CMS Updates

Patricia A. Meier MD, Chief Medical Officer
Michelle Wineinger, Health Insurance Specialist
Kansas City Regional Office
Centers for Medicare & Medicaid Services

April 2019

Topics-Part I

- Patients over Paperwork
- CY 2019 Medicare Physician Fee Schedule Final Rule
- Quality Payment Program, Year 3 (2019)
- CMS Opioid Initiative Updates

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

Approach

CMS has set up an agency-wide process to evaluate and streamline our regulations and our operations with the goal to reduce unnecessary burden, increase efficiencies and improve the customer experience.

- Formal Requests for Information
- Customer Centered Work groups
- Journey Mapping
- Meaningful Measurement Framework
- Promoting Interoperability
- Engaging Stakeholders

Give Us Your Suggestions!

- Many CMS improvements were suggested by providers.
- Keep the ideas coming!

How Your Voice Can Be Heard

Send suggestions and comments to:
ReducingProviderBurden@cms.hhs.gov

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

Final Policies for E/M Visits Starting in 2019

For 2019 and beyond, CMS finalized the following optional but broadly supported documentation changes for E/M visits, that do not require changes in coding/ payment.

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit;
- For history and exam for established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed.

Final Policies for E/M Visits Starting in 2019 (cont.)

- Additionally, we are clarifying that for chief complaint and history for new and established patient office/outpatient visits, practitioners need not re-enter in the medical record information that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information.

Policies for E/M Office/Outpatient Visits Starting in 2021

- Beginning in CY 2021, CMS will implement payment, coding, and additional documentation changes for E/M office/ outpatient visits, specifically:
  - Single rates for levels 2 through 4 for established and new patients, maintaining the payment rates for E/M office/outpatient visit level 5 in order to better account for the care and needs of complex patients;
  - Add-on codes for level 2 through 4 visits that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care

Policies for E/M Office/Outpatient Visits Starting in 2021 (cont.)

- A new “extended visit” add-on code for level 2 through 4 visits to account for the additional resources required when practitioners need to spend additional time with patients.
- For level 2 through 5 visits, choice to document using the current framework, MDM or time;
  - When time is used to document, practitioners will document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary (typical CPT time for code reported, plus any extended/prolonged time).
  - When using current framework or MDM to document, for level 2 through 4 visits CMS will only require the supporting documentation currently associated with level 2 visits.

E&M Payment Amounts

		Current (2018) Payment Amount	Revised Payment Amount***				
	Complexity Level under CPT	***Visit Code Alone****	***Visit Code Alone Payment***	***Visit Code With Either Primary or specialized care add-on code*** **	***Visit Code with New Extended Services Code (Minutes Required to Bill)***	***Visit with Both Add-on and Extended Services Code Added*** **	***Current Prolonged Code Added (Minutes Required to Bill)****
New Patient	Level 2	$76	$130	$143	$197 (at 38 minutes)	$210	
	Level 3	$110					
	Level 4	$167					
	Level 5	$211	$211				$344 (at 90 minutes)
Established Patient	Level 2	$45	$90	$103	$157 (at 34 minutes)	$170	
	Level 3	$74					
	Level 4	$109					
	Level 5	$148	$148				$281 (at 70 minutes)

*This is not a new code. The current prolonged service code, describing 60 minutes of additional time but billable after 31 minutes of additional time, is only billed approximately once per one thousand visit codes reported. It is paid at approximately $133.
Physician groups have routinely complained to CMS that billing prolonged with any regularity tends to prompt medical review and is ultimately cost-prohibitive.
**In cases where one could bill both the primary and specialized care add-on, there would be an additional $13.

***The dollar amounts included in this projection are based on 2019 payment rates; actual amounts in 2021 when the policy takes effect will differ.

Quality Payment
PROGRAM

QUALITY PAYMENT PROGRAM YEAR 3 (KEY CHANGES)

2017 QPP Experience Report

Participation Results

TABLE 1 Overall Participation Rate of MIPS Eligible Clinicians

Total MIPS Eligible Clinicians in 2017	1,057,824
Number of MIPS Eligible Clinicians that Participated in 2017	1,006,319
Participation Rate	95%

NOTE Table 1 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS. Additionally, "participated" is defined as the total number of MIPS eligible clinicians who received at least 3 points (which was the MIPS performance threshold in 2017) and avoided a negative payment adjustment.

Key Insights

- A total of 1,057,824 clinicians were eligible for MIPS in 2017
- 1,006,319 or 95 percent of MIPS eligible clinicians participated in 2017 and avoided a negative payment adjustment

2017 QPP Experience Report

Participation Results

TABLE 2 Overall Participation Count by Reporting Entity

Total MIPS Eligible Clinicians in 2017	1,057,824
Individual Participation	122,897
Group Participation	542,202
MIPS APM Participation	341,220

NOTE Table 2 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS. Participants are counted once based on the submission method used for the clinician's final score.

Key Insights

- Group reporting was the preferred option for participating in the Quality Payment Program
- Significant participation in MIPS through APMs

2017 QPP Experience Report

Participation Results

TABLE 4 Participation Rates for Small and Rural Eligible Clinicians

Small or Rural	Total MIPS Eligible Clinicians	MIPS Eligible Clinicians that Participated	Participation Rate
Small	229,106	186,428	81%
Rural	164,598	155,309	94%

NOTE Table 4 excludes clinicians who were Qualifying APM Participants (QPs) in an Advanced APM as well as Partial QPs who did not elect to participate in MIPS. Small practices are defined as having 15 or fewer clinicians (NPIs billing under the same TIN). A rural practice is one where the TIN has at least one practice site in a zip code designated as a rural area.

Key Insights

- MIPS eligible clinicians in rural practices had a participation rate of 94 percent, which was virtually equal to the overall average
- Illustrates that no matter the location, clinicians want to meaningfully engage and participate in the program

MIPS Year 3 (2019) Final

MIPS Eligible Clinician Types

Year 2 (2018) Final

MIPS eligible clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Registered Nurse Anesthetists
- Groups of such clinicians

Year 3 (2019) Final

MIPS eligible clinicians include:

- Same five clinician types from Year 2 (2018)

AND:

- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Speech-Language Pathologists*
- Audiologists*
- Registered Dieticians or Nutrition Professionals*

**We modified our proposals to add these additional clinician types for Year 3 as a result of the significant support we received during the comment period*

MIPS Year 3 (2019) Final

Low-Volume Threshold Criteria

What do I need to know?

1. Threshold amounts remain the same as in Year 2 (2018)

2. Added a third element – Number of Services – to the low-volume threshold determination criteria

   - The finalized criteria now includes:

     - Dollar amount - $90,000 in covered professional services under the Physician Fee Schedule (PFS)
     - Number of beneficiaries – 200 Medicare Part B beneficiaries
     - Number of services* *(New)* – 200 covered professional services under the PFS

*When we say “service”, we are equating one professional claim line with positive allowed charges to one covered professional service

MIPS Year 3 (2019) Final

Opt-in Policy

- MIPS eligible clinicians who meet or exceed at least one, but not all, of the low-volume threshold criteria may choose to participate in MIPS

MIPS Opt-in Scenarios

Dollars	Beneficiaries	Professional Services (*New*)	Eligible for Opt-in?
≤ 90K	≤ 200	≤ 200	No – excluded
≤ 90K	≤ 200	> 200	Yes (may also voluntarily report or not participate)
> 90K	≤ 200	≤ 200	Yes (may also voluntarily report or not participate)
> 90K	≤ 200	>200	Yes (may also voluntarily report or not participate)
≤ 90K	> 200	> 200	Yes (may also voluntarily report or not participate)
> 90K	> 200	> 200	No – required to participate

MIPS Year 3 (2019) Final

Performance Periods

Year 2 (2018) Final

Performance Category	Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Promoting Interoperability	90-days

Year 3 (2019) Final - *No Change*

Performance Category	Performance Period
Quality	12-months
Cost	12-months
Improvement Activities	90-days
Promoting Interoperability	90-days

MIPS Year 3 (2019) Final

Performance Category Weights

Year 2 (2018) Final

Performance Category	Performance Category Weight
Quality	50%
Cost	10%
Improvement Activities	15%
Promoting Interoperability	25%

Year 3 (2019) Final

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

MIPS Year 3 (2019) Final

Facility-based Quality and Cost Performance Measures

What is it?

- Facility-based scoring is an option for clinicians that meet certain criteria beginning with the 2019 performance period
  - CMS finalized this policy for the 2019 performance period in the 2018 Final Rule
  - Facility-based scoring allows for certain clinicians to have their Quality and Cost performance category scores based on the performance of the hospitals at which they work

MIPS Year 3 (2019) Final

Facility-based Quality and Cost Performance Measures

Applicability: Individual

- MIPS eligible clinician furnishes 75% or more of their covered professional services in inpatient hospital (Place of Service code 21), on-campus outpatient hospital (POS 22), or an emergency room (POS 23), based on claims for a period prior to the performance period

- Clinician would be required to have at least a single service billed with POS code used for inpatient hospital or emergency room

Applicability: Group

- Facility-based group would be one in which 75% or more of eligible clinicians billing under the group's TIN are eligible for facility-based measurement as individuals

MIPS Year 3 (2019) Final

Facility-based Quality and Cost Performance Measures

Attribution

- Facility-based clinician would be attributed to hospital where they provide services to most patients
- Facility-based group would be attributed to hospital where most facility-based clinicians are attributed
- If unable to identify facility with the Hospital Value-based Purchasing (VBP) score to attribute clinician's performance, that clinician would not be eligible for facility-based measurement and would have to participate in MIPS via other methods

Election

- Automatically apply facility-based measurement to MIPS eligible clinicians and groups who are eligible for facility-based measurement and who would benefit by having a higher combined Quality and Cost score
- No submission requirements for individual clinicians in facility-based measurement, but a group would need to submit data for the Improvement Activities or Promoting Interoperability performance categories in order to be measured as a facility-based group

MIPS Year 3 (2019) Final

Facility-based Quality and Cost Performance Measures

Measurement

- For facility-based measurement, the measure set for the fiscal year Hospital VBP Program that begins during the applicable MIPS performance period would be used for facility-based clinicians

- Example: For the 2019 MIPS performance period (Year 3), the measures used would be those for the 2020 Hospital VBP Program along with the associated benchmarks and performance periods

Benchmarks

- Benchmarks for facility-based measurement are those that are adopted under the hospital VBP Program of the facility for the year specified

MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category

Basics:

- 25% of Final Score in 2019
- Must use 2015 Edition Certified EHR Technology (CEHRT) in 2019
- New performance-based scoring
- 100 total category points

Objectives and Measures

Year 2 (2018) Final	Year 3 (2019) Final
• Two measure set options for reporting based on the MIPS eligible clinician's edition of CEHRT (either 2014 or 2015)	• One set of Objectives and Measures based on 2015 Edition CEHRT • Four Objectives: e-Prescribing, Health Information Exchange, Provider to Patient Exchange, and Public Health and Clinical Data Exchange • Added two new measures to the e-Prescribing Objective: Query of Prescription Drug Monitoring Program (PDMP) and Verify Opioid Treatment Agreement

MIPS Year 3 (2019) Final

Promoting Interoperability Performance Category – Point Value

Objectives	Measures	Maximum Points
e-Prescribing	• e-Prescribing	• 10 points
	• Query of Prescription Drug Monitoring Program (PDMP) (new)	• 5 bonus points
	• Verify Opioid Treatment Agreement (new)	• 5 bonus points
Health Information Exchange	• Support Electronic Referral Loops by Sending Health Information (formerly Send a Summary of Care)	• 20 points
	• Support Electronic Referral Loops by Receiving and Incorporating Health Information (new)	• 20 points
Provider to Patient Exchange	• Provide Patients Electronic Access to their Health Information (formerly Provide Patient Access)	• 40 points
Public Health and Clinical Data Exchange	• Immunization Registry Reporting • Electronic Case Reporting • Public Health Registry Reporting • Clinical Data Registry Reporting • Syndromic Surveillance Reporting	• 10 points

MIPS Year 3 (2019) Final

Performance Threshold and Payment Adjustments

Year 2 (2018) Final

Final Score 2018	Payment Adjustment 2020
≥70 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance —minimum of additional 0.5%
15.01-69.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
15 points	• Neutral payment adjustment
3.76-14.99	• Negative payment adjustment greater than -5% and less than 0%
0-3.75 points	• Negative payment adjustment of -5%

Year 3 (2019) Final

Final Score 2019	Payment Adjustment 2021
≥75 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance —minimum of additional 0.5%
30.01-74.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
30 points	• Neutral payment adjustment
7.51-29.99	• Negative payment adjustment greater than -7% and less than 0%
0-7.5 points	• Negative payment adjustment of -7%

Technical Assistance

Available Resources

CMS has free resources and organizations on the ground to provide help to clinicians who are participating in the Quality Payment Program:

PRIMARY CARE & SPECIALIST PHYSICIANS

Transforming Clinical Practice Initiative

- Supports more than 140,000 clinician practices through active, collaborative and peer-based learning networks over 4 years.
- **Practice Transformation Networks (PTNs) and Support Alignment Networks (SANs)** are located in all 50 states to provide comprehensive technical assistance, as well as tools, data, and resources to improve quality of care and reduce costs.
- The goal is to help practices transform over time and move toward Advanced Alternative Payment Models.
- Contact TCPI.ISC@TruvenHealth.com for extra assistance.

Locate the PTN(s) and SAN(s) in your state

SMALL & SOLO PRACTICES

Small, Underserved, and Rural Support (SURS)

- Provides outreach, guidance, and direct technical assistance to clinicians in **solo or small practices (15 or fewer), particularly those in rural and underserved areas**, to promote successful health IT adoption, optimization, and delivery system reform activities.
  - Assistance will be tailored to the needs of the clinicians.
  - There are 11 SURS organizations providing assistance to small practices in all 50 states, the District of Columbia, Puerto Rico, and the Virgin Islands.
  - For more information or for assistance getting connected, contact QPPSURS@IMPAQINT.COM.

LARGE PRACTICES

Quality Innovation Networks-Quality Improvement Organizations (QIN-QIO)

- Supports clinicians in **large practices (more than 15 clinicians)** in meeting Merit- Based Incentive Payment System requirements through customized technical assistance.
- Includes one-on-one assistance when needed.
- There are 14 QIN-QIOs that serve all 50 states, the District of Columbia, Guam, Puerto Rico, and Virgin Islands.

Locate the QIN-QIO that serves your state

Quality Innovation Network (QIN) Directory

TECHNICAL SUPPORT

All Eligible Clinicians Are Supported By:

Quality Payment Program Website: qpp.cms.gov
Serves as a starting point for information on the Quality Payment Program.

Quality Payment Program Service Center
Assists with all Quality Payment Program questions.
1-866-288-8292 TTY: 1-877-715-6222 QPP@cms.hhs.gov

Center for Medicare & Medicaid Innovation (CMMI) Learning Systems
Helps clinicians share best practices for success, and move through stages of transformation to successful participation in APMs. More information about the Learning Systems is available through your model's support inbox.

Learn more about technical assistance: https://qpp.cms.gov/about/help-and-support#technical-assistance

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

New Medicare Part D Prescription Opioid Policies for 2019

Information for Prescribers

Background

- CMS finalized new policies for Medicare drug plans to follow starting on January 1, 2019.
- These policies involve further partnership with providers and prescription drug plans.
- Providers are in the best position to identify and manage potential opioid overutilization in the Medicare Part D population.

Opioid Policy Summary

- The new policies include (1) improved **safety edits** when opioid prescriptions are dispensed at the pharmacy and (2) **drug management programs** for patients determined to be at-risk for misuse or abuse of opioids or other frequently abused drugs.

- CMS tailored its approach to help distinct populations of Medicare Part D opioid users:
  - New opioid users (opioid naïve),
  - Chronic opioid users,
  - Users with potentially problematic concurrent medication use, and
  - High risk opioid users.

Opioid Policy Exclusions

- The policies are not “one size fits all”.

- Residents of long-term care facilities, those in hospice care, patients receiving palliative or end-of-life care, and patients being treated for active cancer-related pain are exempt from these interventions.

- These policies also should not impact patients’ access to medication-assisted treatment (MAT), such as buprenorphine.

Myth #1

MYTH:

"Medicare is requiring that all patients fill opioid prescriptions for a 7 days supply at a time."

FACT:

- A fill for a prescription opioid will be limited to a 7 days supply only for Medicare Part D patients who have not filled an opioid prescription recently (such as within the past 60 days).
- This does not apply to patients already taking opioids.

Myth #2

MYTH

"Medicare is forcing all patients to taper their prescription opioids below a certain amount."

FACT:

- Decisions to taper or stop prescription opioids must be carefully considered and are individualized between the patient and prescriber.
- Tapering opioids can be especially challenging in established patients who have been on high dosages of opioids for many years.
- Policies seek to address opioid overuse without negative impact on patient-doctor relationship.

Myth #3

MYTH:

"There is nothing I can do to help my patients who need more opioids."

FACT:

- If patient is subject to an opioid safety edit at the pharmacy, and the pharmacy can't fill the prescription as written, the prescriber can contact the plan to ask for a coverage determination on their behalf.
- Prescriber can also request an expedited or standard coverage determination in advance of prescribing an opioid.
- Prescriber only needs to attest to the plan that the cumulative level or days supply is the intended and medically necessary amount.

1. Opioid Safety Alerts

- CMS expects Medicare Part D drug plans to implement the following safety alerts (pharmacy claim edits) for pharmacists to review when an opioid prescription is filled at the pharmacy:

  - Seven-day supply limit for initial opioid fills for opioid naïve patients (hard edit),
  - Care coordination edit at 90 morphine milligram equivalents (MME) (soft edit with pharmacist-prescriber consultation),
  - Concurrent opioid and benzodiazepine use (soft edit),
  - Duplicative long-acting (LA) opioid therapy (soft edit), and
  - Optional safety alert at 200 MME or more (hard edit).

Opioid Naïve Seven-day Supply Limit

- Medicare Part D patients who have not filled an opioid prescription recently (such as within the past 60 days) will be limited to a supply of 7 days or less.
- *This alert should not impact patients who already take opioids.*
- Pharmacists can dispense partial quantities of an opioid prescription consistent with state and federal regulations.
- Limiting the amount dispensed with the first opioid prescription may reduce the risk of patients developing a future dependency or overuse of these drugs.

Opioid Naïve Seven-day Supply Limit

Prescriber Actions

- When the alert is triggered, the opioid naïve patient may receive up to a 7 days supply.

- If a prescriber assesses upon re-evaluation that a patient will need additional opioid therapy, subsequent prescriptions will not be subject to the 7 days supply limit, as the patient will no longer be considered opioid naive.

Opioid Naïve Seven-day Supply Limit

Prescriber Actions

- If patient needs the full days supply initially, the patient or prescriber on the patient's behalf has the right to request a coverage determination, including the right to request an expedited or standard coverage determination in advance of prescribing an opioid (for example, for a surgical procedure).

- Prescriber only needs to attest to plan that the days supply is the intended and medically necessary amount.

Care Coordination Alert

- This alert will be triggered at the pharmacy when a Medicare Part D patient presents an opioid prescription at the pharmacy and their cumulative morphine milligram equivalent (MME) per day across all of their opioid prescription(s) reaches or exceeds 90 MME.

- Some plans use this alert only when the patient uses multiple opioid prescribers and/or opioid dispensing pharmacies.

- The pharmacist will consult with the prescriber to resolve the alert. This may be an opportunity for pharmacists to inform the prescriber of other opioid prescribers or increasing level (MME) of opioids.

Care Coordination Alert

Prescriber Actions

- ***This alert is not a prescribing limit.*** Decisions to taper or discontinue prescription opioids are individualized and agreed upon between the patient and prescriber.

- Regardless of whether individual prescription(s) are written below the threshold, the alert will be triggered by the fill of the prescription that reaches the cumulative threshold of 90 MME or greater.

- CMS encourages prescribers to respond to pharmacists' outreach in a timely manner.

Care Coordination Alert

Prescriber Actions

- Once a pharmacist consults with a prescriber on a patient's prescription for a plan year, the prescriber will not be contacted on every opioid prescription written for the same patient after that unless the plan implements further restrictions.

- If the prescription cannot be filled at the pharmacy, the patient or the prescriber on the patient's behalf has the right to request a coverage determination for a drug(s), including the right to request an expedited or standard coverage determination in advance of prescribing an opioid.

Additional Opioid Safety Alerts

- Other soft edits will trigger when the patient is taking opioids and benzodiazepines concurrently or is taking multiple duplicate long-acting opioids.

- The pharmacist will conduct additional safety reviews to determine if the patient's opioid use is safe and clinically appropriate. The prescriber may be contacted.

Optional Safety Alert at 200 MME or Higher

- Some plans may implement a hard safety alert when a patient's cumulative opioid daily dosage reaches 200 MME or more.

- Some plans use this alert only when the patient uses multiple opioid prescribers and/or opioid dispensing pharmacies.

- ***This is not a prescribing limit.*** Decisions to taper or discontinue prescription opioids are between the patient and prescriber.

Optional Safety Alert at 200 MME or Higher

Prescriber Actions

- On the patient's behalf, the physician or other prescriber has the right to request a coverage determination for the drug(s), including the right to request an expedited or standard coverage determination in advance of prescribing an opioid.

- In the absence of other submitted and approved utilization management requirements, the plan should allow the patient to access his/her medication(s) once the prescriber(s) attests that the identified cumulative MME level is the intended and medically necessary amount for the patient.

Coverage Determination Request Reminders

- In the case of one of the opioid safety alerts, if the prescription cannot be filled as written, the pharmacist should provide the patient with a written copy of the standardized CMS pharmacy notice, "Medicare Prescription Drug Coverage and Your Rights."

- On the patient's behalf, the physician or other prescriber has the right to request a coverage determination for a drug(s) subject to the alert, including the right to request an expedited or standard coverage determination in advance of prescribing an opioid (for example, for a surgical procedure).

- The timeframe for an expedited coverage determination request applies when the prescriber indicates, or the plan decides, that applying the standard timeframe may seriously jeopardize the enrollee's life, health, or ability to regain maximum function.

Preparing for New 2019 Opioid Policies

- Providers may want to discuss the risks of an accidental overdose or having an adverse reaction to opioids with patients since these risks are not necessarily associated with misuse.

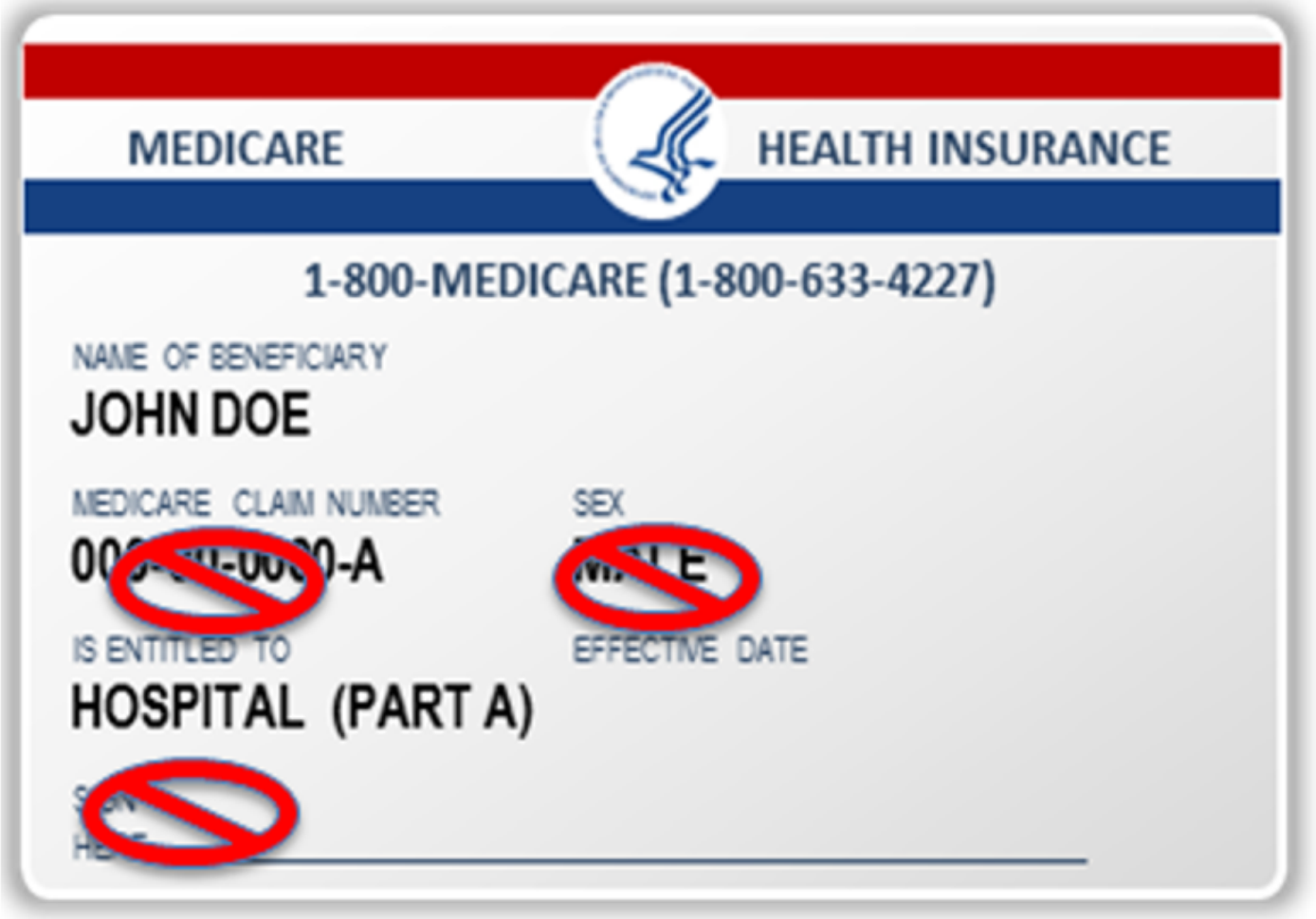
- As the new opioid safety alerts are implemented in 2019, on-going communication among the pharmacist, the Medicare drug plan, and the prescriber will be critical.

- Actions that prescribers may want to consider taking include:
  - Responding to pharmacists' or plan sponsors' telephone calls or case management notices in a timely manner.
  - Initiating coverage determinations when clinically appropriate and, where possible, proactively in advance of prescribing an opioid if the prescriber has assessed that the patient will need the full quantity written (e.g. a plan may not be aware a patient is exempt based on a new exclusion such as cancer).
  - Give appropriate training to on-call prescribers when necessary.

Topics-Part II

- New Medicare Card
- DMEPOS Competitive Bidding Program
- Medicare Diabetes Prevention Program (MDPP)
- Interoperability of Electronic Health Information
- Rural Health

New Medicare Card



DMEPOS Competitive Bidding

- Temporary delay in moving forward with next steps of Round 2019 DMEPOS Competitive Bidding Program

- Beginning January 1, 2019 until new contracts are awarded, people with Medicare can go to any Medicare enrolled supplier (only for items furnished beginning 1/1/2019)

Medicare Diabetes Prevention Program (MDPP)

- 25 percent of Americans 65 years and older are living with type-2 diabetes, which costs Medicare $104 billion annually, and growing
- MDPP is a preventive service to respond to this trend
  - Health behavior change sessions promoting weight loss through healthy eating and physical activity
- Can be covered under Parts B and/or C
- Supplier enrollment began in January 2018 and MDPP suppliers could begin supplying services and billing Medicare starting April 1, 2018

Medicare Diabetes Prevention Program (MDPP)

Months 0-6 Core Sessions	Months 7-12 Core Maintenance Sessions	Months 13-24 Ongoing Maintenance Sessions
A minimum of 16 sessions offered at least a week apart during the first 6 months	A minimum of 6 monthly sessions during the second 6 months of core sessions	Monthly sessions for an additional 12 months
		Eligible beneficiaries have coverage for 3 month intervals of monthly maintenance sessions for 1 year
Available to eligible beneficiaries regardless of weight loss and attendance		Available to eligible beneficiaries who achieve and maintain weight loss and attendance goals
A CDC-approved curriculum is used to guide sessions		
In-person and virtual make-up sessions are available and must meet specific requirements		

Medicare Diabetes Prevention Program (MDPP)

- Beneficiary Eligibility Requirements:
  - Enrolled in Medicare Part B or Part C
  - BMI of at least 25 (23 if self-identified as Asian) on the date of the first core session
  - Meet 1 of 3 blood test requirements within the 12 months prior to attending the first core session:
    1. A hemoglobin A1c test with a value between 5.7% and 6.4%, or
    2. A fasting plasma glucose of 110-125 mg/dL, or
    3. A 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerance test)
  - No previous diagnosis of diabetes prior to the date of the first core session (with the exception of gestational diabetes)
  - Does not have ESRD
  - Has not previously received MDPP services

Medicare Diabetes Prevention Program (MDPP)

- Medicare Payments:
  - Beneficiary is eligible
  - Supplier meets all program/Medicare requirements
  - Sessions are furnished by an eligible coach
  - Weight loss measurements are taken in-person at an MDPP session
  - Beneficiary meets attendance and/or weight loss goals

Interoperability of Electronic Health Information

- Proposed Rule issue February 11, 2019
- Supports MyHealthEData Initiative
- Two Requests for Information (RFIs)
- Visit www.federalregister.gov and select “Public Inspection” to view document 2019-04270
- Comments due no later than 5:00 EST on May 6, 2019

Rural Provider Outreach

From Here

To Here

Resources

New Medicare Card
www.cms.gov/Medicare/New-Medicare-Card/

Medicare Diabetes Prevention Program
https://innovation.cms.gov/initiatives/medicare-diabetes-prevention-program/

Interoperability Proposed Rule
https://www.cms.gov/newsroom/fact-sheets/cms-advances-interoperability-patient-access-health-data-through-new-proposals

Rural Health
https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/rural-health/index.html

Medicare Learning Network
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNGenInfo/Index.html

Contact Info

Michelle Wineinger
Health Insurance Specialist
Rural Health Coordinator
Centers for Medicare & Medicaid Services
Kansas City Regional Office
michelle.wineinger@cms.hhs.gov

Questions

patricia.meier@cms.hhs.gov