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Networking for Education and Transformation

Monthly Network Call

November 21, 2019

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Agenda

- Final Updates on the Medicare Physician Fee Schedule
- Final Updates on the Hospital Outpatient Prospective Payment System
- Oncology Care First – concept paper, RFI, Q&A

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Speakers

Sybil Green
Director, Strategic Initiatives
ASCO Policy & Advocacy

Brian Bourbeau
Director, Business Metrics and Analysis
ASCO Clinical Affairs

Margarita Valdez
Assistant Director Government Relations
ASTRO

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Medicare Physician Fee Schedule / Quality Payment Program

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PFS/QPP Final Policies

Proposed	ASCO Position	Final Rule
Alignment of E&M codes with AMA RUC recommendations	Supported	Finalized

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Proposed Payment Increase for 2021 E&M Visits

- 2019 MPFS Proposed Rule
  - Documentation changes – medical decision-making, time or current framework
  - Collapse 99202-99205 and 99212-99215
  - Add-on codes for primary care (GPC1X) and certain specialty visits (GCG0X) and prolonged visits
- 2019 MPFS Final Rule
  - Finalized documentation changes
  - Collapse 99202-99204 and 99212-99215, beginning in 2021
  - Finalized add-on codes GPC1X and GCG0X, for only visit levels 2-4, and prolonged visits
- 2020 MPFS Proposed Rule
  - Adopts revised AMA CPT definitions – level of service based on medical decision-making or time; eliminates 99201; add 99XXX for prolonged visits
  - Accepts several payment recommendations made by the AMA RUC
  - Collapses add-on codes to GPC1X for primary care or specialty

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Proposed Payment Increase for 2021 E&M Visits

HCPCS	2018 Rate	2019 Proposed Rule	2019 Final Rule, effective 2021	2020 Proposed Rule, eff. 2021
99201	$45	$43	$44	N/A
99202	$76	$134	$135	$77
99203	$110	$134	$135	$119
99204	$167	$134	$135	$177
99205	$172	$134	$211	$232
99211	$22	$24	$24	$24
99212	$45	$92	$93	$60
99213	$74	$92	$93	$96
99214	$109	$92	$93	$136
99215	$148	$92	$93	$190

99XXX – Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services). $35

GPC1X – Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. $17

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PFS/QPP Final Policies

Proposed	ASCO Position	Final Rule
Alignment of E&M codes with AMA RUC recommendations	Supported	Finalized
Flexibility in physician supervision of PAs	Supported	Finalized
Medical record verification by physician (and other clinicians)	Supported	Finalized, expanded

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Aligning Physician Supervision of Physician Assistants (PA) with State Laws and Scope of Practice Rules - Finalized

- CMS is proposing to modify their regulation on physician supervision of PAs to give PAs greater flexibility to practice more broadly

- ***Statutory physician supervision requirement -*** would be met when a PA furnishes their services in accordance with state law and state scope of practice rules for PAs in the state in which the services are furnished

- ***Absence of state law -*** the physician supervision required by Medicare for PA services would be evidenced by documentation in the medical record of the PA's approach to working with physicians in furnishing their services

- Final Rule: CMS clarified, when there are no state supervision requirements, the PA must document at the practice how services were provided in collaboration with a physician. CMS indicated this expansion of scope of practice will better align supervision requirements for non-physician professionals and clinical nurse specialists.

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Medical Documentation Requirements - Finalized

- "In response to feedback received through the Patients Over Paperwork Initiative"
- Providers can review and verify (sign and date), rather than re-document, notes made in the medical record by other physicians, residents, nurses, students, or other members of the medical team
- Applies to physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives
- Final Rule: CMS added additional types of students permitted to document notes in a patient's medical record to be reviewed rather than re-documented: PAs, NPs, CNSs, CNMs, CRNAs, medical students; these students alongside physicians, residents, nurses and other members of the care team can document information in a medical record
- This provision provided additional flexibility for PAs and APRNs to review and verify information in a medical record rather than re-document information

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Flexibility in physician supervision of PAs	Supported	Finalized
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Expansion of bundled payments under the PFS	Opposed	Not finalized; potential future rulemaking

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Bundled Payments in the MPFS – Not Finalized

- In general, separate payments for each service provided under the MPFS
- By statute CMS is required to pay for services based on the resources required - but they believe there is flexibility within the physician fee schedule to become more efficient
- In recent years CMS has developed bundled payments for the fee schedule and other Medicare payment systems
  - Many of these models have been implemented under CMMI
- CMS solicited comment on opportunities to expand the concept of bundling to improve payment for services under the MPFS
- Final Rule: CMS received numerous comments from stakeholders and indicated they will consider these comments in potential future rule making.

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Expansion of bundled payments under the PFS	Opposed	Not finalized; potential future rulemaking
Increase weight of cost performance category in MIPS (from 15% to 20%)	Opposed	Not finalized; cost remains at 15% for 2020
Updated performance thresholds for MIPS (45 points to break even, 80 for exceptional)		Modified (45 points to break even, 85 for exceptional)
Revised MSPB & TPCC measures	Opposed	Finalized
Delete or modify opioid measures in PI category	Supported	Finalized

Final Performance Category Weights

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

CMS originally proposed increasing cost to 20% and decreasing quality to 40%; this proposal was not finalized

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Final Performance Thresholds & Payment Adjustments

Thresholds & Adjustments	2019	2020
Performance Threshold	30	45
Exceptional Performance Threshold	75	85
Max Payment Adjustment (Budget Neutral)*	+/- 7%	+/- 9%
Additional Exceptional Payment Adjustment	Up to 10% ($500m)	

*$584m (estimated)

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Establishment of MVPs	Further engagement	Finalized

MIPS “Value Pathways” (“MVPs”) - Finalized

- For CY 2021, CMS proposing “MIPS Value Pathways” (MVPs)
- Moves away from siloed activities and measures, towards an aligned set of measure options more relevant to a clinician’s scope of practice and meaningful to patient care
- Clinicians would be scored on a “bundle” of aligned quality and cost measures and improvement activities, with the use of health information technology playing a foundational role
- CMS also proposing to include “public health” or “population health” measures

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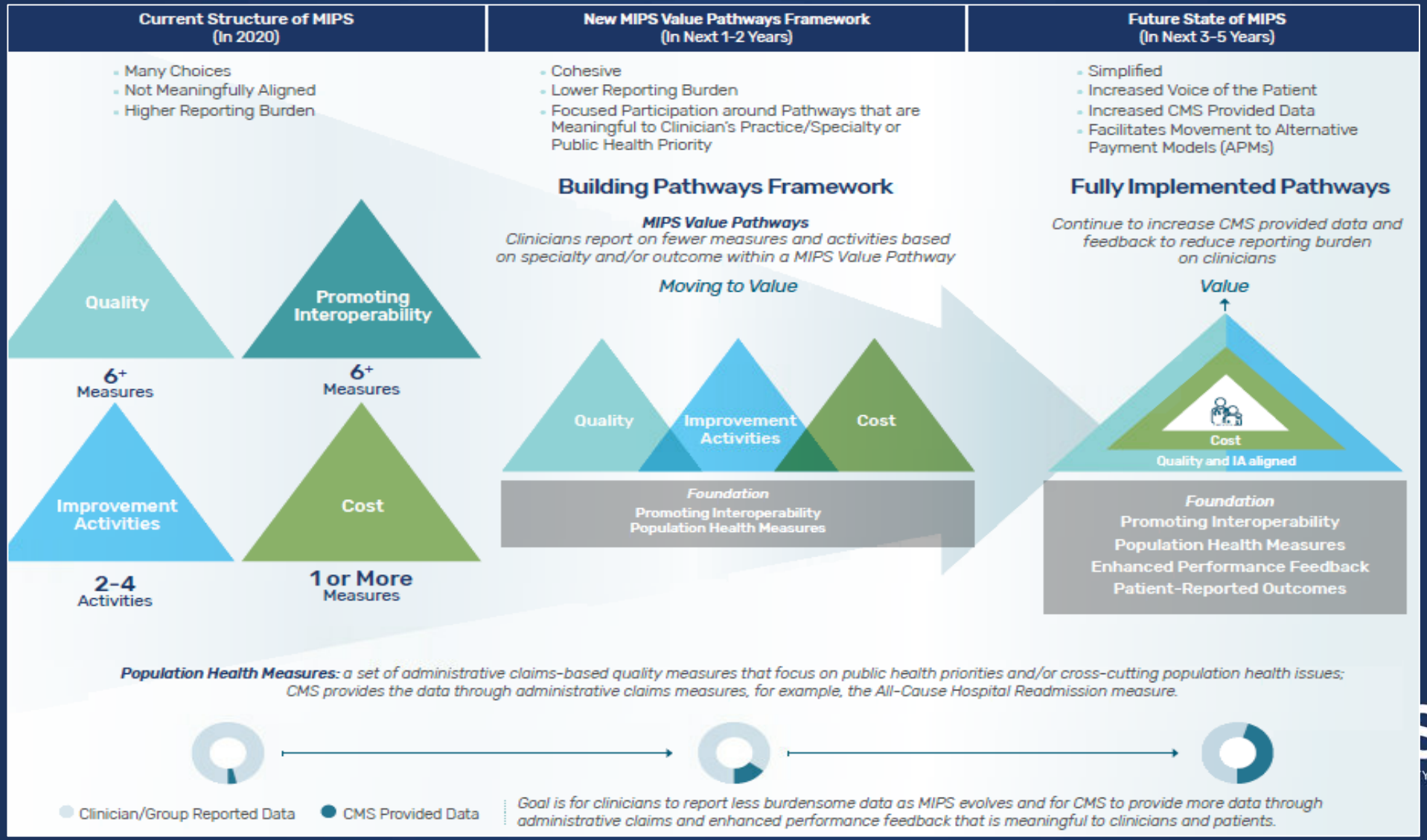
CMS' MVP Vision



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Hospital Outpatient Prospective Payment System

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HOPPS Final Policies

Proposed	ASCO Position	Final Rule
340B Reimbursement (ASP -22.5%)	Opposed	Finalized, likely further rulemaking pending court rulings

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340B Reimbursement - Finalized

- CMS proposing continued cuts to the 340B drug pricing program
- For 2019, the agency finalized a cut from Average Sales Price (ASP) plus 6 % to ASP minus 22.5% for certain separately payable drugs or biologics
- CMS acknowledges ongoing litigation
- CMS soliciting comments on alternative payment options for CY 2020 and potential remedies for 2018 and 2019 payments in the event of an adverse ruling by the United States Court of Appeals
- Final Rule: CMS anticipates proposing a specific remedy in the CY 2021 OPPS/ASC proposed rule
- Final Rule: The agency also indicated it may use the comments received and/or 340B hospital survey data on drug acquisition costs in CYs 2018 and 2019 to develop a remedy and/or future payment rates

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340B Reimbursement (ASP -22.5%)	Opposed	Finalized, likely further rulemaking pending court rulings
E&M Visits in Off-campus Centers (40% of OPPS rate)	Opposed	Finalized, despite adverse District Court ruling, appeal likely

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Site neutral reimbursement policy for excepted clinic visits

- **In CY 2019 OPPS rule, CMS finalized a policy to reduce reimbursement for clinic visits in excepted (grandfathered) off-campus PBDs.**
  - Proposed: CMS proposed to reduce payment to the "Physician Fee Schedule equivalent" payment rate of 40 percent of the OPPS payment amount.
  - Final: CMS will phase-in policy over two years: In CY 2019, clinic visits will be paid at 70 percent of the OPPS rate, and beginning in CY 2020, 40 percent of the OPPS rate.
- **CY 2020 proposed rule: CMS proposes to continue to fully implement this policy.**

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Site- Neutrality - Finalized

- Clinic visits and E/M services billed under G0463
- CMS assertion:
  - Medicare Payment for the same services might be lower when furnished in an off-campus PBD, rather than a physician office
  - Anticipated savings to beneficiaries: $150 million per year by lowering average copays from $23 to $9
  - However, there is no methodology to separately value resources and cost incurred by a provider versus the facility

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Site Neutral Challenge

Challenge brought by American Hospital Association and other groups

Cause of Action and anticipated losses:

- Along with other cuts, like the 340B cuts, CMS new reimbursement rates to achieve site neutrality directly undercut the clear intent of Congress to protect hospital outpatient departments. Real and crucial differences between hospitals and other sites of care warrant different payment mechanisms.
- estimated losses of $380 million in 2019 and $760 million in 2020.

Ruling: (CMS) overstepped its authority when it finalized a plan to extend a site-neutral payment policy to clinic visits with the goal of paying the same in Medicare for evaluation and management services at physician offices and hospitals.

Next step: CMS and hospitals must agree to a suitable resolution (briefings were submitted Oct. 1 and Oral arguments were this past week)

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Price Transparency	Cautious Support	Not finalized; to be addressed in separate future rulemaking

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Price Transparency – 2021

- Proposed “expansion of hospital charge display requirements to include charges and information based on negotiated rates and for common shoppable items and services, in a manner that is consumer-friendly.”*

- Specifically, all hospitals would need to ensure the availability of
  - a machine-readable file containing a list of all standard charges – gross and negotiated rates – for all items and services, and
  - a consumer-friendly list of standard charges – payer-specific negotiated rates – for a limited set of shoppable services
  - Includes physicians and other practitioners employed by the hospital
- Final Rule: CMS did not address this proposal in the final rule for 2020; on November 15, released a final rule, effective January 2021

*Implementing the President's June 24 executive order, “Improving Price and Quality Transparency, Put Patients First”

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Hospital Supervision (Direct vs. General)	Supported	Finalized

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Hospital Supervision - Finalized

- Proposed change to the generally applicable, minimum required level of supervision for hospital outpatient therapeutic services from direct supervision to general supervision for services furnished by all hospitals and Critical Access Hospitals (CAHs)
- General supervision means that the procedure would be furnished under the physician's overall direction and control, but that the physician's presence is not required during the performance of the procedure
- Applies to chemotherapy and radiation therapy services, unless later specified as direct supervision by the Hospital Outpatient Payment Panel and accepted by CMS
- Providers should be mindful of state laws regarding scope of practice, as they would not be impacted by this provision - this proposal would only impact hospitals and their outpatient departments (CMS is not proposing to change the supervision requirements for physician clinics and freestanding centers)

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Hospital Supervision (Direct vs. General)	Supported	Finalized
Prior Authorization (5 categories of services)	Opposed	Finalized

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Prior Authorization - Finalized

- Proposed: a process through which providers submit a prior authorization request for provisional affirmation of coverage before a covered hospital Outpatient Department service is provided to a Medicare beneficiary and before the claim is submitted for processing
- Impacted service categories proposed for July 1, 2020: blepharoplasty; botulinum toxin injections; panniculectomy; rhinoplasty; vein ablation
- Final rule added 2 botulinum toxin injection codes
- Hospitals will be ultimately responsible for the provision affirmation, the prior authorization request can be submitted by physicians or hospitals

CMS may expand this process to other procedures that are showing "growth" in the outpatient setting in future rulemaking – the "slippery slope"

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Oncology Care First

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Oncology Care First: Informal Request for Information

Potential Elements:

- Voluntary, first-year model
- January 2021 to December 2025
- Care Transformation:
  - 24/7 access, patient navigation, IOM care plan, clinical guidelines, use CHERT, data for quality improvement, ePROs.
- Monthly Population Payment:
  - Prospective payment includes a Management Component (Enhanced Services, E&Ms) and an Administration Component (drug administration services, E&M payments to HOPDs where applicable)
- Performance-based Payment:
  - Total episode expenditures reconciled against a benchmark or target amount, with possibility of receiving a PBP or owing a PBP recoupment
- Three risk tracks (incl. one-sided for limited time)

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Public Listening Session: Informal RFI on the Oncology Care First Model

Share

The Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (Innovation Center) previously announced a Public Listening Session and informal Request for Information (RFI), to gather feedback on a potential Oncology Care First (OCF) Model.

We will accept written feedback on the informal RFI, until **Friday, December 13, 2019**. Please note that we have extended the feedback period from Monday, November 25, 2019 as we wish to give the public more time to respond. Written feedback can be sent to OCF@cms.hhs.gov, until the close of the feedback period on Friday, December 13, 2019.

In submitted written feedback, we hope to gather stakeholder input on the following targeted topics:

1. The potential OCF Model would seek to improve health outcomes and quality of care for Medicare beneficiaries with cancer. How could the potential model support participants' care transformation through practice redesign activities? Specifically, how could the potential model build on lessons learned from the implementation of the practice redesign activities included in the Oncology Care Model (OCM)? What revisions or additions should be made to the OCM practice redesign activities in the potential model?
2. We welcome feedback on the potential payment methodology, including the structure and design of the monthly population payment and the performance-based payment. We are considering the inclusion of additional services in the monthly population payment, such as imaging or lab services, and seek feedback on adding these or other services to the monthly population payment.
3. We encourage feedback on the conceptualized risk arrangements, in particular, how a downside risk arrangement might be best constructed in terms of the level of risk.

We invite feedback on the interest of physician group practices (PGPs) and hospital outpatient departments (HOPDs) in participating in a potential OCF Model. We are particularly interested in hearing from PGPs and HOPDs about the conceptualized participation eligibility parameters (e.g., the grouping concept), and whether they think that meeting those parameters would be feasible. We also invite feedback from potential payer partners, including commercial payers and state Medicaid agencies. We welcome suggestions about the model concept that would better incentivize participation in the potential model.

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Comments due December 13!

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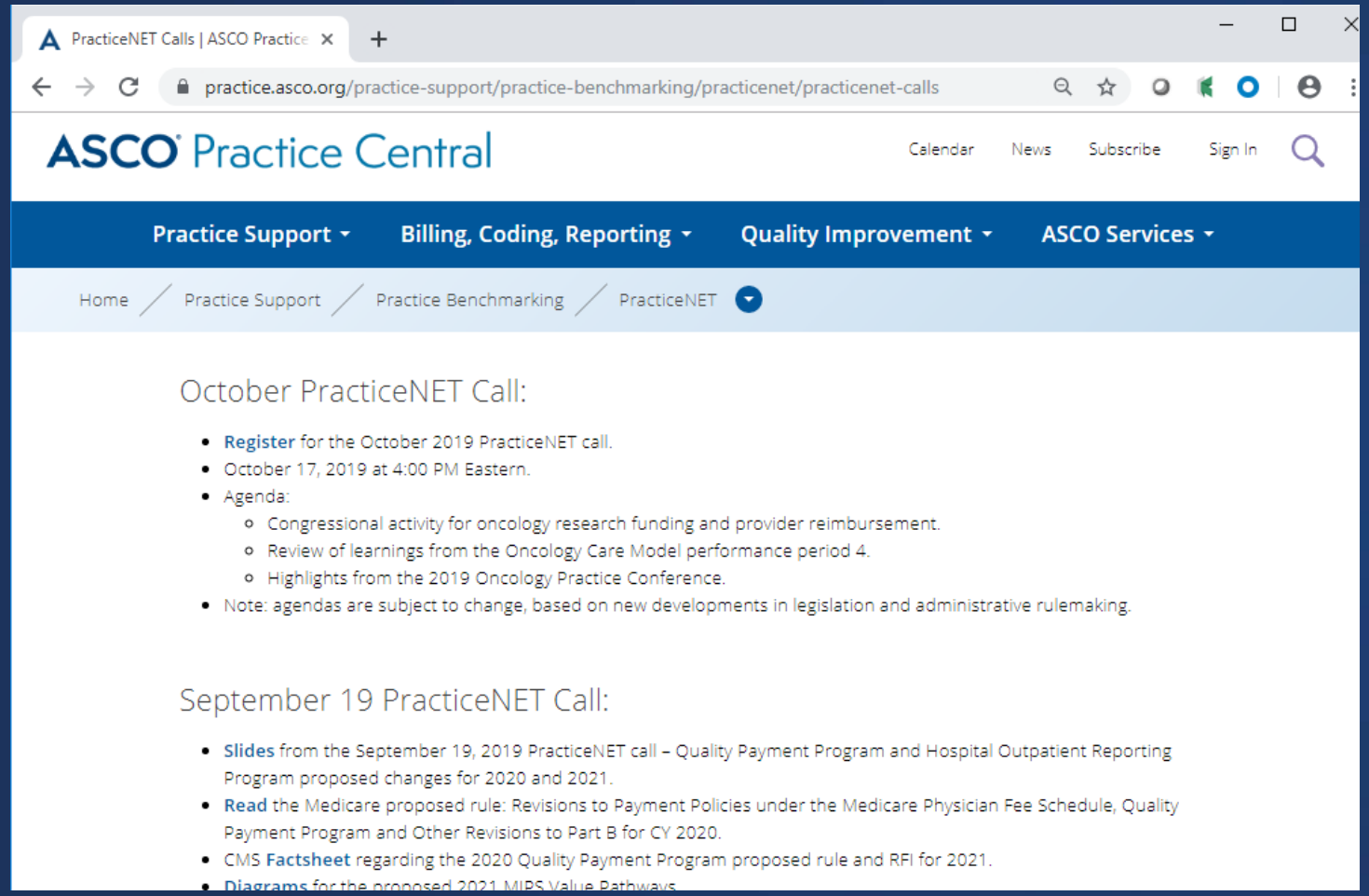
PracticeNET Calls



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