CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS Update

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This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

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Introduction

- MACRA - QPP
- New Medicare Card
- Calendar Year (CY) 2019 Medicare Physician Fee Schedule (PFS) Proposed Rule
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  - Level of E/M Visits
  - How to Streamline E/M Payment and Reduce Clinician Burden
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What is "MACRA"?

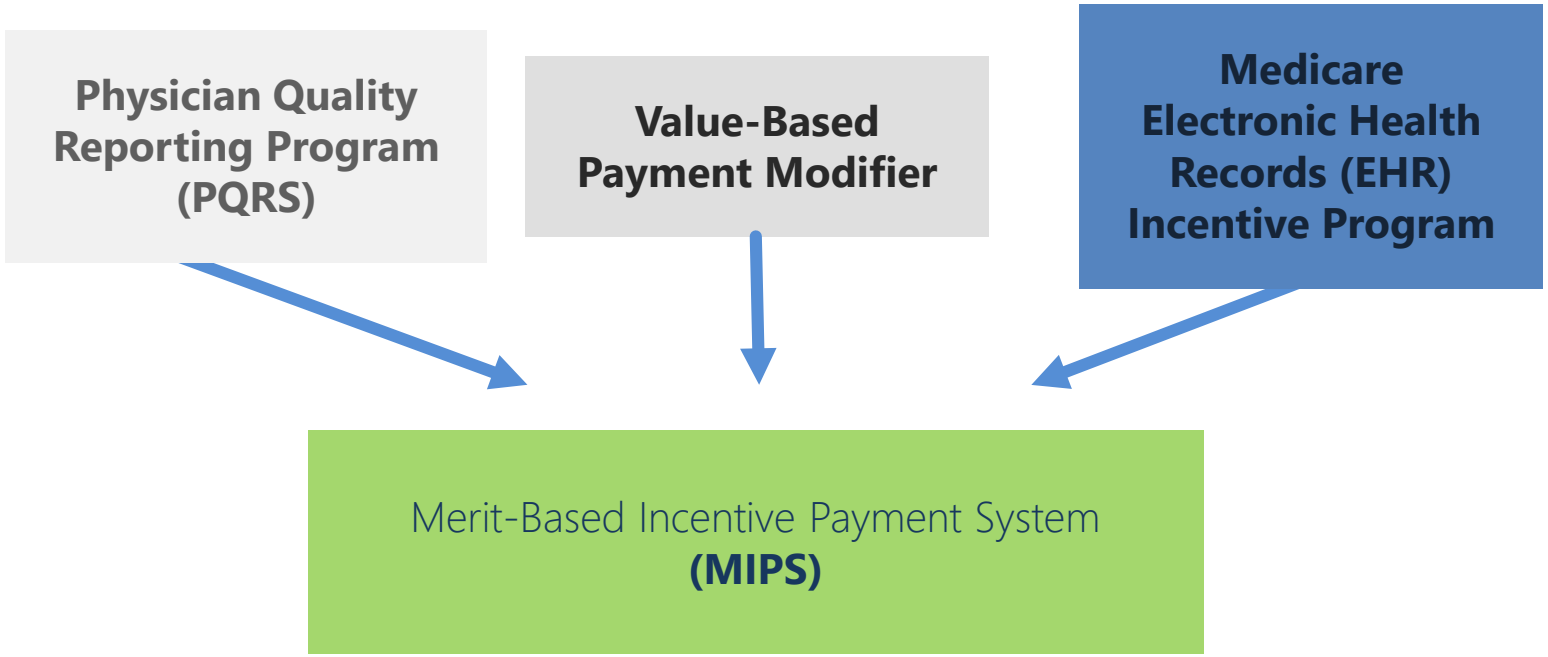
MACRA stands for the **Medicare Access and CHIP Reauthorization Act of 2015**, bipartisan legislation signed into law on April 16, 2015.

What does it do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare pays clinicians** and establishes a new framework to reward clinicians for **value** over volume
- **Streamlines** multiple quality reporting programs into 1 new system (MIPS)
- **Provides bonus payments** for participation in ***eligible* alternative payment models (APMs)**

Medicare Reporting Prior to MACRA

MACRA streamlines these programs into **MIPS.**



The Quality Payment Program

The Quality Payment Program policy will:

- Reform Medicare Part B payments for more than 600,000 clinicians
- Improve care across the entire health care delivery system

Clinicians have two tracks to choose from:

MIPS

The Merit-based Incentive Payment System (MIPS)

If you decide to participate in traditional Medicare, you may earn a performance-based payment adjustment through MIPS.

OR

Advanced APMs

Advanced Alternate Payment Models (APMs)

If you decide to take part in an Advanced APM, you may earn a Medicare incentive payment for participating in an innovative payment model.

MACRA affects Medicare Part B clinicians.

Affected clinicians are called **"eligible professionals" (EPs)** and will participate in MIPS. The types of **Medicare Part B** health care clinicians affected by MIPS may expand in the first 3 years of implementation.

Years 1 and 2

Physicians, PAs, NPs, Clinical nurse specialists, Nurse anesthetists

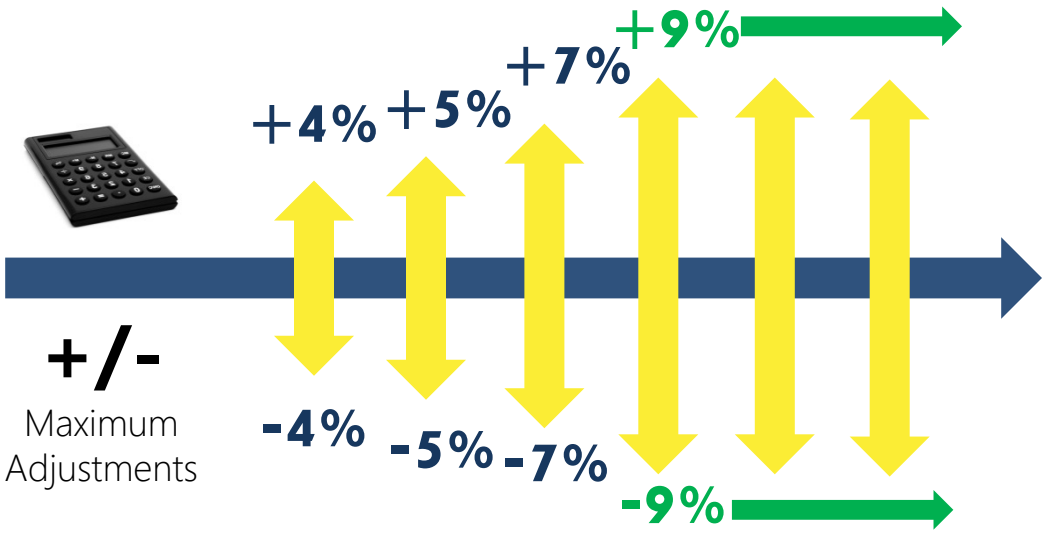
Secretary may broaden EP group to include others such as

Years 3+

Physical or occupational therapists, Speech-language pathologists, Audiologists, Nurse midwives, Clinical social workers, Clinical psychologists, Dietitians / Nutritional professionals

How much can MIPS adjust payments?

Based on a composite performance score, clinicians will receive **+/- or neutral** adjustments **up to** the percentages below.

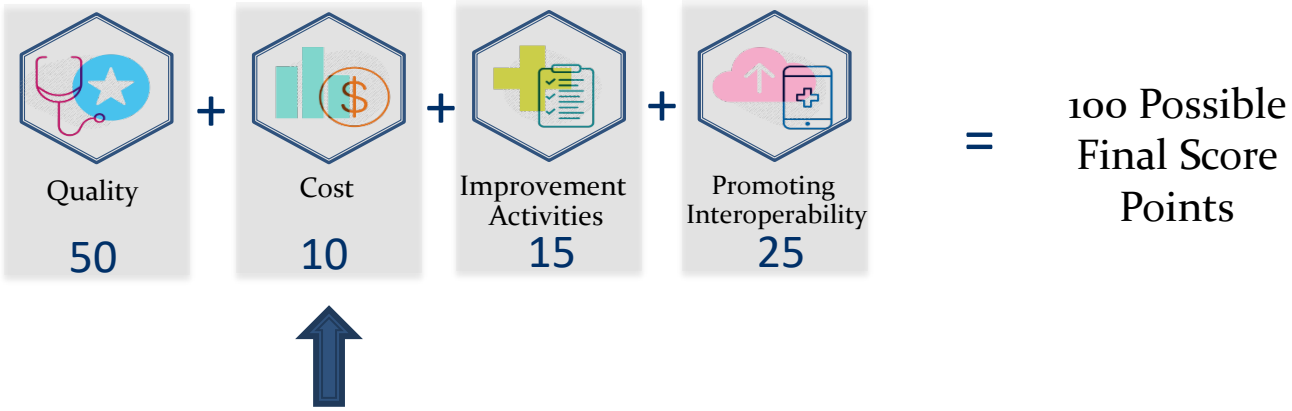


Adjusted Medicare Part B **payment** to clinician

*The potential **maximum** adjustment % will **increase** each year from **2019 to 2022***

Quality Payment Program: Year 2

MIPS Performance Categories for Year 2 (2018)

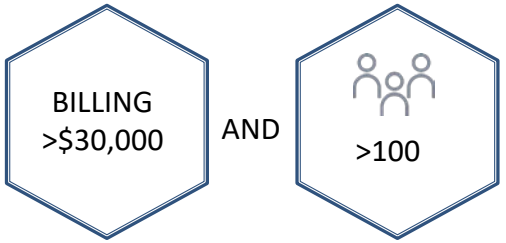


- Comprised of **four** performance categories in 2018.
- **So what?** *The points from each performance category are added together to give you a MIPS Final Score.*
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a **positive**, **negative**, or **neutral payment adjustment**.

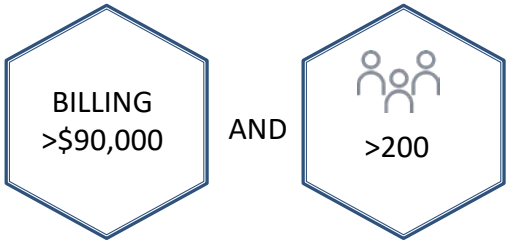
Quality Payment Program: Year 2

Who is Included?

Transition Year 1 (2017) Final



Year 2 (2018) Final



- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists

Who is Exempt?

Newly-enrolled in Medicare

- Enrolled in Medicare for the first time during the performance period (exempt until following performance year)

Below the low-volume threshold

- Medicare Part B allowed charges less than or equal to **$90,000** a year

OR

- See **200** or fewer Medicare Part B patients a year

Significantly participating in Advanced APMs

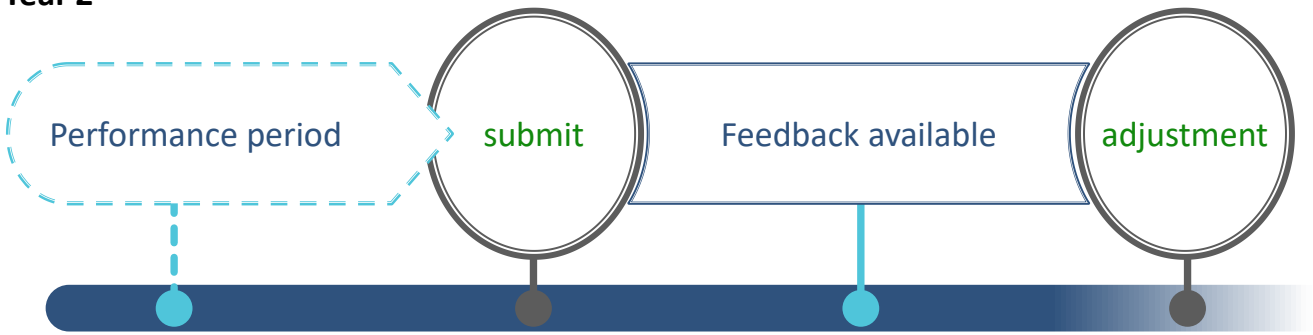
- Receive 25% of their Medicare payments

OR

- See 20% of their Medicare patients through an Advanced APM

Quality Payment Program: Year 2

Timeline for Year 2



2018
Performance Year

- Performance period opens January 1, 2018.
- Closes December 31, 2018.
- Clinicians care for patients and record data during the year.

March 31, 2019
Data Submission

- Deadline for submitting data is March 31, 2019.
- Clinicians are encouraged to submit data early.

Feedback

- CMS provides performance feedback after the data is submitted.
- Clinicians will receive feedback before the start of the payment year.

January 1, 2020
Payment Adjustment

- MIPS payment adjustments are prospectively applied to each claim beginning January 1, 2020.

MIPS Year 3 (2019) Proposed
MIPS Eligible Clinician Types

- MIPS eligible clinicians include:
- Same five clinician types from Year 2 (2018)

- AND:
- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Clinical Social Workers

MIPS Year 2 (2018)
Who is Exempt?

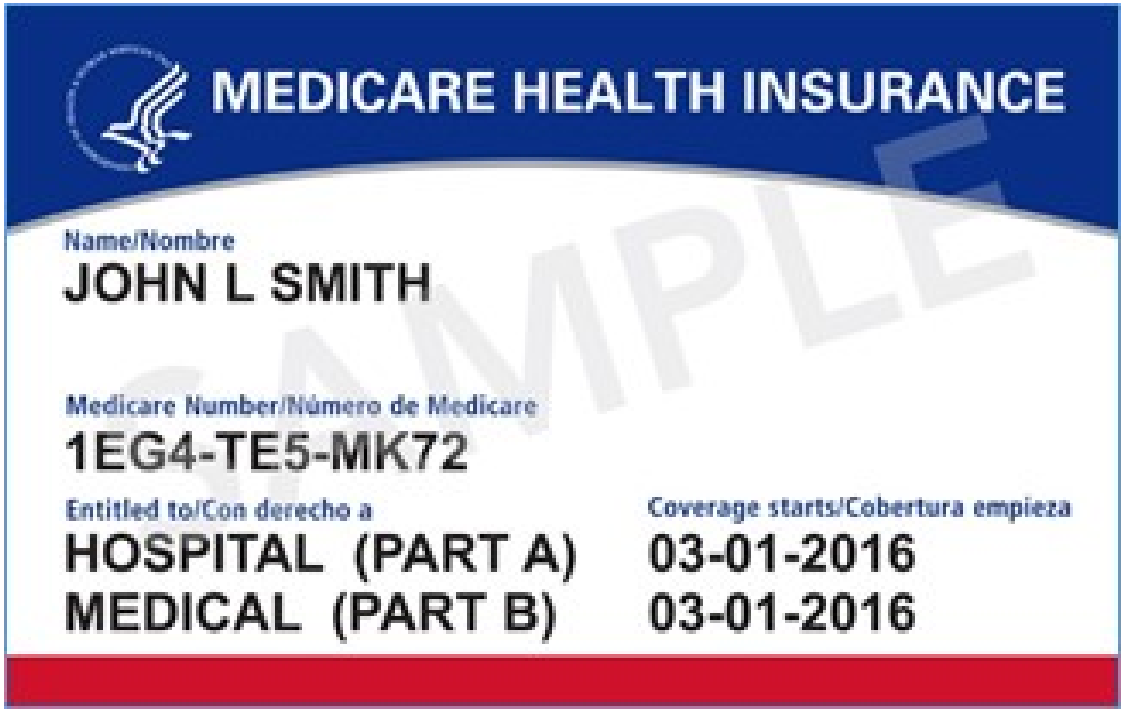
- No change except for the low-volume threshold
- Medicare Part B allowed charges less than or equal to $90,000 a year
- OR
- See 200 or fewer Medicare Part B patients a year

MIPS Year 3 (2019) Proposed

- Performance Periods – No changes for 2019

- Performance Category Weights – Quality changes from 50% to 45%. Cost changes from 10% to 15%. No changes to Improvement or Promoting Interoperability

New Medicare Card



Program Background

- The Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 mandates the removal of the Social Security Number (SSN)-based HICN from Medicare cards to address current risk of beneficiary medical identity theft

- The legislation requires that CMS mail out new Medicare cards with a new Medicare Beneficiary Identifier (MBI) by April 2019

SSN Removal solution

1. **Generate Medicare Beneficiary Identifiers (MBI) for all beneficiaries:** Includes existing (currently active, deceased, or archived) and new beneficiaries

2. **Issue new, redesigned Medicare cards:** New cards containing the MBI to existing and new beneficiaries

3. **Modify systems and business processes**: Required updates to accommodate receipt, transmission, display, and processing of the MBI

CMS Used and will continue to use an MBI generator to:

- Assign 150 million MBIs in the initial enumeration (60 million active and 90 million deceased/archived) and generate a unique MBI for each new Medicare beneficiary
- Generate a new unique MBI for a Medicare beneficiary whose identity has been compromised

New Medicare Number Characteristics

The Medicare Beneficiary Identifier (MBI) will have the following characteristics:

- The same number of characters as the current HICN (11), but will be visibly distinguishable from the HICN
- Contain uppercase alphabetic and numeric characters throughout the 11-digit identifier
- Occupy the same field as the HICN on transactions
- Be unique to each beneficiary (e.g., husband and wife will have their own MBI)
- Be easy to read and limit the possibility of letters being interpreted as numbers (e.g., alphabetic characters are upper case only and will exclude S, L, O, I, B, Z)
- Not contain any embedded intelligence or special characters
- Not contain inappropriate combinations of numbers or strings that may be offensive

CMS anticipates that the MBI will not be changed for an individual unless the MBI has been compromised

What does the new Medicare Card look like?

The new Medicare Card includes:

- Name
- New Medicare number
- Dates that Medicare Part A and Medicare Part B coverage started

The new cards remove:

- Signature
- Social Security Number
- Gender

Only the Medicare card and number are changing

- Medicare benefits stay the same
- Social Security Number remains
- No impact on supplemental, Part C or Part D plans.

Sending New Medicare Cards

- Medicare started mailing new cards in April 2018
  - Newly-eligible beneficiaries receive a card with a unique number, regardless of where they live
  - Existing beneficiaries will get a new card over a period of approximately 12 months
  - Distribution of cards will be randomized by geographic location

- People can go to **Medicare.gov/newcard** to sign up for emails about the card mailing and to check the card mailing status in their state

- People with Medicare should use the new card once they get it, but either the SSN-based or the new random alphanumeric-based numbers can be used through December 2019

- The transition period will run from **April 2018 through December 31, 2019**

- Beginning January 1, 2020 *only* the new card will be usable

New Medicare Card Mailing Waves

Wave	States Included	Cards Mailing
Newly Eligible People with Medicare	All - Nationwide	April 2018 - ongoing
1	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	Beginning May 2018 **COMPLETE**
2	Alaska, American Samoa, California, Guam, Hawaii, Northern Mariana Islands, Oregon	Beginning May 2018 **COMPLETE**
3	Arkansas, Illinois, Indiana, Iowa, Kansas, Minnesota, Nebraska, North Dakota, Oklahoma, South Dakota, Wisconsin	Beginning June 2018 **COMPLETE**
4	Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Vermont	Beginning July 2018
5	Alabama, Florida, Georgia, North Carolina, South Carolina	Beginning August 2018
6	Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Texas, Utah, Washington, Wyoming	After August 2018
7	Kentucky, Louisiana, Michigan, Mississippi, Missouri, Ohio, Puerto Rico, Tennessee, Virgin Islands	After August 2018

Using the New Medicare Number – During Transition

- The transition period will run from **April 2018 through December 31, 2019**
- CMS will accept, use for processing, and return to stakeholders either the MBI or HICN, whichever is submitted on the claim, **during the transition period**
- All stakeholders who submit or receive transactions containing the HICN should now be ready to submit or exchange the MBI.
- CMS will actively monitor use of HICNs and MBIs during the transition period to ensure that everyone is ready to use MBIs only by January 1, 2020

Using the New Medicare Number – Providers

Providers

- When a provider checks a beneficiary's eligibility, the CMS HIPAA Eligibility Transaction System (HETS) will return a message on the response indicating that CMS mailed that particular beneficiary's new Medicare card

- Beginning October 2018 through the end of the transition period, when a **valid and active** HICN is submitted on Medicare fee-for-service claims **both the HICN and the MBI** will be returned on the remittance advice

- During the transition period, we'll process all claims with either the HICN or MBI, even when both are in the same batch

Using the New Medicare Number – Providers (2)

Providers (cont'd)

- Starting June 2018 - Providers/Suppliers can look up the MBI on MAC portals
- For additional information please go to the provider tab in www.CMS.gov/newcard (you can reference the portal instructions sent to all providers last September)

- Providers/Suppliers will need the following beneficiary information to look-up MBIs:
  Patient SSN
  Patient Last Name
  Patient First Name
  Patient Date of birth
  Provider/Supplier NPI

- Providers/Suppliers can use any MAC portal to look up patient MBI

Remittance Advice

- **Medicare Remit Easy Print (MREP):** Starting October 1, 2018, we'll update the MREP so that it also gives you the MBI when you submit a claim with a valid and active HICN
  - We're changing the current MREP Remittance Advice HICN label to Medicare ID (MID) and adding a new MID label and field that will show the MBI number
  - Sample MREP: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Downloads/MREP-Example.pdf

- **PC Print (Medicare Part A Providers & Facilities):** Starting October 1, 2018, we'll update PC Print so that it also gives you the MBI when you submit a claim with a valid and active HICN. We're changing the current PC Print Remittance Advice HICN label to Medicare ID (MID) and adding a new MID Corrected (MID COR) label and field

- Your MAC can give you access to free PC Print software so you can see and print remittance advice information
  - Sample PC Print: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Downloads/PC-Print-Example.pdf

Remittance Advice (2)

- **Standard Paper Remits (SPRs):** Starting October 1, 2018, we'll update the SPRs so it also gives you the MBI when you submit a claim with a valid and active HICN. Here are SPR examples:
  - FISS (Medicare Part A/Institutional): https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Downloads/FISS-SPR-Example.pdf
  - MCS (Medicare Part B/Professional): https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Downloads/MCS-SPR-Example.pdf
  - VMS (DMEPOS): https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Downloads/VMS-SPR-Example.pdf

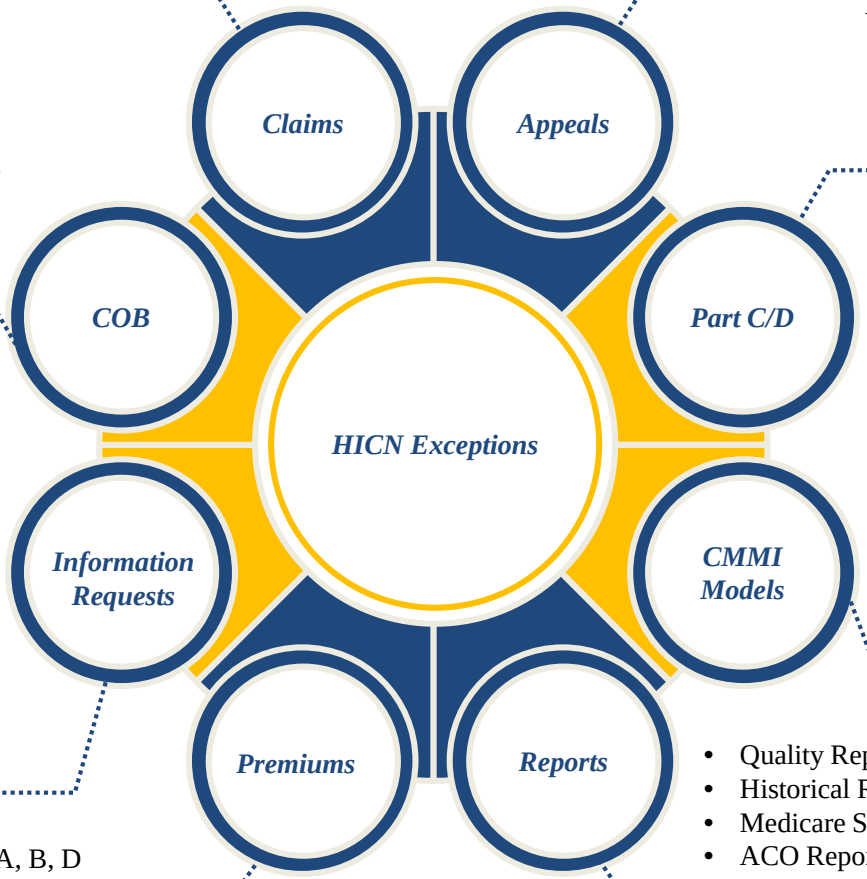
- **Note: Don't forget that if you submit claims electronically, you'll get an Electronic Remittance Advice (ERA). You can also see and print the ERA through MREP and PC Print.**

New Medicare Number HICN Exception Usage After the Transition Period

Beginning on January 1, 2020, CMS will only accept the MBI for external data exchanges. CMS will continue to accept the HICN on the following data exchanges after January 1, 2020.

- Claims status queries
- Claims held in suspense
- Span data claims
  - Inpatient Hospital
  - Home Health
  - Religious Non-Medical Health Care Institutions
- Adjustments

All Appeal Types



- Prescription Drug Events (PDE)
- Encounter Risk Adjustments
- Retiree Drug Subsidy (RDS)
- Incoming encounter data records

- All external data exchanges except COBA eligibility files

- General Inquiry (Beneficiary, Provider, Plans, etc..)
- Quality Reporting
- Disproportionate Share Hospital (DSH) requests
- Medicare Secondary Payer
- Congressional inquiry
- Responses to forms or notices
- Outgoing request for medical document

- Oncology Care Model (OCM) and Million Hearts (MH) Data registry UI and Participating Organization Reports
- Medicare Shared Savings Program (MSSP)

- Incoming Premium payments (Part A, B, D IRMAA)

- Quality Reporting
- Historical Reports
- Medicare Summary Notices
- ACO Reports
- Provider Statistical & Reimbursement (PS&R)

Note: CMS, Federal Partners and States will continue to use HICN for internal processing during and after the transition period.

Communications & Outreach Approach

- Raise awareness that new cards are coming and direct people to **Medicare.gov/NewCard** to find out when cards are coming to their area

- Communicate core messages:
  - New cards protect your identity by removing social security numbers
  - New cards have a unique number that is unique to you
  - Your new Medicare card will automatically come to you – you don't need to do anything

- Audiences: People with Medicare, Caregivers, Stakeholders

- Beneficiaries will get information about the new card in the 2018 Medicare & You handbook they will receive this October

Key Points to Reinforce with Beneficiaries

- Understand that mailing everyone a new card will take some time. Your card might arrive at a different time than your friend's or neighbor's
- Make sure your mailing address is up-to-date. If your address needs to be corrected, contact Social Security at ssa.gov/myaccount or 1-800-772-1213. TTY: 1-800-325-0778
- Beware of anyone who contacts you about your new Medicare card. We will never ask you to give us personal or private information to get your new Medicare number and card

Calendar Year (CY) 2019 Medicare Physician Fee Schedule (PFS) Proposed Rule

Documentation Requirements and Payment for Evaluation and Management (E/M) Visits & Advancing Virtual Care

Patients over Paperwork

- At CMS, we strive to make patients our top priority:
  - CMS has established an internal process to evaluate and streamline regulations with a goal to reduce unnecessary burden, increase efficiencies, and improve the beneficiary experience.
  - CMS is moving the needle to remove regulatory obstacles that get in the way of providers spending time with patients and healthcare consumers.

Patients over Paperwork: What We Are Hearing

- **Example:** Claims being denied for a chemotherapy agent because the nurse's administration record was initialed rather than signed with a full signature…

- **Example:** Requiring providers to report on several Meaningful Use measures that may have been anything but meaningful to them….

Patients over Paperwork: Goals

- Patient over Paperwork aims to:
  - Increase the number of customers – clinicians, institutional providers, health plans, etc. engaged through direct and indirect outreach;
  - Decrease the hours and dollars clinicians and providers spend on CMS-mandated compliance; and
  - Increase the proportion of tasks that CMS customers can do in a completely digital way.

Patients over Paperwork: Customer Work Groups

- We have established customer-centered workgroups focusing first on clinicians, beneficiaries, nursing homes, and hospitals.
- The job of these workgroups is to learn from and understand the customer experience, internalize it, and remember these perspectives as we do this work.
- Over time, we'll establish similar workgroups across the health care spectrum.

Patients Over Paperwork

- The **Patients Over Paperwork** initiative is focused on reducing administrative burden while improving care coordination, health outcomes and patients' ability to make decisions about their own care.
- Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care.
- This Administration has listened and is taking action.
- The proposed changes to the Physician Fee Schedule address those problems head-on, by proposing to streamline documentation requirements to focus on patient care and proposing to modernize payment policies so seniors and others covered by Medicare can take advantage of the latest technologies to get the quality care they need.

Medical Record Documentation Supports Patient Care

- Clear and concise medical record documentation is critical to providing patients with quality care and is required for physicians and others to receive accurate and timely payment for furnished services.
- Medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient's health history.
- Medical record documentation helps physicians and other health care professionals evaluate and plan the patient's immediate treatment and monitor the patient's health care over time.
- **Many complain that notes written to comply with coding requirements do not support patient care and keep doctors away from patients.**

Documenting E/M Requires Choosing the Appropriate Code

- **Currently, documentation requirements differ for each level and are based on either the 1995 or 1997 E/M documentation guidelines.**
- Billing Medicare for an Evaluation and Management (E/M) visit requires the selection of a Current Procedural Terminology (CPT) code that best represents:
  - Patient type (new v. established),
  - Setting of service (e.g. outpatient setting or inpatient setting), and
  - **Level of E/M service performed.**

Level of E/M Visits

- The code sets to bill for E/M services are organized into various categories and levels. In general, the more complex the visit, the higher the level of code a practitioner may bill within the appropriate category.

- The three key components when selecting the appropriate level of E/M services provided are **history**, **examination**, and **medical decision making**. For visits that consist predominantly of counseling and/or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M services.

Proposed Payment for Office/Outpatient Based E/M Visits

- Proposing a single PFS payment rate for E/M visit levels 2-5 (physician and non-physician in office based/outpatient setting for new and established patients).
- Proposing a **minimum documentation** standard where, for Medicare PFS payment purposes for an office/outpatient based E/M visit, practitioners would only need to document the information to support a level 2 E/M visit (except when using time for documentation).

Why Change?

- Stakeholders have said that the 1995 and 1997 Documentation Guidelines for E/M visits are clinically outdated, particularly history and exam, and may not reflect the most clinically meaningful or appropriate differences in patient complexity and care. Furthermore, the guidelines may not be reflective of changes in technology, or in particular, the way that electronic medical records have changed documentation and the patient's medical record.

- According to stakeholders, some aspects of required documentation are redundant

- Additionally, current documentation requirements may not account for changes in care delivery, such as a growing emphasis on team-based care, increases in the number of recognized chronic conditions, or increased emphasis on access to behavioral health care.

Medical Decision Making or Time

- We propose to allow practitioners to choose, as an alternative to the current framework specified under the 1995 or 1997 guidelines, either MDM or time as a basis to determine the appropriate level of E/M visit.

- This would allow different practitioners in different specialties to choose to document the factor(s) that matter most given the nature of their clinical practice.

- It would also reduce the impact Medicare may have on the standardized recording of history, exam and MDM data in medical records, since practitioners could choose to no longer document many aspects of an E/M visit that they currently document under the 1995 or 1997 guidelines for history, physical exam and MDM.

Proposed Payment for Office/Outpatient Based E/M V

Level	Current Payment* (established patient)	Proposed Payment **
1	$22	$24
2	$45	$93
3	$74	
4	$109	
5	$148	

Level	Current Payment* (new patient)	Proposed Payment* *
1	$45	$44
2	$76	$135
3	$110	
4	$167	
5	$211	

* Current Payment for CY 2018
**Proposed Payment based on the CY2019 proposed relative value units and the CY2018 payment rate

Resource Use During a Visit

- We recognize that primary care services frequently involve substantial non-face-to-face work, and note that there is currently coding available to account for many of those resources, such as chronic care management (CCM), behavioral health integration (BHI), and prolonged non-face-to-face services.

- The currently available coding still does not adequately reflect the full range of primary care services, nor does it allow payment to fully capture the resource costs involved in furnishing a face-to-face primary care E/M visit.

- We are proposing to create a HCPCS G-code for primary care services, GPC1X (Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to an established patient evaluation and management visit)).

Resource Use During a Visit

- We are also proposing to create a HCPCS G-code to be reported with an E/M service to describe the additional resource costs for specialty professionals for whom E/M visit codes make up a large percentage of their overall allowed charges and whose treatment approaches we believe are generally reported using the level 4 and level 5 E/M visit codes rather than procedural coding. Due to these factors, the proposed single payment rate for E/M levels 2 through 5 visit codes would not necessarily reflect the resource costs of those types of visits.

- Therefore, we are proposing to create a new HCPCS code GCG0X (Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management-centered care (Add-on code, list separately in addition to an evaluation and management visit)).

Summary: How to Streamline E/M Payment and Reduce Clinician Burden

- Proposing to provide practitioners choice in documentation for office/outpatient based E/M visits for Medicare PFS payment: 1) 1995 or 1997 documentation guidelines, 2) medical decision-making or 3) time.
- Proposing to expand current policy regarding history and exam, to allow practitioners to focus their documentation on **what has changed** since the last visit or on pertinent items that have not changed, rather than re-documenting information, provided they review and update the previous information.
- Proposing to allow practitioners to **review and verify** certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering it.
- Soliciting comment on how documentation guidelines for medical decision making might be changed in subsequent years.

Proposed Additional Payment Codes

- Proposing **~$5 add-on payment** to recognize additional resources to address inherent complexity in E/M visits associated with primary care services.

- Proposing **~$14 add-on payment** to recognize additional resources to address inherent visit complexity in E/M visits associated with certain non-procedural based care.

- Proposing a **multiple procedure payment adjustment** that would reduce the payment when an E/M visit is furnished in combination with a procedure on the same day.

- Proposing an **~$67 add-on payment for a 30 minute prolonged E/M visit**.

Advancing Virtual Care

- In response to the CY 2018 PFS Proposed Rule, we received feedback from stakeholders supportive of CMS expanding access to services that support technological developments in healthcare.

- We are interested in recognizing changes in healthcare practice that incorporate innovation and technology in managing patient care.

- We are aiming to increase access for Medicare beneficiaries to physicians' services that are routinely furnished via communication technology by clearly recognizing a discrete set of services that are defined by and inherently involve the use of communication technology.

Advancing Virtual Care

To support access to care using communication technology, we are proposing to:

- Pay clinicians for virtual check-ins – brief, non-face-to-face assessments via communication technology;
- Pay Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for communication technology-based services and remote evaluation services that are furnished by an RHC or FQHC practitioner when there is no associated billable visit;
- Pay clinicians for remote evaluation of patient-submitted photos or recorded video; and
- Expand Medicare telehealth services to include prolonged preventive services.

For Further Information

See the Physician Fee Schedule website at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html

Patients over Paperwork: Resources

For more information visit:

https://www.cms.gov/About-CMS/story-page/patients-over-paperwork.html

Sign up for the newsletter here:
https://public.govdelivery.com/accounts/USCMS/subscriber/new?topic_id=USCMS_12350

Read past newsletters here:

https://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/PatientsOverPaperwork.html

QUESTIONS?

Thank You

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