California Association of Health Facilities, Summer Conference, San Diego, CA

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(CMS) Division of Financial Management &
Fee for Service Operations
July 17, 2019

Agenda

- Patient Driven Payment Model (PDPM) Overview;
- What PDPM Does Change;
- What PDPM Does Not Change;
- RUG-IV – PDPM Transition;
- PDPM & Medicaid;
- New Medicare Card;
- Patients Over Paperwork;
- FY 2020 Medicare Hospital IPPS & LTCH Proposed Rule & Request for Information
- Emergency Triage, Treat & Transport (ET3) Model; and
- Combatting the Opioid Epidemic.

PDPM Overview

PDPM Overview

- Issues with the current case-mix model, the Resource Utilization Group, Version IV (RUG-IV), have been identified by CMS, OIG, MedPAC, the media, among others.
  - Therapy payments under the SNF PPS are based primarily on the amount of therapy provided to a patient, regardless of the patient's unique characteristics, needs or goals.
  - SNF patients who may have significant differences in terms of nursing needs and costs often receive the same payment for nursing services.

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PDPM Overview

- The Patient Driven Payment Model (PDPM) represents a marked improvement over RUG-IV for the following reasons:
  - Improves payment accuracy and appropriateness by focusing on the patient, rather than the volume of services provided.
  - Significantly reduces administrative burden on providers.
  - Re-allocates SNF payments to currently underserved beneficiaries without increasing total Medicare payments.

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PDPM Overview

- RUG-IV consists of two case-mix adjusted components:
  - Therapy: Based on volume of services provided
  - Nursing: The nursing case-mix index does not currently reflect specific variations in non-therapy ancillary utilization.
- RUG-IV uses a constant per diem rate, meaning that the payment rate for a given RUG is the same on Day 1 and Day 100 of a patient's stay.
  - This results in too few resources at the outset of a SNF stay when costs are higher.

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PDPM Overview

- PDPM consists of five case-mix adjusted components, all based on data-driven, stakeholder-vetted patient characteristics:
  - Physical Therapy (PT)
  - Occupational Therapy (OT)
  - Speech Language Pathology (SLP)
  - Non-Therapy Ancillary (NTA)
  - Nursing
- PDPM also includes a "variable per diem adjustment" that adjusts the per diem rate over the course of the stay to better align SNF payments with not just what costs are incurred, but when they are incurred.

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PDPM Overview

PT	PT Base Rate	✖	PT CMI	✖ VPD Adjustment Factor
✚				
OT	OT Base Rate	✖	OT CMI	✖ VPD Adjustment Factor
✚				
SLP	SLP Base Rate	✖	SLP CMI	
✚				
NTA	NTA Base Rate	✖	NTA CMI	✖ VPD Adjustment Factor
✚				
Nursing	Nursing Base Rate	✖	Nursing CMI	✖ 18% Nursing Adjustment Factor (Only for Patients with AIDS)
✚				
Non-Case-Mix	Non-Case-Mix Base Rate			

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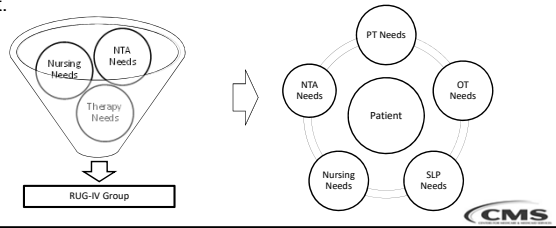
Model Snapshot

- While the RUG-IV model (left) reduces everything about a patient to a single, typically volume-driven case-mix group, PDPM (right) focuses on the unique, individualized needs, characteristics and goals of each patient.



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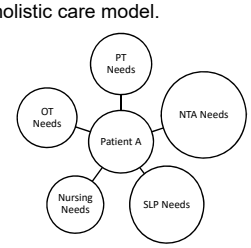
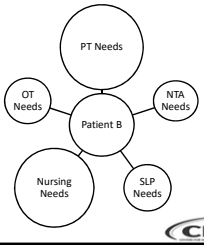
Model Snapshot

- By addressing each of a patient's unique needs independently, PDPM improves payment accuracy and encourages a more patient-driven and holistic care model.





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What PDPM Does Change

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What PDPM Does Change

- PDPM represents the single largest change to the SNF PPS since its inception, with impacts on patient classification, assessment burden, care planning and care design.
- Understanding the differences between RUG-IV and PDPM and the impact of these differences under the SNF PPS is essential to the success of the PDPM.

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What PDPM Does Change: Payment Classification Data

- While both RUG-IV and PDPM utilize the MDS as the basis for patient classification, the data elements used are quite different.
- For over 90 percent of the days billed under RUG-IV, the only two patient characteristics relevant for payment purposes are the patient's functional status and how much therapy the patient received.
  - These elements tell us very little about the actual patient and more about the services the facility furnished to the patient.

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What PDPM Does Change: Payment Classification Data

- For every day billed under PDPM, the patient characteristics relevant for payment purposes are also those relevant for care planning purposes:
  - Primary diagnosis
  - Comorbidities
  - Functional Status
  - Cognitive Status
  - Nutrition and Swallowing Needs
  - And many more.

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What PDPM Does Change: Emphasis of Care

- Under RUG-IV, SNF patients are classified as being either "therapy" patients or "non-therapy" patients.
  - This dichotomy, coupled with the payment incentives that exist under RUG-IV, has caused a significant increase in SNF patients skilled only for a single aspect of care and facilities admitting fewer medically complex patients.
- Under PDPM, all SNF patients are classified under each component of care, highlighting the importance, complexity, and unique qualities of SNF care and SNF patients.

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What PDPM Does Change: Payment/Quality Alignment

- CMS measures the quality of care provided to SNF patients in a variety of ways.
  - SNF Quality Reporting Program
  - SNF Value Based Purchasing
  - Nursing Home Compare Star Ratings
- Value driven care is, by definition, a balance between care quality and care cost.
  - High-value, efficient providers are those who are able to deliver high quality care for low cost.

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What PDPM Does Change: Payment/Quality Alignment

- Under RUG-IV, existing quality metrics are aligned, in many ways, with perverse payment incentives.
  - Example: By trying to achieve the highest possible therapy classification, a patient will receive a significant amount of therapy, thereby reducing the chance of the patient developing a worsening pressure ulcer.
- PDPM redefines the relationship between payment and quality measures, realigning payment incentives and quality incentives.

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What PDPM Does Change: PPS Assessments

- The most often criticized aspect of the SNF PPS is the array of assessments that providers are required to complete.
  - Scheduled assessments, unscheduled assessments, combining assessments…assessments, assessments, assessments.
- The complexity of the RUG-IV assessment schedule represents a significant potential financial risk for providers (i.e., default billing and provider liability), and means clinicians focusing less on direct patient care and more on meeting administrative requirements.

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What PDPM Does Change: PPS Assessments

Scheduled PPS assessments			
Medicare MDS assessment schedule type	Assessment reference date	Assessment reference date grace days	Applicable standard Medicare payment days
5-day	Days 1-5	6-8	1 through 14
14-day	Days 13-14	15-18	15 through 30
30-day	Days 27-29	30-33	31 through 60
60-day	Days 57-59	60-63	61 through 90
90-day	Days 87-89	90-93	91 through 100
Unscheduled PPS assessments			
Start of Therapy OMRA	5-7 days after the start of therapy		Date of the first day of therapy through the end of the standard payment period.
End of Therapy OMRA	1-3 days after all therapy has ended		First non-therapy day through the end of the standard payment period.
Change of Therapy OMRA	Day 7 (last day) of the COT observation period		The first day of the COT observation period until end of standard payment period, or until interrupted by the next COT-OMRA assessment or scheduled or unscheduled PPS Assessment.
Significant Change in Status Assessment	No later than 14 days after significant change identified		ARD of Assessment through the end of the standard payment period.

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What PDPM Does Change: PPS Assessments

- The PDPM assessment schedule is much more streamlined and simple, reducing the financial risk on providers and allowing clinicians to focus more time on patients and less time on paperwork.
- Assessments under PDPM also make use of more standardized data elements, such as section GG functional status items, allowing us to further reduce burden by retiring legacy data elements and improving coordination of care and communication among different provider types.

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What PDPM Does Change: PPS Assessments

Medicare MDS assessment schedule type	Assessment reference date	Applicable standard Medicare payment days
5-day Scheduled PPS Assessment	Days 1-8	All covered Part A days until Part A discharge (unless an IPA is completed).
Interim Payment Assessment (IPA)	Optional Assessment	ARD of the assessment through Part A discharge (unless another IPA assessment is completed).
PPS Discharge Assessment	PPS Discharge: Equal to the End Date of the Most Recent Medicare Stay (A2400C) or End Date	N/A.

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What PDPM Does Change: Concurrent/Group Therapy

- Under RUG-IV, no more than 25% of the therapy services delivered to SNF patients, for each discipline, may be provided in a group therapy setting, while there is no limit on concurrent therapy
- Definitions:
  - Concurrent Therapy: One therapist with two patients doing different activities
  - Group Therapy: One therapist with four patients doing the same or similar activities

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What PDPM Does Change: Concurrent/Group Therapy

- Under PDPM, we use a combined limit both concurrent and group therapy to be no more than 25% of the therapy received by SNF patients, for each therapy discipline.
- Compliance with the concurrent/group therapy limit will be monitored by new items on the PPS Discharge Assessment (O0425):
  - Providers will report the number of minutes, per mode and per discipline, for the entirety of the PPS stay
  - If the total number of concurrent and group minutes, combined, comprises more than 25% of the total therapy minutes provided to the patient, for any therapy discipline, then the provider will receive a warning message on their final validation report.

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What PDPM Does Change: Interrupted Stay

- Under RUG - IV, each time a SNF patient is discharged from a Part A - covered stay (leaves the facility, drops below skilled coverage, etc.), and returns to a Part A - covered stay, the provider must treat each admission as a new SNF admission.
- Due to the incentives created as a result of the variable per diem, PDPM introduces to the SNF PPS an “Interrupted Stay” policy.

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What PDPM Does Change: Interrupted Stay

- If a patient is discharged from a SNF and readmitted to the same SNF no later than 11:59 p.m. of the third consecutive calendar day after having left Part A coverage, then the subsequent stay is considered a continuation of the previous stay:
  - Three-day window referred to as the "interruption window."
- An interrupted stay has an effect on the patient's assessment schedule and variable per diem schedule.
  - Assessment schedule continues from the point just prior to discharge.
  - Variable per diem schedule continues from the point just prior to discharge.

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What PDPM Does Change: Interrupted Stay

- If a patient is discharged from SNF and readmitted outside the interruption window, or admitted to a different SNF, then the subsequent stay is considered a new stay: Assessment schedule and variable per diem schedule resets to day 1.
- This policy applies not only in instances when a patient physically leaves the facility, but also in cases when the patient remains in the facility but is discharged from a Medicare Part - A covered stay. Example: If a patient in a SNF stay remains in the facility under a Medicaid-covered stay, but returns to skilled care within the interruption window.

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What PDPM Does Change: Medical Review and Data Monitoring

- Regardless of the payment model used, ensuring appropriate safeguards for program integrity is always essential.
  - Ensuring program integrity can also represent an administrative burden and potential financial risk for providers.
- Under RUG-IV, given the high percentage of billed days in therapy groups, program integrity and monitoring efforts tend to focus on documentation and billing for therapy services, ensuring that the therapy furnished to a SNF patient is reasonable, necessary and individualized based on the patient's unique condition.

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What PDPM Does Change: Medical Review and Data Monitoring

- Given the more holistic style of care emphasized under PDPM, program integrity and data monitoring efforts will also be more comprehensive and broad.
- For program integrity, we expect provider risk will be more easily mitigated to the extent that reviews focus on more clearly defined aspects of payment, such as documentation supporting patient diagnoses and assessment coding.
  - If the provider codes that the patient's primary diagnosis is a major joint replacement, then the reviewer should be able to verify that the patient received a major joint replacement.

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What PDPM Does Change: Medical Review and Data Monitoring

- Therapy services will still represent an important and significant part of data monitoring and program integrity efforts.
  - New items are being added to the MDS to allow CMS to track therapy service delivery, both in terms of intensity and the manner of delivery
- CMS will be monitoring therapy service provision under PDPM, as compared to RUG-IV, at the national, regional, state, and facility level.
  - Significant changes in the amount of therapy provided to SNF patients under PDPM, as compared to RUG-IV, or the manner in which it is delivered, may trigger additional program reviews and potential policy changes.

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What PDPM Does Not Change

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What PDPM Does Not Change: Actually, a lot!

- Despite the significant changes occurring under PDPM, many SNF PPS policies remain unchanged under PDPM.
  - Basic administrative processes under SNF PPS
  - Payment rate adjustments (wage index, QRP, VBP, etc.)
  - Denial notice policies, ABNs, NOMNCs
  - Payment and policy associated with therapy evaluations
  - Student supervision policies
- There are three particular areas that remain unchanged under PDPM that are of particular note.

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What PDPM Does Not Change: What's Covered

- The SNF PPS covers skilled nursing care, skilled rehabilitation services and other goods and services.
- PDPM does not change what is covered under the SNF Part A benefit, or what is not covered.
- Whether under RUG-IV or PDPM, in order to be covered, SNF services must be skilled services, required on a daily basis, and be reasonable and necessary for the treatment of a patient's particular illness or injury, based on the individual's particular medical needs, and accepted standards of medical practice.

CMS 32

What PDPM Does Not Change: What You Should Document

- Section 30.2.2.1 of Chapter 8 of the Medicare Benefit Policy Manual states that SNF claims must include sufficient documentation that would allow a reviewer to determine:
  - Skilled involvement is required in order for services to be furnished safely and effectively,
  - The services are reasonable and necessary for the treatment of a patient's illness or injury, i.e., consistent with…the individual's particular medical needs.
  - The documentation must also show that the services are appropriate in terms of duration and quantity, and that the services promote the documented therapeutic goals.

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What PDPM Does Not Change: What You Should Document

- PDPM does not change these documentation requirements, but rather strengthens the importance of documenting all aspects of a patient's care, consistent with PDPM's focus on a more holistic care model.
- Given the increased relevance of a greater set of data elements supporting payment under PDPM, providers should ensure that there is strong documentation and support for the care associated with each PDPM component.

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What PDPM Does Not Change: What Your Patient Needs

- While PDPM changes how patients are classified into payment groups, PDPM does not change what SNF patients need, their goals, or the unique characteristics of each patient that should drive care planning.
  - If a patient needs 720 minutes of therapy per week as of September 30, 2019, and nothing changes clinically about the patient, then the patient needs 720 minutes of therapy per week as of October 1, 2019.
  - If group therapy is not clinically indicated for the patient as of September 30, 2019, and nothing changes clinically about the patient, then it is not clinically indicated for the patient as of October 1, 2019.

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What PDPM Does Not Change: What Your Patient Needs

- A major component of CMS' PDPM monitoring strategy is monitoring for consistency in care provision between RUG-IV and PDPM.
  - Therapy intensity, duration, and manner of delivery
  - Increased utilization of mechanically altered diets
  - Anomalies in comorbidity coding
- Any significant shifts in care provision between RUG-IV and PDPM could draw significant scrutiny from CMS review entities.

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RUG-IV – PDPM Transition

RUG-IV – PDPM Transition

- As discussed in the FY 2019 SNF PPS Final Rule, there is no transition period between RUG-IV and PDPM, given that running both systems at the same time would be administratively infeasible for providers and CMS:
  - RUG-IV ends September 30, 2019
  - PDPM begins October 1, 2019

RUG-IV – PDPM Transition

- In order to receive a RUG-IV HIPPS code that can be billed for services furnished prior to October 1, 2019, providers must use an assessment with an ARD set for on or prior to September 30, 2019.
- For instance, if a patient is admitted to the facility in the last few days of September 2019, providers must have an assessment with an ARD set for on or prior to September 30, 2019, in order to receive a RUG-IV HIPPS code.
  - Providers still have the usual 14-day completion period and 14-day submission period, regardless of the assessment ARD.

RUG-IV – PDPM Transition

- For patients admitted prior to October 1, 2019, but whose stays continue past this date, in order to receive a PDPM HIPPS code that can be used to bill for services furnished on or after October 1, 2019, providers must complete an IPA with an ARD no later than October 7, 2019:
  - October 1, 2019, will be considered Day 1 of the VPD schedule under PDPM, even if the patient began their stay prior to October 1, 2019.
  - Any "transitional IPAs" with an ARD after October 7, 2019, will be considered late and relevant penalty for late assessments would apply.
- If the patient's stay begins on or after October 1, 2019, then the provider would begin with the 5-day assessment, as usual.

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PDPM & Medicaid

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PDPM & Medicaid

- While PDPM was created to replace the case-mix classification system used under Medicare, it also has effects on Medicaid payment programs.
- There are two main areas of Medicaid payment affected by PDPM:
  - Upper Payment Limit (UPL) Calculation
  - Case-mix Determinations

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PDPM & Medicaid

- UPL represents a limit on certain reimbursements for Medicaid providers:
  - Specifically, the UPL is the maximum a given State Medicaid program may pay a type of provider, in the aggregate, statewide in Medicaid fee-for-service.
- While budget neutral in the aggregate, PDPM changes how payment is made for SNF services, which can have an impact on UPL calculations:
  - States will need to evaluate this effect to understand revisions in their UPL calculations.
  - MedicaidUPL@cms.hhs.gov

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PDPM & Medicaid

- For purposes of Medicaid reimbursement, states utilize a myriad of different payment methodologies to determine payment for Nursing Facility (NF) patients, including versions of RUG-III and RUG-IV.
- Case-mix states also may rely on PPS assessments to capture changes in patient case-mix, including scheduled and unscheduled assessments:
  - As of October 1, 2019, all scheduled PPS assessments (except the 5-day) and all current unscheduled PPS assessments will be retired.
  - To support case-mix states during this transitional period, CMS created the Optional State Assessment (OSA), which may be required by states for NFs to classify NF patients for payment purposes.

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PDPM & Medicaid

- With PDPM implementation, CMS will continue to provide technical support for legacy payment models, such as RUG-III and RUG-IV, beyond 10/01/2020 through continued use and support of the OSA.
- We are aware that states require Section GG and the PDPM related payment items in order to consider a transition to PDPM for their Medicaid payment systems.
  - We will continue our technical support for legacy payment models for a period that will allow states to collect and analyze the data necessary for a transition to PDPM.

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PDPM Resources

- PDPM website: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/PDPM.html
- For questions related to PDPM implementation and policy: PDPM@cms.hhs.gov
- For questions related to the OSA, contact your state RAI coordinator and/or state Medicaid agency.

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New Medicare Card

https://www.cms.gov/medicare/new-medicare-card/nmc-home.html

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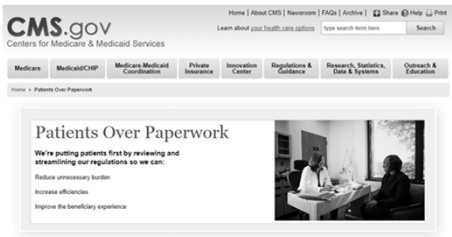
PATIENTS OVER PAPERWORK



https://www.cms.gov/About-CMS/story-page/patients-over-paperwork.html

PATIENTS OVER PAPERWORK

CMS BLOG
https://www.cms.gov/blog/when-it-comes-our-health-every-second-counts

June 10, 2019
By Seema Verma, Administrator, Centers for Medicare & Medicaid Services

When It Comes To Our Health – Every Second Counts

PatientsoverPaperwork@cms.hhs.gov

- Request for Information on Reducing Administrative Burden: CMS is especially seeking innovative ideas that broaden perspectives on potential solutions to relieve burden and ways to improve:
  - Reporting and documentation requirements
  - Coding and documentation requirements for Medicare or Medicaid payment
  - Prior authorization procedures
  - Policies and requirements for rural providers, clinicians, and beneficiaries
  - Policies related to beneficiary enrollment and eligibility determination
  - CMS processes for issuing regulations and policies
- **Comments are due August 12, 2019** and can be submitted here: https://www.federalregister.gov/documents/2019/06/11/2019-12215/request-for-information-reducing-administrative-burden-to-put-patients-over-paperwork.

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Fiscal Year (FY) 2020 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH)
Proposed Rule and Request for Information
April 23, 2019

- *Addressing Wage Index Disparities* – proposing changes to the wage index calculation, including:
  - A methodology to increase the wage index for certain low wage index hospitals
  - Changes to how the statutory rural floor wage index values are calculated
- *Hospital-Acquired Conditions (HAC) Reduction Program* – proposing to:
  - Specify the dates to collect data used to calculate performance for the FY 2022 HAC Reduction Program
  - Clarify processes for validating National Healthcare Safety Network (NHSN) Healthcare-associated Infection (HAI) data submitted by hospitals to the Centers for Disease Control and Prevention
- *Hospital Readmissions Reduction Program (HRRP)* – CMS is proposing to:
  - Establish the performance period for the FY 2022 program year
  - Update the definition of "dual eligible"
- *Hospital Inpatient Quality Reporting (IQR) Program* – CMS is proposing to:
  - Remove the Claims-Based Hospital-Wide All-Cause Readmission measure and replace with the proposed Hybrid Hospital-Wide All-Cause Readmission (Hybrid HWR) Measure
  - Establish reporting and submission requirements for the hybrid measure
    - Require reporting beginning with the FY 2026 payment determination after 2 years of voluntary reporting
  - Adopt two new opioid-related electronic clinical quality measures (eCQMs) beginning in 2021, including
    - Safe Use of Opioids – Concurrent Prescribing eCQM
    - Hospital Harm – Opioid-Related Adverse Events eCQM

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Fiscal Year (FY) 2020 Medicare Hospital Inpatient Prospective Payment System (IPPS) and Long Term Acute Care Hospital (LTCH)
Proposed Rule and Request for Information
April 23, 2019

- ***LTCH Quality Reporting Program (QRP)***
  - **Proposing to adopt new quality measures pertaining to:**
    - Transferring health information
    - Standardized patient assessment data elements that assess either
      - Functional status,
      - Cognitive function and mental status,
      - Special services,
      - Treatments and interventions,
      - Medical conditions and comorbidities,
      - Impairments, or
      - Social determinants of health (race and ethnicity, preferred language and interpreter services, health literacy, transportation, or social isolation)
  - **In response to stakeholder input, CMS is proposing to:**
    - Modify the previously adopted Discharge to Community measure to exclude nursing home residents who already reside in the nursing home,
    - Move the implementation date of future versions of the LTCH CARE Data Set from April to October
    - To adopt data collection and public display periods for various measures, and
    - To no longer publish a list of compliant LTCHs on the LTCH QRP website.

https://www.cms.gov/newsroom/fact-sheets/fiscal-year-fy-2020-medicare-hospital-inpatient-prospective-payment-system-ipps-and-long-term-acute

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Emergency Triage, Treat & Transport (ET3) Model

EXISTING CHALLENGES	MODEL INTERVENTIONS	MODEL GOALS
• Medicare primarily pays for emergency ground ambulance services when individuals are transported to a hospital emergency department (ED). • Therefore, beneficiaries who call 911 with a medical emergency are often transported to a high-acuity care setting, even when a lower-acuity, less costly destination may be more appropriate.	• Ambulance transport to alternative destinations • Treatment in place via a qualified health care practitioner • Medical triage line • Performance-based payment adjustment for achievement on key quality measures	• Provide person-centered care • Increase efficiency in the EMS system • Encourage appropriate utilization of services to meet health care needs effectively

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Emergency Triage, Treat, and Transport (ET3) Model

https://innovation.cms.gov/initiatives/et3/

Appropriate care, at the right time, in the right place

The **ET3 Model** provides greater flexibility to ambulance care teams responding to 911 calls, aimed at **reducing expenditures** while **preserving or enhancing quality of care** for beneficiaries

Goals:

1. **Provide person-centered care** and give beneficiaries greater control of their care
2. **Encourage appropriate utilization of services** to meet health care needs effectively
3. **Increase efficiency in the EMS system** to more readily respond to high-acuity cases

Request for Applications anticipated Spring 2019
Notice of Funding Opportunity anticipated Late 2019

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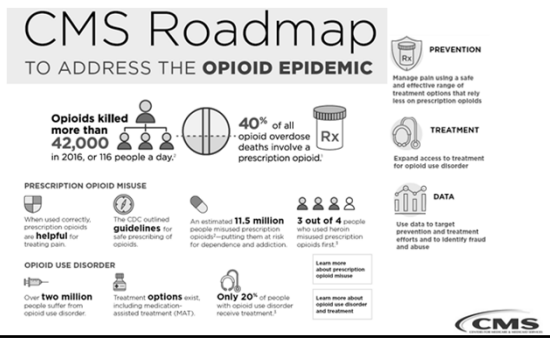
https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf



CMS

SUPPORT for Patients and Communities Act

- **Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder and Other Substance Use Disorders**
- Through an interim final rule with comment period, CMS is implementing a provision from the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act that **removes the originating site geographic requirements and adds the home of an individual as a permissible originating site for telehealth services furnished for purposes of treatment of a substance use disorder** or a co-occurring mental health disorder for services furnished on or after July 1, 2019.
- Additionally, the SUPPORT for Patients and Communities Act **establishes a new Medicare benefit category for opioid use disorder treatment services furnished by opioid treatment programs (OTP) under Medicare Part B**, beginning on or after January 1, 2020. We note that **there is a 60-day period to comment on the provisions of the interim final rule**, during which we are requesting information regarding services furnished by OTPs, payments for these services, and additional conditions for Medicare participation for OTPs that stakeholders believe may be useful for CMS to consider for future rulemaking to implement this new Medicare benefit category.
- For additional information, please see the 2019 PFS Final Rule: https://www.federalregister.gov/documents/2018/11/23/2018-24170/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions

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Opioids- Open Letter

- Instructions went to MACs to send to clinicians at end of February
- 4-page letter highlighting CMS' effort in combatting the opioid crisis
- Mentions roadmap: 3 prongs: prevention, treatment and using data to target prevention and treatment activities
- Guidance for co-prescribing naloxone
- New Medicare Part D opioid policies Safe and effective pain management treatments

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Disclaimer

- This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently, so links to the source documents have been provided within the document for your reference.
- This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.

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Questions and Answer Session