

Centers for Medicare and Medicaid Services
Rural Health
Open Door Forum
Moderator: Jill Darling
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1:00pm CT

Coordinator: Welcome and thank you for standing by. Today's call is being recorded. If you have any objections, you may disconnect at this time. All participants are in a listen-only mode until the QA section of today's conference. At that time you may press star 1 on your phone to ask a question. I would now like to turn the conference over to (Tevin Warren). Thank you. You may begin.

(Tevin Warren): Thank you, (Sarah). Good morning and good afternoon everyone. I'm (Tevin Warren) with CMS' Office of Communications. And thank you for joining us today for today's Rural Health Open Door Forum.

Before we begin, one brief announcement -- this open door forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov. And now I will hand the call off to Carol Blackford.

Carol Blackford: Thank you and good afternoon or good morning for everyone joining us. We have a small crowd today but wanted to thank you for taking the time to join us on the call. We have an important proposed rule that we'd like to discuss during our time slated for our Rural Health Open Door Forum call. As you know, we've talked about the administrators patients over paperwork initiative before in other calls. And that initiative is really focused on reducing

administrative burden while improving care coordination, health outcomes, and patient's ability to make decisions about their own care.

We have done a lot of outreach across the country, talking to many people around the patients over paperwork initiative and things that we as an agency can do to reduce administrative burden. And one thing that we have heard continually from physicians is that they struggle with excessive regulatory requirements and unnecessary paperwork that steal time away from patient care. And that came from not only physicians but all clinicians who are dealing with the documentation and the paperwork that can come in between the time that they spend with the patients.

And we've listened to all of the feedback that we've received from those many conversations and we are proposing to take some action. And you see some of that in the calendar year 2019 physician fee schedule proposed rule, which we'll be spending our time today talking about.

The proposed changes in the physician fee schedule proposed rule address those problems head on. We are proposing to streamline documentation requirements to focus on patient care. And we're proposing to modernize payment policy. So seniors and others covered by Medicare can take advantage of the latest technologies to get the quality of care that they need.

The comment period on this proposed rule ends September 10th. So I want to encourage everyone on the call today to take advantage of the opportunity to submit comments. You've heard me talk about this before. We really do read each and every comment that's submitted and your thoughts on the proposals and how to make them work for you as you provide care in rural areas are really important to the decision process that we use to then develop the policies included in the final rule.

So please take advantage of the opportunity to submit those comments and information on the process that you use to submit the comments is available in the rule itself. And information is available also up on our website.

So with that, let's go ahead and dive right into some of the key proposals included in the 2019 physician fee schedule proposed rule. And I think we are going to start by talking about the evaluation and management proposals. And (Lindsey) is going to start that presentation.

(Lindsey Baldwin): Yes. Thanks, Carol. So as Carol mentioned, CMS is proposing a number of coding and payment changes to reduce administrative burden and improve payment accuracy for E and M visits. We propose to allow practitioners to choose to document office outpatient E and M visits using medical decision-making or time instead of applying the current 1995 or 1997 E and M documentation guidelines, or alternatively practitioners could choose to continue using the current framework.

We propose to expand current options by allowing practitioners to use time as the governing factor in selecting visit level and documenting the E and M visit, regardless of whether counseling or care coordination dominate the visit. We propose to expand current options regarding the documentation of history and exam, to allow practitioners to focus their documentation on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting information, provided they review and update the previous information.

We propose to allow practitioners to simply review and verify certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering it. And we're also soliciting comment on

how documentation guidelines for medical decision-making might be changed in subsequent years.

To improve payment accuracy and simplify documentation, we propose new, single blended payment rates for new and established patients for office outpatient E and M level two through five visits and a series of add-on codes to reflect resources involved in furnishing primary care and complex non-procedural services.

As a corollary to this proposal, we propose to apply a minimum documentation standard where Medicare would require information to support a level two office visit code for history, exam and/or medical decision-making in cases where practitioners choose to use the current framework, or, as proposed, medical decision-making to document E and M level two through five visits.

In cases where practitioners choose to use time to document E and M visits, we propose to require practitioners to document the medical necessity of the visit and show the total amount of time spent by the billing practitioner face-to-face with the patient. Practitioners could choose to document additional information for clinical, legal, operational or other purposes. And we anticipate that for those reasons, they would continue generally to document medical record information consistent with the level of care furnished. However, we would only require documentation to support the medical necessity of the visit and that associated with the current level two office visit code.

In order to recognize efficiencies that are realized when E and M visits are furnished in conjunction with other procedures, we propose a multiple procedure payment adjustment that would apply in those circumstances. We

also propose new coding to recognize podiatry E and M visits that would more specifically identify and value these services. We propose a new prolonged face-to-face E and M code to be billed for visits requiring additional time as well as a technical modification to the practice expense methodology.

We propose to eliminate the requirement to justify the medical necessity of a home visit in lieu of an office visit and solicit public comment on potentially eliminating a policy that prevents payment for same-day E and M visits by multiple practitioners in the same specialty within a group practice. For E and M visits furnished by teaching physicians, we also propose to eliminate potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team.

We are also soliciting public comment on the implementation timeframe of these proposals, as well as how we might update E and M visit coding and documentation in other care settings in future years. CMS believes these proposals would allow practitioners greater flexibility to exercise clinical judgment in documentation, so they can focus on what is clinically relevant and medically necessary for the beneficiary.

That being said, we also have proposals to modernize Medicare physician payment by recognizing communication technology-based services. We're proposing to pay separately for two newly defined physicians' services furnished using communication technology.

One is a brief communication technology-based service or virtual check-in. And the other is a remote evaluation of recorded video and/or images submitted by the patient. Practitioners could be separately paid for the brief

communication technology-based service when they check in with beneficiaries via telephone or other telecommunications devices to decide whether an office visit or other service is needed. This would increase efficiency for practitioners and convenience for beneficiaries.

Similarly, the remote evaluation of recorded video and/or images submitted by the patient would allow practitioners to be separately paid for reviewing patient-transmitted photo or video information that is pre-recorded to assess whether a visit is needed. In addition to that, we're also proposing to pay separately for new coding describing chronic care remote physiologic monitoring and inter-professional internet consultation.

Additionally, we are seeking comment on creating a bundled episode of care for management and counseling treatment for substance use disorders. We're also seeking comment for regulatory and sub-regulatory changes to help prevent opioid use disorder and improve access to treatment under the Medicare program. We seek comment on methods for identifying non-opioid alternatives for pain treatment and management, along with identifying barriers that may inhibit access to these non-opioid alternatives including barriers related to payment or coverage.

Under traditional Medicare telehealth services -- those are the one that are subject to 1834M of the statute -- for CY 2019 we're proposing to add prolonged preventive services. So the list is eligible telehealth services. And finally, we're also proposing to implement the requirement of the Bipartisan Budget Act of 2018 for telehealth services related to beneficiaries with end-stage renal disease receiving home dialysis and beneficiaries with acute stroke -- both of those effective January 1, 2019.

We propose to add renal dialysis facilities and the homes of ESRD beneficiaries receiving home dialysis as eligible originating sites, and to not apply originating site geographic requirements for hospital-based or critical access hospital-based renal dialysis centers, renal dialysis facilities, and the beneficiary's homes for purposes of furnishing the home dialysis monthly ESRD-related clinical assessments.

We also propose to add mobile stroke units as originating sites and not to apply originating site type or geographic requirements for telehealth services furnished for the purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.

That is it from me. Next I think we will hear an update from our colleagues in QPP.

(Aucha Prachanronarong): Hi. This is Aucha Prachanronarong from the Center for Clinical Standards and Quality. And I'm going to provide a high level overview of the proposals related to the Merit-based Incentive Payment System track of the Quality Payment Program.

So as you know, the Quality Payment Program is a big change which is why we implemented the first two years of the program gradually to provide doctors and other clinicians the opportunity to familiarize themselves with the basic requirements of the program and to participate successfully.

For year three as you'll see in our proposals program simplification and burden reduction continue to be a main priority for us. The Bipartisan Act of 2018, which was enacted earlier this year, provides us with additional authority to continue the gradual transition in MIPS for three more years. In

this rule, we've included several proposals that draw upon this authority to help further reduce clinician burden.

These proposals include changing the application of the MIPS payment adjustment so that adjustments will not apply to all items and services under Medicare part B but will now apply only to covered professional services. And this change would start with payments in 2019.

We're also proposing to change the way the low-volume threshold calculations are performed. Beginning with performance periods in 2018 the low-volume threshold calculations will now be based on allow charges for covered professional services and the number of covered professional services furnished to patients rather than all part B services.

The Bipartisan Budget Act of 2018 also provides additional flexibility in the weighting of the cost performance category of MIPS in the final score for three additional years. Instead of requiring this performance category to have a weight of 30% in the third year of MIPS, we are now able to weight the cost performance category anywhere between not less than 10% and not more than 30% for the third, fourth, and fifth years of MIPS.

So accordingly we're proposing to weight the cost performance category at 15% in year three while also proposing to add eight new episode-based cost measures to this performance category. As a result of this proposal the weight of the quality performance category would also decrease to 45% for year three.

And then lastly the Bipartisan Budget Act of 2018 allows flexibility in establishing the performance threshold for three additional years to ensure a

gradual and incremental transition to a performance threshold for year six that's based on the mean or median of the final scores.

So for the third year of MIPS we're proposing to set the performance threshold at 30 points so that MIPS eligible clinicians whose final scores are below 30 points will see a negative payment adjust of up to 7% in 2021. Those with MIPS final scores of 30 points would see no effect or change in their payments in 2021. And then those with MIPS final scores above 30 points will see a positive payment adjustment in 2021 of up to 7% plus a scaling factor not to exceed three. These adjustments will be determined as a way to achieve budget neutrality of course.

And then aside from the proposals that are directly related to the Bipartisan Budget Act of 2018, other prominent proposals include expanding the definition of a MIPS eligible clinician to include new clinician types. Specifically we are proposing to include as MIPS eligible clinicians physical therapists, occupational therapists, clinical social workers, and clinical psychologists.

We are also proposing to add a third element to the low volume threshold determination whereby to be exclude from MIPS clinicians or groups would need to meet one of the following three criteria -- either having \$90,000 or less in allowed charges for covered professional services, 200 or fewer part B beneficiaries or 200 or fewer covered professional services.

We are also proposing starting with the 2019 MIPS performance period to let clinicians who do fall below the low volume threshold opt in and participate in MIPS if they meet or exceed two but not all components of the low volume threshold so that they could participate, be scored, and receive payment adjustments in accordance with their scores.

In addition to proposing to reduce the weight of the quality performance category to 45% we're also proposing the immediate removal of 34 MIPS quality measures. Many of these measures are low value process measures and/or are extremely topped out -- meaning that their performance rates average close to or are 100%. And we're proposing to replace these measures with ten new MIPS quality measures.

And then lastly we are proposing to overhaul the promoting interoperability performance category, or what we formerly called the advancing care information performance category. And I will turn it over to my colleague (Ashley Hain) to go over those proposals.

(Ashley Hain): Thank you (Aucha). For the promoting interoperability performance category, our proposal is designed to focus on interoperability health information exchange and providing patients access to their health information.

In the proposed rule, it reiterates that clinicians are required to use 2015 edition (CERT) for the 2019 performance period. We finalized this requirement in the 2018 quality payment program final rule.

We are proposing to align with the Medicare Promoting Interoperability Program -- formally called the EHR Incentive Program -- for eligible hospitals and critical access hospitals. We are also proposing to retain the performance based scoring and eliminate the base performance and bonus scoring structure. The security risk analysis measure is required but will not be scored in our proposal for the scoring structure.

We are also proposing to reduce the number of scored objectives from six objectives to four objectives. So it will eliminate several measures, combine

measures, rename measures, and are proposing three new measures for the promoting interoperability performance category.

We are also proposing that all measures are required with the exception of the two new measures. If reported they will earn bonus points. For the public health and clinical data exchange objective, we are proposing to require two measures submitted for this objective. There are some exclusions for the measures and if the exclusions are claimed, their points will be reallocated to the other measures.

And that summarizes the high level proposals for the promoting interoperability performance category. And now I will be handing over to my colleague (Corey Henderson) to discuss the proposals for the advanced APM.

(Corey Henderson): Currently we continue supporting a pathway to participating and alternative payment models and advanced APMs. And our year three proposals are a reflection of that effort. Our proposals for the advanced APM side of the program build off many policies that we finalized for year two while increasing flexibility and reducing burden.

At a high level, specifically for advanced APMs we're proposing some adjustments to the advanced APM criteria. Updating the advanced APM (CERT) threshold so that an advanced APM must require at least 75% of eligible clinicians in each APM use (CERT). We're also extending the 8% revenue based nominal amount standard for advanced APMs through performance year 2024.

For the all payer combination option and other payer advanced APMs, we're proposing for (CERT) use increase the (CERT) use criterion threshold for other payer advanced APMs so that in order to qualify other payer as

advanced APM as of January 1, 2020 the number of eligible clinicians participating in the other payer arrangement who are using (CERT) must be 75%. For the revenue base nominal amount standard, maintain the revenue based nominal amount standard for other payer advanced APMs at 8% through performance period 2024.

We're also increasing flexibility for the all payer combination option and other payer advanced APMs for non-Medicare payers to participate in the Quality Payment Program. We're establishing a multi-year determination process where payers and eligible clinicians can provide information on the length of agreement as part of their initial other payer advanced APM submission and have any resulting determination be effective for the duration of the agreement.

We propose this streamlined process to reduce burden on payers and eligible clinicians allowing QP determinations at the ten level in addition to the current options for determinations at the APM entity level and the individual level in instances when all clinicians who bill under the ten participate as a single APM entity. This will provide additional flexibility to eligible clinicians under the all payer combination option.

Moving forward with allowing all payer types to be included in the 2019 paying initiated other payer advanced APM determination process for the 2020 QP performance period. We'll also streamline the definition of a MIPS comparable measure in both the advanced APM criteria and other payer advanced APM criteria to reduce confusion and burden among payers and eligible clinicians submitting payment arrangement information to CMS.

Under MIPS APMs and the APM scoring standard, we're proposing clarifying the requirement for MIPS APMs to assess performance on quality measures

and cost utilization. In other words, we're reordering the wording of this criterion to state that the APM bases on quality measure bases payment on quality measures and cost utilization, which would clarify that the cost utilization part of the policy is broader than specifically requiring the use of a cost utilization measure. Updating the MIPS APM measures sets that apply for the purposes of the APM scoring status is also a proposal.

We're also proposing aligning PI reporting requirements under -- and that's the promoting interoperability reporting requirements -- under the APM scoring standard so that the MIPS eligible clinicians and any MIPS APMs -- including the shared savings program -- can report promoting interoperability in any manner permissible under MIPS at either the individual or group level.

And finally, we will continue working with stakeholders to understand the needs of clinicians and practices and identify where models are designed. That's all for the APM and advanced APM section.

(Simone Dennis): All right. Thank you. My name is Simone Dennis and I'm going to talk about the two RHC and FQHC specific proposals in the CY 2019 Physician Fee Schedule Rule (PFS).

So the first proposal is regarding payment for care management services. In the CY 2018 rule, we finalized payment for HCPCS code G0511. This is for general care management and it's for use by RHCs and FQHCs only. The payment amount for G0511 is set at the average of the non-facility rate for three services paid under the PFS.

We are proposing to add a fourth code to determine the payment rate for G0511. The fourth code is a new service for CY 2019. It is for 30 minutes or more of chronic care management services furnished by a physician or

another health care provider. Adding this code to the payment methodology will result in a small increase in the rate for a G0511 and we propose this change effect for January 1, 2019.

The second proposal is regarding payment for communication technology based services and remote evaluation. My colleague Lindsey Baldwin discussed that these services will be payable for practitioners billing under the PFS. In the past we've waited a year before establishing payment for RHCs and FQHCs. For this year we're putting forth a proposal at the same time. We propose that RHCs and FQHCs receive payment for the service when at least five minutes of it are furnished by an RHC or FQHC practitioner to an established patient. That is one that has been seen within the previous year.

These services may only be billed when the remote medical discussion is for a condition not related to an RHC or FQHC service provided within the previous seven days and does not lead to an RHC or FQHC service within the next 24 hours or at the soonest available appointment. Email or text communication can initiate the service. However, it's only the time spent using real time communication, like talking on the phone with the patient, will count towards that five minute minimum requirement for billing.

In regards to payment, we established a similar payment methodology as care management services. We propose to create a new, virtual communications G code for RHCs and FQHCs only. And the payment rate will be set at the average of two services under the PFS. We do not have the statutory authority to waive coinsurance or deductible for these services. And unlike care management, there are no requirements for patient consent.

This proposal is also effective for January 1, 2019. And we encourage you to submit comments on both these aspects of the proposal. I'm going to turn it over to Sarah Shirey- Losso.

(Sarah Shirey- Losso): Thanks, (Simone). I'm going to briefly discuss two proposals in the physician fee schedule limited to laboratories and/or physician office laboratories. Beginning January 1, 2018 the payment amount for tests on the clinical lab fee schedule is generally equal to the weighted median of the private payer rate determined for the test based on applicable laboratory information that is collected during a specific data collection period and then reported to CMS.

In anticipation of the upcoming next data collection period beginning on January 1, 2019. And one of our objectives is to obtain as much applicable information as possible from the broadest possible representation of the laboratory market. And without imposing due burden on those entities.

In the interest of facilitating this, we're proposing a change to the way Medicare Advantage payments are treated in our definition of applicable laboratory. And if we were to finalize the proposed change, additional laboratories of all types serving a significant population of beneficiaries enrolled in Medicare part C could meet the majority of Medicare revenue thresholds and potentially qualify as an applicable laboratory and report data to CMS.

In addition, we have a couple of comment solicitations regarding alternative approaches for defining an applicable laboratory. For example, one of which is using the CMS form 1450. That's for the (14X) type of bill. Or use a clear certificate number to define applicable laboratory.

And we're also looking at comments on potential changes to low expenditure threshold component in the definition. We're particularly interested in receiving comments from the physician community -- particularly those with physician office labs and small independent labs as to the burden and relief associated with these proposed revisions.

A particular interest maybe to physician offices regarding WAC based payments or Wholesale Acquisition Cost-based payments for part B drugs. We have a proposal for drugs during the first quarter of sales when ASP is unavailable. The drug payment add-on would be 3% in place of the 6% add-on that is currently being used.

Also if we finalize this proposal, we would also update manual provisions in order to permit Medicare administrative contractors to use an add-on percentage of up to 3% as well when utilizing the wholesale acquisition cost in the pricing of new drugs.

And I will pass it on to - sure, sorry, (Marge).

((Crosstalk))

Woman: Is next.

(Sarah Shirey- Losso): (Marge) is on the phone. Thank you.

(Marge Watchorn): Hi everybody. This is (Marge Watchorn) and I will be speaking about a couple of the payment proposals in the physician fee schedule rule. You may be aware that in last year's physician fee schedule proposed rule we had a comprehensive request for information on ways that we could reduce burden for physicians, non-physician practitioners, suppliers, and providers. And two

of the issues that we heard about quite a bit from stakeholders we've actually decided to propose burden reduction this year in the CY 2019 PFS proposed rule.

The first issue has to do with the supervision level that applies for diagnostic service - I'm sorry, radiology services that are furnished by radiologist assistants when they're supervised by physicians. Currently these services are required to be furnished under the most restrictive level of physician supervision, which is personal supervision.

What we heard through the request for additional information is that a direct level of supervision -- which is a slightly less restrictive level of supervision -- what we heard is that the direct level of supervision would be much more appropriate for these particular practitioners -- for the radiologist assistants. And so we're proposing to change the supervision level for those services when furnished by a radiologist assistant. And that proposal if finalized would go into effect January 1 of 2019.

The other area that we heard about has to do with functional reporting requirements for outpatient therapy services. These are requirements that currently are in place. We put them in place January 1 of 2013. And these essentially are requirements where every time an outpatient therapy service is billed to Medicare, the claim has to include a description of the patient's functional limitation and severity at periodic intervals during the course of the outpatient therapy services.

The requirement has been in effect since 2013. And we heard from stakeholders that the requirements are burdensome and can present confusion for therapists and for providers. So in the proposed rule this year, we're proposing to discontinue those reporting requirements and like the other

proposal that I described, if we finalize it this would go into effect January 1 of 2019.

Next I wanted to highlight one of the two requests for additional information that we have in this year's proposal in the CY 2019 proposed rule. And as you've heard my colleagues who spoke about the quality payment program, interoperability is definitely an issue that the agency is focusing on not only for the Medicare program but also for the Medicaid program.

So we have included not only in this payment rule but in other payment rules as well a request for additional information on promoting interoperability and electronic health care information exchange to possible revisions to the CMS patient health and safety requirements for hospitals and other Medicare and Medicaid participating providers and suppliers.

Next I wanted to turn the mike over to Dr. (Terri Postma) who will speak about our other RFI.

(Terri Postma): Great. Thanks, Marge. Hi, I'm Terri Postma, Medical Officer in the Center for Medicare. And today I'd like to tell you about a price transparency Request For Information in this proposed rule where we're seeking your thoughts on how we can together empower consumers through better transparency of prices for health services.

When Secretary Azar took office here at HHS, he identified using value-based transformation of our entire health system as one of the top four priorities for the department -- including giving consumers greater control over health information and encouraging transparency from providers and payers.

Increasing quality, improving outcomes, and lowering costs of course aren't new concepts. We've long talked about the need to move towards a more sustainable system -- one that pays for value and not merely volume. And some progress has been made, but if we're going to take the final steps we have to activate that most important force in our health care system for creating value -- the patient.

In virtually every sector of the economy, you're aware of the cost of a service before you purchase it except for in health care. Patients deserve and need to know the cost of services before they're going if they're going to be empowered to shop for value. We believe the system can only be fixed by placing patients at the center of both cost and quality decisions, empowered with the information they need to make the best choices for themselves and their families.

This means that providers and insurers must become more transparent about their pricing. There's no more powerful force than an informed consumer. Through this empowerment, we believe there will be competitive advantage amongst providers to deliver coordinated quality care at the best value to attract patients who are shopping for high quality care.

Some insurers and employers have already taken steps to promote transparency in prices, including such things as developing tools that show people what different local providers charge for a procedure. Even some practitioners -- for example, those engaged in alternative payment models -- have taken steps to integrate pricing information into point of care shared decision making and when making referrals.

CMS has also taken some steps. For example, we're expanding the data we make available to researchers through public use files. We're taking an API

approach to modernizing how we exchange data with our partners. And as noted in this Request For Information, we recently updated our hospital charge master guidelines to require hospitals to post their charges online in a machine readable format.

We know these initial steps don't fully address patient needs but we're just getting started and through this Request for Information -- such as the one in this proposed rule -- we are asking you, the public, for ideas about what additional information patients need to make informed decisions about their care.

We need your ideas and input. We need the benefit of your individual expertise and experience and we look forward to hearing from you on this important initiative. Carol?

Carol Blackford: All right. Thank you very much for...

(Marge Watchorn): Carol I think you might've dropped off.

Carol Blackford: Sorry about that, (Marge). I was struggling with the mute button. I just wanted to thank everyone for walking through the key provisions of the calendar year 2019 physician fee schedule proposed rule and remind those on the phone that the comment period ends September 10th. Encourage everyone to take that opportunity to submit your comments to us through the process laid out in the rule itself.

And I think we've got some time or questions. So we'll go ahead and turn that over to the Operator.

Coordinator: If you would like to ask a question, please press star 1 from your phone and unmute your line. Speak your name clearly when prompted. If you would like to withdraw your question, please press star 2. Again, if you would like to ask a question please press star 1. One moment as we wait for the first question. Again if you would like to ask a question please press star 1 from your phone and speak your name clearly when prompted.

Carol Blackford: Well, thank you again everyone for participating on the call today. I know we covered a lot of detailed information about the proposals in the PFS proposed rule. There is a FAQ sheet and press release available on CMS' website. And additional information around the proposals relating to E and M and the communication technology based services are also available on our patients over paperwork website.

And of course if you have any questions that you weren't able to ask or if you have any suggestions for future agenda topics, please send them to me at Carol.Blackford -- B-L-A-C-K-F-O-R-D at CMS.HHS.Gov. Thank you so much for your time today.

Coordinator: Thank you for your participation in today's conference. You may disconnect at this time.

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