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Official CMS news from the Medicare Learning Network®

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HHS To Deliver Value-Based Transformation in Primary Care

On April 22, HHS Secretary Alex Azar and CMS Administrator Seema Verma announced the CMS Primary Cares Initiative, a new set of payment models that will transform primary care to deliver better value for patients throughout the health care system.

"As we seek to unleash innovation in our health care system, we recognize that the road to value must have as many lanes as possible," said CMS Administrator Seema Verma. "Our Primary Cares Initiative is designed to give clinicians different options that advance our goal to deliver better care at a lower cost while allowing clinicians to focus on what they do best: treating patients."

The CMS Primary Cares Initiative will provide primary care practices and other providers with five new payment model options under two paths: Primary Care First (PCF) and Direct Contracting (DC). The five payment model options are:

- PCF
- PCF - High Need Populations
- DC – Global
- DC – Professional
- DC – Geographic

The PCF payment model options will test whether financial risk and performance based payments that reward primary care practitioners and other clinicians:

- Are easily understood
- Have actionable outcomes that reduce total Medicare expenditures
- Preserve or enhance quality of care
- Improve patient health outcomes

The DC payment model options are also focused on transforming primary care, allowing health care providers to take greater control of managing the costs of care for an aligned population of Medicare Fee-For-Service (FFS) beneficiaries. While the PCF models are focused on individual primary care practice sites, the DC payment model options aim to engage a wider variety of organizations that have experience taking on financial risk and serving larger patient populations, such as Accountable Care Organizations, Medicare Advantage plans, and Medicaid managed care organizations.

CMS anticipates these five payment model options could:

- Provide better alignment for over 25 percent of all Medicare FFS beneficiaries
- Offer new participation and payment options and opportunities for an estimated 25 percent of primary care practitioners, as well as other health care providers
- Create new coordinated care opportunities for a large portion of the 11-12 million beneficiaries dually eligible for Medicare and Medicaid, specifically those in Medicaid managed care and Medicare FFS

For More Information:

- Primary Care First: Foster Independence, Reward Outcomes Fact Sheet
- Direct Contracting Fact Sheet
- Delivering Value-Based Transformation in Primary Care Fact Sheet
- Direct Contracting: Geographic Population-Based Payment Model Option Request for Information

See the full text of this excerpted CMS Press Release (issued April 22).

New Part D Opioid Overutilization Policies: Myths and Facts

CMS implemented new opioid policies for Medicare drug plans effective January 1. This is the second message in our series on common myths about these new policies and the facts for providers

Myth: “Medicare is forcing all Part D enrollees to taper prescription opioids below a certain amount.”
Fact:

- Prescribers and their patients must carefully consider decisions to taper or stop prescription opioids
- It can be especially challenging to taper opioid use in patients who have been on high dosages of opioids for many years
- The intent of the new opioid policies is to address opioid overuse without a negative impact on the patient-doctor relationship

Medicare Part D opioid policies are not prescribing limits and generally do not apply to enrollees who have cancer; get hospice, palliative, or end-of-life care; or who live in a long-term care facility. The new policies encourage collaboration and care coordination among Medicare drug plans, pharmacies, prescribers, and patients to improve opioid management, prevent opioid misuse, and promote safer prescribing practices.

For More Information:

- Roadmap
- Letter to providers about reducing opioid misuse
- Prescriber's Guide to New Medicare Part D Opioid Overutilization Policies for 2019 MLN Matters Article
- Training materials for prescribers, pharmacists, and patients

Medicare Shared Savings Program: Do You Plan to Apply to be an ACO?

CMS announced Notice of Intent to Apply (NOIA) and application cycle dates for a January 1, 2020, start date for the Medicare Shared Savings Program – Pathways to Success. Beginning June 11, 2019, CMS will start accepting NOIAs via the Accountable Care Organization (ACO) Management System (ACO-MS). You must submit a NOIA if you intend to apply to the BASIC or ENHANCED track of the Shared Savings Program, apply for a Skilled Nursing Facility 3-Day Rule Waiver, and/or establish and operate a Beneficiary Incentive Program.

NOIA submissions are due no later than June 28 at noon ET. A NOIA submission does not bind your organization to submit an application; however, you must submit a NOIA to be eligible to apply. Each ACO should submit only one NOIA. ACOs will have an opportunity to make changes to their tracks, repayment mechanisms, and other NOIA-related information during the application submission period. Also, CMS allows ACOs to submit sample documentation (e.g., sample ACO participant agreements) with their NOIA in order to receive feedback from CMS before the application period opens.

The application submission period will be open from July 1 through 29, 2019, at noon ET.

For More Information:

- Shared Savings Program website
- Application Types and Timeline webpage
- Application Toolkit webpage
- For questions email SSPACO_Applications@cms.hhs.gov

Open Payments: Review and Dispute Data by May 15

Pre-publication review and dispute for program year 2018 Open Payments data is available through May 15. CMS will publish program year 2018 data and updates to the previous program years' data in June. Physician and teaching hospital review of the data is voluntary, but strongly encouraged:

- Records eligible for review and dispute: All records submitted during the submission period of the current calendar year, including newly edited, submitted, and re-attested records from previous calendar years; See the Physician and Teaching Hospital Review and Dispute Tutorial
- Disputes must be initiated by May 15: See the Review and Dispute Timing and Data Publication Quick Reference Guide
- We do not meditate or facilitate disputes: Work directly with reporting entities to resolve disputes
- Registration in the Open Payments system is required: Visit the Registration for Physicians & Teaching Hospitals webpage for instructions

If you are already registered, log in to review your data:

- If you have not accessed your account in 60 days or more, you will need to unlock your account in the CMS Portal
- If you have not accessed your account in 180 days or more, your account has been deactivated, and you will need to contact the Open Payments Help Desk to reinstate your account

For More Information:

- Open Payments website
- Materials from March 13 Medicare Learning Network call
- Contact the Open Payments Help Desk at openpayments@cms.hhs.gov or 855-326-8366; TTY 844-649-2766

Proposed Rules on Interoperability: Comment Period Extended to June 3

HHS extended the public comment period by 30 days for two proposed regulations aimed at promoting the interoperability of health information technology and enabling patients to electronically access their health information. The new deadline for comments is June 3.

The extension of the public comment period coincides with release of:

- Second draft of the Trusted Exchange Framework and Common Agreement and related Notice of Funding Opportunity from the HHS Office of the National Coordinator for Health Information Technology
- FAQs from the Office for Civil Rights

For More Information:

- Notice of Proposed Rulemaking to Improve the Interoperability of Health Information webpage
- CMS Advances Interoperability & Patient Access to Health Data through New Proposals Fact Sheet
- Interoperability website

Quality Payment Program: MIPS 2019 Call for Measures/Activities Ends July 1

You can submit Promoting Interoperability measures and Improvement Activities for consideration for future years of the Merit-based Incentive Payment System (MIPS) through July 1. CMS is currently accepting submissions for:

- Electronic health record measures for the Promoting Interoperability performance category
- Activities for the Improvement Activities performance category

For More Information:

- Call for Measures and Activities: Fact sheet and materials
- Resource Library webpage
- Webinar Library webpage

SNF PPS Patient Driven Payment Model: Get Ready for Implementation on October 1

On October 1, the new Patient Driven Payment Model (PDPM) is replacing Resource Utilization Group, Version IV for the Skilled Nursing Facility (SNF) Prospective Payment System (PPS). CMS has resources to help you prepare:

- PDPM webpage, including fact sheets, FAQs, presentation, and coding crosswalks/classification logic
- Materials from the Medicare Learning Network call in December
- New Medicare Webpage on PDPM MLN Matters Article
- Implementation of the SNF PDPM MLN Matters Article

Ensuring Safety and Quality in America's Nursing Homes

CMS is charged with developing and enforcing quality and safety standards across the nation's health care system. We are undertaking a comprehensive review of our regulations, guidelines, internal structure, and processes related to safety and quality in nursing homes to ensure:

- Residents are treated with dignity and kept safe from abuse and neglect
- Nursing homes are rewarded for value and quality
- Patient outcomes are transparent to consumers
- Unnecessary paperwork does not keep you from focusing on patients

Find out what we are doing to:

- Strengthen oversight
- Enhance enforcement

- Increase transparency
- Improve quality
- Put patients over paperwork

See the full text of this excerpted CMS Blog (issued April 15).

Compliance

Proper Use of the KX Modifier for Part B Immunosuppressive Drug Claims

A 2017 Office of the Inspector General (OIG) report noted that, in some cases, pharmacies incorrectly billed Medicare Part B for claims using the KX modifier for immunosuppressive drugs. It is estimated that Medicare paid $4.6 million for these claims that did not comply with Medicare requirements.

In response to this report, CMS clarified manual instructions on the use of the KX modifier to help pharmacies document the medical necessity of organ transplant and eligibility for Medicare coverage. Resources for pharmacies:

- Pharmacy Billing of Immunosuppressive Drugs MLN Matters Article
- Clarification of the Billing of Immunosuppressive Drugs MLN Matters Article
- OIG Report on the proper use of the KX modifier for Part B immunosuppressive drug claims

Claims, Pricers & Codes

DMEPOS 2019 Fee Schedule File Revision

CMS revised the fees for power wheelchair components (HCPCS codes E2330RRKU and E2369RRKU) in the 2019 Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) fee schedule. The updated January and April 2019 files are on the Fee Schedule webpage.

Events

Vitamin D Testing: Comparative Billing Report Webinar — May 7

Tuesday, May 7 from 3 to 4 pm ET

Register for this webinar.

Join us for a discussion of the Comparative Billing Report on Vitamin D Testing, an educational tool for providers who submit Medicare Part B claims. See the CBR website for more information.

Air Ambulance Transports: Comparative Billing Report Webinar — May 9

Thursday, May 9 from 2 to 3 pm ET

Register for this webinar.

Join us for a discussion of the Comparative Billing Report on Air Ambulance Transports, an educational tool for providers who submit Medicare Part B claims. See the CBR website for more information.

Promising Practices for Duals with Substance Use Disorders Webinar— May 16

Thursday, May 16 from 1:30 to 3 pm ET

Register for this webinar:

This webinar discusses common Substance Use Disorders (SUDs) among dually eligible older adults; identifies promising practices for screening, treatment, and care coordination; and demonstrates practical strategies for meeting the needs of older adults with SUDs. Continuing Medical Education (CME) and Continuing Education (CE) credits may be available.

MLN Matters® Articles

Appeals of Claims Decisions - Revisions

A new MLN Matters Article MM11042 on Pub. 100-04, Chapter 29 – Appeals of Claims Decisions - Revisions is available. Learn about policy updates.

New Waived Tests

A new MLN Matters Article MM11231 on New Waived Tests is available. Learn about claims submission updates.

NCD: Next Generation Sequencing — Revised

A revised MLN Matters Article MM10878 on National Coverage Determination (NCD90.2): Next Generation Sequencing (NGS) is available. Learn about missing CPT codes.

Implementation to eMDR for Registered Providers via the esMD System — Reissued

A reissued MLN Matters Article MM11003 on Implementation to Exchange the List of Enrollment in Electronic Medical Documentation Requests (eMDR) for Registered Providers via the Electronic Submission of Medical Documentation (esMD) System is available. Learn about registration and instructions.

Publications

2019 MIPS Group Participation

CMS posted a Merit-based Incentive Payment System (MIPS) 2019 Group Participation Guide, covering the following topics:

- Eligibility and participation
- Group registration for CMS Web Interface and CAHPS® for MIPS Survey
- Data collection and submission for each MIPS performance category
- Scoring and payment adjustments

Provider Compliance Tips for Ordering Lower Limb Orthoses — Revised

A revised Provider Compliance Tips for Ordering Lower Limb Orthoses Medicare Learning Network Fact Sheet is available. Learn about:

- Differentiating factors for proper coding
- Reasons for claim denials
- How to prevent future denials

Provider Compliance Tips for Ordering Lower Limb Prostheses — Revised

A revised Provider Compliance Tips for Ordering Lower Limb Prostheses Medicare Learning Network Fact Sheet is available. Learn about:

- Medical necessity determinations
- Reasons for claim denials
- How to prevent future denials

Provider Compliance Tips for Ostomy Supplies — Revised

A revised Provider Compliance Tips for Ostomy Supplies Medicare Learning Network Fact Sheet is available. Learn about:

- Coverage requirements
- Reasons for denials
- How to prevent future claim denials

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