CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

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Official CMS news from the Medicare Learning Network®

SPECIAL EDITION

Tuesday, August 4, 2020

News

News

Trump Administration Proposes to Expand Telehealth Benefits Permanently for Medicare Beneficiaries Beyond the COVID-19 Public Health Emergency and Advances Access to Care in Rural Areas

CMS is proposing changes to expand telehealth permanently, consistent with the Executive Order on Improving Rural and Telehealth Access that President Trump signed. The Executive Order and proposed rule advance our efforts to improve access and convenience of care for Medicare beneficiaries, particularly those living in rural areas. Additionally, the proposed rule implements a multi-year effort to reduce clinician burden under our Patients Over Paperwork initiative and to ensure appropriate reimbursement for time spent with patients. This proposed rule also takes steps to implement President Trump's Executive Order on Protecting and Improving Medicare for our Nation's Seniors and continues our commitment to ensure that the Medicare program is sustainable for future generations.

Expanding Beneficiary Access to Care through Telehealth:

Over the last three years, as part of the Fostering Innovation and Rethinking Rural Health strategic initiatives, CMS has been working to modernize Medicare by unleashing private sector innovations and improve beneficiary access to services furnished via telecommunications technology. Starting in 2019, Medicare began paying for virtual check-ins, meaning patients across the country can briefly connect with doctors by phone or video chat to see whether they need to come in for a visit. In response to the COVID-19 pandemic, CMS moved swiftly to significantly expand payment for telehealth services and implement other flexibilities so that Medicare beneficiaries living in all areas of the country can get convenient and high-quality care from the comfort of their home while avoiding unnecessary exposure to the virus. Before the Public Health Emergency (PHE), only 14,000 beneficiaries received a Medicare telehealth service in a week, while over 10.1 million beneficiaries have received a Medicare telehealth service during the PHE from mid-March through early-July. For more information on Medicare's unprecedented increases in telemedicine and its impact on the health care delivery system, visit the CMS Health Affairs blog.

As directed by President Trump's Executive Order on Improving Rural and Telehealth Access, through this rule, CMS is taking steps to extend the availability of certain telemedicine services after the PHE ends, giving Medicare beneficiaries more convenient ways to access health care particularly in rural areas where access to health care providers may otherwise be limited.

“Telemedicine can never fully replace in-person care, but it can complement and enhance in-person care by furnishing one more powerful clinical tool to increase access and choices for Americas seniors,” said CMS Administrator Seema Verma. “The Trump Administration’s unprecedented expansion of telemedicine during the pandemic represents a revolution in health care delivery, one to which the health care system has adapted quickly and effectively. Never one merely to tinker around the edges when it comes to patient-centered care, President Trump will not let this opportunity slip through our fingers.”

During the PHE, CMS added 135 services such as emergency department visits, initial inpatient and nursing facility visits, and discharge day management services that could be paid when delivered by telehealth. CMS is proposing to permanently allow some of those services to be done by telehealth, including home visits for the evaluation and management of a patient (in the case where the law allows telehealth services in the patient’s home) and certain types of visits for patients with cognitive impairments. CMS is seeking public input on other services to permanently add to the telehealth list beyond the PHE in order to give clinicians and patients time as they get ready to provide in-person care again. CMS is also proposing to temporarily extend payment for other telehealth services, such as emergency department visits for a specific time period, through the calendar year in which the PHE ends. This will also give the community time to consider whether these services should be delivered permanently through telehealth outside of the PHE.

Prioritizing Investment in Preventive Care and Chronic Disease Management:

Under our Patients Over Paperwork initiative, the Trump Administration has taken steps to eliminate burdensome billing and coding requirements for Evaluation and Management (E/M) (for office/outpatient visits) that make up 20 percent of the spending under the Physician Fee Schedule. These billing and documentation requirements for E/M codes were established 20 years ago and have been subject to longstanding criticism from clinicians that they do not reflect current care practices and needs. After extensive stakeholder collaboration with the American Medical Association and others, simplified coding and billing requirements for E/M visits will go into effect January 1, 2021, saving clinicians 2.3 million hours per year in burden reduction. As a result of this change, clinicians will be able to make better use of their time and restore the doctor-patient relationship by spending less time on documenting visits and more time on treating their patients.

Additionally, last year, the Trump Administration finalized historic changes to increase payment rates for office/outpatient E/M visits beginning in 2021. The higher payment for E/M visits takes into account the changes in the practice of medicine, recognizing that additional resources are required of clinicians to take care of their Medicare patients, of which two-thirds have multiple chronic conditions. The prevalence of certain chronic conditions in the Medicare population is growing. For example, as of 2018, 68.9% of beneficiaries have 2 or more chronic conditions. In addition, between 2014 and 2018, the percent of beneficiaries with 6 or more chronic conditions has grown from 14.3% to 17.7%.

In this rule, CMS is proposing to similarly increase the value of many services that are comparable to or include office/outpatient E/M visits, such as maternity care bundles, emergency department visits, end-stage renal disease capitated payment bundles, physical and occupational therapy evaluation services, and others. The proposed adjustments, which implement recommendations from the American Medical Association, help to ensure that CMS is appropriately recognizing the kind of care where clinicians need to spend more face-to-face time with patients, like primary care and complex or chronic disease management.

Bolstering the Health Care Workforce/Patients Over Paperwork:

CMS is also taking steps to ensure that health care professionals can practice at the top of their professional training. During the COVID-19 public health emergency, CMS announced several temporary changes to expand workforce capacity and reduce clinician burden so that staffing levels remain high in response to the pandemic. As part of its Patients over Paperwork initiative to reduce regulatory burden for providers, CMS is proposing to make some of these temporary changes permanent following the PHE. Such proposed changes include:

- Nurse practitioners, clinical nurse specialists, physician assistants, and certified nurse-midwives (instead of only physicians) to supervise others performing diagnostic tests consistent with state law and licensure, providing that they maintain the required relationships with supervising/collaborating physicians as required by state law

- Clarifying that pharmacists can provide services as part of the professional services of a practitioner who bills Medicare
- Allowing physical and occupational therapy assistants (instead of only physical and occupational therapists) to provide maintenance therapy in outpatient settings
- Allowing physical or occupational therapists, speech-language pathologists, and other clinicians who directly bill Medicare to review and verify (sign and date), rather than re-document, information already entered by other members of the clinical team into a patient's medical record

For More Information:

- CY 2021 Physician Fee Schedule and Quality Payment Program Proposed Rule: Public comments are due by October 5, 2020.
- CY 2021 Physician Fee Schedule Proposed Rule Fact Sheet
- CY 2021 Quality Payment Program Proposed Rule Fact Sheet
- Medicare Diabetes Prevention Program Fact Sheet

Trump Administration Proposes Policies to Provide Seniors with More Choices and Lower Costs for Surgeries

Outpatient Prospective Payment System (OPPS) & Ambulatory Surgical Center (ASC) proposed rule advances CMS' commitment to increasing competition

As directed by President Trump's Executive Order on Protecting and Improving Medicare for Our Nation's Seniors, CMS is proposing several policies that would give Medicare beneficiaries more choices in where they seek care and lower their out-of-pocket costs for surgeries. The proposed rule takes steps that would allow hospitals and ambulatory surgical centers to operate with better flexibility and patients to have what they need to make informed decisions on where they receive care.

"President Trump's mandate is to put patients and doctors back in charge of health care," said CMS Administrator Seema Verma. "Following through on that mandate entails loosening the stranglehold of government control that has accumulated over decades. Surgeries can be expensive. Patients should have as many options as possible for lowering their costs while getting quality care. These proposed changes, if finalized, would do exactly that, help put patients and doctors back in the driver's seat and in a position to make decisions about their own care."

For patients having surgery, hospital outpatient departments are subject to the same quality and safety standards as inpatient settings under Medicare rules. With this in mind, for 2021, CMS proposes to expand the number of procedures that Medicare would pay for in the hospital outpatient setting by eliminating the "Inpatient Only list," which includes procedures for which Medicare will only make payment when performed in the hospital inpatient setting. This proposed change would remove regulatory barriers to give beneficiaries the choice to receive these services in a lower cost setting and convenience to go home as early as the same day after a procedure, when their clinician decides such a setting is appropriate. CMS would phase-in this proposal over three years and would gradually allow over 1,700 additional services to be paid when furnished in the hospital outpatient setting. In 2021, approximately 300 musculoskeletal services (such as certain joint replacement procedures) would be newly payable in the hospital outpatient setting. The proposed change would be the largest one-time reduction to the Inpatient Only list by far; from 2017 through 2020, approximately 30 services total were removed from the Inpatient Only list.

Medicare pays for most services furnished in ASCs at a lower rate than hospital outpatient departments. As a result, when receiving care in an ASC rather than a hospital outpatient department, patients can potentially lower their out-of-pocket costs for certain services. For example, for one of the most common cataract surgeries, currently, on average, a Medicare beneficiary pays $101 if the procedure is done in a hospital outpatient department compared to $51 if done in a surgery center.

CMS proposes to expand the number of procedures that Medicare would pay for when performed in an ASC, which would give patients more choices in where they receive care and ensure CMS does not favor one type of care setting over another. For CY 2021, we propose to add eleven procedures that Medicare would pay for

when provided in an ASC, including total hip arthroplasty. Since 2018, CMS has added 28 procedures to the list of surgical services that can be paid under Medicare when performed in ASCs.

Additionally, we propose two alternatives that would further expand our goals of increasing access to care at a lower cost. Under the first alternative, CMS would establish a process where the public could nominate additional services that could be performed in ASCs based on certain quality and safety parameters. Under the other proposed alternative, we would revise the criteria used to determine the procedures that Medicare would pay for in an ASC, potentially adding approximately 270 procedures that are already payable when performed in the hospital outpatient setting to the ASC list. Under this alternative, we solicit comment on whether the ASC conditions for coverage (the baseline health and safety requirements for Medicare-participating ASCs) should be revised given the potential for a significant expansion in the nature of services that would be added under this alternative proposal.

As part of the Trump Administration's commitment to lowering drug prices, CMS is proposing a change that would lower beneficiaries' out-of-pocket drug costs for certain hospital outpatient drugs. In 2018 and 2019, CMS implemented a payment policy to help beneficiaries save on coinsurance for drugs that were administered at hospital outpatient departments and acquired through the 340B program, which allows certain hospitals to buy outpatient drugs at lower costs. Due to CMS' policy change, which was recently upheld by the United States Court of Appeals for the D.C Circuit, Medicare beneficiaries now benefit from the steep discounts that 340B-enrolled hospitals receive when they purchase drugs through the 340B program.

For 2021, CMS would provide even larger discounts for beneficiaries by proposing to further reduce the payment rate for drugs purchased through the 340B Program based on hospital survey data on drug acquisition costs. CMS is proposing to pay for 340B acquired drugs at average sales price minus 28.7 percent. With this proposed change, CMS estimates that, in 2021, Medicare beneficiaries would save an additional $85 million on out-of-pocket payments for these drugs and that OPPS payments for 340B drugs would be reduced by approximately $427 million. The savings from this change would be reallocated on an equal percentage basis to all hospitals paid under the OPPS. We propose that children's hospitals, certain cancer hospitals, and rural sole community hospitals would continue be excepted from these drug payment reductions. In the alternative, and in light of the court's recent decision, we propose to continue our current policy of paying ASP minus 22.5% for 340B drugs.

In continuing the agency's Patients Over Paperwork Initiative to reduce burden for health care providers, CMS is proposing to establish, update, and simplify the methodology to calculate the Overall Hospital Quality Star Rating (Overall Star Rating) beginning with CY 2021. The Overall Star Rating summarizes a variety of quality measures published on the Medicare.gov Hospital Compare tool for common conditions that hospitals treat, such as heart attacks or pneumonia. Along with publicly reported data on Hospital Compare, the Overall Star Rating helps patients make better informed health care decisions.

Responding to stakeholder feedback about the current methodology used to calculate the Overall Star Rating, CMS is proposing revisions on how to calculate the ratings and grouping hospitals in the Readmission measure group by the hospital's percentage of patients who are dually enrolled in Medicare and Medicaid, which would help provide better insight on health disparities. These and other proposed changes are intended to reduce provider burden, improve the predictability of the star ratings, and make it easier to compare ratings between similar hospitals.

As part of the agency's Rethinking Rural Health Initiative, in the FY 2020 Inpatient Prospective Payment System (IPPS) final rule, CMS increased the wage index for certain low wage index hospitals for at least four years, beginning in FY 2020. In the CY 2020 OPPS/ASC Payment System final rule, CMS adopted changes to the wage index for outpatient hospitals as were finalized in the FY 2020 IPPS final rule, including the increase in wage index for certain low wage index hospitals. The OPPS wage index adjusts hospital outpatient payment rates to account for local differences in wages that hospitals face in their respective labor markets. For 2021, under the OPPS, CMS proposes to continue to adopt the IPPS post-reclassified wage index, including the wage index increase for certain low wage index hospitals. The increase would address a common concern that the current wage index system contributes to disparities between high and low wage index hospitals. Overall, CMS estimates that payment for outpatient services in rural hospitals across the country would increase by 3 percent, which is 0.5 percent higher than the national average increase of 2.5 percent.

For More Information:

- Proposed Rule
- Fact Sheet

CMS Updates Medicare Payment Policies for IRFs

On August 4, CMS finalized a Medicare payment rule that further advances our efforts to strengthen the Medicare program by better aligning payments for Inpatient Rehabilitation Facilities (IRFs). The final rule updates Medicare payment policies and rates for facilities under the IRF Prospective Payment System (PPS) for FY 2021. This final rule also includes making permanent the regulatory change to eliminate the requirement for physicians to conduct a post admission visit since much of the information is included in the pre-admission visit. This flexibility was offered during the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE), and the rule would make this flexibility permanent beyond the expiration of the PHE. In recognition of the interdisciplinary role that non-physician practitioners are currently performing with patients in the IRF, CMS is also finalizing that a non-physician practitioner may perform one of the three required visits in lieu of the physician in the second and later weeks of a patient's care when consistent with the non-physician practitioner's state scope of practice. Additionally, for FY 2021, CMS is updating the IRF PPS payment rates by 2.4 percent.

For More Information:

- Final Rule
- Fact Sheet