Impactful Areas for 2019 Payment System Rulemaking

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Expectations for Presentation

- Review of the regulatory landscape for inpatient and outpatient payment system rules
- Presented as potential impact on EHRs/Health IT to provide insight as to:
  - What questions you may want to ask your vendor;
  - What may need updated solutions;
  - Timing;
- Will not be an advertisement for Cerner
- Will not be a complete review of rulemaking

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No Promoting Interoperability (Meaningful Use) – But If You Want to Talk About It……

Meaningful Measures

Reducing Burden – CMS Meaningful Measures

- Address high impact measure areas that safeguard public health
- Patient-centered and meaningful to patients
- Outcome-based where possible
- Relevant for and meaningful to providers
- Minimize level of burden for providers
- Significant opportunity for improvement
- Address measure needs for population based payment through APMs
- Align across programs and/or with other payers (Medicaid, commercial)

Meaningful Measures - Next Steps

There are three dimensions to the implementation of Meaningful Measure areas:

1. Conduct thorough review of existing measures and remove ones that don't meet criteria;
2. Analyze measure sets to identify gaps based on the Meaningful Measures Framework; focus any new measures on filling these gaps and moving from lower value process measures towards higher value measures such as outcome measures; and
3. Work with clinicians, providers, registries, EHR vendors and other federal stakeholders to advance measurement systems to lower burden particularly around the area of reporting.

Additionally, there will be ongoing efforts to receive stakeholder input to further improve the Meaningful Measures Framework, work across CMS components to implement the Framework, and evaluate current measure sets to inform measure development.

Meaningful Measures

CMS seeking to apply Meaningful Measures guiding principles to quality reporting programs in payment system rules for 2019

Expanded consideration for information collection burden and cost – to include

- Facility information collection burden and related cost and burden associated with submitting/reporting quality measures to CMS
- Facility cost associated with complying with other quality programmatic requirements
- Facility cost associated with participating in multiple quality programs, and tracking multiple similar or duplicative measures within and across those programs
- CMS cost associated with program oversight of the measure
- Facility cost associated with compliance with other federal or applicable state laws

And What Have We Seen

	IPPS Final	OPPS NPRM	ASC NPRM	HHA NPRM	PAC Final (SNF/IRF)	Hospice Final	IPF Final
Adopted Prior Measures	15 eCQM 46 CQMs	29 CQMs	15 CQMs	26 CQMs	SNF – 7 IRF - 18	9 CQMs	18 CQMs
2019 Measures (Next Program Year)	15 eCQM 26 CQMs	22 CQMs	11 CQMs	19 CQMs	SNF – 12 IRF - 16	9 CQMs	13 CQMs

NOTE: HCAPHS Measures Counted as 1

HIT Considerations

EHR Vendors already need to make annual updates for specifications on eCQMs, which require annual updates for software

As the Meaningful Measures programs continues, vendors and providers will need to continually monitor measures that are being removed and being added to the program

Look for Patient Reported Outcome (PRO) measures and administrative claims measures with clinical data submission requirements

2019 Inpatient Prospective Payment System Rule

Strengthening Move Towards Pricing Transparency for Medicare

Current requirement is to make public a list of standard charges or at least allow public to request a charge list

New requirement would require standard charges to be posted “via the Internet in a machine readable format” and to update it at least annually

CMS still has concerns use of charge master data not terribly useful or meaningful to consumers – but only a starting point

HIT Consideration – Standard charges as stored in a HIT system are not typically what a hospital would want to publish and HIT vendors typically don’t have access to publish on a hospital’s website

Admission Order for Payment

Relaxing requirements for need to have explicit distinct admission order as Condition of Payment

- Physician instruction to admit may be documented in a variety of ways such as an admit order, statements in a progress note or by other means
- Need for a separate admission order not warranted if other required documentation for the inpatient admission includes physician instruction to admit
- Auditors to not condition inpatient payment recovery on absence of a distinct admission order

HIT Considerations

- HIT systems may have rules or alerts based on admission orders (including for CQMs)
- Revenue Cycle Systems may use admission orders for calculation of inpatient charges
- Hospitals may have rules or alerts based on admission orders
- Documentation of admission requirements are still required

Medicare Part B Payment Policies for Outpatient and PFS Payments

2019 OPPS/ASC Final Rule

Major Topics – Off Campus Departments

Non-excepted off-campus Provider Based Depts (PBDs) must use a PN modifier and are paid under the PFS Relativity Adjuster of 40%

CMS will pay excepted off-campus PBDs to be paid for HCPCS G0463 at the same 40% rate in 2019 and beyond

- Code G0463 - hospital outpatient clinic visit for assessment and management of a patient

CMS is limiting excluded off-campus PBDs to providing only services in the same clinical family as provided between Nov 1, 2014 – Nov 1, 2015

- New services would be billed with PN modifier at 40% rate instead of PO modifier

Paying non-excepted off-campus PBDs at -22.5% of ASP for 340B drugs

Requiring all off campus EDs to use “ER” modifier on all claim lines

Clinical Families for Off-Campus PBDs

Clinical Families	APCs
Airway Endoscopy	5151–5155
Blood Product Exchange	5241–5244
Cardiac/Pulmonary Rehabilitation	5771; 5791
Diagnostic/Screening Test and Related Procedures	5721–5724; 5731–5735; 5741–5743
Drug Administration and Clinical Oncology	5691–5694
Ear, Nose, Throat (ENT)	5161–5166
General Surgery and Related Procedures	5051–5055; 5061; 5071–5073; 5091–5094; 5361–5362
Gastrointestinal (GI)	5301–5303; 5311–5313; 5331; 5341
Gynecology	5411–5416
Major Imaging	5523–5525; 5571–5573; 5593–5594
Minor Imaging	5521–5522; 5591–5592
Musculoskeletal Surgery	5111–5116; 5101–5102
Nervous System Procedures	5431–5432; 5441–5443; 5461–5464; 5471
Ophthalmology	5481, 5491–5495; 5501–5504
Pathology	5671–5674
Radiation Oncology	5611–5613; 5621–5627; 5661
Urology	5371–5377
Vascular/Endovascular/Cardiovascular	5181–5184; 5191–5194; 5200; 5211–5213; 5221–5224; 5231–5232
Visits and Related Services	5012; 5021–5025; 5031–5035; 5041; 5045; 5821–5823

HIT Considerations

- Modifiers will be required on every claim line for certain off-campus PBDs and EDs
- Need to discuss with your vendor if there are rules or functionality that can be used to assist in ensuring the modifier placement
- Ensure these are updated with the changes for 2019, including the excepted off-campus PBDs use of both PN and PO modifier, depending on service provided

Non-Opioid Pain Management – ASCs and OP Surgery

Historical Treatment

- Have regarded non-opioid pain management drugs as packaged supplies

Policy Issues

- Incent use of non-opioid based methods
- Provide for separate payment for what formerly was a supply
- Exparel only such item proposed
- Broader Implications with SUPPORT Act

CoP Updates

H&P for Outpatient Surgery

- CMS is proposing to allow hospitals and ASCs additional flexibility in determining the level of H&P required prior to outpatient surgeries
- Does not apply to inpatient surgeries
- Policy must be documented in Medical Staff bylaws and outline – which procedures don't ned full H&P, who can perform the H&P, timing of the H&P, etc
- Consideration must be given to patient age, diagnosis, type and number of surgeries and procedures, comorbidities, level of anesthesia, nationally recognized guidelines, and state/local law
- HIT Considerations – Impacts documentation requirements that must be met for billing and there may be rules/alerts based on H&P in the system

2019 Physician Fee Schedule

E/M Visits

Collapse visit level to three payments – Level 1, Levels 2-4 and Level 5

Additional codes to describe variance or exception in visit service

Beginning in 2021, provide for more options for visit documentation

- Current Method
- One based on MDM
- One based on medical necessity and time/duration

Minimum documentation requirements - Level 2

Relax requirements for re-transcribing what was documented by other care team members

- Focus on documenting complimentary and/or differences in findings

E/M Visits

Changes apply to office/outpatient visit codes (CTP codes 99201 through 99215), except where otherwise specified (not ED visits)

Documentation requirements	Payment simplification

Implementation date – January 1, 2021

Documentation changes for E/M visits is optional	Talk to Your HIT Vendor About Their Adoption Support!

Teaching Physician Documentation Requirements for E/M Services

- Medical records must document that the teaching physician was present at the time the service is furnished
- Must document the extent of the teaching physician's participation in the review and direction of services

HIT Impacts – E/M Documentation

- Dialogue with HIT vendor on how to address various documentation options
  - Cerner response
  - Take on other models
- Moving away from the current approach may break the current approach
  - Embedded workflows; which CMS did request comments on how it will impact current workflows
    - Integrated algorithms that would specify CPT codes
  - Other payers not impacted so remember them in your conversations!
    - Providers will have to identify patients by payer source for documentation requirements

Telehealth

Service expansion under recent statutory direction

- New services for communication technology and remote evaluation of pre-reported patient information
- Expand service offerings that can be offered or originated through FQHC and RHC
- New services for extended preventive services, home dialysis and stroke

Potential to make up for issues of rural or underserved access issues

HIT Impacts - Telehealth

- Evaluate investment in Telehealth
  - Business use-cases
  - Originating and receiving site telehealth costs of technology
    - Loosening of the restrictions
  - Potential sign of things to come
    - ACO waivers for MSSP
    - ESRD
    - SUPPORT Act, Opioid use treatments
    - FQHC and Rural Health opportunities

Appropriate Use Criteria for Advanced Diagnostic Imaging

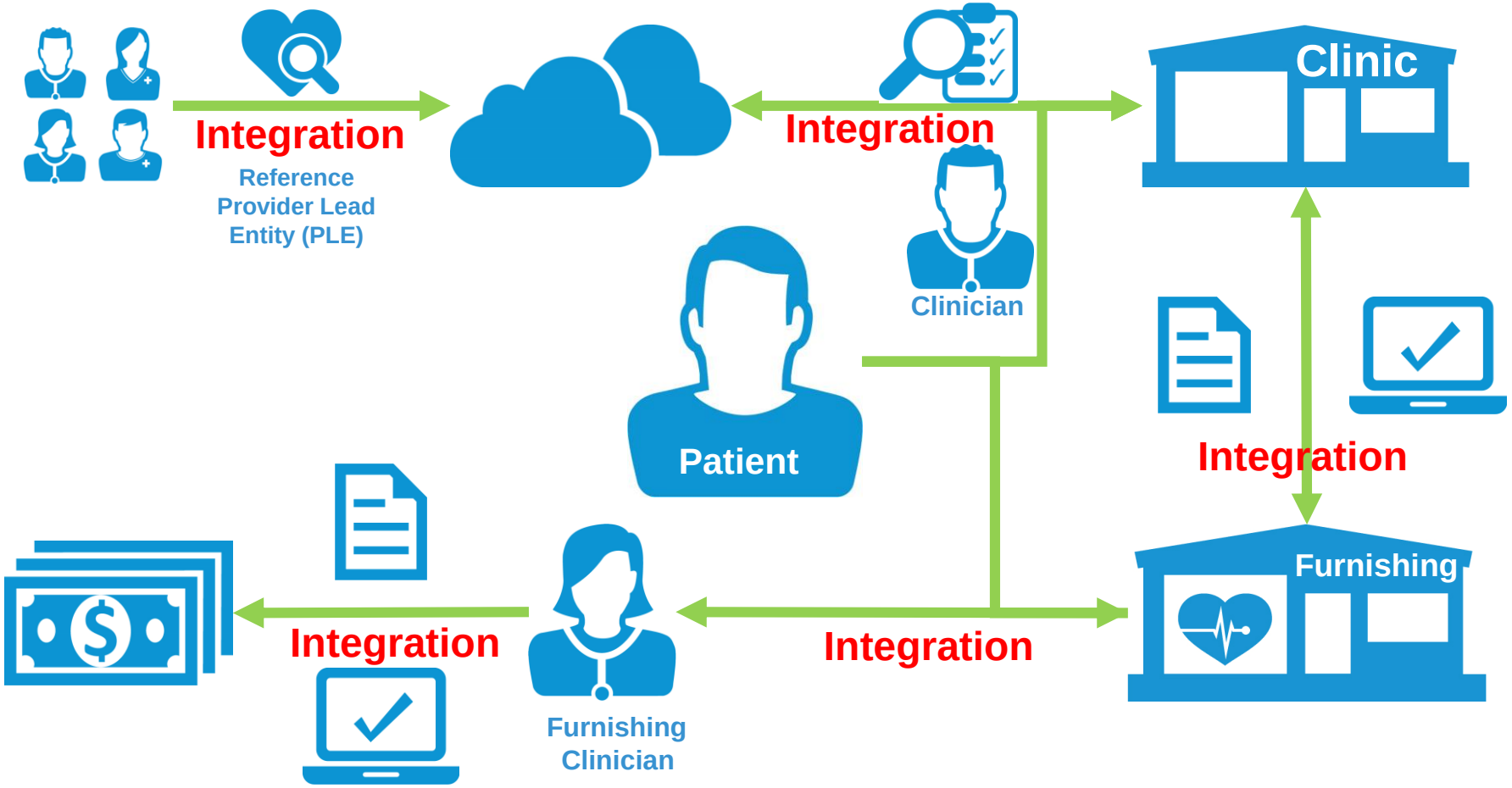
- Program to begin January 1, 2020
  - First year educational and operational testing period and will not withhold payment for incorrect documentation on claims
- Retains major components of original CY2018 PFS final rule
- Prior authorization component is delayed; CMS asking for comment on calculation
- Expanding applicable setting to include independent diagnostic testing facility (IDTF)
- AUC through a qualified clinical decision support mechanism (CDSM) may be performed by clinical staff working under direction of the ordering professional (subject to State rules)

Reporting AUC

AUC Consultation Information

- Both the professional component (furnishing) and the technical component (facility) must be reported
- Not limited to the furnishing professional claim
- Claim based reporting with G-codes and modifiers

HIT Impacts - Appropriate Use Criteria



Therapy Services

- Dates of service on or after January 1, 2020
  - New modifier when an outpatient service is provided in whole or in part by a therapy assistant
    - New PT Assistant services modifier
    - New OT Assistant services modifier
    - Revised GP modifier (Services provided by PT)
    - Revised GO modifier (Services provided by OT)
    - Revised GN modifier (services provided by SLP)
  - Discontinue the functional reporting requirements
    - Eliminates claim edits

HIT Impacts – Therapy Services

- Items that may need to be turned off in the documentation
  - How does the HIT support the functional reporting?
    - Automatic inclusion of modifiers based on the services rendered
- Understand what your vendor will be doing to support the attachment of the modifier
  - Clinical documentation and coding

Remainder of 2018

Conditions of Certification - § 4002

The HIT Developer:

- Does not take any action that constitutes information blocking
- Provides assurances they will not prohibit appropriate exchange, access, or use of Health IT
- Has published APIs and allows health information to be accessed, exchanged, and used without special effort
- Has successfully tested real world use of interoperability technology in the setting it is marketed
- Submits reporting criteria as required in EHR Reporting program

HIT developer does not prohibit or restrict communication on –

- The usability of the health IT
- The interoperability of the health IT
- The security of the health IT
- Relevant information regarding users experiences when using the health IT
- The business practices of developers of health IT related to exchange of electronic health information
- The manner in which the user of the health IT has used the health IT

21st Century Cures Act Definitions

Interoperable Health IT:

- Enables the secure exchange of electronic health information with, and use of electronic health information from, other health IT *without special effort* on the part of the user
- Allows complete access, exchange, and use of *all electronically accessible health information* for authorized use under State or Federal law; and
- Does not constitute information blocking

Information Blocking –

- If *conducted by a HIT developer, HIE, or HIN*, such developer, exchange or network *knows, or should have known*, that such practice is likely to interfere with, prevent or materially discourage the access, exchange, or use of health information
- If *conducted by a health care provider*, such provider *knows* that such practice is unreasonable and is likely to interfere with, prevent, or materially discourage the access, exchange, or use of health information

Health Care Providers

- Includes a hospital, SNF, NF, HHA or other LTC facility, health care clinic, community mental health center, renal dialysis facility, blood center, ASC, emergency medical services provider, FQHC, group practice, a pharmacist, a pharmacy, a laboratory, a physician, a practitioner, IHS, tribal organization, or urban Indian organization, a RHC, a therapist, and any other category of health care facility, entity, practitioner, or clinician determined by the Secretary

U.S. Core Data for Interoperability (USCDI)

ONC released a draft USCDI on January 5, 2018 along with draft TEFCA documents

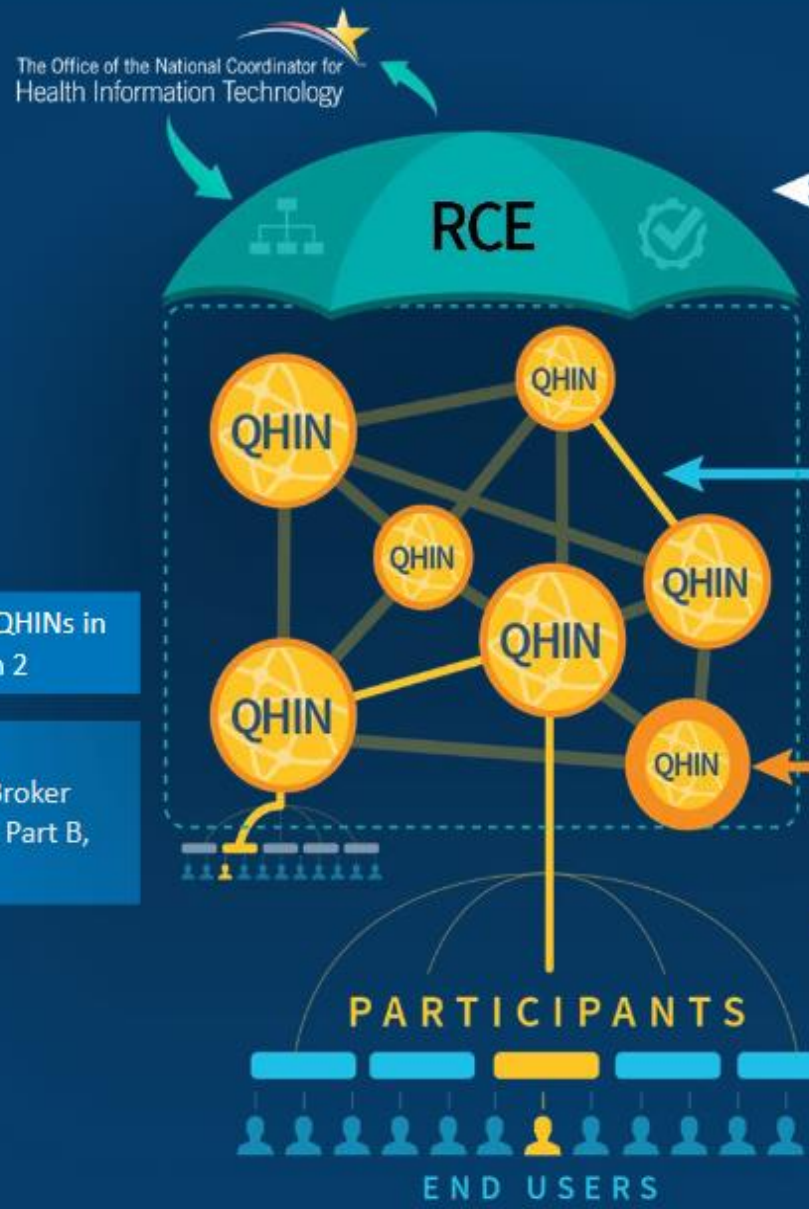
ONC connects USCDI to the definition of Interoperability in being able to define “all electronic health information”

USCDI begins with a CCDS base, but builds quickly to a larger set of data

ONC identifies the USCDI as a method for the industry to define data needed for exchange and prioritize the technical standards and implementation guidance associated to such data

USCDI’s connection to interoperability likely connects it to information blocking

How Will the Trusted Exchange Framework Work?



RCE provides oversight and governance for Qualified HINS.

Qualified HINs connect directly to each other to serve as the core for nationwide interoperability.

QHINs connect via connectivity brokers.

Each Qualified HIN represents a variety of networks and participants that they connect together, serving a wide range of end users.

READ MORE: QHINs in Part B, Section 2

READ MORE: Connectivity Broker Capabilities in Part B, Section 3

Information Blocking

Penalties

- HIT Vendors, HIEs, HINs – up to $1 million per violation
- Health Care Providers – determined by appropriate agency

Potential Examples of Information Blocking

- Definitely –
  - Deny connection with a competitor
  - Willfully slow down enabling a connection that is technically feasible
  - Implementing HIT in a non-standard way likely to increase the burden in accessing, exchanging, or using electronic health information
- Maybe –
  - Missing regulatory deadlines to provide information to providers/patients
  - Withholding Certain Lab Results from the Patient
- Not Information Blocking
  - Internet outages
  - Extreme and uncontrollable circumstances

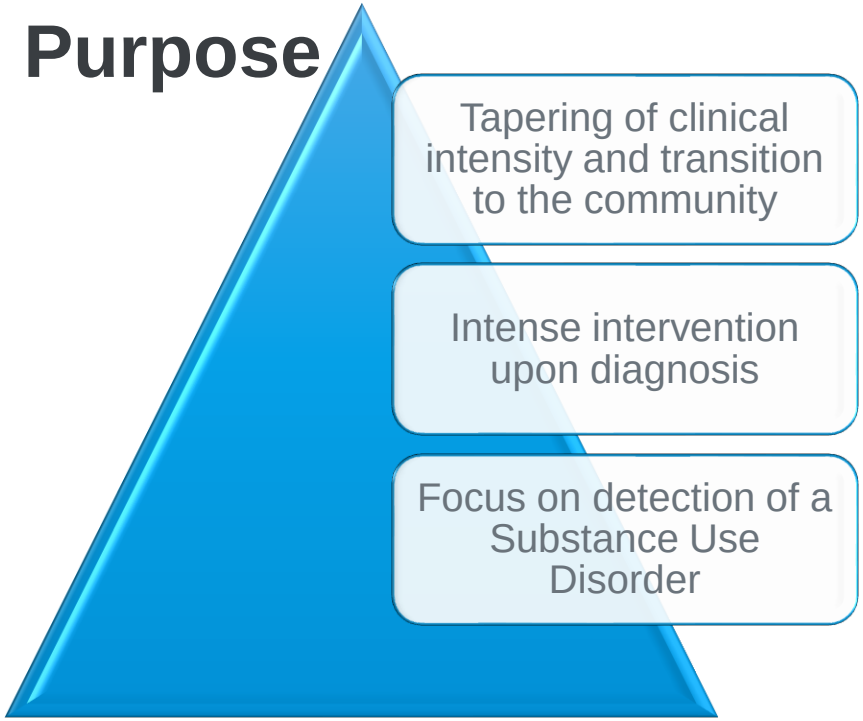
Discharge Planning CoP Updates

- Updating and standardizing discharge planning requirements between hospitals, LTCHs, IRFs, CAHs
- Standardizes what information needs to be shared and with whom as part of a discharge
- Could be part of a interoperability requirement if certain information must be able to be shared electronically

Oh And One More Thing – SUPPORT Act: What Has Our Attention As It Unfolds

SUPPORT for patients and communities act - opioid crisis

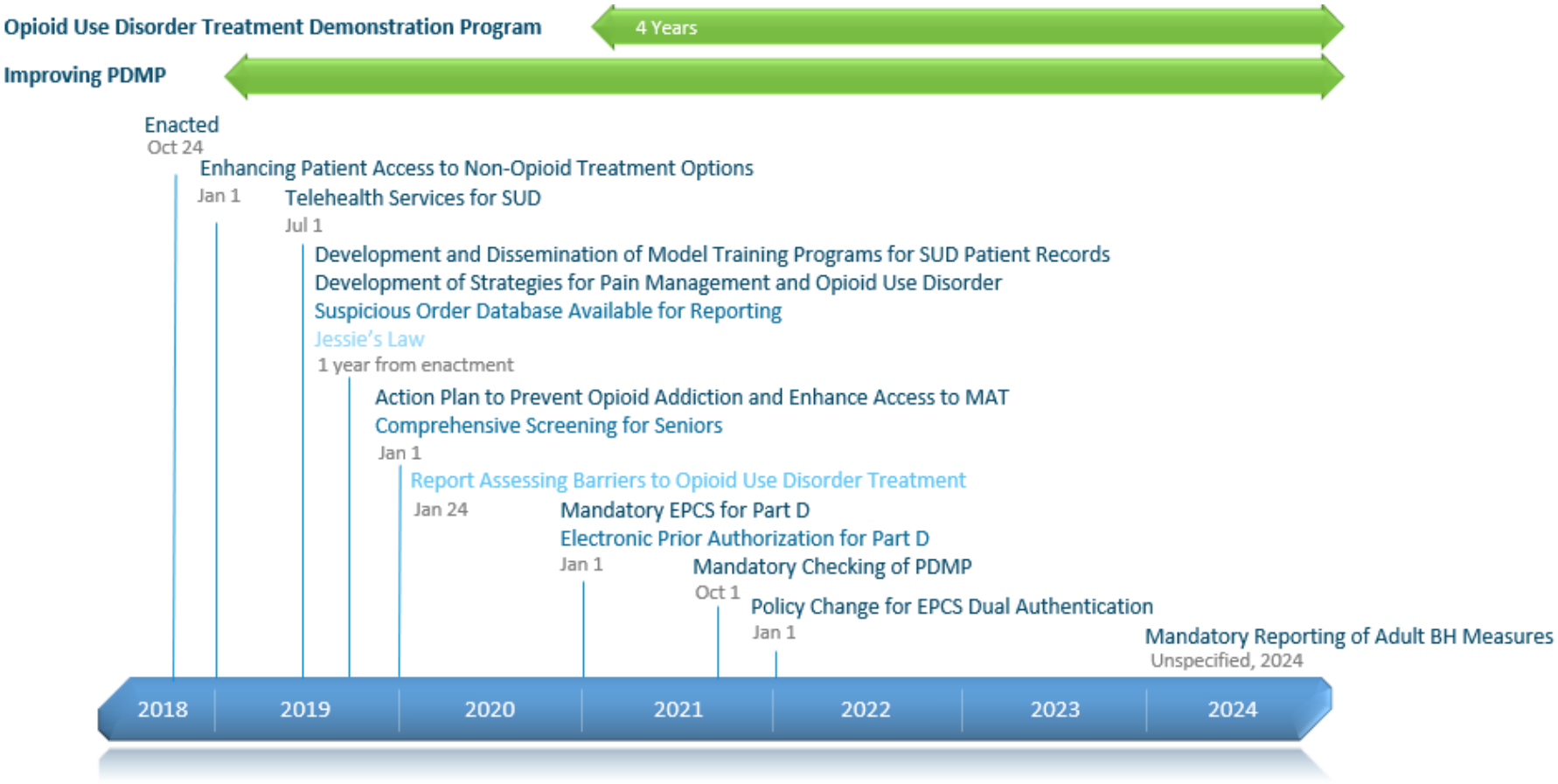
Purpose



Background

- Signed October 24, 2018
- Lays groundwork for development of legislation, regulations, guidance and best practices
- Decrees actions through 2024
- Involves a plethora of Federal agencies including FDA, CMS, CDC, DEA, HHS, OCR, etc.

SUPPORT for Patients and Communities Act - Timeline



Section 7051 Jessie's Law

- Public Health Provision
- Timeline: 1 Year from Enactment (October 24, 2019)
- Requirement:
  - Prominent display of SUD information in the EHR
  - Attainment of patient consent
- IT Impact:
  - Interpretation of forthcoming best practices
  - Design and development of location within the EHR where such information will be displayed

Section 2002 Comprehensive Screening for Seniors

- Medicare Provision
- Timeline: January 1, 2020
- Requirement of the Initial Preventive Physical Exam (IPPE) and Annual Wellness Exam (AWE):
  - Review of potential risk factors for opioid use disorder
  - Evaluation of severity of pain and current treatment plan
  - Provision of non-opioid treatment options
  - Referral to a specialist, as appropriate
- IT Impact:
  - Potentially subject to regulatory requirement per the Medicare Physician Fee Schedule rule
  - Potential updates to the Cerner Ambulatory EHR

Section 2003 Mandatory EPCS for Part D

- Medicare Provision
- Timeline: January 1, 2021
- Requirement:
  - Must perform EPCS for all schedule II-IV Part D Covered Drugs
- IT Impact:
  - Adoption of EPCS capabilities and NCPDP 2017071 updates within Millennium 2018.01.09
- Policy Change for EPCS Dual Authentication
  - Timeline: January 1, 2022
  - Requirement: Ability to comply with updated standards for biometric positive identification for dual authentication
  - IT Impact
    - Requires recertification under the DEA EPCS program
    - Requires adoption of subsequent updated software

Section 6062 Electronic Prior Authorization for Part D

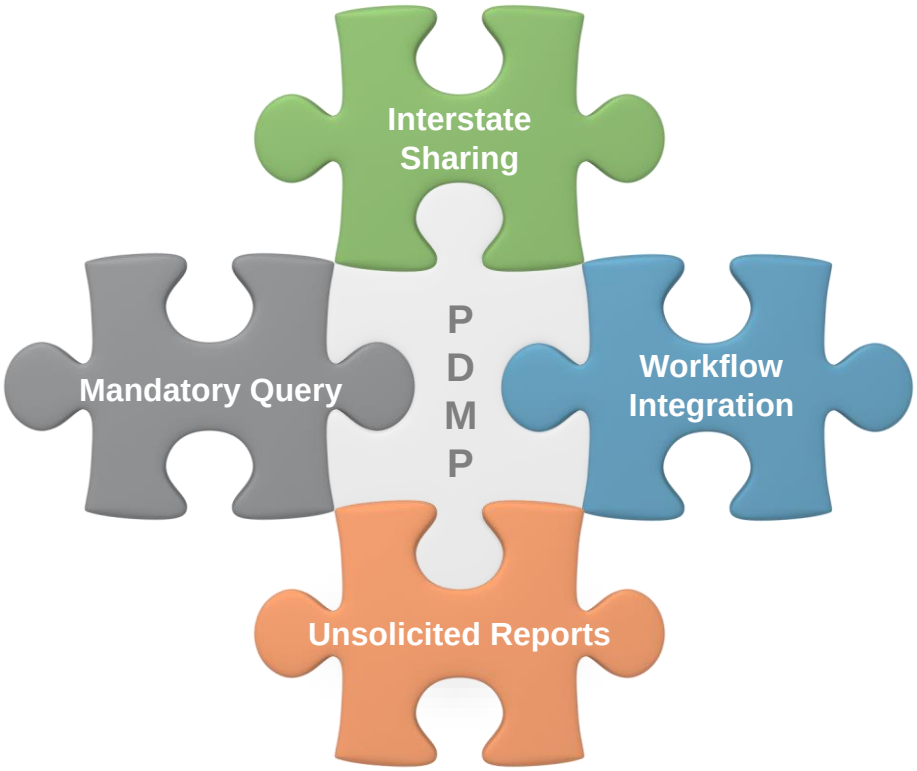
- Medicare Provision
- Timeline: January 1, 2021
- Requirement: Transact a prior authorization request, and a response for all covered Medicare Part D drugs
- IT Impact:
  - NCPDP D.0 transaction set which may require certification
  - Prior authorization workflows for all venues that deal with prescribing of Part D medications

Section 5042 and 7162 Prescription Drug Monitoring Program (PDMP)

- Timeline: October 1, 2021
- Requirement:
  - Mandatory checking of medication history via a "qualified" PDMP prior to prescribing a controlled substance
    - Good faith efforts to check a PDMP must be documented along with the reason why the provider was unable to conduct the check
    - Medicaid Provision
  - Guidelines specifying a uniform electronic format for reporting, sharing, and disclosure of information
    - Public Health Provision

IT Impact:

- Integration of information into the provider workflow
- Documentation within the EHR
- Potential use case for TEFCA
- Possible certification requirement (already face this for Promoting Interoperability for hospitals and eligible clinicians)



Pertaining to Performance and Quality Measures

Section 7121 Comprehensive Opioid Recovery Centers

- Public Health Provision
- Timeline: 3-5 year grant, indeterminant timing
- Requirement:
  - Use of a secure, confidential and interoperable electronic health information system
  - Reporting on outcomes for receipt of incentive payment
- IT Impact: Ability to support the reporting of outcomes

Section 5001 CMS Adult Core Measure Set

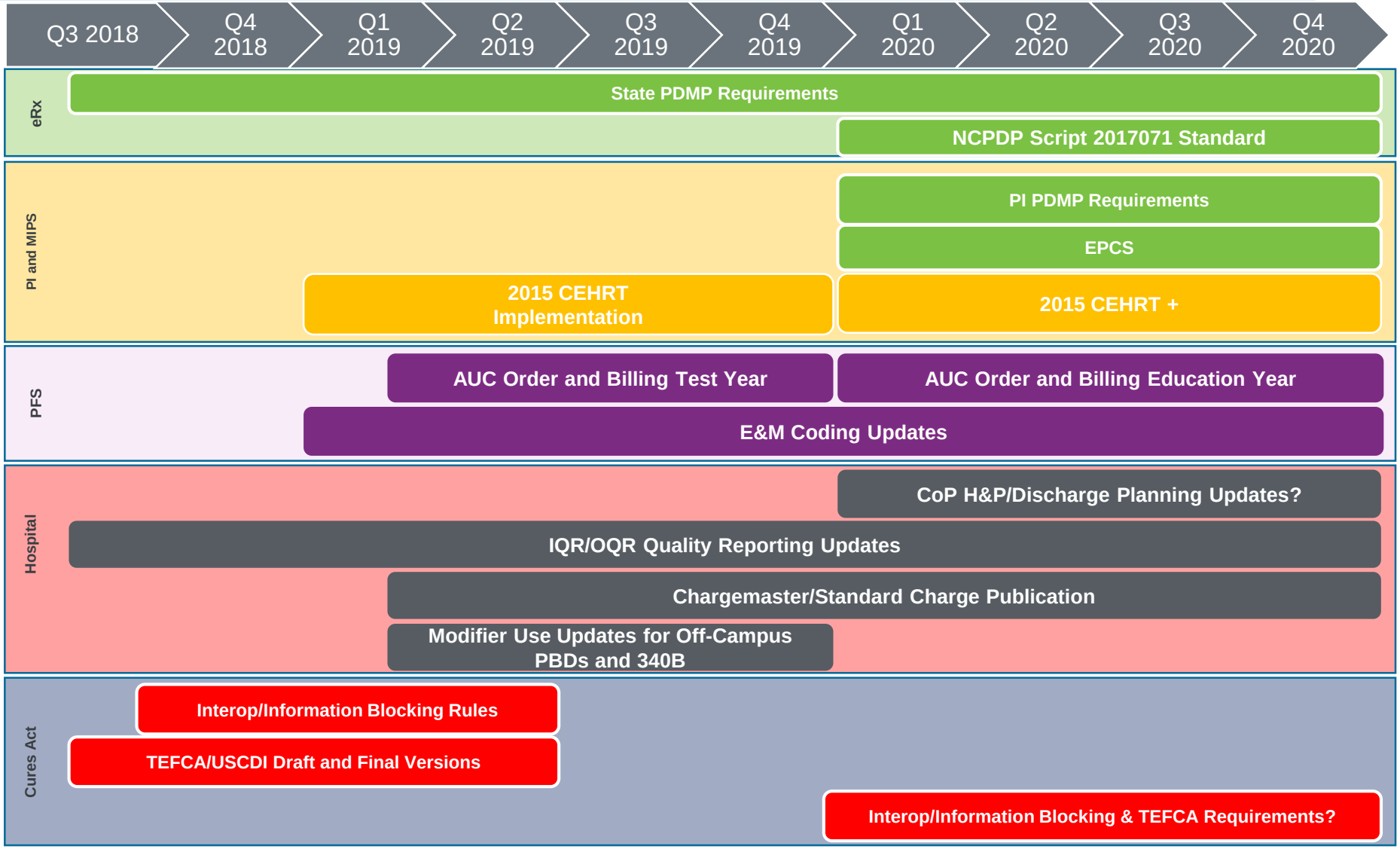
- Medicaid Provision
- Timeline: Unidentified, 2024
- Requirement:
  - Mandatory reporting of behavioral health measures in the adult core measure set
  - Crosses Medicaid reporting programs
- IT Impact: Ability to support the reporting of measures

Section 6001 Testing of Incentive Payments for BH Providers for Adoption and Use of CEHRT

- Medicare Provision
- Timeline: Undefined
- Requirement:
  - Adoption and use of CEHRT
  - Impact to State Medicare Programs:
    - behavioral health providers, community mental health centers, hospitals that participate in a State plan under title XIX or a waiver, Mental Health or SUD providers that participate in a State plan or waiver, clinical psychologists, nurse practitioners providing psychiatric services, and clinical social workers
- IT Impact:
  - Behavioral Health Solution certification to CEHRT standards

And to Conclude: The Reg Stackup

The Reg Stack up – Hospital and Physician



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