

# 2018 Medicare Regulatory Update

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# Agenda

- Physician Fee Schedule
- OPPS
- IPPS
- SUPPORT Act

# PFS: Overview

- Final Rule published in the Federal Register on November 1, 2018.
- Payment rates impact:
  - PFS conversion factor of \$36.04, up from \$35.99 in 2018.
- Notable changes:
  - E/M Codes
  - Virtual Care/Telehealth
  - Part B Drug Costs
  - Medicare Shared Savings Program

# Big E/M Changes

- Big changes in 2021 for new and established office visits. No change to hospital, critical care, SNF etc.
- Levels 2-4 folded into one reimbursement amount. Still choose the code, but paid the same.
- Choice of 1995 or 1997 guidelines, time, or MDM.

# Add-on Codes

- GPC1X: Visit complexity E/M assoc w/ primary medical care services that serve as the focal point for all needed services.
- GCG0X: Visit complexity E/M assoc w/ non-procedural specialty including....
- Each code pays \$13.

# Extended Visit

- Totally time dependent.
- Established:
  - 34-69 min for level 2-4
  - 70 min. for level 5.
- New:
  - 38-89 min. for level 2-4.
  - 90 min. for level 5.

# TABLE 24B: Comparison of 2018 and 2021 Estimated National Payment Amounts for Visits

	Complexity Level under CPT	Visit Code	Visit Code	Visit Code With Either Primary or specialized care add-on code*	Visit Code with New Extended Services Code
<b>New Patient</b>	Level 2	\$76	\$130	\$143	\$197
	Level 3	\$110			
	Level 4	\$167			
	Level 5	\$211	\$212		
<b>Established Patient</b>	Level 2	\$45	\$90	\$103	\$157
	Level 3	\$74			
	Level 4	\$109			
	Level 5	\$148	\$149		

\*In cases where one could bill both the primary and specialized care add-on, there would be an additional \$13.

# Home Visits: Effective 1/1

- No longer need medical necessity for a home visit.

# Teaching Physician Rule

- Current regulation requires the physician to personally document involvement in E and M services. (42 CFR 415.172(a)(3)(v))
- That section deleted. Replaced with a statement teaching physician's participation may be documented by a physician, resident or nurse.
- Commenters concerned of shift of document responsibility from physician to resident or nurse.
- One of the few regs requiring documentation.

# Has there been a time change?

“As another alternative, the practitioner can document using time, which will require documentation of the medical necessity of the visit and **that the billing practitioner personally spent at least the typical time associated with the level 5 CPT code that is reported face-to-face with the patient (40 minutes for an established patient and 60 minutes for a new patient)**. Since there will be no new intra-service time associated with the level 5 visit codes, we are finalizing our proposed alternative to use the typical time associated with the CPT code reported on the claim, consistent with current policy when counseling and/or coordination of care accounts for more than 50% of the face-to-face physician/patient encounter.” 83 FR 59633

# Time Keeps Flowing Like a River

“If choosing to document using time, for PFS payment purposes we will **require the billing practitioner to document** that the visit was medically reasonable and necessary and that the billing practitioner personally spent the current typical time for the CPT code reported (for example, 15 minutes when reporting CPT code 99213 (a level 3 established patient visit)). For administrative simplicity, it may be most straight forward to track the typical time for the CPT code.”

83 FR 59634

# Roundabout?

- CPT introduction p. xvi: “When codes are ranked in sequential typical times and the actual time is between two typical times, the code with the typical time closest to the actual time is used.’ See also the Evaluation and Management Service Guidelines.”

# Removing Redundancy in E/M Visit Documentation

- “Practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed.”
- 83 FR 59635

# Removing Redundancy in E/M Visit Documentation

- “Practitioners need not re-enter in the medical record information on the patient’s chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information.” [Practitioners] may choose to continue the current process of entering, re-entering and bringing forward information.
- 83 FR 59635

# Is This A Change?

- Who can record information in the medical record?
- What is the source for the claim?
- How has information been recorded at different periods in time.

# What Didn't Happen

- Eliminate modifier -25.
- Two visits on the same day allowed.
- Global surgical visit changes.
- New podiatry-specific codes.

# Virtual Care/Telehealth Updates

- CMS attempt to increase access to physician services routinely furnished via communication technology.
  - Not subject to limitations on Medicare telehealth services.
- Finalized proposal to pay separately for certain physician services furnished using communication technology:
  - Brief communication technology-based service, e.g. virtual check-in (HCPCS code G2012)
  - Remote evaluation of recorded video and/or images submitted by an established patient (HCPCS code G2010)
  - Interprofessional internet consultation (CPT codes 99451, 99452, 99446, 99447, 99448, and 99449)

# Virtual Care/Telehealth Updates

- CMS is adding the following to the list of covered telehealth services:
  - Prolonged preventive service(s) (HCPCS codes G0513 and G0514)
- Added renal dialysis facilities and homes as originating sites for ESRD-related assessments.
- Originating site geographic requirements not applicable for hospital or CAH-based renal dialysis centers, renal dialysis facilities, and beneficiary homes for purposes of these assessments.

# Virtual Care/Telehealth Updates

- Finalized proposal to add mobile stroke units as originating sites without geographic requirements.
- Interim final rule with comment period, CMS is implementing a provision from the opioid bill.
- Removes originating site geographic requirements and adds home as an originating site for telehealth services furnished for treatment of a substance use disorder or co-occurring mental health disorder.
  - For services furnished on or after July 1, 2019.
  - Interim final rule with 60-day comment period.

# Part B Drug Costs

- Finalized proposal to change payment for Part B drugs.
- Most Part B drug payments are based on Average Sales Price (ASP) and include 6% add-on payment.
- Some Part B drug payments are based on wholesale acquisition cost (WAC), which typically exceed ASP.
- Starting January 1, 2019, during the phase in which Part B drugs are reimbursed based on WAC, drugs will be reimbursed at WAC plus 3% of ASP, as compared to the current methodology of WAC plus 6% of ASP.
- Changes apply only to WAC-based payment for new Part B drugs.

# Medicare Shared Savings Program

- Removing eight measures from the quality measure set and increasing the focus on outcomes measures, such as patient experience.
- Voluntary 6-month extension for existing ACOs whose participation agreements expire Dec. 31, 2018.
- Allowing beneficiaries who voluntarily align to an NP, PA, CNS, or a physician with a specialty not used in assignment to be prospectively assigned to an ACO if their clinician is participating in an ACO.
- Providing relief for ACOs and clinicians impacted by extreme and uncontrollable circumstances.

# Merit-based Incentive Payment System (MIPS)

- Expanding MIPS to include new clinician/ancillary clinician types previously excluded.
  - PTs, OTs, SLPs, audiologists, clinical psychologists, registered dietitians and nutrition professionals
- Clinicians who were left out of MIPS due to low-volume threshold can now opt in to the program.
- Finalized addition of 8 MIPS quality measures and removal of 26.
  - Part of CMS’s “Meaningful Measures” effort attempting to streamline documentation and reporting requirements associated with programs such as MIPS.

# Other PFS Items

- Payment rates for non-excepted off-campus provider-based hospital departments will remain at 40% for 2019.
- Request for information related to price transparency and improving beneficiary access to provider and supplier charge information.
- Revising physician supervision requirements so diagnostic tests performed by a radiologist assistant that would otherwise require personal supervision of a physician may be furnished under direct physician supervision to the extent permitted by state law.

# IPPS

- Final rule published in the Federal Register on 8/17/2018
- Some highlights:
  - Overall increase of \$4.8b (~+1.85% for EHR users)
  - Meaningful Measures Initiative
  - Documentation changes
  - Transparency

# IPPS: Meaningful Measures Initiative

- Criteria for removal included:
  - Duplicative
  - No meaningful distinction in performance (“topped out”)
  - Factor does not align with clinical guidelines or practice
  - Improvement on measure does not improve patient outcomes
  - Overly costly to maintain/report in comparison to benefit of reporting

# IPPS: Meaningful Measures Initiative

- Programs affected:
  - Inpatient Quality Reporting Program
  - Value-Based Purchasing Program
  - Hospital-Acquired Conditions Program (delayed removal of measures)
  - Readmissions Reduction Program
- Removing 18 measures
- De-duplicating another 25 measures

# IPPS: Documentation Changes— Physician Certification

- 42 C.F.R. § 424.11 provides that if specific information required for the certification is contained in other parts of the record, “it need not be repeated.”
- Amends regulatory text to remove requirement that the certification “indicate[s] where the information is to be found.”

# IPPS: Documentation Changes— Inpatient Orders

- 424 C.F.R. § 412.3(a) provides documentation requirements inpatient admissions.
- Amends regulatory text to remove language requiring specific documentation of inpatient admission as a condition of Part A payment.
- Standard for inpatient admission has not been changed (no alteration to 2-midnight rule).

# IPPS: Transparency

- Hospitals have been required to make their standard charges available since 2015
- Clarification that “make available” means “make available a list of current standard charges via the internet in a machine readable format and to update this information at least annually, or more often as appropriate.”
- RFI for how price transparency could be increased (highlighting surprise OON costs, unexpected facility fees)

# OPPS

- Final rule published in the Federal Register on 11/21/2018
- Some highlights:
  - Overall increase of +1.35%
  - Focus on site-neutrality
    - Clinical families of services
    - G0463
    - 340B reimbursement
  - Meaningful Measures Initiative

# OPPS: Site Neutrality

- In the past few years, there has been a focus on narrowing the availability for Part A payment for off-campus PBDs.
- Core concerns:
  - The same service should be reimbursed at the same level in similar settings.
  - Enhanced payment for off-campus PBDs encourages consolidation and reduces competition.

# OPPS: Site Neutrality

- Bipartisan Budget Act of 2015 (11/2/2015)
  - Removed off-campus PBDs from OPPS.
  - Grandfathered off-campus PBDs that were billing under the OPPS as of 11/2/2015.

# OPPS: Site Neutrality— Clinical Families of Services

- As initially implemented, grandfathered space could be modified/upgraded/add service lines and still bill under the OPPS, as long as the space did not relocate to a new suite number/address.
- The 2017 OPPS proposed to limit grandfathering to to the “clinical families of services” provided as of 11/2/2015.
  - Not adopted in the 2017 final rule

# OPPS: Site Neutrality— Clinical Families of Services

- No proposal in the 2018 OPPS rulemaking.
- The 2019 OPPS proposed rule again proposed to limit grandfathering such that OPPS payment would be limited to the “clinical families of services” provided as of 11/2/2015.
  - Proposal again was not adopted in the final rule.
  - But CMS continues to express concern about this issue.
- For the moment, new service lines at existing off-campus PBDs will be paid under the OPPS, but that could change in the future. Based on the 2017 and 2019 proposals, a change in the future would likely refer back to a baseline at 11/2/2015.

# OPPS: Site Neutrality—G0463 and 340B Reimbursement

- Code G0463
  - Proposed 40% of OPPS rate
  - Finalized 2-year phase-in: 70% OPPS (2019) and 40% OPPS (2020)
    - Excludes “dedicated emergency departments”
- 340B
  - Average sale price minus 22.5%, regardless of hospital location where drugs are dispensed
- Applies to grandfathered facilities
- Not budget neutral
- Litigation

# OPPS: Meaningful Measures Initiative

- Similar criteria for removal as under IPPS
- Programs affected:
  - Hospital Outpatient Quality Reporting Program
  - Ambulatory Surgical Center Quality Reporting Program
- Eliminating 9 measures for hospital outpatient departments and 2 measures for ASCs

# SUPPORT for Patients and Communities Act

- Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act.
- Signed into law on October 24, 2018, Pub. L. 115-271.

# SUPPORT Act

- New and revised Medicaid, Medicare, FDA and Controlled Substance laws.
- Attempts to address the opioid crisis by:
  - expanding Medicaid and Medicare coverage for substance use disorder services;
  - promoting the use of telehealth services;
  - expanding “sunshine” disclosure requirements on arrangements with ancillary health care providers; and
  - adding program integrity measures in the form of new all-payor anti-kickback provisions.

# SUPPORT Act – Key Provisions

- New Medicare benefit category
  - Opioid use disorder treatment services furnished by opioid treatment programs (OTP) under Medicare Part B, beginning on or after January 1, 2020.
- Telehealth
  - Removes the originating site geographic requirements under section 1834(m) for telehealth services furnished on or after July 1, 2019 for the purpose of treating individuals diagnosed with a substance use disorder or a co-occurring mental health disorder.

# Eliminating Kickbacks in Recovery Act of 2018 (“EKRA”)

- Section 8122 of the SUPPORT Act.
- All-payor anti-kickback prohibition that extends to arrangements with recovery homes, clinical laboratories, and clinical treatment facilities.
- Criminal penalties:
  - Fines up to \$200,000, imprisonment of up to 10 years, or both.

# EKRA – Key Considerations

- Applies to “health care benefit programs” – i.e., both government and commercial payors.
- Applies with respect to the soliciting or receipt of remuneration for *any* referrals to recovery homes, clinical treatment facilities, or clinical laboratories, whether or not related to treating substance use disorders.

# EKRA – Text

- ...with respect to services covered by a health care benefit program, in or affecting interstate or foreign commerce, knowingly and willfully—
  - (1) solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind, in return for referring a patient or patronage to a recovery home, clinical treatment facility, or laboratory; or

# EKRA – Text, cont.

(2) pays or offers any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind—

- (A) to induce a referral of an individual to a recovery home, clinical treatment facility, or laboratory; or
- (B) in exchange for an individual using the services of that recovery home, clinical treatment facility, or laboratory...

# EKRA – Exceptions

- Discounts
  - Discounts obtained by providers or entities under a health care program, if the discounts are disclosed and reflected in the provider's or entity's costs or charges; also mirrors the federal AKS safe harbor for Medicare coverage gap drug discounts.
- Individual Compensation
  - Applies to both employees and contractors, unlike the AKS.
  - Requires that compensation not be determined by, or vary with, referrals to a facility, the number of tests or procedures performed, or the amount billed or received from the health care benefit program.
- Personal Services and Management Contracts (AKS safe harbor)

# EKRA – Exceptions, cont.

- Patient Copayments or Coinsurance
  - Non-routine, good-faith waivers or discounts.
- Federally Qualified Health Center Remuneration (AKS)
- Alternative Payment Models
  - Payments made as part of an approved alternative payment model.
- Any Other AG-determined Exceptions
  - EKRA allows the Attorney General, in consultation with the Secretary of HHS, to add any other payments, remuneration, discounts, or reduction by regulation.

# Implementing Regulations – Physician Fee Schedule

- Telehealth Interim Final Rule
  - Removes the originating site geographic requirements and adds the home of an individual as a permissible originating site for telehealth services furnished for purposes of treatment of a substance use disorder or a co-occurring mental health disorder for services furnished on or after July 1, 2019.
  - 60-day period to comment on the provisions of the interim final rule.

# Physician Fee Schedule, cont.

- MIPS
  - Included opioid related quality measures as high priority measures.
    - “Beginning with the 2021 MIPS payment year, an outcome (including intermediate-outcome and patient-reported outcome), appropriate use, patient safety, efficiency, patient experience, care coordination, or opioid-related quality measure.”
  - Added new measures to the MIPS program specifically focused on opioid use.

# Physician Fee Schedule, cont.

- In the CY 2019 PFS proposed rule, CMS sought comment on creating a bundled episode of care for management and counseling treatment for substance use disorders.

# Implementing Regulations – OPPS

- Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey revisions
  - Removing three pain-related communication questions. Effective with October 2019 discharges, for the FY 2021 payment determination and subsequent years.
  - CMS will not publicly report the three revised Communication About Pain questions.

# OPPS, cont.

- CMS will pay separately at ASP plus 6 percent for non-opioid pain management drugs that function as a supply when used in a covered surgical procedure performed in an ASC.

# Implementing Regulations – IPPS

- CMS finalized two new e-Prescribing measures related to e-prescribing of opioids for the Promoting Interoperability Programs.
  - Query of PDMP measure: Optional in CY 2019 and required beginning in CY 2020.
  - Verify Opioid Treatment Agreement will be optional for both CYs 2019 and 2020.

# Questions?

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