Centers for Medicare & Medicaid Services

Physicians, Nurses and Allied Health Professionals Open Door Forum

Moderator: Jill Darling

November 9, 2021

2:00 pm ET

Coordinator: Welcome to the Physician, Nurses and Allied Health Call. At this time all participants are in a listen-only mode. This call is being recorded. If you have any objections, you may disconnect at this point. I will now turn the meeting over to your host, Jill Darling. Jill, you may begin when ready.

Jill Darling: Great. Thank you, (Erin). And hello everyone, good morning and good afternoon. Welcome to today's Physicians, Nurses and Allied Health Professionals Open Door Forum. We appreciate your patience as always as we allow more folks to get in and for our speakers as well as they are coming from another meeting. So again, thank you so much for your patience.

Before we get into today's agenda, I have one brief announcement. This open door forum is open to everyone. But if you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you do have any inquiries, please contact CMS at press@cms.hhs.gov.

And I will hand the call off to our chair, (Gift Tee).

(Gift Tee): Thanks, Jill, and good afternoon and good morning if you're on the West Coast. Appreciate you joining us for today's Open Door Forum.

We'll cover a host of topics this afternoon, highlighting some of the policies that we finalized in the calendar year 2022 for Physician Fee Schedule.

And with that, I will turn it over to Michael Soracoe to talk about our PFS rate setting conversion factor updates.

Michael Soracoe: Thank you, (Gift), and thanks everyone who's here on the call. So, I'm going to discuss conversion factor and then also talk briefly about the clinical labor pricing update that was finalized in the rule.

So, with regards to the conversion factor, I think most people on the call probably know the PFS conversion factor is how we translate RVUs, relative value units, into dollars. The Social Security Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million. And if they do, CMS applies a budget neutrality adjustment.

For 2022 our budget neutrality adjustment was 0.10% or negative 0.1%. So, 1/10 of 1 percentage point in the negative.

Section 101A of the Medicare Access and CHIP Reauthorization Act of 2015 repealed the previous statutory update formula and also specified statutory updates for 2015 and beyond. This particular year for 2022 the update was 0%. So, we did not have a statutory update for this year.

And then in addition, most significant for 2022, we had a statutory change associated with the Consolidated Appropriations Act of 2021 that provided a temporary 3.75% increase to the conversion factor for 2021. That was a one-year increase of 3.75% which is due to expire for 2022. And that was a statutory provision that CMS does not have regulatory authority to alter.

So, after we applied those adjustments, which are each required by law, that was the budget neutrality adjustment of negative 0.10% and the expiration of the 3.75% adjustment that was in place for 2021.

Our final 2022 conversion factor came out at 33.5983. So basically 33.60 which was a decrease of about $1.29 from last year's conversion factor.

The other topic I'm addressing is the clinical labor pricing update which was one of the main drivers of changes in the rates that we finalized for 2022. So, to give a quick background on this, clinical labor rates were last updated in 2002. So that was just about two decades earlier using Bureau of Labor Statistics data and other supplementary sources.

We've had stakeholders raised concern that the long delays since clinical labor pricing is less than updated had created a significant disparity between the clinical wage data that CMS was using and the market averages that people are paying in the real world for clinical labor rates.

Under the statute, CMS is required to set budget neutral payment for services based on relative resource costs. And so, to accomplish this, to make sure that

we are paying based on accurate relative resource costs, it's necessary periodically that we update the information on which we base these costs.

So as a result, we proposed and then ultimately finalized a proposal to update clinical labor rates for 2022 through the use of a four-year transition period. This is something we've used in the past to incorporate new pricing data and we believe the use of a phased transition and updating clinical labor pricing will help provide payment stability and also maintain beneficiary access to care.

As far as payment goes, the impacts of the clinical labor rate updates on PFS payments are largely driven by the share that labor costs represent of the direct PE inputs for each service. In other words, specialties and services that have a substantially lower or higher than average share of direct costs attributable to clinical labor will experience decreases or increases, respectively.

This can get kind of technical and we explain this in more detail in the preamble that's written in the rule which I'd encourage people to read if they're interested in more information on this. But to simplify it for purposes of this call, if a service has kind of a higher share of clinical labor, then that service is more likely to have increased as a result of the clinical labor pricing update.

Conversely, if a service does not use a lot of clinical labor or in other words if it's heavier on supply and equipment pricing, it's more likely that that service would have experienced a decrease in pricing just due to the fact that other

services saw increases from clinical labor whereas a service that's very heavy on supply and equipment pricing wouldn't have seen as much of an increase.

Now we recognize that as we update the clinical pricing data, payment for some services will be reduced due to the PFS budget neutrality requirements. And these services include proportionally more supplies and equipment than clinical labor.

However, other services, such as those primarily furnished by family practice and internal medicine, those involve personally more clinical labor and they will be positively affected by the pricing updates.

We note that payment rates for these services were recently reduced due to the market based supply and equipment pricing updates and the same PFS budget neutrality requirements. We anticipate that a payment increase for these services will increase access to care for disadvantaged groups and underserved communities and we believe that using a four-year transition and implementing the clinical labor pricing update will again help maintain payment stability and mitigate potential negative effects on healthcare providers by gradually phasing in the changes over a four-year transition period.

We note as well that since this is a four-year clinical labor pricing update, we would appreciate any additional information that stakeholders can supply both in terms of direct wage data and identifying the most accurate types of BOS category that could be used for clinical labor prices.

Continue to consider additional pricing data that can be used to update the clinical labor rates during the remaining three years of the transition period. And again, there's much more detail about this in the PFS final rule for anyone who wants to take a closer look at what we've written there.

And with this, I will now turn this over to my colleague Patrick Sartini to discuss telehealth provisions.

Patrick Sartini: Thank you, Michael. So first of all, we are finalizing a revised time frame for inclusion of certain services to be added to the telehealth list on a temporary basis extending from the current deadline of December 31st, 2021 through December 31st, 2023.

In addition, we are implementing provisions of the Consolidated Appropriations Act of 2021 including broadening the removal of the geographic restrictions and the inclusion of the patient's home as a permissible originating site to include telehealth services for the purposes of diagnosis, evaluation or treatment of a mental health disorder effective for services furnished on or after the end of the PHE for COVID-19.

Also, the CAA prohibits payments for a mental health service via telehealth unless the practitioner or physician furnishes an item or service in person first without the use of telehealth within six months before the first time they furnished a telehealth service to the beneficiary and thereafter subsequent in-person services as such times - at such times as the secretary determines appropriate.

And so therefore we are finalizing a requirement for an in-person visit within 12 months of subsequent mental health telehealth services and we are finalizing that. Exceptions may be made based on beneficiary circumstances with the reason documented in the patient's medical record.

And this - the CAA added rural emergency hospitals, the list of permissible telehealth originating sites effective beginning in CY 2023.

We are also finalizing our revision to a regulatory definition of interactive telecommunications system to permit use of audio-only communications technology under certain circumstances for mental health services provided via telehealth to beneficiaries who are in their homes.

We are also finalizing requirement for documentation in the medical record of the reason for the use of audio-only technology.

Based on support from commenters, we're also finalizing our proposal to permanently adopt coding and payment for HCPCS code G2252 which is a longer virtual check-in visit as described in the CY 2021 PFS final rule.

Finally, we are finalizing that certain cardiac and intensive cardiac rehabilitation codes continue to be available through Medicare telehealth on a temporary basis until the end of December 2023.

With that, I will hand it over to (Gift) for a discussion of the implementation of additional CAA requirements.

(Gift Tee): Thank you, Patrick. I'll quickly cover a couple of CAA requirements that we are implementing in this year's rule.

So, CMS finalized the implementation of Section 122 of the CAA of 2021 which provides a special coinsurance rule for procedures that are planned as colorectal cancer screening tests that that become diagnostic test when the practitioner identifies the need for additional services. For example, the removal of polyps.

The provision specifies a phase down in the coinsurance starting with CY 2022 from 20% down to 0% starting in CY 2030.

In addition to the coinsurance for colorectal cancer screening provision, CAA also included a provision specific to the billing of physician assistant services. In this year's rule, CMS is implementing Section 403 of CAA of 2021 which authorizes Medicare to make direct payments to PAs for professional services that they furnish under Part B beginning January 1, 2022. Excuse me.

Medicare is currently only making payments to the employer or independent contractor of a physician assistant. But beginning January 1, 2022, PAs may bill Medicare directly for their professional services, reassign payment for their professional services and incorporate with other PAs and bill Medicare for physician assistant services.

And with that, I will turn it over to my colleague, Pam West.

Pam West: Hi, thanks, Gift. This is Pam and I'm going to be talking about therapy services first and then I'll briefly touch on medical nutrition therapy services.

Through calendar year 2022 rulemaking CMS implemented the final part of Section 53107 of the Bipartisan Budget Act of 2018 which requires payment at 85% of the otherwise applicable Part B payment amount for physical and occupational therapists and for therapy providers for services furnished in whole or in part by physical and occupational therapy assistants effective for dates of service on and after January 1st, 2022.

In response to stakeholders' questions and to promote appropriate care, CMS revised the de minimis standard policy that is the 10% time standard established to determine when the therapy assistant modifiers, CO and CQ, are applied on therapy claims to trigger the reduced payment.

The finalized policy includes two exceptions where the de minimis standard does not apply. The first exception is to the final 15-minute unit of a billing scenario in which the therapist furnishes more than the midpoint, that is 8 minutes or more, to satisfy the Medicare billing criteria for an exception which is termed the 8-minute rule or the midpoint rule.

The second exception is when there are two remaining units to bill. These instances include where the therapist and the therapy assistant each provide between 9 and 14 minutes of the same service with a total time between 23 and 28 minutes. In these 13 cases, one unit is billed with a CQ or CO modifier and one unit is billed without it.

The de minimis standard continues to be applied and reduced payment made when the therapy assistant wholly provides a service or a 15-minute unit of a service. When the therapy assistant provides more than 10% of an untimed service such as group therapy or supervised modalities. When the therapy assistant furnishes 8 minutes or more of the final 15-minute unit of a billing scenario in which the therapist furnishes less than 8 minutes of the same service. And, when both the therapist assistant and the therapist each furnish less than 8 minutes for the final 15-minute unit of a billing scenario.

In the final rule, we also announced the calendar year 2022 KX-modifier threshold amounts at $2150 each.

Now I'll switch topics and address medical nutrition therapy or MNT services. Since January 1st, 2002, registered dietitians and nutrition professionals have been recognized to provide medical nutrition therapy services when referred by a physician, that is a doctor of medicine or osteopathy, for the management of patients with diabetes or renal disease for nutritional, diagnostic, therapeutic and counseling services.

For calendar year 2022, in response to stakeholder concerns about parity with other non-physician practitioners we established regulations for services of registered dietitians and nutrition professionals. This regulation is parallel to regulations in place for other types of non-physician practitioners that are also listed at

Section 1842(b)(18)(C) of the Social Security Act. We also updated the payment regulation for MNT services to clarify that these services are and

have been paid at 100% (instead of 80%) of 85% of the physician fee schedule amount, since 2011, as required by Section 4104 of the Affordable Care Act of 2010.

MNT services qualify for the 100% payment without any cost sharing because they received a Grade B recommendation from the United States Preventive Services Task Force.

Now I'll turn the mic over to Ann Marshall who will give an update for specific E&M services.

Ann Marshall: Thanks, Pam. I'm going to be talking about our finalized policies for evaluation and management visit services which are - were in three areas. The first to split our shared visits and then critical care services and then finally an item on teaching physician services.

And these are part of our ongoing review of payment for E&M visit code sets and some withdrawn manual sections from earlier in the year that we have promised to take through rulemaking.

So first for split or shared visits, we are first explicitly defining these as E&M visits that are provided in a facility setting by a physician and a non-physician practitioner in the same group where incident to payment is not available under our regulations. And the visit will be billed by the physician or practitioner who provides the substantive portion of the visit. Substantive portion will mean more than half of the total time spent by the practitioners starting in 2023.

In 2022 we provided a transitional year with a substantive portion can also be one of the historical key components of a visit of history, exam or medical decision-making.

For critical care visits, starting in 2022 the substantive portion must be more than half of the total time since those visits are already timed.

In the final rule, we also expanded the types of visits that can be billed as split or shared, allowing just for new or established patients, initial and subsequent visits and also prolonged services. We will allow critical care visits to be billed as split or shared visits and also nursing facility visits that are not required to be performed entirely by a physician.

We created a new modifier. It will be F as in Frank, S as in Sam to identify these services on claims and we also laid out a brief set of documentation requirements.

For critical care services we refined and codified some longstanding policies. The first of which is that these services are defined by the CPT editorial panel in the CPT code book prefatory language for the code set. We are also adopting the CPT listing of bundled services.

We finalized the critical care services, as mentioned, can be billed as split or shared visits. We will allow concurrent critical care services on the same day to the same patient for practitioners having different specialties. Critical care services can be paid on the same day as another E&M visit if the other E&M

visit was provided prior at a time when the patient did not require critical care and the services are not duplicative.

Consistent with former manual critical care can be paid separately in addition to a global surgical procedure if the critical care is unrelated to the procedure and we created a new modifier which will be F as in Frank, T as in Tom to identify those unrelated visits.

And finally, we addressed the documentation rules for critical care services including split or shared critical care visits.

And thirdly, for teaching physician services, in this year's rule we were addressing some questions that came in as a result of recent changes to E&M visit coding where a time a medical decision-making can be used for visit level selection. And we are clarifying that when time is used to select visit level, only the time of the teaching physician is counted for purposes of visit level selection that this can include time that the teaching physician was present with the resident. Independent time spent by the resident should not be counted.

And for visits that are furnished under the primary care exception where the teaching physician is not present, medical decision-making must be used instead of time to select visit level for visits where that is an option since residents are less efficient with their time.

And I will be handing the mic over to (Michael K.) for vaccine administration.

(Michael Konieczny): Good afternoon everyone. This is (Michael Konieczny). In the calendar year 2022 Physician Fee Schedule proposed rule, we included a common solicitation on three topics related to Medicare payment for vaccine administration.

First, we sought information on the costs involved in administering preventive vaccines that are included in the Medicare Part B vaccine benefit. These are the influenza, pneumonia and hepatitis B vaccines as well as vaccines for COVID-19 which were added to this list in 2020 under the CARES Act.

Second, we sought feedback on the add-on payment of $35.50 that CMS makes when a COVID-19 vaccine is administered in a patient's home.

And finally, we sought information on the costs involved in administering monoclonal antibodies for COVID-19 which CMS covered under the vaccine benefit during the course of the public health emergency.

Payment for administration of the influenza, pneumonia and hepatitis B vaccine has historically been based on a crosswalk to a code on the physician fee schedule. This method resulted in a decrease in the payment rate over time which was the source of concern within the healthcare community especially with the onset of the COVID-19 pandemic.

Based on the history of payment for vaccine administration and on the feedback that we received in response to our common solicitation in the final rule, we took action to update the payment rates the administration of Part B preventive vaccines.

Specifically, we established a payment rate of $30 for administration of the influenza, pneumonia and hepatitis B vaccines effective January 1st, 2022. I note that this new payment rate is nearly double the rate that Medicare has paid during the past few years.

In addition, CMS will maintain the current payment rate of $40 for administration of COVID-19 vaccines until the end of the calendar year in which the PHE ends. Afterwards, payment for COVID-19 vaccine administration will be aligned with that per other Part B preventive vaccines.

With respect to administration of COVID-19 vaccines in the patient's home, CMS will continue to make the home add-on payment until the end of the calendar year in which the PHE ends. We believe that this extension will maximize access to COVID-19 vaccines for homebound beneficiaries as conditions gradually return to normal following the end of the PHE.

Similarly, CMS will continue to cover monoclonal antibody therapies for COVID-19 under the Part B vaccine benefit until the end of the year in which the PHE ends. This includes the $450 payment rate for administration in a healthcare setting and $750 for administration in a patient's home. It also includes payment for the product itself at 95% of average wholesale price when it is not provided for free by the government.

Effective January 1st of the year - after the year in which the PHE ends CMS will pay for a monoclonal antibody product according to the methodology under Section 1847A of the Social Security Act.

In addition, healthcare providers and practitioners will be paid for administering COVID-19 monoclonal antibodies under the applicable payment system. We believe that the public health needs - the coverage of these products as vaccines will gradually re-stabilize following the end of the PHE and that extending the current payment approach will give healthcare providers adequate time to prepare for the change in payment methodology while continuing to maximize access to beneficiaries.

And with that, I'll pass it off to (Katie Moore) to talk about the Quality Payment Program.

(Kati Moore): Great. Thanks, (Michael). Good afternoon, good morning everyone. Again, my name is (Kati Moore) and I'm just going to give some highlights of our Quality Payment Program updates that were just made in the PFS final rule for 2022.

So, in 2022, the Quality Payment Program we fulfilled certain statutory requirements including setting the performance threshold at either the mean or median of final scores for all narrow-based incentive payment system to MIPS-eligible clinicians for a prior period. And as a result of this, we anticipate clinicians will start to seek greater returns on investment in the program. We've heard this a lot over the years. So, this is finally going to be realized hopefully over the next few years.

Additionally, we'll begin to see more equitable distribution within our scoring system with small practices no longer bearing the greatest share of those negative payment adjustments.

So, some of the key policies for the 2022 performance year include we are revising the definition of a MIPS-eligible clinician to include social workers and certified nurse midwives. We are setting the MIPS performance threshold at 75 points and the exceptional performance threshold at 89 points.

We are - again another statutory requirement we are waiting the cost and quality performance categories equally. So, for 2022 they will be set at 30%. And this will leave 25% for their promoting interoperability performance category and the improvement activities performance category will be at 15% of the clinician's total 100% final score.

We are revising our quality scoring policies to include introduction of a floor for new measures. So, 7 points for first year and then 5 points for second year. And removal of outcomes, high priority measure bonus points and end-to-end electronic reporting bonus point.

We will be extending the CMS Web interface as a collection type and submission type in traditional MIPS for registered groups, commercial groups and the (APMs) for the 2022 performance year only. So, this is definitely a response to some stakeholder feedback that this was - this is needed for another year.

So, we have also finalized a longer transition for electronic clinical quality measures, so eCQM, and MIPS Clinical Quality Measures, CQM, measure reporting for shared savings program accountable care organizations by extending the CMS Web interface as an option for them specifically for three years. So that will be available for shared savings program, ACOs in 2022, 2023 and 2024.

And lastly, I just want to talk a little bit about our MIPS value pathways, what you refer to as MVPs. We have finalized seven. We are very excited to finally have final MVPs to put out there for everybody. They will be available beginning with the 2023 performance year as a reporting option.

And if folks haven't heard of MVPs before or just want more information about them, we do have a specific Web page on qpp.cms.gov that provides a lot more details on MVPs and what they're all about. But at high level they're line sets of measures and activities that are relevant to a given specialty or medical condition.

So, for - beginning in 2023 we will have one for advancing rheumatology patient care, one for coordinating stroke care to promote prevention and cultivate positive outcomes, advancing care for heart disease, optimizing chronic disease management, adopting best practices and promoting patient safety within emergency medicine and improving care for lower extremity joint repair and support of positive experiences with anesthesia.

And then also related to MVPs we've finalized a description of the registration process and more information will definitely be coming early next

year on how folks can go about registering for those different MVPs that will be available that I just listed.

We have also finalized more information about timeline for MVP and subgroup registration. So again, that's coming early next year.

And then just wanted to highlight too all of - just very high level on QPP and we do have - on our QPP resource library, we have a zip file that contains policy comparison table from 2021 to 2022 MVP policy table and frequently asked questions available in the file there. So, more details if you haven't had a chance to read these thousands of pages of the rule yet and looking for QPP information specifically that is available to you.

And also wanted to highlight that we will be having a public Webinar tomorrow specifically on the QPP policies that were finalized. The event is from noon to 1:30 and we have registration information link available on the QPP Webinar library. We have a lot of our different needs available there to help answer any more detailed questions you might have.

But that is it for QPP today. So, I'm going to hand it over to (Kathleen Johnson) to talk more about Medicare Shared Savings Program.

(Kathleen Johnson): Thank you, (Katie). Good morning and good afternoon everyone.

The Medicare Shared Savings Program finalized the following policies in CY '22 Physician Fee Schedule final rule. We are providing along the phase in of the Shared Savings Program quality reporting requirements using the

Alternative Payment Model Performance Pathway, the APP. So, we finalized that for performance years '22, '23 and '24 and ACA would be required to report the ten measures under the CMS Web interface or the three eCQM, MIPS CQM, administer the CAHPS from its survey and CMS would calculate the two claims based measures included under the APP.

For performance year 2025 and subsequent performance years, the ACA would be required to report on the three eCQM, MIPS CQM, fill the CAHPS for MIPS survey and CMS would calculate the two claims based measures included under the APP.

Regarding the Shared Savings Program quality performance standards, we are freezing the Shared Savings Program quality performance standards at the 30th percentile MIPS quality performance category score for performance year 2023.

Additionally, in order to incentivize for ACOs to begin the transition to eCQM, MIPS CQM reporting before performance year 2025, we are finalizing for performance years 2022 and 2023. If an ACO reports the three eCQM, MIPS CQM, meets the data completeness requirement and the case minimum requirement for all three eCQM, MIPS CQM and achieves a quality performance score equivalent to 2 or higher than the 10th percentile of the performance benchmark on at least one of the four outcome measures in the APP measure set and a quality performance or equivalent to or higher than the 30th percentile of the performance benchmark of at least one of the remaining five measures in the APP measure set, the ACO will meet the quality

performance standards used to determine eligibility for shared savings and to avoid maximum share losses, if applicable, for that performance year.

We've also made updates to the APM performance pathway measure set. We finalized our proposal to replace the MCC for ACO's measure with the MCC for MIPS measure for performance year 2022 and subsequent performance years in the APP measure set.

We also finalized policies to update the definition of "primary care services" used in beneficiary assignment, revised the methodology for calculating repayment mechanism amount for risk-based ACOs that reduces the amount by 50% and clarifies how we identify the number of assigned beneficiaries using the repayment mechanism calculations and reduce burden and streamline the application and beneficiary notification processes.

That's all that we have under the Shared Savings Program for today. I'd now like to turn the call over to Marcie O'Reilly who will speak about the radiation oncology model.

Marcie O'Reilly: Thank you, (Kathleen). Hello everyone. In review, the radiation oncology model will test whether a prospective site neutral, modality-agnostic, episode-based payments to physician group practices including freestanding radiation therapy centers and also hospital outpatient departments for radiotherapy episodes of care reduces Medicare expenditures while preserving or enhancing the quality of care for our Medicare beneficiaries.

So, in addition to the PFS final rule on November 2nd, CMS displayed this calendar year 2022 hospital outpatient and prospective payment and ambulatory surgical center payment system final rule which includes finalized modifications related to the radiation oncology model.

We have finalized that the five-year model performance period will start on January 1, 2022, and end December 31st, 2026.

The final rule also includes the following finalized modifications: We've adjusted the pricing methodology by updating the baseline period to 2017 through 2019 and lowering the discounts to 3-1/2% and 4-1/2% for the professional component and technical component, respectively.

We've removed brachytherapy from the included modalities and we've removed liver cancer from the included cancer types.

We have finalized that in cases where a beneficiary switches from traditional fee-for-service Medicare to Medicare Advantage during an episode before treatment is complete, we will consider this an incomplete episode and radiation therapy services will be paid fee-for-service as opposed to the bundled payment.

We are excluding only those hospitals participating in the Pennsylvania Rural Health Model or PRHM, not just PRHM-eligible hospitals. And we're excluding hospital outpatient departments participating in the Community Transformation Track of the new Community Health Access and Rural Transformation or CHART model and that the RO model will follow the same

policy for overlap between the RO model and the Medicare Shared Savings Program ACOs for the CHART ACO transformation track.

And in light of the current public health emergency in several recent natural disasters, we've finalized the addition of an extreme and uncontrollable circumstances or EUC policy. This policy will give CMS the ability to offer flexibilities to reduce administrative burden of our RO model participation during an extreme and uncontrollable circumstance.

Please note that CMS announced on November 2 that we have determined that there is currently an EUC based on the ongoing COVID-19 PHE and unless the secretary terminates his renewal of the COVID-19 PHE prior to January 1st, CMS intends to invoke provisions of this policy on the effective date of this final rule which is January 1, 2022.

The flexibilities include the following: The requirement that RO participants collect and submit quality measures and clinical data elements will be optional in 2022. Because this requirement will be optional, the 2% quality withhold will not be applied to RO model professional episode payments in 2022.

The requirement that RO participants actively engage with an AHRQ-listed patient safety organization or PSO will also be optional in 2022.

And the requirement that RO participants conduct peer review -- that is the audit and feedback on treatment plans -- will be optional in 2022.

And it's very important for you to note that opting out of these requirements in performance year one will not jeopardize a RO participant's advanced APM status.

Additional information regarding the implementation of these changes will be provided to RO participants by CMS via upcoming learning events and materials including Webinars scheduled on November 16th and on December 15th.

Also included in this rule were clarifications to help address questions from stakeholders and future RO participants related to the interaction between the RO model and the Quality Payment Program. Again, please tune in to our Webinar scheduled for December 15th that will further discuss the RO model and QPP.

For more information, please reference the RO model Web site. And I wanted to note that the following items are now on the model Web site since the publication of this role. The RO model - the trend at national base rates for the RO model specific HCPCS codes are posted on the Web site. There's a data dictionary for the data request and attestation or DRA. And there's updated RO Model Quality Measure and Clinical Data Elements Guide Version 2.0 and the related templates on the Web site.

Also, in the Radiation Oncology Administrative portal, you should be able to see your participant's specific adjustments, your eligibility for the low volume opt out and please note you must choose the opt out for performance year one by December 31st. And you can submit a data request and attestation or DRA

to obtain your RO model specific claims data through the Radiation Oncology Administrative portal.

For other questions or additional questions on RO model or for RO participants seeking to obtain their RO model ID or to get access to any of our portals, please contact our helpdesk at radiationtherapy@cms.hhs.gov.

I now pass the baton to Mollie Howerton to discuss the Medicare Diabetes Prevention Program.

Mollie Howerton: Good morning and good afternoon. I want to give you some updates on Medicare Diabetes Prevention Program.

The goal of MDPP is to improve the health - improve health and reduce costs by providing healthcare coaching to beneficiaries at risk of developing type 2 diabetes.

Medicare pays MDPP supplier to furnish this group-based intervention to at-risk Medicare beneficiaries following a curriculum that has been tested and approved by the Centers for Disease Control and Prevention as part of its National Diabetes Prevention Program.

Since the MDPP is a Medicare preventive care service, there are no out-of-pocket costs for beneficiaries. There's never any beneficiary copay for MDPP services and no provider referral is required.

The benefit currently offers up to two years of lifestyle coaching, more intense at the outset with weekly sessions then tapering off to monthly sessions after six months of the program. This coaching includes training about diet and activity and weight loss.

So, I want to provide you some updates regarding the changes to MDPP that were recently finalized in the 2022 physician fee schedule that go into effect January 1st, 2022. These changes are intended to boost supplier enrollment as well an increase beneficiary access to MDPP.

The changes that we finalized include waiving the provider enrollment fee for MDPP supplier. We are using the CMS Innovation Center's waiver authority to waive the provider enrollment Medicare application fee for all organizations that submit an application to enroll Medicare as an MDPP supplier on or after January 1st, 2022.

We are also shortening the MDPP services period to one year on a prospective basis. This applies to participants who start their MDPP set of services on or after January 1st. This final rule will make the MDPP services period consistent with the CDC's National Diabetes Prevention Program.

Keep in mind - finally we have redistributed Year 2 payments to Year 1 and increased the attendance-based payment amount. So, keep in mind that although no physician referral is necessary for Medicare beneficiaries to participate in MDPP, we want to encourage providers to test their patients for prediabetes.

Providers play a critical role in identifying and referring patients to MDPP. You are often the first step in determining someone's eligibility for MDPP by screening Medicare patients for prediabetes and referring them to local suppliers.

As providers, there are several ways for you and your organization to get involved. First, you can enroll as an MDPP supplier to furnish MDPP services. If you are interested in this, your organization must first obtain preliminary - a full CDC recognition before enrolling in MDPP.

The second way to partner - for you to get involved is to partner with a CDC National Diabetes Prevention Program organization. We encourage you to explore partnership opportunities with CDC Diabetes Prevention Program organizations in your area. They are listed on a registry of recognized organizations on CDC's Web site and we have on our Web site a list of Medicare Diabetes Prevention Program approved suppliers. So please check and refer your patients to them. Thank you.

Now it's time for Q&A.

Jill Darling: Yes. Thank you, Mollie, and thank you to all of our speakers today. (Erin), will you please open the lines for Q&A?

Coordinator: I sure can. If you would like to ask a question, please press star 1 at this time. Please unmute your phone and record your name clearly when prompted. Your name is required to introduce your question. To cancel your request, you

can press star 2. And speakers our first question comes from (Betsy). (Betsy), your line is open.

(Betsy): Thank you very much. I have a question about the shared E&M services rule. In one of the tables on Table 26 it says that outpatient visits can be billed as shared services but office visits cannot and that outpatient visits can be built based on history, exam, medical decision-making or time. Do you mean that Office and Outpatient Visit Codes 99202 to 99215 may be billed as shared in place of Service 19 and 21? And if so, since these codes don't have a required level of history and exam anymore, how can a clinician meet the criteria based on history and exam?

Ann Marshall: Hi, this is Ann. Thanks for the question. So, I'll take the second part of it first. Those codes still have a history and exam as medically appropriate and the way that you decide your visit level selection is independent of how the substantive portion is determined. So, you should still use the regular CPT guidance, the new guidance for office and outpatient visits, to select your visit level.

However, when you're deciding who performs a substantive portion for purposes of billing, what we're saying is that for a transitional year we will still allow for that code that - for you to consider the substantive portion to be the history and - a full history, an exam or medical decision-making or more than half of the time.

On the first part of your question, the reason we said that the office visits are not billable is because there's an incident to benefit there. And split and

shared visits have now been defined as visits for which incidents through payment is not available because it's not needed where the incident to benefit provides an alternative mechanism.

So, you are right that for certain places of service you would be able to build that code set. And for others, you would not as with our shared services.

(Betsy): Thank you.

Coordinator: Our next question comes from (Theresa).

Your line is open.

(Theresa): Hi. You discussed the two new modifiers, one for split/shared and one for global critical care E&Ms (unintelligible) global period. Are those effective calendar year '22 or '23?

Ann Marshall: Twenty twenty-two.

(Theresa): I just haven't seen anything on them, so. Thank you.

Ann Marshall: Yes, we'll be issuing - sometimes we don't have the actual alphanumeric code assigned by the time the rule goes into publication but we'll be putting out some manual changes that have the letter in it and we've since gotten the actual alphanumeric and I just wanted to verbally mention it for anyone, you know, looking for that information. We have been getting some e-mails already on that.

(Theresa): Okay. Thank you very much.

Coordinator: Next question is from (Sheila).

(Sheila), your line is open.

(Sheila): Hello. I would like clarification on what kind of services can and cannot be built with chronic care management. We seem to be finding some conflicting statements regarding what can and cannot be billed to the CCM during the same service period or the billing month and this is one of those services.

In the CMS CCM booklet dated July 2019, it says that CCM cannot be billed during the same service period by the same practitioner's hospice. But a 2016 CCM frequently asked document didn't include the qualifier about the same or different physicians. So, what we're asking is if CCM can be billed by a different physician that is billing hospice during the same billing period.

Ann Marshall: Thanks for the question. This is Ann again. I'm going to ask you to submit that an e-mail just so we can make sure that we've dotted the I and crossed the T. But I think that if it is a different practitioner, you should be able to bill it and the prohibition shouldn't be for a patient receiving hospice services but rather the G codes for hospice supervision. But, Jill, I don't know what the best e-mail is but…

(Sheila): I did e-mail this to the rural health ODF e-mail address but I haven't been seeming - to get any responses. So, if there's a better one, I'd like that one.

Jill Darling: Yes. So this is Jill Darling. You can send it into partnership@cms.hhs.gov. And I'll forward it along. It's on the agenda as well for the Physicians Open Door Forum.

(Sheila): Great, thank you very much.

Jill Darling: You're welcome.

Coordinator: Just a reminder if you would like to ask a question, please press star 1 at this time. Speakers our next question comes from (Lauren). (Lauren), your line is open.

(Lauren): Hi, yes. I believe my question has kind of already been answered but when should we anticipate guidance coming out regarding the critical care modifier and where should we be looking for that?

Woman: Yes. It will be coming out through manual updates between now and the end of the year under our regular schedule. We can't update the manual until the rule is published. But we're working on that right now.

(Lauren): Thank you.

Coordinator: Speakers at this time we have no additional questions in queue.

Jill Darling: Okay, great. Thanks everyone. I'll hand it to (Gift) for any closing remarks.

(Gift Tee): I don't think I have any but I know we have Dr. (Freund) on the line. So, if he's got any remarks, I'm sure we'd love to hear them.

Dr. (Freund): I don't have any further remarks. Thanks all for calling into the call. Interesting stuff and detailed.

Jill Darling: All right. Well, great. Thank you everyone for joining us today. As always, if any questions, comments, please e-mail partnership@cms.hhs.gov. Have a great day everyone.

Coordinator: Thank you speakers. That concludes today's conference. Thank you all for participating. You may now disconnect and have an amazing day.

END