Helping states develop integrated programs for individuals who are dually eligible for Medicare and Medicaid

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Spotlight: Final CMS Changes to Medicare Physician Payment and Opioid Use Disorder Benefits for Calendar Year 2020 Could Have Implications for State Medicaid Programs

The Centers for Medicare & Medicaid Services (CMS) issued a final rule in the November 15, 2019 Federal Register that updates policies for services furnished under the Medicare Physician Fee Schedule and for Opioid Use Disorder (OUD) services in calendar year (CY) 2020 and thereafter.

The changes may have implications for states that:

- Cover currently, or will be covering in 2020 Medicaid services for OUD;
  - Note that the SUPPORT Act of 2018 (Public Law 115-271) requires in Section 1006(b) that state Medicaid programs must cover medication-assisted treatment (MAT) for OUD by October 2020.
- Base Medicaid physician payments on the Medicare Resource-Based Relative Value System (RBRVS);
- and/or
- Are interested in coordinating Medicare and Medicaid physician care management services and care plans for their dually eligible beneficiaries.

In addition, CMS updated requirements for the Medicaid Promoting Interoperability Program, which requires provider reporting on electronic clinical quality measures. A fact sheet on the Medicare Physician Fee Schedule final rule and a news release on changes to Medicare payment to Opioid Treatment Programs provide additional information.

Specific items of interest for states in the final rule include:

Payment for Opioid Use Disorder Treatment

The SUPPORT Act of 2018 established a new Medicare Part B benefit for OUD services, including MAT, delivered by opioid treatment programs (OTPs). Medicare will implement this benefit beginning on January 1, 2020. CMS finalized definitions for OUD and OTP, bundled payment rates, and requirements for OTPs, including Medicare enrollment policies for practitioners who are interested in providing this benefit starting on January 1, 2020. CMS also set the copayment at zero for these OTP services for 2020. For additional details on this benefit, see pp. 62630-62673 and p. 63158 of the final rule.

In addition to the services delivered by OTPs, CMS finalized coding and payment methods for a new monthly bundle of OUD treatment services provided under the Physician Fee Schedule that include overall management, care coordination, individual and group psychotherapy, and substance use counseling, as well as an add-on code for additional counseling. This bundled payment for OUD treatment is subject to cost sharing. For additional details on this benefit, see pp. 62673-62677. CMS plans to provide further guidance to states and Medicare Advantage managed care plans on the OTP benefit.

Implications for states:

- Impact of the OTP benefit on Medicaid OUD payments and the OUD service market.
  Medicare will become the primary payer beginning in 2020 for dually eligible beneficiaries who
receive OUD services from OTPs in states that provide this benefit under Medicaid. As noted in section 1006(b) of the SUPPORT Act and p. 62640 of the final rule, states are required to cover MAT through their Medicaid programs from October 1, 2020 through September 30, 2025. CMS noted that the current payer mix for OTP services includes Medicaid, private payers, TRICARE, as well as individual-pay patients, and estimates that the total Medicare and Medicaid impact of the new benefit will total $1,484,000,000 over 10 years. As noted on p. 63158, CMS did not attempt to predict the extent to which Medicare coverage of OTPs may substitute for Medicaid payments, or affect the overall market for these services.

- **Cost sharing for dually eligible beneficiaries.** CMS set the copayment at zero for OTP services for 2020. For dually eligible beneficiaries who are in the Part B deductible phase, CMS will crossover the claim to Medicaid for adjudication. States can review the final rule to determine if they use different codes than CMS for OTP services, which may impact crossover claim payment. See pp. 62661-62662 for the finalized codes.

- **Continuity of care.** CMS noted on p. 62669 that commenters expressed concern that the transition from Medicaid to Medicare as the primary payer for OTP services could cause payment disruption for OTPs that do not enroll in Medicare by January 1, 2020. CMS will issue guidance to states and OTPs on strategies to promote continuity of care for dually eligible beneficiaries. CMS noted on p. 62669 that Medicaid must pay for OUD services provided by Medicaid-enrolled OTPs that are not enrolled in Medicare.

- **Alignment with Medicare.** States that would like to expand OUD treatment options in Medicaid or align Medicaid OUD benefits with Medicare OUD policies may want to review the final codes for the OTP benefit on pp. 62661-62662 and the Physician Fee Schedule benefit on p. 62677 to assess how they might be used in Medicaid.

### Payment for Evaluation and Management (E/M) Services

- **Changes to the Medicare E/M payment system.** E/M services provided by physicians and other practitioners are divided for payment purposes into five levels based on site of service, level of complexity, and whether the patient is new or established. In August of this year, CMS proposed revisions to this system in order to correspond with recommendations from the American Medical Association Current Procedural Terminology Editorial Panel. This included changes in the CPT code definitions, times, and revised guidelines for selection of code levels for office/outpatient E/M services. The final rule adopts these proposed revisions. Specifically, the Medicare physician payment system will use Levels 1-5 for E/M services for established patients and Levels 2-4 for new patients (deleting the Level 1 new patient CPT code 99201), starting in CY 2021. In addition, CMS has revised coding details for these levels. For example, the level of medical decision making or the time a practitioner spends on a visit will now determine the visit level, rather than practitioner use of history and exam. In addition, the time ranges spent on services within each level and medical decision making criteria have been revised.

  - **Implications for states.** These changes could have implications for states that use the Medicare resource-based relative value scale (RBRVS) payment model for their Medicaid payment systems. These states may wish to consider making changes to their systems if they want to align Medicaid payment for E/M services with the revised Medicare payment system. A 2017 MACPAC report has information on which states use the RBRVS, along with state-specific details. In the 2015-2016 period covered by the MACPAC report, 23 states used the RBRVS model for Medicaid physician payment, usually with state-specific variants. For additional details on the CY 2021 E/M payment system changes, see pp. 62844-62860 of the final rule.

- **Valuation updates for E/M services.** CMS also adopted the American Medical Association’s recommendations for the valuation of office/outpatient E/M services, which will increase the payment rates for these E/M services. Because changes in physician fee schedule spending are required by statute to be budget neutral overall, these changes to the valuation of office/outpatient E/M services necessitate updated payment rates in other areas, and
will therefore lead to increased Medicare payment for some specialty types and decreased Medicare payment for other specialty types.

- **Implications for states.** States that are interested in updating their Medicaid payment systems to align with the CMS changes for Medicare can review the discussion on pp. 63154-63157 of the final rule for more details. Table 120 on pp. 63156-63157 of the final rule displays the impact of the proposed valuation changes for each specialty type.

### Changes to Medicare Care Management Services

- **Payment for Chronic Care Management and Principal Care Management services.** In 2015, CMS established Chronic Care Management (CCM) codes for beneficiaries who have two or more chronic conditions. For CY 2020, CMS is establishing a new CCM add-on code to allow providers to bill incrementally to reflect additional time and resources beyond the 20 minutes now allowed that are needed for beneficiaries with non-complex conditions. This new add-on code is discussed on pp. 62689-62690 of the final rule. The existing CCM codes are shown in Table 21 on p. 62688, and CCM services are described in Table 22 on the same page. The CCM system also includes payment for Principal Care Management (PCM) services for patients with only a single serious and high risk chronic condition. Payment for PCM services is discussed on pp. 62692-62697 of the final rule, and Table 24 on p. 62696 summarizes PCM services. States interested in encouraging coordination among providers who serve dually eligible beneficiaries, aligning Medicare and Medicaid coding and payment, and avoiding duplicative Medicare and Medicaid payments can review the CCM payment system to inform Medicaid care coordination efforts.

ICRC prepared a [technical assistance brief](#) in November 2015 that provides additional details on the implications of Medicare coverage of CCM services for states serving dually eligible beneficiaries.

- **Description of elements included in typical comprehensive care plans.** CMS discusses on pp. 62691-62692 of the final rule the elements that are typically included in a comprehensive care plan, and includes in that section some new language to simplify and clarify the description of those elements. States interested in aligning Medicaid care plan elements for dually eligible beneficiaries with those used in Medicare can review this CMS discussion.

### Updates to the Medicaid Promoting Interoperability Program

Under the Medicaid Promoting Interoperability Program, Medicaid eligible professionals (EPs) – including physicians, nurse practitioners, and dentists who meet federal eligibility criteria to receive incentive payments for implementing electronic health record technology – are required to report on electronic clinical quality measures (eCQM). CMS finalized its proposal to amend EP requirements for the CY 2020 performance period by aligning EP eCQMs with those used by the Medicare Merit-based Incentive Payment System and allowing EPs to conduct security risk analyses at any time during 2021. For additional details, see pp. 62899-62903 and pp. 63161-63162 of the final rule.

- **Implications for states.** States interested in aligning Medicaid quality measures with those used by Medicare can review CMS’ discussion for impacts to their Medicaid programs and integrated care for their dually eligible beneficiaries. CMS expects this change to reduce burden for Medicaid EPs and have a minimal impact on states through minor adjustments to state systems to maintain current eCQMs and measure specifications. CMS acknowledged that the change to EP security risk analyses could create burden for states, due to adjustments to pre-payment and post-payment verification plans and audits. State expenditures required as a result of these changes are eligible for 90 percent Federal financial participation.

For more information, see CMS’ website on [Medicaid Promoting Interoperability Program requirements](#).
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