an OTP on a non-contract basis.
- We will inform MA plans that for all enrollees, including the dually eligible individuals, who are currently in treatment with an OTP provider with whom the plan does not contract, the plan should create a transition process in which the individual can continue to see the current OTP provider while the plan works with the individual to transition to a network provider.



OTPs: Enrolling in Medicare Call on November 12

- Tuesday, November 12 from 3 to 4:30 pm ET
- Target Audience: Fully certified and accredited OTPs and related staff, as well as interested stakeholders
- Learn about the new benefit, the Medicare program, and how to enroll
- [Register](#)



Bundled Payments under the PFS for Opioid Use Disorders

- CMS is finalizing the creation of new coding and payment for a monthly bundle of services for the treatment of OUD that includes:
 - Overall management
 - Care coordination
 - Individual and group psychotherapy
 - Substance use counseling
 - Add-on code for additional counseling
- This will create an avenue for clinicians to bill for a group of services in the office setting similar to the services being paid for under the new OTP benefit for opioid treatment program clinics
- CMS will consider coding and payment amounts that recognize different levels of patient need and different types of practice arrangements for future rulemaking, including use of MAT in the emergency department setting



CY 2020 OPPS/ASC

Tiffany Swygert
Elise Barringer



Changes to the Inpatient Only List

- Finalizes changes to the Inpatient Only (IPO) list:
 - Removal of total hip arthroplasty, six spinal surgical procedures, and certain anesthesia services from the list.
 - Makes these procedures eligible to be paid by Medicare in the hospital outpatient setting in addition to the hospital inpatient setting.
 - Decision on the appropriate site of service is a complex medical judgment made by the physician based on the clinical characteristics of the patient. The 2-midnight rule offers guidance on when payment is generally appropriate under Medicare Part A or Part B.
- Establishes a two-year exemption, rather than the one year we proposed, from certain medical review activities relating to patient status for procedures removed from the IPO list beginning in CY 2020 and subsequent years.



Changes to the Inpatient Only List

- Beneficiary Family Centered Care-Quality Improvement Organization reviews of short-stay inpatient claims for procedures that have been removed from the IPO list within the first two years will be for medical necessity of the underlying services and to educate providers and practitioners regarding compliance with the 2-midnight rule:
 - Claims will not be denied based on patient status (that is, site of service) alone
 - These procedures will not be eligible for referral to the Recovery Audit Contractor for noncompliance with the 2-midnight rule for a two-year period after their removal from the IPO list
 - Two-year exemption period will allow providers time to update their billing systems and gain experience with respect to newly removed procedures eligible to be paid under either the Inpatient Prospective Payment System (IPPS) or OPFS, while avoiding potential adverse site of service determinations



ASC Covered Procedures List

- List of covered surgical procedures that are eligible for payment under Medicare when furnished in an ASC:
 - Covered surgical procedures are those procedures that would not be expected to pose a significant risk to beneficiary safety and for which the beneficiary would not typically be expected to require active medical monitoring and care at midnight following the procedure
 - CMS is adding Total Knee Arthroplasty, Knee Mosaicplasty, six additional coronary intervention procedures, and twelve procedures with new CPT codes to the list



Alternative Pathway for Breakthrough Devices

- For transformative devices that have an FDA Breakthrough Device designation, CMS is providing an alternative pathway to qualify for device pass-through payment status, under which the “substantial clinical improvement” criterion would not apply to these devices:
 - Devices would still need to meet the other criteria for pass-through status
 - This alternative pathway will apply to devices that receive pass-through payment status effective on or after January 1, 2020
 - Goal of this policy is to give Medicare beneficiaries more timely access to new therapies and reduce the uncertainty that innovators face regarding payment for these therapies
- Effective January 1, 2020, CMS is approving five device pass-through applications that meet the criteria to be granted transitional pass-through status for a period of three years, including AquaBeam® Robotic System, AUGMENT® Bone Graft, Surefire® Spark Infusion System, Optimizer® Smart System, and CustomFlex® ArtificialIris



Meaningful Measures/Patients Over Paperwork

- Hospital Outpatient Quality Reporting Program:
 - Remove one web-based measure for the CY 2022 Program Year, External Beam Radiotherapy for Bone Metastases
 - Removal is on the basis that the costs associated with the measure outweigh the benefit of its continued use in the program
 - Complexity of reporting this measure places substantial administrative burden on hospitals
- Ambulatory Surgical Center Quality Reporting Program:
 - CMS did not propose to remove any measures in this rulemaking as our analysis of the current measure set indicates that there are no measures that meet the measure removal factors following last year's comprehensive removal initiative
 - CMS is adopting one claims-based measure beginning with the CY 2024 payment determination, ASC-19: Facility-Level 7-Day Hospital Visits after General Surgery Procedures Performed at Ambulatory Surgical Centers



Question & Answer Session



Resources

Physician Fee Schedule and Quality Payment Program Final Rule:

- [Final Rule](#)
- [Press Release](#)
- [Physician Fee Schedule Fact Sheet](#)
- [Quality Payment Program Fact Sheet](#)
- [E/M Visits](#) webpage
- [Quality Payment Program](#) website
- [OTP](#) webpage



Resources

OPPS and ASC Payment Systems Final Rule:

- [Final Rule](#)
- [Fact Sheet](#)
- [Hospital OPPS](#) website
- [ASC Payment](#) website



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