Physician Fee Schedule and OPPS/ASC Final Rules Call

Moderated by: Leah Nguyen
November 6, 2019 — 2:15 pm ET

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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event.

All lines will remain in a listen only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objection, you may disconnect at this time.

I would now turn the call over to Leah Nguyen. Thank you. You may begin.

Announcements & Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I'd like to welcome you to this Medicare Learning Network Call on the Physician Fee Schedule and Quality Payment Program Final Rule, and the Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System Final Rule.

Changes to the Physician Fee Schedule are aimed at reducing burden, recognizing clinicians for the time they spent taking care of patients, removing unnecessary measures, and making it easier for clinicians to be on the path towards the value-based care.

Topics include payment and supervision policy updates, Merit-based Incentive Payment System Value Pathways, Streamlining the Quality Payment Program to reduce clinician burden, and creating the new Opioid Treatment Program benefit in response to the opioid epidemic.

In addition, updates and policy changes under the Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center payment systems lay the foundation for a patient-driven health care system. Topics include changes to the inpatient-only list, ASC covered procedures list, Alternative Pathway for Breakthrough Devices, and Meaningful Measures, Patients Over Paperwork.

A question and answer session follows the presentation. Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL, go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

Today's event 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 question and answer session. If you have inquiries, contact press@cms.hhs.gov.

At this time, it's my great pleasure to introduce our CMS Administrator, Seema Verma, who will provide opening remarks. Administrator Verma.

Opening Remarks

Seema Verma: Thank you and good afternoon everyone, and thanks for joining the call.

Last month, President Trump laid out his vision for Medicare in a historic Executive Order. His vision strengthens Medicare for beneficiaries by providing more choices, promoting competition in the market, and ensuring the financial stability of the program.

Under his leadership, this administration is building on what works in Medicare and fixing what is broken. We are promoting competition remedying government cost distortions and ensuring the financial sustainability of the program for future generations of seniors. The final rules we released last week bring that bold and comprehensive vision to life.

First, I'd like to start with the Physician Fee Schedule, which will ease burden on providers and increase quality of care for patients. Our extensive work with stakeholders is reflected in the roughly 42,000 comments that we received on the proposed rule.

The verdict from clinicians on the status quo was overwhelming. Our existing burdensome regulations make their life harder and divert them from taking care of patients.

So, this rule moves the needle in the opposite direction. Last year, for the first time in over 20 years, we made major changes to the requirements for Evaluation and Management or E/M visits, essentially doctor's office visits. Because these visits make a significant proportion of Medicare payments, this rule will have a massive impact. It will ease the burden on providers, a top culprit of physician burnout, and lower administrative cost.

Most importantly, patient will notice change for the better as their doctors will spend less time on paperwork and more time with them.

Soon after we originally released our rule with our changes last year, the group responsible for developing standard codes and guidelines, the CPT Editorial Panel made their own updates to the E/M code set.

CPT codes are used by the entire healthcare system, not just Medicare. There are changes though containing differences in the details accomplished similar goals. And so, this year's proposed rule adopted the CPT changes to ensure consistency across the entire system. That's the rule that we finalized, and it will lighten the load on clinicians considerably.

So, allow me to offer some examples of the real-world effects this change will now have. Clinicians will no longer have to take into account unnecessary requirements when determining billing. They will have the option to bill the appropriate code based solely on the minimum amount of time spent in a visit.

And here's another example. Traditionally, clinicians had to conduct an entire physical exam and history to bill for an office visit. Now they can use their clinical judgment to determine whether that is medically necessary. The lightened load on overburden clinicians will result in doctors having more time with their patients.

But our work doesn't end there. President Trump's Executive Order directs us to correct misaligned payment structures that don't reward doctors adequately for the services that are most valuable to patients. Under the current system, the total amount that Medicare pays physicians is fixed.

So, as Medicare pays more for additional procedures the relative value of the common office visit has decreased. But the complexity of patient care and the demands on physicians during office visits have actually increased. As they now spent more time managing patients with complex conditions, evaluating genetic

information, and addressing social determinants of health. And some of the most important care patients received takes place during these visits.
Payment to doctors should reflect that. So, we're increasing payment for all E/M visits. This historic change will bring the scale back into balance, rewarding time spent with the patients, help address long standing payment concerns from doctors from all specialties that the system needs to account for that time spent with patients.

The rule also improves codes and payment for care of beneficiaries who are chronically ill. Nearly 1 in 5 Medicare beneficiaries have 6 or more chronic conditions and account for over 50 percent of Medicare fee-for-service spending. Care management, the ongoing services rendered by a physician to a person with chronic illness, allow patients to keep their condition under control. But clinicians told us that billing requirements were burdensome, and payment was low, limiting access to the services, so with only nine percent of beneficiaries currently receiving these critical services the numbers bear that out.

The final rule, like the proposed rule, fixes this. We will pay doctors more for these vital services. So, for example, we are increasing payment for care management of patients after they leave the hospital by 8 percent, and starting January 1st, 2020, Medicare will start paying for care management for patients with just a single high-risk condition like diabetes or high blood pressure. Something as simple making sure a patient is taking their medication can improve a patient's health or even save their life. So, these changes will increase patient access to these crucial services.

And finally, the rule overhauls the Merit-based Incentive Payment System or MIPS to reduce provider burden. Clinicians told us that MIPS is confusing. There are too many measures that often aren't relevant to their specialty. The rule MIPS Value Pathways or MVPs addresses their concerns.

The new framework streamlines reporting requirements and focuses on reporting what is actually meaningful to clinicians and making life easier for clinicians. The rule boosts the quality of care that patients receive over time.

So, let's take surgery as an example. Right now, under MIPS, a surgeon may report on measures of quality and improvement activities that are more relevant for a primary care doctor. Under a surgical MIPS Value Pathway, a surgeon could pick a measure set that would include a smaller set of measures and activities that are all clinically related to performing surgeries. And we look forward to continuing to work closely with medical professional societies on the MVPs over the coming months so that we can build a better program together.

And so now I'll move on to Hospital OPPS and the Ambulatory Surgery Center Final Rule.

Before doing so, I'll just note that the price transparency proposals that were a part of this proposed rule will be addressed in a separate final rule later this year. So, we're not backing away from these proposals. But we are considering the comments we received on these proposal as we work to finalize the hospital price transparency final rule alongside with a more comprehensive proposal for health plan price transparency, so stay tuned.

President Trump's Executive Order encourages competition in Medicare and so this rule gives seniors more lower cost options on where they can get their care and gives them the freedom to work with their doctor to determine the best setting to obtain care.

This rule expands the services that can be provided in hospital outpatient departments and ambulatory surgery centers, which can offer patients a lower-cost alternative to hospitals for many same-day procedures.

So generally, Medicare pays ambulatory surgery centers about half of what is paid to hospital outpatient departments. And for example, a beneficiary would have to, on average, pay a $46 copayment for an MRI in a hospital outpatient department and only a $24 copayment at an ambulatory surgery center for the same service.

In addition, we are allowing patients to get total knee replacements and certain coronary procedures at ambulatory surgery centers. Medicare will also pay for some procedures when provided in the hospital outpatient department instead of only in the hospital inpatient setting.

So, our proposed rule limited that change to total hip replacements, but based on public feedback, we decided to add certain spinal procedures as well. And this gives patients the option to go home sooner and avoid an expensive hospital stay.

Ultimately, the decision on where to get care should be between the beneficiary and their physician. And our rules just provide more flexibility.

Taken together, these historic rules reflect the Trump administration's commitment to secure and protect Medicare to lower costs and increases in increased choices and quality to ensure that clinicians can deliver high-quality care to our beneficiaries.

And with that, I'll turn it over to our talented CMS team to discuss these policies in more detail. Thank you.

Presentation

Leah Nguyen: Thank you, Administrator Verma. Our first presentation is on the Physician Fee Schedule Payment and Physician Assistant Supervision Policy Updates. I'll now turn the call over to Christiane Labonte from the Center for Medicare.

PFS Payment and PA Supervision Policy Updates

Christiane Labonte: Thanks, Leah. Good afternoon everyone or good morning to those of you out west. This is Christiane Labonte from the Physician Fee Schedule team. Emily Yoder and I will be discussing the Payment and Supervision Policy for Physician Assistant Provisions in the final rule, which Leah just discussed.

We'll start with the coding and documentation policies for Office and Outpatient Evaluation and Management Visit. As you may know, and as the Administrator mentioned, we've been in a multiyear process to modernize E/M coding documentation and payment as part of our ongoing efforts to reduce burden and we continue down that pathway this year.

After considering all the comments that we received for calendar year 2021, we are largely aligning our Evaluation and Management coding with changes laid out by the American Medical Association CPT Editorial

Panel for office and outpatient E/M visit, which largely means were finalizing what was in the proposed rule for calendar year 2021.

By way of reminder, this means that we will retain five levels of coding for established patients, reduce the number of levels to four for new patients, and revise the code definition.

We'll revise the times and medical decision-making guidelines for all the codes and require performance of history and exam only as medical approved – medically appropriate. And finally, allow clinicians to choose the E/M visit level based on either medical decision-making or time. We included a link here to the AMA CPT E/M webpage for more details and we provided that link for you to navigate to.

We believe that this approach reflects CMS goals of reducing documentation burden and allowing practitioners to spend more time with their patients, which the Administrator discussed in her opening remarks.

Now I'll turn over to Emily to discuss the payment rates.

Emily Yoder: Thank you, Christiane. We are on slide 8, for everyone's reference.

The AMA's Relative Value Unit Update Committee, or RUC, which develops payment rates for CPT codes, undertook a rigorous resurvey of the office, outpatient E/M codes, surveying more than 50 specialty societies. We believe that the resurvey values increased payment accuracy for most office, outpatient E/M codes, and are finalizing these values as proposed.

As we note here, this will increase payment for office, outpatient E/M visits beginning in CY 2021.

While we believe that the revalued codes more accurately account for the resources involved in furnishing the typical office, outpatient E/M visit, we continue to believe that the lack of payment variation results in undervaluing certain types of visits, mainly primary care or visits associated with ongoing care related to a patient's single, serious, or complex chronic condition.

We are therefore finalizing a HCPCS G-code add-on to provide additional payments for those types of visits. We want to underscore that this service is not meant to reflect difference in payment by Medicare enrollment specialty, but to provide a better recognition of the different resource costs associated with different kinds of visits.

And finally, we are not adopting any changes to the global surgical packages as we continue to evaluate data about those post-operative visits.

Slide 9 shows the current payment rates for the office, outpatient E/M visit, and the payment rates finalized for 2021. We also note that the new prolonged services code will pay approximately $22 while the HCPCS G-code for primary care or medical care services that are part of ongoing care related to a patient single, serious or complex chronic condition will have a payment of approximately $15.

I will hand it back to Christiane to discuss the Physician Supervision Requirements for PAs.

Christiane Labonte: Thanks, Emily. Slide 10 discusses the Physician Supervision Requirements for Physician Assistant that we finalized for calendar year 2020. So, to briefly recap, we propose to modify our regulation on physician supervision of PA to give them greater flexibility to practice more broadly in the current health care system in accordance with state law and state scope of practice.

In the absence of state law governing physician supervision of PA services, the physician supervision required by Medicare for their services would be evident by documentation in the medical record of the PA's approach to working with physicians and furnishing their services.

After considering all the comments we received, we are modifying our regulation to give Physician Assistants greater flexibility to practice more broadly in the healthcare system and according to state law and state scope of practice rules in the state in which the PA professional services are furnished.

What this means is that 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 the relevant section of the Social Security Act, and we have listed the full provision of the law.

In the absence of any state rules, we are finalizing a revision to the current supervision requirement to clarify that physician supervision is a process by which a PA has a working relationship with one or more physicians to supervise the delivery of their health care services.

Now back to Emily.

Emily Yoder: Thanks. We're on slide 11 for Care Management Services. In recent years, we have updated PFS payment policies to improve payment for care management and coordination, primary care, and certain types of non-procedure-based specialty care.

Working with the AMA CPT Editorial Panel and other clinicians, CMS expanded the suite of codes describing the services. New codes were created that differ and whether the services are face-to-face, represents a single encounter, monthly service, or both, our primary versus specialty care, address specific conditions and represent the work of physicians, their clinical staff, or both.

Transitional care management describes 30 days of care management that begin upon discharge from care in a facility, such as an inpatient acute care hospital or psychiatric hospital to a non-facility, for example, home or community settings such as assisted living.

For CY 2020, we are finalizing an increase in payment for TCM services. Chronic Care Management describes care management and coordination services for patients with two or more chronic conditions. For 2020, we are finalizing changes to several aspects of CCM care planning and the HCPCS G-code add-on for additional time spent beyond the initial 20 minutes for non-complex CCM services.

One of the gaps in coding and payment for care management services we identified was care management performed by practitioners who treat patients with a single, serious, and high-risk chronic condition. We have heard from certain specialists that there can be significant resources involved in care management for single, serious, high-risk chronic conditions and that these are not well accounted for an existing coding.

Therefore, we propose and are finalizing coding and payment for principal care management, which describes care management for patients with a single, serious, and high-risk chronic condition.

Now back to Leah.

Quality Payment Program

Leah Nguyen: Thank you, Emily. Our next presentation is on the Quality Payment Program. I will now turn the call over to Molly MacHarris from the Center for Clinical Standards and Quality.

Molly MacHarris: Thank you, Leah. As a brief reminder for folks under the Quality Payment Program, there are two tracks whereby clinicians can participate under; the first is by participating under the MIPS program. And the second track is participating through an Alternative Payment Model.

Moving on to slide 13, I'm going to go ahead and start talking through the MIPS track of participation and particularly focusing on the MIPS Value Pathways or MVP that Administrator Verma touched on previously.

The MVPs are a participation framework that will begin in the 2021 performance year. The overall goal of the MVPs is to move away from the siloed activities and measures and move towards an aligned set of measure options that are more relevant to a clinician's scope of practice that is meaningful to patient care.

The MVPs framework aims to align and connect measures and activities across the quality, cost, promoting interoperability and improvement activities, performance categories of MIPS for different specialties or conditions.

We envision under this new MVP framework that a clinician or group participating in one MVP associated with their specialty or clinical condition would report on the same measures and activities as other clinicians and groups in that MVP.

In addition, the MVP framework will incorporate a foundation that leverages promoting interoperability measures and a set of administrative claims-based quality measures that focus on population health, public health priorities, and reduce reporting burden by limiting the number of required specialty or condition-specific measures, so all clinicians or groups reporting on a clinical area would be recording the same measure set.

We believe this combination of administrative claims-based measures and specialty conditions-specific measures will streamline its reporting, reduce complexity and burden, and make participation more meaningful for clinicians and payments beginning in 2021.

I also wanted to mention on slide 14 as part of our new MVP framework, we have created a few dedicated MVP resources. We do envision over the coming months; additional resources will become available. But as

reflected on slide 14, we have a dedicated MVP website as well as a short video that outlines our vision for the MVP framework.

Moving on to slide 15, there are just a couple diagrams I wanted to briefly go over with you all today. These are similar to the diagrams that we had about as the proposed rule. But they have been updated very slightly.

So, as you can see on slide 15, the current structure of MIPS have a very siloed field. There seems to be a very separate and distinct things that clinicians have to do under the 4 performance categories. And the number of measures and activities aren't meaningfully aligned and there's too much choice and selection burden.

As you can see in the middle column here, the MVP framework will begin in 2021. And as you can see, we're starting to more closely align the 3 performance categories quality, improvement activities and cost while maintaining that foundational layer of promoting interoperability and our administrative claims population health measures.

As we continue to build out the MVPs in a collaborative manner with stakeholders, we look to further align the quality and improvement activities and cost performance categories while continuing to build out the foundational layer.

On slide 16 and then on slide 17, we also have 2 examples of what the MVPs could look like. On slide 16, there's a surgical example. And then on slide 17, there's an example for clinicians who would be focused on diabetes care. I won't be going over these diagrams in detail right now, but happy to take any questions on them when we get to the Q&A period.

So, let's go ahead and move on to slide 18 to talk through the rest of the MIPS changes for the 2020 year. Within the 4 performance categories, we didn't finalize too many changes, but some of the key areas I do want to highlight are that within quality, we did finalize our proposal to increase the data completeness threshold to 70 percent. We also removed closed to 16 percent of measures from the MIPS measurement set by further implementation of the Meaningful Measures framework. Those measures were low-bar measures, standard of care process measures or measures that were extremely topped out.

We also finalize our policies to address different benchmarking approaches for certain measures that could potentially over-incentivize inappropriate treatment. And we also finalized 7 new specialty sets within the quality performance category.

Within cost, we finalize our proposals to revise the 2 global measures, the Medicare Spending Per Beneficiary and Total Per Capita Cost measure, to redefine the attribution methodology to have it more closely be associated to a clinic – to the primary clinician. We also finalized 10 new episode measures.

Within the improvement activities performance category, we did finalize our proposal to increase the group threshold from a single clinician to 50 percent. We did finalize it with a slight modification that instead of requiring that the entire group complete the improvement activities within one 90-day period, they can complete the improvement activity by the entire group during any 90-day period throughout the performance year. We also finalize the conclusion of our study on Factors Associated with Reporting Quality Measures.

Lastly, for the promoting interoperability performance category, we finalized the ability to keep the Query of PDMP measure as optional and we removed the Verify Opioid Treatment Agreement Measure and updated our threshold for hospital-based clinicians.

Moving on to slide 19 for our Performance Category Weights, we did not finalize the proposed changes that we made for this upcoming year, year four. So that means that quality still contributes 45 points toward the clinician's final score, cost still contributes 15 points towards the clinician's final score, and improvement activities and promoting interoperability still contribute 15 and 25 points.

Moving on to slide 20, we did finalize our proposals of the performance threshold for years 4 and 5 of 45 and 60 points respectively. As a reminder, the performance threshold is the number that can range between 0 and 100 points that clinicians want to aim to have their final score at or above.

For clinicians whose final score is at or above the performance threshold, they will be able to receive a positive adjustment, or if their final score is at the performance threshold, they would receive a neutral adjustment. If their final score falls below the performance threshold, they would be receiving a negative payment adjustment.

We also did finalize the exceptional performance bonus of 85 points for both years 5 and 6. We did have a slight increase from year 5 to ensure that that exceptional performance bonus can be distributed to the top performers within the MIPS program.

And then moving on to slide 21, we also finalized a number of our proposed policies related to third-party intermediaries. The focus here is really to improve our partnership with these entities and to ensure that they can be a one-stop shop for clinicians.

Beginning with the 2020 performance period, we have required that QCDRs need to harmonize their measures within a one-year timeframe. The majority of the third-party intermediary requirements have been finalized with a one-year effective delay, meaning that they wouldn't be effective until calendar year 20 – or until the 2021 performance periods.

Namely, we finalize that the QCDRs would need to be able to submit data for all three performance categories, so quality, improvement activities, and promoting interoperability. And we also finalized the requirements that the QCDRs would need to provide enhanced performance feedback 4 times a year, including how clinicians compared to their peers, as well as enhanced requirements for the QCDR measure approvals, including the requirements of testing data.

We also finalized a few additional changes related to our targeted review process. And we also finalized a new policy that allows reweighting in rare instances when data integrity concerns exist.

Moving on to slide 22, I will turn this over to my colleague, Brittany LaCouture. Brittany?

Brittany LaCouture: Thanks, Molly.

So, for the 2020 Performance Year regarding MIPS APM, so those are participants in APM who are also eligible MIPs clinicians. We are now going to be allowing APM entities to report on the MIPS quality performance category through MIPS, using MIPS measures at the entity level or the taxpayer identification number, TIN level or individual level. And the goal of this is to offer flexibility and to improve meaningful measurements and ensuring that our eligible clinicians are being represented by measures that they are actually engaging in, in things like scoring and physician compare.

We're also going to be implementing a 50 percent APM Quality Reporting Credit that will be credited towards the quality performance category for APM participants in MIPS APMs that do not require reporting through MIPS, meaning that they are required to report quality measures, both to MIPS and to their APMs separately.

Another change for APM participants, this is on the advanced APM side of the house. We have a small update to the definition of that average marginal risk rate that is applicable both to MIPS APMs and other payer advanced APMs.

And that's it for CPT for this year. Turn it over to Lindsey, I believe.

Opioid Treatment Programs

Leah Nguyen: Thank you, Brittany.

Our next presentation is on the Opioid Treatment Programs. I now turn the call over to Lindsey Baldwin from the Center for Medicare.

Lindsey Baldwin: Great, thanks, Leah. Starting on slide 24, I'll give a little bit of background. So, Section 2005 of the SUPPORT Act established a new Medicare Part B benefit for opioid use disorder or OUD treatment services, including medications for Medication-Assisted Treatment, furnished by Opioid Treatment Programs or OTPs. These policies will be effective as of January 1st, 2020.

Moving on to slide 25, we finalize the definition of OUD treatment services, which includes FDA-approved opioid agonist and antagonist treatment medications, the dispensing and administering of such medications, if applicable, substance abuse counseling, individual and group therapy, toxicology testing, which includes both presumptive and definitive testing, intake activities, and periodic assessments.

We are also allowing counseling and therapy services described in the bundle payments to be furnished via two-way interactive audio-video communication technology as clinically appropriate.

On slide 26, we also finalized 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, 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 a full list of the payment rates. Rates for the non-drug component will be adjusted by geographic locality and will be updated on an annual basis. We also finalize zero beneficiary copayment for 2020.

Additionally, on slide 27, 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 23rd, 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.

On slide 28 under key changes from the proposed rule, CMS is amending the proposed policies as follows. For the drug component of the OPT 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 NADAC's pricing when ASP is not reported.

For the non-drug component of the OTP bundle, we're 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.

On slide 29, in addition to the items and services specified by the statute for CMS to include in the bundle, CMS is also finalizing additional payments for intake and periodic assessment activities, which OTPs are required to provide under SAMHSA regulations. We're 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 delivery of at least one service in the bundle, which can be from either the drug or non-drug component.

CMS adjusted the screening protocols for OTP that have been fully and continuously certified by SAMHSA since October 23rd, 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 23rd, 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. This is on slide 30. Along with creating the OTP benefit, the SUPPORT Act also mandates all states to cover OTPs in their Medicaid programs effective October 2020, subject to an exception process as defined by the Secretary.

Starting January 1st, 2020, Medicare will be the primary payer for OTP services for dually eligible beneficiaries who currently get OTP services through Medicaid.

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 that the service is covered in the state plan.

Medicaid will later recoup the Medicaid payments made to the OTP, back to the effective date of OTP's Medicare enrolment. And the OPT will then bill Medicare for those services.

OTP providers should enroll in Medicare now to be able to bill for services starting January 1st, 2020. See the link on – in this slide, slide 30 of this presentation for more information about this on the OTP webpage.

Under 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.

We would also like to highlight that there will be an additional MLN call next Tuesday, November 12 from 3:00 to 4:30 pm Eastern Time. The target audience for that call is fully certified and accredited OTPs and related staff, as well as interested stakeholders. There's also a link on this slide, slide 32, that you click on to register for that presentation.

And finally, under 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, and add-on code for additional coun – and then 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.

And with that, I'll pass back to Leah.

CY 2020 OPPS/ASC

Leah Nguyen: Thank you, Lindsey. Our final presentation is on the Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center. I'll now turn the call over to Tiffany Swygert from the Centers for Medicare.

Tiffany Swygert: Thanks, Leah. And we are now on slide 35. So, starting with the Inpatient Only list changes for 2020. We finalized changes to the Inpatient Only list, including the removal of total hip arthroplasty or total

hip replacement, as well as six spinal surgical procedures and related anesthesia services from the list. This removal makes them eligible to be paid by Medicare in both the hospital inpatient and outpatient settings.

Additionally, in response to public comments, we establish a 2-year exemption rather than a 1-year exemption that we had proposed from medical review activities related to patient status for procedures removed from the Inpatient Only list starting with 2020 and subsequent years.

More specifically, we finalized that the QIO or quality improvement reviews of short-stay inpatient claims for these newly removed procedures for the first 2 years will not be counted against a provider, a hospital provider in the context of the Two-Midnight rule.

The QIOs will have the opportunity to review those claims in order to provide education and outreach to providers and this will be regarding compliance of the Two-Midnight rule. However, they will not review them for patient status, nor will be referring them to the recovery audit contractors for purposes of non-compliance with the Two-Midnight rule.

Moving on to the next slide, the ASC Covered Procedures List is a list of covered surgical procedures that are eligible for payment under Medicare when furnished in an ASC. And covered surgical procedures are those procedures that in part 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 or care at midnight following the surgical procedure.

For calendar year 2020, we finalize our proposal to add Total Knee Arthroplasty, Knee Mosaicplasty, 6 additional coronary intervention procedures, as well as 12 procedures for new CPT codes that were newly created in 2020, to the ASC Covered Procedures List.

With that, I will turn it over to Elise Barringer to discuss additional policies from the OPPS/ASC rule.

Elise Barringer: Thank you, Tiffany. We are on slide 38 now, talking about the Alternative Pathway for Breakthrough Devices.

For transformative devices that meet the FDA Breakthrough Device designation, CMS finalized an alternative pathway to qualifying for device pass-through payment status, under which the substantial clinical improvement criterion would not apply to these devices.

The 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 1st, 2020. The 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.

Additionally, effective January 1st, 2020, CMS approves five device pass-through applications that meet the criteria to be granted transitional pass-through status for a period of 3 years.

Now, I'll turn it over to Vinitha to discuss Meaningful Measures and Patients Over Paperwork.

Vinitha Meyyur: Thank you. We are on slide 39, Meaningful Measures/Patients Over Paperwork. Under the Hospital Outpatient Quality Reporting Program, CMS removed one web-based measure for the calendar year 2020 program year. This is the External Beam Radiotherapy for Bone Metastases measure.

Complexity of reporting this measure places substantial administrative burden on hospitals, so removal is on the basis that the costs associated with the measure outweigh the benefit of its continued use.

Under the Ambulatory Surgical Center Quality Reporting Program, CMS did not propose to remove any measures in this rulemaking because there are no measures that meet the measure removal factors.

CMS is adopting one claims-based measure beginning with the calendar year 2024 payment determination. This is the ASC 7-day Hospital Visit after General Surgery Procedures Performed at the ASC.

Question & Answer Session

Leah Nguyen: Thank you, Vinitha. We will now take your questions. As a reminder, this event is being recorded and transcribed. We have subject matter experts available to answer your questions about only the topics discussed on today's presentation. In an effort to get to as many of your questions as possible, each caller is limited to one question.

Today's call is not a forum for specific questions about your medical practice or place of business. Preference will be given to general questions applicable to a larger audience and we will be mindful of the time spent on each question.

Also, the subject matter experts available today will not be able to address any questions related to pending litigation. We appreciate your understanding. All right, Blair, we are ready for our first caller.

Operator: To ask a question, press star followed by the number one on your touch tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question, to ensure clarity.

Once your line is open, state your name and organization. Please note, your line will remain open during the time you're asking your question, so anything you say, or any background noise, will be heard in the conference. If you have more than one question, press star, one, to get back in the queue and we will address additional questions as time permits.

Please hold while we compile the Q&A roster. Please hold while we compile the Q&A roster.

Your first question comes from the line of Stephanie Brooks. Stephanie, your line is open. You may be muted on your end. …

Leah Nguyen: Blair, we will take the next question.

Operator: Next question comes from the line of Ronald Hirsch.

Ronald Hirsch: Hi there, Tiffany. My question is about the moratorium on audits for the total hip rep or anything coming out the Inpatient Only list. So, I understand it's 2 years, is that solely looking at status and are they still allowed to look for medical necessity of the procedure itself? And if they are, will they also be denying physician payments for the procedure?

Tiffany Swygert: Hi. Thank you, Dr. Hirsch. This is Tiffany Swygert and you are correct that the QIOs will be reviewing for patient status – or will not be reviewing for patient status, however, they are still able to review for medical necessity, so there still has to be – the procedure still has to be medically necessary. I can't speak to physician reviews, but we'll be happy to take that question back to other colleagues.

Ronald Hirsch: Okay. And with the RUCs to audit, the way it works now, they have to ask for permission from CMS to get an issued place under the list. Since total knees will now be eligible as of January 1st, do they have to ask you for permission, and do they have to wait for referrals from the QIOs or can they just start doing like they're doing every other issue now and just randomly audit?

Tiffany Swygert: I can't speak to the RUC review protocol in general, but I do want to clarify that total knees was removed 2 years ago from the Inpatient Only list. It's now added to the ASC list effective January 1st, 2020.

Ronald Hirsch: Right.

Tiffany Swygert: And you were asking about the hospital reviews, but certainly we can get you in touch with the RUC program experts for additional information on that.

Ronald Hirsch: Okay. Thank you. I'll get back in line.

Leah Nguyen: Thank you.

Operator: Your next question is from the line of Jason Shropshire.

Jason Shropshire: Hi, can you hear me?

Leah Nguyen: Yes, we can.

Jason Shropshire: Hello. Yes, I …

Leah Nguyen: We can hear you.

Jason Shropshire: I can – I've not been able to go through the entire final rule, but I don't see much documentation regarding how MIPS Value Pathways will work for large multi-specialty groups. Can you expand a little bit on that, especially with, you know, CMS keeping, you know, relaying that they're reducing the burden for providers, that is the goal from this side of your pathways, but I don't understand how that's going to work for groups that have several specialties, because it would seem like you're suddenly asking for many more counts of measures than we had to do before.

Molly MacHarris: Yes. Hi, Jason. This is Molly MacHarris. So, for this year's rule, what we finalize regarding MIPS Value Pathways is the framework itself, the definition. And as a reminder, as Administrator Verma mentioned in her remarks, that will begin in 2021.

So, the specific details that you're looking for of exactly how multi-specialty practices would participate within the MVPs, those are items that we'll be addressing through future rulemaking. So, stay tuned for upcoming rulemaking where we'll be discussing that in more detail. Thank you.

Leah Nguyen: Thank you.

Operator: The next question is from the line of Barry Allison.

Barry Allison: Yes, good afternoon. I was curious about the TCM payment adjustment for the Transitional Care Management. I didn't hear or have read anything in the Federal Register concerning what the adjustment amount would be. I read that would be an increase, but I was wondering if you could speak to that or referenced an RVU of another code concerning that, please. Thank you.

Ann Barshaw: Hi, this is Ann Barshaw in the Physician Schedule Division. We don't have the exact RVUs in front of us, but if you send us an e-mail, we can get them for you, or they are in files on the Physician Fee Schedule website. But it was about an – it was about an eight percent increase based on – we adopted the RUC recommendation for when the credits were resurveyed.

Barry Allison: And what is the e-mail address, please?

Leah Nguyen: To send in a question, you can send it to mlneventsteam@cms.hhs.gov.

Barry Allison: Okay, thank you very much.

Leah Nguyen: Thank you.

Operator: The next question is from the line of Dianne McHelen.

Dianne McHelen: Hi, this is Dianne from CalHIPSO. So, was there anything in the final rulemaking for Medicaid promoting interoperability, the EHR Incentive Program that still goes for 2020 and 2021?

Molly MacHarris: Hi, this is Molly MacHarris. I know there was a portion within the Physician Fee Schedule that touched on the Medicaid promoting interoperability requirements. I unfortunately don't have subject matter expertise to speak to that and I just heard – Leah if we have those SMEs on the line, I don't believe that we do, but yes, there is a small section within the rule on that program.

Leah Nguyen: Yes, I don't think we do have anyone else on the line unfortunately but thank you.

Operator: And as a reminder, if your question has been answered you may remove yourself from the queue at any time by pressing the pound key.

The next question will come from the line of Todd Thomas.

Todd Thomas: Good afternoon. I'm wondering with the more – with more focus being on medical decision-making for the office E/M code, is there going to be anything from CMS to help create a more uniform method of scoring medical decision-making as opposed to all the individual MAC having their own systems then being applied in a variety of methods across the payers?

Ann Marshall: Hi, this is Ann Marshall in the Division of Practitioner Services. Again, I think at this point, we have not developed specific strategies with the MACs. They would be looking at the information as it's laid out on the AMA's website. Those were the guidelines that we have finalized to adopt.

Ann Marshall: And at this time, I don't think there are …Todd Thomas: Sorry, go ahead.

Ann Marshall: This is the website on the slide – there is a link that …

Female: Yes, slide 7.

Ann Marshall: Yes, if you go to that link there is a chart, these are our new medical decision-making guidelines and tables that passed at the AMA CPT Editorial Panel and we have finalized adoption of them as they are contained in that document.

Todd Thomas: And at the top of the document it says they will not be applied for CPT 2020; they will be effective January 2021.

Ann Marshall: That's correct and that is also the policy that we finalized to begin in 2021.

Leah Nguyen: Thank you.

Todd Thomas: Okay. Thank you very much.

Operator: The next question will come from the line of Laura Hill.

Laura Hill: Hello, I'm a family doctor in Virginia Beach, and just to piggyback on the last question. Can we use the new E/M coding guidelines now or do we have to wait till 2021?

Christiane Labonte: Hi, this is Christiane Labonte from the Division of Practitioner Services. The CPT Editorial Panel created those codes for January 2021 so that is when we will be effectively using them for Medicare purposes.

Laura Hill: Okay, thank you.

Leah Nguyen: Thank you.

Operator: Our next question will come from the line of Hamilton Lambert.

Hamilton Lambert: Hello, this is Hamilton Lambert with TeamHealth. The 2020 Physician Fee Schedule seems to indicate that we can take a physician's documentation by the nurse with the history and physical exam. Historically, a physician had to document the history or physical exam, this is in a section about teaching physicians but the way its worded seems to apply to all physician interactions. And I just wanted to confirm that as a physician I can take a nurse's documentation for the history of present illness in the physical exam as long as I appropriately review it and verify it.

Leah Nguyen: Hi, this is Leah. I think we do have an FAQ that we can direct you to, but can you go ahead and e-mail that in and I'll send it to you? And the address again is mlneventsteam@cms.hhs.gov.

Hamilton Lambert: Very good. Thank you very much.

Leah Nguyen: Thank you.

Operator: The next question will come from the line of Teresa Cagg.

Teresa Cagg: Hi, thanks very much for the call. I find this very informative and very much appreciate this. My question is with regards to MVP, and the quality category measure choices. The examples appear to show that there'll be very few quality choices left, so different quality measures to choose from within the category, then I'm trying to determine if I am interpreting that correctly.

So, the surgery and the diabetes examples appear to show that all clinicians who would be reporting under that MVP would have the same specific quality measures, and I'm trying to determine if that's correct so that I could start to implement any of those that we're currently not tracking with our team now.

Molly MacHarris: Sure. This is Molly MacHarris again, thank you for that question. And yes, so if you take a look at the diagrams that are on slide 15, 16, and 17, you can see that we outline a few examples of what some of the quality measures, what some of the improvement activities, and what some of the cost measures could be.

I want to reiterate again the MVPs themselves would not begin until 2021, so not next year, but again we still have this until 2021. And I also want to clarify the diagrams on the slide here on slide 15, 16, 17, these are examples of what MVPs could look like, these are not specific MVPs; we would have to propose and finalize those MVPs through future rulemaking.

But to address your question of is the number of measures correct and how would that work for different folks within your group, so we are currently envisioning that we would have within each MVP a smaller set of measures and activity, so MIPS the way it works today, it's another quality clinicians typically have to perform on six measures.

As you can see for both of these examples, we have outlined three measures; with that being said though, these are just examples. We haven't yet finalized what the set number of measures or activities would have to be within each of the categories within the MVP themselves.

For the question on how would works for groups, and would they be required to report on all of the measures and activities within MVP, as reflected within our comment consultation, our vision is that clinicians that are able to report on a given MVP that they would be reporting on that MVP in a uniform manner, meaning that they would report on all of the measures and activity.

But that also is a topic that we will address through a future rule making. We received a lot of really valuable feedback from stakeholders through the comment consultation this year to rule that we want to work through in more detail and will be making proposals on.

So, I hope that helps clarify the MVPs. Thank you.

Teresa Cagg: It does. Thank you.

Leah Nguyen: Thank you.

Operator: The next question will come from the line of Rebecca Yerhon.

Female on participant line: Sherry for you.

Sherry Smith: Hi, this is Sherry Smith with the American Medical Association. First since I had it handy, I thought I'd just give the transitional care management numbers that was requested before 99495 it's 5.20, 99496 is 6.87 so that's a 13 percent and 5 percent increase respectively.

And then my question about slide 9, I just want to make sure it's clear here. The approximate finalized payment would assume that there's no budget neutrality impact from the per annum increases. The budget neutrality impact is eight percent.

So actually, unless there are some congressional actions to waive budget neutrality, or there are some other changes within the fee schedule, these numbers an approximate finalized payment on slide 9 would actually be eight percent less than what was posted there, correct?

Emily Yoder: Hi Sherry, this is Emily Yoder from DPS. You are correct. The payment rates on slide 9 were calculated using an approximate current conversion factor as we don't know all of the sort of changes to other rates under the PFS that are going to be in effect for 2021. We have not made any projections for the conversion factor for that year.

Leah Nguyen: Thank you.

Operator: The next question will come from the line of Tiffany Sailor.

Tiffany Sailor: Hi. I think my question already got answered. It was the same question regarding the MVPs in the multi-specialty groups where a large organization with specialties, primary care, dentists, and it would definitely increase burden on us to have to follow MVPs for each individual specialty rather than supporting as a group for the same measures across the entire group, so I will just look forward to future regulation on that.

Leah Nguyen: Thank you.

Operator: As a reminder, if your question has been answered you may withdraw your registration at any time by pressing the pound key.

The next question will come from the line of Norman Brooks.

Norman Brooks: Good afternoon and thanks for doing a great job summarizing the 2,475 pages that I enjoyed reading over the weekend specifically looking for clarification. The changes in E/M documentation guidelines reducing the burden of history – history and physical examination relying heavily on medical decision making, would that become effective on January 1, 2020 or 2021?

Christiane Labonte: Hi, this is Christiane Labonte from the Division of Practitioner Services. The effective date is January 1st, 2021.

Norman Brooks: Thank you.

Leah Nguyen: Thank you.

Operator: The next question will come from the line of Sarah Sillesen.

Sarah Sillesen: Hello and thank you for taking my call. This is Sarah. And I would like to know if you could repeat the implementation timeline for price transparency mandates that require hospitals to post prices for 70 shoppable services. That was mentioned at the beginning of the call and it would be very helpful to hear it again.

Tiffany Swygert: This is Tiffany. There wasn't a timeline mentioned. The Administrator said that there would be a forthcoming final rule related to price transparency.

Sarah Sillesen: Great. Do you know if it will be before the end of the year and effective January 1st, 2020?

Tiffany Swygert: We haven't made statements about that at this point, but we do expect the final rule to come out soon.

Sarah Sillesen: Thank you.

Operator: Your next question will come from the line of Amy Thorpe.

Amy Thorpe: Hi, thank you and good afternoon. I just want to confirm one more time. This question might have already been answered. The MIPS Value Pathways, they will not be required necessarily by every clinician in 2021. Will there be some sort of phase-in or transition between MIPS and the MVP program?

Molly MacHarris: Sure, this is Molly again. So, we haven't yet made our proposals and finalized any policies of what the implementation timeline would look like for participation within the MVPs. We did highlight within our responses within the final rule, the general feedback we heard from stakeholders asking us to move slowly due to a variety of factors. So that's something we definitely are keeping in mind.

And, again, we'll address the actual implementation timeline of MVP for future rulemaking. But to reiterate, again, MVPs are finalized effective for 2021. That would be the first available opportunity. I hope that helps. Thank you.

Operator: The next question will come from the line of Karen Bertram.

Karen Bertram: Yes, I had a question regarding the new regulations for E/M services. I know the level can be chosen based on either medical decision making or time. Is time face-to-face time or total time spent on that date of service in care of the patient whether face-to-face or not?

Ann Marshall: Hi, this Ann Marshall, again. It is all of the time on the date of the service. So that includes – but it's the time of the reporting practitioner. So, it's both face-to-face time and non-face-to-face time for the 24 hours on that date.

Karen Bertram: Great, thank you.

Leah Nguyen: Thank you.

Operator: The next question will come from the line of Dale Retzler.

Dale Retzler: Thank you. My question is also about MVP, but I think it's different than the previous questions. Multiple times now I've seen the example of an MVP for surgery or an MVP for diabetes. And I actually think those are pretty easy because there were already a robust set of performance made that you could choose from to develop those MVPs.

I'm more curious about the process of developing MVPs for specialty practices, and where there currently is a very, very limited set of performance measures. How will you go about doing that and what will be the stakeholder input into developing MVPs or many of the other specialties that have not been shown in the two examples that show up consistently in your presentations?

Molly MacHarris: Sure. Thanks, Dale, this is Molly, again. Appreciate the feedback. So, as we reflected within the final rule, and as Administrator Verma touched on in her opening remarks here today, what we've heard really loud and clear from stakeholders is that they want to work with us on developing the MVP. That's something we agree with.

We very much want to work with as many stakeholders as possible as we look to implement these. So, again, as I've mentioned a couple of times here today that that's why we are thinking through our approach very carefully. We very much understand that the amount of change for clinicians and healthcare systems to absorb at any one time. So again, we finalize the MVP approach for 2021.

We are looking to fill in some of the additional details through future rulemaking. And we look to continue to engage with stakeholders, so stay tuned for more information for – Dale, I believe you're already signed up for this listserv, but I'll just go ahead and make a plug now.

If any other folks on the call here today that are interested in working with us on future opportunities for developing MVPs, I highly encourage all of you to sign up for our QPP listserv, which is available at our website, qpp.cms.gov. So, I just want to mention that. I hope that helps. Thank you.

Operator: The next question will come from the line of Kathleen Chub.

Kathleen Chub: Yes, thank you for this very good call. And I have a question in regards to the outpatient department change from a requirement for direct supervision to general supervision.

And I was wondering exactly, are you going to be changing some of the rules that have been written for us and passed a final rule that talked about such things as not accepting telephone orders? And if there was a list of what types of procedures could be general versus direct supervision? There's a lot of confusion about the implementation of this particular rule.

Tiffany Swygert: Hi, this is Tiffany Swygert. Thank you for the question. We actually didn't discuss that particular policy on today's call. But in general, the new policy will apply for January 1st, 2020. So, we typically don't go back and change prior rules related to that.

I would encourage you, if you have specific questions about how the rule will actually work in practice, you can submit those to your Medicare Administrative Contractor. In addition, just to make a quick plug for another call will be having.

That's the Hospital Open Door Forum, where we expect to talk about this and other issues that were included in the rule. That call is scheduled for November 19th at 2:00 pm Eastern right now, so if you're signed up for that, we'd be happy to have further discussion with you then.

Kathleen Chub: Thank you.

Tiffany Swygert: Sure.

Operator: The next question will come from the line of Greg Fulton.

Greg Fulton: Yes, hello. Thank you. In the reference section on physician assistance, there was a reference to an Executive Order. Is that a reference specifically to the October Executive Order or one prior?

Leah Nguyen: If you could send that question into us, that would be great. We'll make sure we give you the right information. You can send it to mlneventsteam@cms.hhs.gov.

Greg Fulton: I'll do that, yes. In the final rule, I didn't see a reference to that specific one, but I did see references to Executive Orders. I'll ship that to you. Thank you.

Leah Nguyen: All right, thank you.

Operator: Your next question comes from the line of Gary Fascilla.

Gary Fascilla: Yes, thank you. You spoke about removing barriers to the Alternative Payment Model participation and you spoke about Physician Assistants. One current barrier has to do with specialty groups that are trying to participate in more than one ACO Alternative Payment Model.

If you're utilizing advanced practitioners, they're being categorized as primary care, physicians and as a result, the specialty group is not allowed to practice in more than one ACO model. Is that something that's been looked at?

Brittany LaCouture: Hi, this is Brittany. So, for the purposes of looking administration multiple models, SSP is currently the only APM that does not allow concurrent participation in multiple models.

So, if there is another model that would be more appropriate for some of your participants – I'm sorry, so they allow participants in multiple ACOs or multiple APM entities, but they – there are other models that do allow that and you could also participate in different types of APMs and different models.

So, there are options available for people within different specialties. It's just might mean that you can't be in multiple entities within that APM with an SSP.

Leah Nguyen: Thank you.

Operator: As a reminder if the question has been answered, you may withdraw your registration at any time by pressing the pound key.

Our next question will come from the line of Michael Banks.

Michael Banks: Good afternoon. Thank you for the overview. I'm a frontline Orthopedic Surgeon. And this Quality Payment Program MIPS thing, I've been around a long time, 20 years. We went to PQRI, PRQS, Meaningful Use, MIPS now MVP. Has any of this shown any – anything but just utter burden to physicians?

And now this MVP thing looks like you're be arranging the chairs on the Titanic? There's nothing less burdensome about this. It's, you know, wholly burdensome for small groups to go through these enormous changes every single year. And we get zero feedback, zero. And all for just like potentially a tiny increase, tiniest increase in Medicare reimbursement. Otherwise, you get penalized like crazy.

So, can someone please tell me, is there a study out that says MVP is better? Not just believe it is or you think it is, but it is better. So, is there something out there? That says what all you guys have been doing for a decade is helping. It doesn't appear to be. We're all frontliners. I hope you are listening. Thank you.

Leah Nguyen: Thank you. We appreciate that.

Operator: The next questions will come from the line of Debra Pecardio.

Debra Pecardio: Hi, I have a question for you. You make referenced a few times about changes in Inpatient Only list and you're referencing being like six spinal surgical procedures are being added. Where can we find the specific CPT code?

Tiffany Swygert: Hi, they are in the final rule. This is Tiffany Swygert. They're also in the addendum to the final rule. I believe it's Addendum E.

Debra Pecardio: Okay.

Tiffany Swygert: But if you're not able find them, please shoot an email and we'll point you to them.

Debra Pecardio: Perfect. Thank you so much.

Tiffany Swygert: Sure.

Operator: Our next question comes from the line of Doris Garcia.

Doris Garcia: Hi. I was wanting to know for 2020, when will the quality – clinical quality measurement specs be available?

Molly MacHarris: Sure. This is Molly. We will be hosing the quality measures specifications on our website qpp.cms.gov no later than the end of this year.

Doris Garcia: So, also like at least by January 1 or something like that?

Molly MacHarris: Yes, they should be before the end of December.

Doris Garcia: Perfect. Thank you.

Molly MacHarris: Thank you.

Operator: The next question will come from the line of John Travis.

John Travis: Hi. I wanted to ask if you have any projection or when billing guidance will be available for the opioid treatments benefits because of the weekly and monthly benefit structures, or I should say billing structures. That's probably a fairly new model of billing for ambulatory practices and for the types priors that will be involved in that.

Lindsey Baldwin: Hi, this is Lindsey Baldwin. Thanks for your question. Yes, I think one thing you can do is join us for our call next Tuesday, November 12th at 3:00 Eastern time. We will be talking more during that call about enrollment but also how to build a new bundled payment code. And we are working on putting up some additional guidance about billing those codes as well which will be release prior to January 1st.

John Travis: Thank you.

Leah Nguyen: Thank you.

Operator: Your next question will come from the line of Susan Mile.

Susan Mile: Hi, on the E/M code, the decision to use MDM on time to determine the E/M level, is it per encounter, or is it for the year, or for the practice in general to adopt, or can they – can the provider change it – from encounter to encounter as to which rules they use?

Christiane Labonte: It depends on the code level. So whichever code you are deciding to bill for that particular patient, again, that's your decision to make based on whatever the code requires.

Susan Mile: So, it's per encounter. I can change – use MDM on this encounter and time on another encounter.

Christiane Labonte: Yes, that's right.

Susan Mile: Thank you.

Leah Nguyen: Thank you.

Operator: The next question comes from the line of Orlando Rivero.

Orlando Rivero: Hi, this is Orlando Rivero and I'm the health policy product manager for the American Academy of Sleep Medicine. My question is regarding the initial remarks during this presentation. I may have misheard, but did the person state that an additional final rule will be released, following further comments on the MVPs and looks like an addendum, or will this be included in the future draft for the rule next year?

Molly MacHarris: Sure, this is Molly. I can address the comment on MVPs. I'm not sure though if you were talking about any of the other opening remarks, but yes. So, for MIPS MVPs, again, within this final rule, we finalized the framework definition which would be effective beginning calendar year 2021. The additional details of how clinicians would be participating within MVPs and the implementation of those will be addressed through future rulemaking. I hope that helps your question was regarding MIPS. Thank you.

Orlando Rivero: Yes, yes, that answered it. Thank you.

Operator: The next question will come from the line of Heather Beck.

Heather Beck: Hi, how are you doing today? I just wanted to see if you knew what the payment reimbursement was going to be for the new PCM coding and for the additional minute coding for the CCM.

Emily Yoder: Hi, this is Emily Yoder. Much like with PCM, I actually don't have those rates with me right now. But if you submit a question through the MLN mailbox, we can get those to you. There are also – the RVUs are in the final rule, preamble text, and also in the final rules Addendum B.

Heather Beck: Okay, thank you so much.

Leah Nguyen: And that mailbox again is mlneventsteam@cms.hhs.gov. Thank you.

Operator: Your next question will come from the line of Ronald Hirsch.

Ronald Hirsch: Hi there. I know in the opening comments that Administrator Verma talked about patient liability. And my concern is that with the move to more expensive procedures to surgery centers, such as cardiac interventions and the knee replacement, the patient copayments are going to be significantly higher than they – if they had them done in a hospital outpatient setting.

So, is there any discussion about putting in a limit to patient copayment or coinsurance on outpatient procedures at surgery centers?

Tiffany Swygert: Hi, Dr. Hirsch, this is Tiffany Swygert. There is some discussion of that in the final rule as you correctly state, there is a cap on cost-sharing, coinsurance on the hospital outpatient side. It's capped at the inpatient deductible. That is by statute. There is not a similar statutory provision that applies in the EOT setting.

However, all of the payment rates and the cost-sharing implications are publicly available to both patients and their physicians and that's the decision. It's no different. None of the policies that we've adopted this year change, sort of what the cost-sharing implications are for either setting.

But we expect that patients and physicians will make the appropriate decision based on the medical needs and any cost-sharing implications. And we also note both in the final rule and just in general that many Medicare beneficiaries do have supplemental insurance that can help with out-of-pocket expense. And so again, that's a decision that patients are able to make.

Ronald Hirsch: Okay. Thank you.

Tiffany Swygert: Sure.

Operator: Your next question is from the line of Julia Forester.

Julia Forester: Hi. My question is about the optional documentation guidelines that will be effective in – will apply in 2019. But for any ancillary staff or beneficiary that is documenting the chief complaint and part of the history for that visit, that provider can choose to, like you said, just refer back to her indicating that medical records that they've reviewed it.

Two questions to that. Is there any certain wording or preferred verbiage that you guys like to see? Will that be an FAQ that comes out to address that?

And then the second part of the question is, can it apply to any previous visits? If they make that notation in the medical record, that certain part of the history has not changed or is unchanged from a previous visit, can they do that as well?

Leah Nguyen: Thank you for that question. I think that one also pertains to last year's rule and we do have an FAQ out about that that we can send to you. Could you send the question in to our mailbox at mlneventsteam@cms.hhs.gov?

Julia Forester: Yes. Thank you.

Leah Nguyen: Thank you.

Operator: The next question will come from the line of Kara Gainer.

Kara Gainer: Yes, hi, thank you. I'm Kara Gainer, APTA Director of Regulatory Affairs. And I have a question regarding the online digital e-visit codes. The digital e-visit CPT codes 98970 to 72 refer to qualified non-physician health care professional online digital evaluation and management service.

Whereas the G codes, the HCPCS codes, G2061 through 2062, 2063 refer to qualified non-physician healthcare professional online assessment.

So, my question is, if physical therapists and other non-physician qualified healthcare professionals provide these services, would they be using the 98970 CPT codes or the HCPCS G-codes? And I asked that because CMS states in the rule that CPT codes for online digital e-visit 99421 to 99423 are for practitioners who can independently bill E/M services while CPT codes 98970 through 72 or for practitioners who cannot independently bill E/M services. And so the question is – so then, for non-physicians who don't bill E/M, should they be using the 98970 codes or the G codes?

Leah Nguyen: Thank you for that. We want to do – just do a little research and make sure we get you the right answer. Could you send your question in to our mailbox at mlneventsteam@cms.hhs.gov?

Kara Gainer: I will.

Leah Nguyen: Thank you.

Kara Gainer: Thank you.

Operator: The next question is from the line of Jewel Cider.

Jewel Cider: Hi, thank you. And I apologize in advance to the fact that I'm a little bit dense on this particular issue and would appreciate some clarification. I'll read you three sentences from the final rule. And then if you can please clarify, I'll ask you a specific question.

It has to do with off-campus, outpatient clinics, and it says we acknowledge the United States Columbia vacated the volume control for 2019. And we are working to ensure affected 2019 claims where clinic visits are paid consistent with the courts order.

The next statement says, we do not believe it's appropriate at this time to make a change to the second year, the 2-year phase-in of the clinic visit policy. So again, I'm a little dense, but it sounds like you're saying we're going to make people hold for 2019 but then we're going to implement the second phase of the reduction in 2020. Do I have that right?

Tiffany Swygert: Hi, this is Tiffany Swygert. So, I won't comment on the pending litigation aspect, but you are correct that for 2020 the policy has been adopted to pay the equivalent – the Physician Fee Schedule equivalent payments. And for 2019, you're also correct that CMS stated that we will comply with the court's order, which spoke directly to the 2019 rule.

Leah Nguyen: Thank you. Blair, can we take one final question.

Operator: Next question will come from the line of Brooke Stevens.

Brooke Stevens: Yes. Hi, my name is Brooke Stevens. Let me just get you off this here. And I'm a clinical social worker and I understand that clinical social workers are not eligible for MIPS at this point. But if we do become eligible in the future, can we choose not to participate? Or will we get a negative reimbursement rate? And also, if we don't fill out the MIPS properly, how much of a percentage adjustment will there be, financially?

Molly MacHarris: Sure, this is Molly MacHarris again.

So, you're correct that as of now, and for this upcoming year, clinical social workers are not considered a MIPS eligible clinician. That would be a matter that we would be – that would be addressed in future rulemaking if and when clinical social workers become a MIPS eligible clinician.

By law beginning in the 2020-year and for all future years, the total amount of payment we can distribute is up to 9% subject to a scaling factor to maintain budget neutrality. So, if in the future clinical social workers became a MIPS eligible clinician, and if they did – if you – they did not participate at all, they would receive the automatic negative adjustment. But again, all of this would be a subject for future rulemaking. So, I hope that helps. Thank you.

Brooke Stevens: So, they so they automatically – it would go down by nine percent?

Molly MacHarris: If they did not comply with any of the MIPS performance requirements, and if they were considered to be a MIPS eligible clinician.

Brooke Stevens: Okay. So, you have to comply, and you have to do it properly, otherwise you lose the nine percent increase.

Molly MacHarris: You would have the ability to receive up to a negative nine percent adjustments subject to …

Brooke Stevens: Oh, okay.

Molly MacHarris: … neutrality and scaling factor.

Brooke Stevens: Got you. Thank you very much.

Additional Information

Leah Nguyen: Thank you. Unfortunately, that is all the time we have for questions today. We hope you will take a few moments to evaluate your experience. See slide 43 for more information. An audio recording and transcript will be available in about two weeks at go.cms.gov/npc.

Again, my name is Leah Nguyen. I'd like to thank our presenters and also thank you for participating in today's Medicare Learning Network event on the Physician Fee Schedule and Quality Payment Program Final Rule and the Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System's Final Rule. Have a great day everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect. Presenters, please hold.