New Proposals for RHCs and FQHCs on Care Management Services and ACO Assignments Listening Session

Moderated by: Hazeline Roulac
August 1, 2017, 2:00 pm ET

Table of Contents

Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® event. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Hazeline Roulac. Thank you, you may begin.

Announcements & Introduction

Hazeline Roulac: Thank you, Dorothy. Hello, everyone. I'm Hazeline Roulac from the Provider Communications Group here at CMS, and I'm your moderator for today. I would like to welcome you to this Medicare Learning Network call on the New Proposals for RHCs and FQHCs on Care Management Services and ACO Assignments Listening Session.

During this call, our subject matter experts will review proposals for Rural Health Clinics and Federally Qualified Health Centers in the Physician Fee Schedule proposed rule on requirements and payment for care management services, which includes chronic care management, general behavior health integration, and psychiatric Collaborative Care Model services. You will also hear about the CMS chronic care management campaign and the proposed new process for using RHC and FQHC claims to assign beneficiaries to Accountable Care Organizations, or ACOs, participating in the Medicare Shared Savings Program. Following the presentation, we will have a question-and-answer session.

There is a slide presentation for this call. You should have received a link to it in your confirmation email when you registered. If you haven't already done so, please download the presentation from the CMS website at go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

At this time, it is my pleasure to turn the call over to our first speaker, Corinne Axelrod. Corinne?

Presentation

Corinne Axelrod: Thank you, Hazeline. Hi, everybody. I'm Corinne Axelrod. I'm here with my colleagues from the Division of Ambulatory Services and the Office of Minority Health to talk about the proposed changes in the 2018 Physician Fee Schedule proposed rule for RHCs and FQHCs that are either furnishing or interested in furnishing care management services. I hope that everybody was able to access the slides, which are posted on the webpage that Hazeline just mentioned, and can follow along.

Care Coordination Services—Background

So let's go to slide 4. When we talk about care coordination services, we are talking about three types of services: chronic care management (CCM) services, general behavioral health integration (BHI) services, and psychiatric Collaborative Care Model (psychiatric CoCM) services.

On slide 5 now. Most of you are probably familiar with CCM, which is at least 20 minutes of care management services directed by an RHC or FQHC practitioner, per calendar month, for patients with multiple—which means two or more—chronic conditions expected to last at least 12 months or until the death of the patient, and chronic conditions that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline.

Added this year for practitioners billing under the Physician Fee Schedule is complex CCM, which has the same required elements but is at least 60 minutes of services for patients of moderate to high complexity.

Also new this year for practitioners billing under the Physician Fee Schedule is general BHI services, which is at least 20 minutes of care management time directed by an RHC or FQHC practitioner, per calendar month, for any behavioral health or psychiatric condition being treated by the RHC or FQHC primary care practitioner, including substance use disorders that, in the clinical judgment of the RHC or FQHC practitioner, warrants BHI services.

On slide 7, also new this year for physicians and practitioners billing under the Fee Schedule, psychiatric CoCM services, which is at least 70 minutes in the first calendar month and at least 60 minutes in subsequent calendar months of psychiatric CoCM services, including the services of a behavioral health care manager and psychiatric consultant, also for any behavioral health or psychiatric condition being treated by the RHC or FQHC primary care practitioner, including substance use disorders, again, in the clinical judgment of the RHC or FQHC practitioner, that warrants psychiatric CoCM services.

You can see that the required elements are the same for general BHI and psychiatric CoCM, but the services are quite different, which we'll go into in more detail in a few minutes.

On slide 8, payment for care coordination services is fairly new in Medicare. Payment for CCM services began January 1st of 2015 for practitioners billing under the Physician Fee Schedule. Payment for CCM began January 1st of 2016 for RHCs and FQHCs. For RHCs and FQHCs, payment is based on the Medicare Physician Fee Schedule national nonfacility payment rate for CPT code 99490. The rate is updated annually if there's no geographic adjustment. And the RHC and FQHC face-to-face requirements are waived.

Beginning January 1st of 2017, we revised the requirements so that RHCs and FQHCs can furnish CCM and also TCM, which is transitional care management, services under general supervision requirements instead of under direct supervision requirements.

We also revised the scope of service requirements pertaining to the initiating visit, the electronic care plan, beneficiary consent, and some other aspects of the requirements, you know, consistent with the Physician Fee Schedule scope of service changes in order to reduce the burden of furnishing these services and to promote beneficiary access to these services.

Payment for complex CCM, general BHI, and psychiatric CoCM services began January 1st of 2016 for practitioners billing under the Physician Fee Schedule. RHCs and FQHCs are not currently authorized to bill for these services either as an RHC or FQHC or under the Physician Fee Schedule.

I do want to mention that, in the 2017 Physician Fee Schedule Final Rule, we invited comments on whether an additional code specifically for mental health conditions is necessary for RHCs and FQHCs that want to include beneficiaries with mental health conditions in their CCM services. And we thank those of you that sent us comments. They were very helpful.

Okay. On slide 11, we have a chart with the five relevant care management codes, their time requirements, and the payment amount under the Physician Fee Schedule. You can see that, currently, RHCs and FQHCs are only paid for CCM code 99490, which is why we are proposing some changes.

Proposed for 2018

So, proposed for 2018, on slide 13. In the 2018 Physician Fee Schedule proposed rule, we have proposed to revise the CCM payment for RHCs and FQHCs and establish requirements and payment for general BHI and psychiatric CoCM services furnished in RHCs and FQHCs.

So let's start getting into some details. I went through the background fairly quickly because I want to spend a little bit more time on the actual proposals.

First, we are proposing to revise the CCM payment for RHCs and FQHCs and add payment for general BHI. Specifically, we would establish a new General Care Management G code GCCC1, and a payment amount for GCCC1 would be set at the average of the national nonfacility Physician Fee Schedule payment rates for CCM code 99490, complex CCM code 99487, and general BHI code G0507.

On slide 15, using 2017 rates, the payment amount for general care management would have been approximately $61. Here's the calculation. You can all check my math to make sure it's correct. Once the 20-minute threshold is met for either CCM or general BHI, reporting and tracking of additional time increments would not be required. Payment would be the same if 20 minutes or 30 minutes or 60 minutes of care coordination services are furnished.

Slide 16. GCCC1 would be billed alone or in addition to other services furnished during the RHC or FQHC visit. It could be billed once per month per beneficiary. It could not be billed if other care management services such as TCM or home health care supervision are billed for the same period.

Care would be directed by the RHC or FQHC primary care practitioner, who must remain involved through ongoing oversight, management, collaboration, and reassessment. These services are typically furnished in a non–face-to-face setting by clinical personnel working under general supervision of the RHC or FQHC primary care practitioner. And time spent by administrative or clerical staff cannot be counted towards the time required to bill these services.

Slide 18. Let's look more closely at the requirements for billing GCCC1.

The first requirement, the initiating visit, which is the same for CCM and general BHI, is that an evaluation and management, an Annual Wellness Visit, or Initial Preventive Physical Exam visit occurred no more than 1 year

prior to commencing care coordination services that were furnished by a primary care physician, NP, PA, or CNM and was billed as an RHC or FQHC visit. Again, this is the same for both CCM and general BHI.

Slide 19. The next requirement, beneficiary consent, is also the same for CCM and general BHI. Consent must be obtained during or after the initiating visit and before provision of care coordination services by the RHC practitioner or clinical staff. It can be written or verbal and must be documented in the medical record. And it must include information on the availability of care coordination services and applicable cost sharing, that only one practitioner can furnish and be paid for care coordination services during a calendar month, that the patient has the right to stop care coordination services at any time, effective at the end of the calendar month, and that the patient has given permission to consult with relevant specialists.

I want to emphasize how important beneficiary consent is, because care management services are primarily non–face-to-face services. So it's important that patients understand why they may be billed for services that are being done on their behalf yet are not visible to them.

Slide 20. The billing requirements are also the same for CCM and general BHI. To bill for GCCC1, at least 20 minutes of care coordination services per calendar month that is furnished under the direction of the RHC or FQHC primary care physician, NP, PA, or CNM and furnished by an RHC or FQHC practitioner or by clinical personnel under general supervision of the RHC or FQHC practitioner.

Slide 21. As I noted on slides 5 and 6, patient eligibility is different for CCM and BHI services. Patient eligibility for CCM is multiple chronic conditions expected to last at least 12 months or until the death of the patient and place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Patient eligibility for general BHI is any behavioral health or psychiatric condition being treated by the RHC or FQHC primary care practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants BHI services. The patient must meet either one of these requirements for General Care Management code GCCC1 to be billed.

Slide 22. Next, we have the required service elements for CCM. I'm not going to go through all of these. But you can see that the service elements for CCM are extensive.

Let's jump to slide 26. These are the required service elements for general BHI: initial assessment or followup monitoring, including the use of applicable validated rating scales; behavioral health planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, pharmacotherapy, counseling, and/or psychiatric consultation; and continuity of care with a designated member of the care team.

So to recap, the initiating visit, beneficiary consent, and billing requirements are the same for general and – I'm sorry – for CCM and general BHI. But the patient eligibility and service elements are different.

Slide 27. We are also proposing to establish a new psychiatric CoCM G code, which would be GCCC2, for RHCs and FQHCs. The payment amount would be set at the average of the national nonfacility Physician Fee Schedule payment rates for psychiatric CoCM codes G0502 and G0503.

Slide 28. Using calendar year 2017 rates, the payment amount for psychiatric CoCM for RHCs and FQHCs would have been approximately $134. And there, you can see how we arrived at that number.

For GCCC2, that would – just like in GCCC1, it would be billed alone or in addition to other services furnished during the RHC or FQHC visit. It could be billed once per month per beneficiary. And it could not be billed if other care management services are billed for the same time period.

As with GCCC1, GCCC2 services are directed by the RHC or FQHC primary care practitioner, who remains involved through ongoing oversight, management, collaboration, and reassessment. Care coordination services are typically furnished in a non–face-to-face setting primarily by a non-RHC or FQHC practitioner working under general supervision requirements. And, again, time spent by administrative or clerical staff is not counted towards the time required to bill for these services.

Slide 31. Let's go through the requirements for psychiatric CoCM because some of them are significantly different than CCM or general BHI.

First is the initiating visit and beneficiary consent. These are the same as CCM and general BHI.

Billing requirements: at least 70 minutes in the first calendar month and at least 60 minutes in subsequent calendar months of psychiatric CoCM services that is furnished under the direction of the RHC or FQHC primary care practitioner and furnished by an RHC or FQHC practitioner or behavioral health care manager under general supervision.

Patient eligibility for psychiatric CoCM is any mental, behavioral health, or psychiatric condition being treated by the RHC or FQHC primary care practitioner, including substance use disorders, that, in the clinical judgment of the RHC or FQHC practitioner, warrants CoCM services.

Slide 32. For psychiatric CoCM, the RHC or FQHC primary care practitioner's responsibilities are to direct the behavioral health care manager or clinical staff; to oversee the beneficiary's care, including prescribing medications, providing treatments for medical conditions, and making referrals to specialty care when needed; and the RHC or FQHC primary care practitioner would remain involved through ongoing oversight, management, collaboration, and reassessment.

Slide 33. For psychiatric CoCM, there must be a behavioral health care manager. And this person would provide assessment and care management services, including the administration of validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; provision of brief psychosocial interventions; ongoing collaboration with the RHC or FQHC practitioner; maintenance of the registry; and acting in consultation with the psychiatric consultant. The behavioral health care manager must also be available to provide services face-to-face with the beneficiary and have a continuous relationship with the patient and a collaborative, integrated relationship with the rest of the care team and, also, to be available to contact the patient outside of regular RHC or FQHC hours as necessary to conduct the behavioral health care manager's duties.

Slide 34. There must also be a psychiatric consultant. And this person would participate in regular reviews of the clinical status of patients receiving CoCM services; advise the RHC or FQHC practitioner regarding diagnosis, options for resolving issues with beneficiary adherence and tolerance of behavioral health treatment, making adjustments to behavioral health treatment for beneficiaries who are not progressing, managing any negative interactions between beneficiaries' behavioral health and medical treatments; and facilitate referral for direct provision of psychiatric care when clinically indicated.

If this rule is finalized as it is proposed, then RHCs and FQHCs would continue to receive payment for CCM when CPT code 99490 is billed alone or with other payable services on an RHC or FQHC claim until December 31st of this year. Claims with CPT code 99490 that are submitted on or after January 1st of 2018 would not be paid. Beginning on January 1st of 2018, RHCs and FQHCs would use the new General Care Management G code (GCCC1) either alone or with other payable services on an RHC or FQHC claim when billing for CCM or general BHI services and GCCC2, the new psychiatric CoCM G code, either alone or with other payable services on an RHC or FQHC claim when billing for psychiatric CoCM services.

Slide 36. We considered other options when we were discussing payment for RHCs and FQHCs for care management services. We considered allowing RHCs and FQHCs to bill for each code in the same manner as we currently allow CPT code 99490 to be added to a claim. We also considered creating one G code based on the average rate of all five codes. And we considered developing three G codes: one for the CCM code, one for the general BHI code, and one for the psychiatric CoCM code.

We chose to propose creating these two new G codes because we believe they are the least burdensome – they're less burdensome than separating – than separate reporting for each code because they require less recordkeeping, monitoring, and coding expertise. We also chose this method because there may be more care management codes in the future and there – that could result in a long string of codes to monitor and track and, also, because this methodology is more consistent with the RHC and FQHC payment methodology of averaging actual costs to determine a payment rate and not paying for services based on time increments.

Slide 38. So in summary, we are proposing two new G codes for RHCs and FQHCs for care coordination services: GCCC1, which is the CCM or general BHI services, paid at the average of CPT 99490, 99487, and HCPCS code G0507, and using the 2017 payment rates, the payment would be $61.37 for 20 minutes or more of CCM or general BHI services; and GCCC2, psychiatric CoCM services, paid at the average of HCPCS codes G0502 and 503, and that would have been $134.58 for initial or subsequent psychiatric CoCM service using the 2017 payment rates.

On the next slide, on slide 39, is a link to the calendar year 2018 Physician Fee Schedule proposed rule. Comments are due by September 11. And there's also a link to submit any comments. If you like what we have proposed, please let us know. And if you don't, you can let us know that too.

So I want to thank you all for calling in today. And I'm now going to turn this over to Michelle Oswald from the Office of Minority Health, who has been leading CMS's outreach efforts on chronic care management and is a great resource on information to assist you in implementing these programs. Michelle?

Resources

Michelle Oswald: Great. Thanks so much, Corinne. And that's a lot of great information that you presented today to the group.

I just want to briefly update those of you on this call about a new campaign that we launched a few months ago, through the CMS Office of Minority Health in partnership with the Federal Office of Rural Health Policy at the Health Resources and Services Administration, called *Connected Care*, which we call the chronic care management campaign. So this is a national public education campaign that seeks to raise awareness of the benefits of chronic care management services among health care professionals and patients, specifically in rural areas and among racial and ethnic minority populations.

So as part of this initiative, we've offered multiple resources at no cost to health care professionals and their patients to learn about chronic care management with information on our website listed here, which is go.cms.gov/ccm. One of these resources is a web-based health care professional toolkit that is available to download as a PDF, which is on the website. This may be used as a guide, if you are just getting started with chronic care management, to have information on how to talk to your staff and patients, who CCM is for, why it's beneficial, and how to bill for CCM services. We also have in-clinic posters available to display at your practice as well as postcards that can be shared with your patients all highlighting the benefits as well.

And, recently, we just launched some new products to include an animated video that you can play in your waiting areas. And you may have heard our radio PSAs that have been broadcast in radio stations across the country, just starting this past week. And we have a new testimonial video that's on our website with health care professionals sharing their experience with implementing CCM programs.

And, again, all of our educational materials are available on our website at go.cms.gov/ccm. You can also link to other CMS resources about chronic care management and care management that were talked about today, from our website. And if you have specific questions on CCM or want to partner with us on the *Connected Care* campaign, you can email us at ccm@cms.hhs.gov.

And now, I'm going to turn it over to Terri Postma, our medical officer, to talk about the 2018 Physician Fee Schedule proposals for the Shared Savings Program.

Proposed New Process for Using RHC and FQHC Claims To Assign Beneficiaries to MSSP ACOs

Dr. Terri Postma: Great. Thank you, Michelle. Hi, everyone. Thanks for having us today. Thanks for being here. As Michelle noted, I'm going to be talking to you a little bit about the proposals that we're making in the 2018 PFS proposed rule related to some of the methodologies that the Shared Savings Program uses to assign beneficiaries to ACOs that include FQHCs and RHCs as ACO participants.

You may recall that the Shared Savings Program was established in 2011 as a result of the passage of the Affordable Care Act. And it provides a forum for providers and suppliers to join together into what are known as Accountable Care Organizations, or ACOs. When these providers join together in ACOs, they seek to improve the quality of care for beneficiaries that are assigned to them and reduce the growth and cost of care for those

beneficiaries by better coordinating the care from site to site. The Affordable Care Act requires us to assign fee-for-service beneficiaries to each ACO that's participating in the Shared Savings Program based on that beneficiary's use of primary care services furnished by a physician that's participating in the ACO. When we finalized our rules in 2011, we established a beneficiary eligibility requirement for assignments such that, if a beneficiary has had at least one primary care service during an assignment window furnished by a physician who is an ACO professional in the ACO, who is a primary care physician, or who has a specialty designation used in our assignment methodology, then that beneficiary would be eligible for assignment. Once we determine the beneficiaries that are eligible, we then apply a two-step process to determine if the beneficiary has had enough primary care services identified by specific HCPCS or CPT codes to hold the ACO accountable for that beneficiary's care for the upcoming performance year.

When we established the Shared Savings Program through rulemaking in 2011, RHC and FQHC stakeholders asked CMS to permit them to form an ACO and to include their beneficiaries in the assignment methodology. However, RHC and FQHC claims contain very limited information concerning the individual practitioner or even the type of health professional who provided the service because this information wasn't necessary to determine payment for services in RHCs and FQHCs. So, unlike the Physician Fee Schedule claims, there was no direct way for us to determine if a claim was for a service furnished by a physician as the statute required. Therefore, in the absence of special rules under the Shared Savings Program, we wouldn't have been able to establish an eligible pool of beneficiaries for ACOs that contain RHCs and FQHCs, because of that. We established special rules for ACOs that included FQHCs and RHCs so that we could, in fact, assign beneficiaries seen in those facilities and consider them under the assignment methodology.

Specifically, we currently require that, at the time of application as part of the ACO participant list, the ACO must submit the NPIs, the national provider identifiers, of the physicians that provide direct patient care in FQHC or RHC settings and attest to that. We also use revenue center codes as proxies for primary care services because the billing rules that took effect in October 2014 and April 2016 for FQHCs and RHCs, respectively, were not required to use HCPCS or CPT codes for billing purposes.

So the special process that I just described to you that's currently in place imposes an additional burden on ACOs that wish to include or be formed by RHCs and FQHCs. But, in addition, due to operational complexities, the program integrity and screening that we apply in other issues, we only permit submission of the NPIs and attestation to them on an annual basis. Our stakeholders have told us that tracking NPIs across sites of care and the sheer number of necessary submissions is prone to error and may result in fewer claims being considered from FQHCs and RHCs for purposes of Shared Savings Program assignment than would otherwise occur if they were treated equitably as PFS claims are.

So in part, to address these issues and as a result of the lobbying efforts of FQHCs and RHCs, Congress passed an amendment to the statutory language governing the Shared Savings Program assignment methodology through the 21st Century Cures Act in December. The 21st Century Cures Act amends the Shared Savings Program requirements regarding assignment and, instead, requires the Secretary to assign beneficiaries to ACOs participating in Shared Savings Program based not only on their utilization of primary care services furnished by a physician but also based on utilization of services furnished by RHCs and FQHCs effective for performance year beginning on or after January 1st, 2019. The statute provides the Secretary with broad discretion to determine how to incorporate those services into the Shared Savings Program beneficiary assignment methodology.

Therefore, because of this broadened flexibility, we're proposing in the Physician Fee Schedule starting with performance year 2019 several things. First, we're proposing to remove the requirement for ACOs that include RHCs and FQHCs as ACO participants to identify and attest to physicians who directly provide primary care services in those facilities. Second, we're proposing to use all RHC and FQHC claims to establish beneficiary eligibility for assignment rather than looking at revenue center codes or HCPCS or CPT codes. And finally, we're proposing to consider all RHC and FQHC claims as primary care services without regards to those HCPCS codes or CPT codes that are – or revenue center codes that are included on the claims.

We believe that these proposals will drastically reduce the operational burdens for ACOs that include RHCs or FQHCs and bring greater consistency to our assignment methodology. We're looking forward to seeing your comments on this. I encourage you to go to the *Federal Register* site and submit your comments before September 11. And we're very interested in hearing them as well as any comments you have on the other proposals related to the Shared Savings Program.

Thanks. Hazeline?

Hazeline Roulac: Thanks, Dr. Postma. We will now move on to the question-and-answer session of our call. As a reminder, this call is being recorded and transcribed. Please note feedback received during this listening session will not be considered formal comments on the rule. Review the proposed rule for information on submitting comments by the close of the comment period on September the 11th, 2017.

All right, Dorothy. We are ready for our first caller.

Question & Answer Session

Operator: To ask a question, press star followed by the number 1 on your touch-tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to ensure clarity. Once your line is open, state your name and organization.

Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. If you have more than one question, press star 1 to get back into the queue, and we will address additional questions as time permits. Please hold while we compile the Q&A roster.

Please hold while we compile the Q&A roster.

Your first question comes from the line of Cindy Gillespie.

Cindy Gillespie: Hi. Can you hear me?

Hazeline Roulac: Yes, Cindy, we can hear you. Go ahead with your question.

Cindy Gillespie: Okay. We are providing the CCM services right now. And we are having problems getting patients signed up due to their copay. They can't afford it. They don't want to pay the $8 a month or whatever. Is there anything we can do about that?

Corinne Axelrod: Hi, Cindy. This is Corinne, and thank you for your question. The deductible and copayments aren't – have not been waived for CCM services. So they would apply to CCM and care management services in the same manner that they apply to any other RHC or FQHC service. So for RHCs, the copayment and deductible applies. For FQHCs, just the copayment applies. And there's no statutory authority for us to waive those charges. We would note that, if there – if the clinic offers a sliding fee schedule, that CCM and care management services are treated the same way as any other service – so – but, it's the reason that we really emphasize patient consent so that patients can really understand the benefit of these services even though they are paying for them and they're not seeing the services, that there really is a benefit to them. But – so it's a long answer to your question. No, there is no – we have no authority to waive the copayment or deductible.

Cindy Gillespie: Okay. Thank you.

Operator: Your next question comes from the line of Shirley Gamble.

Shirley Gamble: Good afternoon. My name's Shirley Gamble, and I'm with the Sterling Medical Center in Sterling, Kansas. And I just wanted to clarify, on page 35 of the handout, the new code needs to be used for claims that are submitted on or after January 18th. So any claims that would be maybe for December of 2017 towards the end of the month would need to be used with the new code because they may be submitted for payment after January 1. Is that correct?

Corinne Axelrod: Thank you, Shirley. That's an important distinction, and I probably should have made that more clear on the slide. So the payment for 2017 is only for CCM using CPT code 99490 for services furnished in 2017. For services furnished in 2018, you would use the new G code. And we will issue additional instructions after the final rule to address sort of that overlap period of billing for services that occurred in the prior year. So thank you for bringing that up. And I think Simone wants to also add to that.

Simone Dennis: Yes. This is Simone Dennis. And maybe to clarify, if it helps, it'll be for claims with dates of service on or after January 1, 2018. That's when you would begin to use the new code, again, with the date of service after January 1, 2018.

Shirley Gamble: That's very important because, earlier this year, they changed our billing methodology and it was based on when the claim was received into CMS for processing, and it caused a lot of denials because of the gap between the claim leaving our office, going through the clearinghouse, and being received for payment. So it is going to be date of service—January 1, '18, or after—we use the new code.

Corinne Axelrod: Yes, that's correct. So thank you for bringing that up. And we will work with our claims processing colleagues. And our goal is to make this as seamless as possible. So – and again, we will provide additional instructions and subregulatory guidance once the rule is finalized.

Shirley Gamble: Thank you.

Operator: Your next question comes from the line of Yvonne Ketchum-Ward.

Yvonne Ketchum-Ward: Hi. I was wondering, on the second half of the presentation where you were talking about the Medicare Shared Savings plan, is that information available in writing? It wasn't in the slide presentation, and it was a little hard to follow just having the verbal. So is there a document that I can refer to?

Dr. Terri Postma: Yes. Thank you, Yvonne. This is Terri Postma. For the Medicare Shared Savings Program, you know, as you know, this is a voluntary program. We do have information on our Shared Savings Program website regarding the current methodology. It can be found in our assignment specification document.

And in terms of the proposals, we have maybe a very short bullet point in the fact sheet that's associated with the 2018 Physician Fee Schedule proposed rule. But probably the best place to go to read more extensively about this and about our proposals is to the *Federal Register*. And read the preamble description of our proposal that can be found in the *Federal Register*. And also, this call will have a transcript associated with it. So you'll be able to get at least my stumbling explanation of it.

Hazeline Roulac: This is Hazeline Roulac. That transcript will be available approximately 2 weeks following the call. And we will put an announcement in the MLN Connects® when it is available. It'll be a written transcript and an audio recording.

Yvonne Ketchum-Ward: Okay, thank you. I'll look for that.

Hazeline Roulac: You're welcome.

Operator: Your next question comes from the line of North Country HealthCare.

Veronica: Hi. My name is Veronica. And we wanted to know what rev code is going to be attached to the CCM codes.

Simone Dennis: Hi. This is Simone. Can you repeat that one more time for us?

Veronica: Sure. We would like to know which rev code is going to be attached to the CCM codes.

Simone Dennis: The new CCM codes can be reported with revenue code 052x.

Veronica: 052x?

Simone Dennis: Yes.

Veronica: Okay. Thank you.

Simone Dennis: You're welcome.

Operator: Your next question comes from the line of Shauna Nadeau.

Shauna Nadeau: Hello. My question is for the G code GCCC1. I know that the G code for the – for regular providers, there's a copay. Is there one associated with the GCCC1?

Simone Dennis: Hi. This is Simone Dennis. Yes. There is copayment associated with reporting GCCC1.

Shauna Nadeau: All right. Thank you.

Operator: Your next question comes from the line of Mary Pipa.

Mary Pipa: Hi. And going back to that revenue code where the – you said the allowable code was 052x. The "x" stands for something. What is the exact code that the "x" stands for? Because you've got 0 through 9. Which code do we select? Because you did not provide that.

Simone Dennis: The clinic should report the most appropriate digit that corresponds to, I believe, where the service is being furnished or the site of where it's – the facility is located. We have some resources on our web in the benefit – in the Claims Processing Manual on the CMS website.

Mary Pipa: Because your clinic offices usually use a one. So I didn't know if we could use "other" because there is nothing else to describe the CCM type of visit.

Simone Dennis: Right. So one would be most appropriate.

Mary Pipa: Okay. Thank you.

Operator: Your next question comes from the line of Karen Schnell.

Karen Schnell: Hello. You said that CCM would – you can bill it with something else or by itself. So if it was billed with a visit, would you get reimbursed the AIR rate plus the rate for the CCM?

Corinne Axelrod: So, Karen, you're a little bit hard to hear. But I think you're asking if you can bill for a visit at the same time as billing for care management. Is that what you're asking?

Karen Schnell: Yes. Would you get reimbursed for both, or would it just roll into the AIR rate?

Corinne Axelrod: Yes. So just like now, you can bill for 99490 with other services or alone on a claim. It would be the same thing. So you can put it on the same claim as other services or submit a claim with just the GCCC1 or 2 on it.

Karen Schnell: Okay. Thank you.

Operator: Your next question comes from the line of Karen Robinson.

Karen Robinson: Hi. Is there anything in the final rule that would prohibit an RHC/FQHC provider from contracting with a third party to provide the required elements under the provider's supervision?

Corinne Axelrod: So first, let me just make sure that we all understand this is a proposed rule. It's not a final rule. And that based on your comments, we will finalize it, and there could be some changes. So based on the proposed rule, there's nothing that prohibits RHCs and FQHCs from contracting out these services. The initiating visit must be done at the RHC or FQHC, and it would be the RHC or FQHC practitioner that would oversee the care. But, for the actual care management services, that can be contracted out and anybody who is doing that would be working under general supervision requirements.

Karen Robinson: Okay. Thank you.

Corinne Axelrod: Yes. Thank you.

Operator: Your next question comes from the line of Angela Fileccia.

Angela Fileccia: Hi. Thanks for taking our questions. One question we would have is talking about the psychiatric consultant. Would that also include a psychiatric nurse practitioner?

Corinne Axelrod: Angela, I would have to doublecheck that. I don't think so, because I think that the psychiatric consultant has to be able – has to have full prescribing authority. But I'm not an expert on state scope of practices for that. So I would have to doublecheck on that. And that might be a good question to submit in a comment.

Angela Fileccia: Thank you.

Operator: Your next question comes from the line of Denise Kennedy.

Jennifer: Hi. My name is Jennifer, and I'm from Hermann Area District Hospital. And my question was kind of like the last one. When it comes to the BHI, the primary care practitioner—that doesn't have to be LCSW? That can be any provider?

Corinne Axelrod: So for general BHI for CCM and, actually, for all of these services, these are services that are being – we're paying to enhance the care coordination. And it's the primary care practitioner that is kind of the link here. So it would be the physician, nurse practitioner, physician assistant, or certified nurse midwife that would be the one who is leading the care, and the clinical social worker could be the health care manager for the CoCM services. But there has to be the primary care practitioner that would be the person overseeing the care management.

Jennifer: Okay. So can an LCSW or an LMSW provide services with primary care?

Corinne Axelrod: So they could provide – they could service a behavioral health care manager and the – if the RHC or FQHC is furnishing psychiatric CoCM services.

Jennifer: Okay. Thank you.

Corinne Axelrod: Thank you.

Operator: Your next question comes from the line of Jacqueline Clonk.

Jacqueline Bloink: I think you mean Jacqueline Bloink. My question is regarding Medicaid. What about the Medicaid rules for each State? When would those be revised and implemented?

Corinne Axelrod: We can only address – this is Corinne, and we can only address Medicare. So we don't have any information on Medicaid rules. Sorry.

Jacqueline Bloink: All right. Thank you.

Corinne Axelrod: Thank you.

Operator: Your next question comes from the line of Jackie Taylor.

Hazeline Roulac: Hi, Jackie. Are you there?

Jackie King: Is it Jackie King maybe?

Hazeline Roulac: Yes. You may go ahead. Ask your question.

Jackie King: Okay. So this is Jackie King. And I am asking a question about beneficiary assignment. I have the *Federal Register* up in front of me—the proposed. So what I'm reading is section 425.404 about assignment. If the provider performs a primary care service and the ACO professional is a nonphysician and the NPI on the claim for the primary care service is part of an RHC, it sounds to me like you're going to allow those mid-levels to be included in the initial assignment based on this proposed rule when they're excluded at this point. Am I reading that correctly? It's kind of vague.

Dr. Terri Postma: Yes. Thanks for your question. This is Terri Postma. So as I noted earlier, our current constraint by the statute is that we are required to assign beneficiaries based on primary care services furnished by physicians. And we do that by looking to see if the beneficiary has had at least one primary care service with the physician at the ACO. And that creates a pool of beneficiaries. We call that the pre-step.

After the pre-step, we do a two-step methodology that includes all primary care services furnished to the beneficiary by physicians, NPs, PAs, CNSs, and other physician specialty types that we outline in the rule. So NPs and PAs that furnish services in FQHCs and RHCs are currently included in those – in that first and second step. But in terms of identifying an eligibility – or a beneficiary that's eligible for the pre-step, we can only currently use the services that are furnished by physicians.

Jackie King: Yes. I understand.

Dr. Terri Postma: Yes. So now what we're proposing as a result of the flexibilities afforded to us by Congress as a result of the 21st Century Cures Act is to gather up basically all the claims billed by FQHCs and RHCs and other clinics under the PFS rule that are participating as ACO participants in the Shared Savings Program, collect all those claims, and use them to determine whether a beneficiary is eligible as part of that pre-step. So

the FQCH and RHC claims are going to be used for that pre-step regardless of whether different service was furnished by a physician or whether that service was provided by a nonphysician practitioner.

Jackie King: Wonderful.

Dr. Terri Postma: Yes.

Jackie King: Wonderful.

Dr. Terri Postma: I know you guys have been asking for that for a very long time.

Jackie King: I'm excited. Thank you so much for your answer. I like it.

Dr. Terri Postma: Yes. You're welcome.

Operator: Your next question comes from the line of Megan Cody.

Megan Cody: Yes. My question and – is about the reporting and tracking of the time increments for CCM. Can you direct me to how that is exactly supposed to look like? For instance, do you record the start and stop time, or just what you've done with those 20 minutes?

Corinne Axelrod: Hi. This is Corinne. And we will be providing more information after the rule is finalized on specifics like that. So if you don't mind waiting until then, we'll try to provide more information more specifically towards that.

Megan Cody: Okay. Can you direct me to where the current rule is? Or is it ...

Hazeline Roulac: Just a moment.

Megan Cody: Sure. Thank you.

Corinne Axelrod: We're not really clear what your question is. Would you mind repeating it, please?

Megan Cody: Sure. For when we document our – or when our clinicians document the 20 minutes that they've spent on the patient or, as it will be in the future, maybe 20 minutes or more, even though they only have to document that first 20, what does CMS want that to look like in the record for it if we're audited or when they go back to look at that? Is there a rule for how that should look?

Corinne Axelrod: So, you know, we don't really provide guidance on how that should be documented in the medical records. And so, I think we just – we'll have to check if on the Physician Fee Schedule side – if there is any guidance on that. But I don't recall seeing any. So we'll take a look, but I don't think there is any guidance on that.

Michelle Oswald: And, Corinne,

Megan Cody: Yes.

Michelle Oswald: This is Michelle Oswald. I know there are some examples and information out on the CMS Care Management page under the regular Physician Fee Schedule side. So if you go to cms.gov and then type in "care management," if you go to that page, they have their fact sheets and FAQs. And I think there are probably some examples and information there that could be applicable here if and when this goes into effect. So that may be helpful for you.

Megan Cody: Okay. Thank you.

Michelle Oswald: You're welcome.

Operator: Your next question comes from the line of Dana Paul.

Dana Paul: Hi. My question is, while I realize that the CCC1 and CCC2 are governed by the primary care physician, the revenue code for the psychiatric—would that be a 900 revenue code or would it still be the 052x? Because for psychiatric care, we have to bill – we bill with a 900 revenue code.

Simone Dennis: Hi. This is Simone Dennis. We really appreciate that question. I think Corinne spoke earlier about subregulatory guidance. And that's something that we would like to clarify in subregulatory guidance. So we appreciate if you can also maybe submit that in a comment to us so we can further clarify that at a later date.

Dana Paul: Okay.

Hazeline Roulac: Can we have another question, Dorothy?

Operator: Your next question comes from the line of Denise Seratosley.

Hazeline Roulac: Hi, Denise. Are you there?

Operator: The callers withdrew their question.

Your next question comes from the line of Anne Middleton.

Anne Middleton: Hello. Can you hear me?

Hazeline Roulac: Hi, Anne. Yes, we can hear you.

Anne Middleton: I'm looking at slide 5 where it says that the complex CCM services CPT 99487 is alluding to the fact that it is payable in RHCs and FQHCs currently. Correct?

Corinne Axelrod: This is Corinne. No, that is not correct. Currently, only 99490 is billable for RHCs and FQHCs. The complex CCM was added this year for practitioners billing under the Physician Fee Schedule. But it is not a billable code for RHCs or FQHCs at this time.

Anne Middleton: That was the clarification I wanted to see because, in the ICN that came out December 2016, it did say it could not be used. And I just wanted to make sure that something didn't change that I missed during the year.

Corinne Axelrod: Great. Thank you.

Anne Middleton: Thank you.

Operator: Your next question comes from the line of Felicia Ducana.

Alicia Ducuna: Hi. I think that was Alicia Ducuna. So my question is in regards to slide number 20. There's mention of a clinical personnel. Can this clinical personnel be a clinical pharmacist practicing under a collaborative drug therapy agreement?

Corinne Axelrod: Yes. Hi. So yes, it could be. Pharmacists are considered auxiliary personnel in RHCs and FQHCs. And so they certainly would qualify to – well, wait, I'm sorry. Are you asking about the furnishing under the direction of CCM and general BHI, or whether they could be a behavioral health care manager?

Alicia Ducuna: So both. We actually have a pharmacist who is completing a psychiatric pharmacy rotation, and our health center is looking to incorporate her under our behavioral health integrative team, so providing additional behavioral health care. And then also for the other – for the CCM services in terms of the medication reconciliation and adherence, the pharmacist participates in that as well.

Corinne Axelrod: So for RHCs and FQHCs, RHC and FQHC practitioners are statutorily defined, and they do not include pharmacists.

Alicia Ducuna: Yes.

Corinne Axelrod: So the – a pharmacist could not be the person that initiates care management services in an RHC or FQHC. The pharmacist could provide care management services as auxiliary personnel just like a nurse could or other clinical personnel.

Alicia Ducuna: Okay. All right. Thank you very much.

Corinne Axelrod: Thank you.

Operator: Your next question comes from the line of Emily Fletcher.

Emily Fletcher: Hi. This is Emily from Mercy. In the proposed rule for 2018 for attribution, they refer back to the 2017 change where a patient was able to start designating a main doctor in 2017 on MyMedicare.gov that would then in 2018 be prospectively attributed. I was wondering, has that gone live on MyMedicare.gov?

Dr. Terri Postma: Hi. This is Terri Postma. Thanks for your question. Yes, the MyMedicare.gov website, which is a free, secure patient portal where a patient signs in, logs in to their account, and there's a new functionality that you just alluded to, which is that the beneficiary can actually select or designate a practitioner as the one that they believe is most responsible for coordinating their overall care. The shared – under the Shared Savings Program as finalized in last year's rule, we're going to be using that information to hold ACOs accountable for that beneficiary's care in a prospective manner if the beneficiary has selected a practitioner that is participating in an ACO. And this is really important because, you know, if the beneficiary believes that that practitioner is responsible for their overall care coordination and we know that that practitioner is participating in an ACO, then it's reasonable to hold them accountable for their care for the upcoming year. And yes, that website is active, live, and I walked through it with my mother the other day and had her select her primary care practitioner.

Emily Fletcher: Is there instructions posted anywhere on Medicare how to do that? We looked at the tutorial since we don't have a Medicare account to really log in to and play around with it. Is there anywhere where instructions are listed for how a patient designates that?

Dr. Terri Postma: It's a really good question. I know that 1-800-Medicare—the folks that man those lines—have instructions on helping a beneficiary walk through it. I believe that we're developing some materials that ACOs can share with their practitioners so that they have that information available at the point of care. But I'm not aware of any particular website that has that available just generally. But let me look into that. That's a great question. And we should have those somewhere available. If we don't, we'll work on it.

Emily Fletcher: Thank you so much.

Dr. Terri Postma: Sure.

Operator: Your next question comes from the line of Barb Newton.

Barb Newton: Hi. I'm – my question was on the voluntary assignment that they were supposed to have a webinar on. And we're trying to find out more about it because I thought it went into effect 1/1/2018. So is there going to be a webinar? Is there a website we can look at? And if a patient says that this is my primary care provider, when does that attribution start?

Dr. Terri Postma: Yes. Great questions. So I'm going to share information with Hazeline, with links if I can find some that have this information. Is that okay? Is that something that you can share with the folks on the call or no? Sorry, think about it. So I'll think about how I can work with Hazeline to get that information out. And if not, we will – we'll look to see how we can make that information more generally available.

The voluntary alignment will override claims assignment. So if by claims, it looks like during the past 12 months a beneficiary has frequently seen Provider A but, then, based on the information that the – that we got from the beneficiary directly, they believe that Provider B is the one that's responsible for their overall care, then we're going to use that information preferentially to assign to an ACO rather than relying on claims like we're doing currently.

And we're collecting that information now. Like I said, that functionality is available. It's up and running on MyMedicare.gov right now. And we're going to be using that information when we create assignments for ACOs for the 2018 performance year. So you will see that information incorporated starting for the 2018 performance year.

Hazeline Roulac: And we will work – this is Hazeline Roulac. We'll work with Terri to get that information out to you—the links that she mentioned.

Barb Newton: So I was under the impression that this didn't actually start until 2018. But you're saying you can put it in now, and then it would apply in 2018?

Dr. Terri Postma: Correct. By starting in 2018, it means we'll incorporate it into – that information into the assignment methodology starting with performance year 2018. But the functionality is available now for beneficiaries to go in and to indicate who they believe is responsible for their overall care.

Barb Newton: So if during 2018 they go in, then does it take another year before they're actually – change their assignment?

Dr. Terri Postma: Yes. If a beneficiary goes in in the middle of 2018 and makes a different selection, then that information would be incorporated for the 2019 performance year.

Barb Newton: So – and you are going to give us some website that we can look at this for information?

Dr. Terri Postma: I'll find out what's available. Yes. I'll find out what's available. And if there are some easy links available, I'll work with Hazeline to get those out to you. If they're not available, I will work with – internally here and try to get that information more readily available to folks. Okay?

Barb Newton: Thank you.

Dr. Terri Postma: Thanks.

Operator: Your next question comes from the line of Deepak Adhikari.

Deepak Adhikari: Hello. My question is about allowed charges that come from federally qualified to the FQHC and RHC because usually they will be an institutional claim. So in that case, how…

Hazeline Roulac: Hi, sir. I'm sorry. Could you speak up just a little bit? We can't hear you?

Deepak Adhikari: Okay. My question is about allowed charges for the – how do you determine allowed charges that come from RHC or FQHC because they file an institutional claim? So did you determine for that?
So I guess like the main criteria for the – assigning beneficiary for issuant, whoever has maximum allowed charges or authority for allowed charges. So, how did we determine allowed charges in those institutional claims?

Dr. Terri Postma: Hi. This is Terri Postma from the Shared Savings Program. I believe you're asking about our two-step assignment methodology where we determine where a beneficiary has received the plurality of their primary care services based on allowed charges and how we determine what allowed charges are for FQHC and RHC claims.

And I believe that's just a very simple calculation of determining the costs associated with the facility charges as well as the PFS charges for primary care services that are associated with that particular beneficiary. We have a lot more detailed information on our assignment methodology in the assignment specification document that you can find on our website at sharedsavingsprogram.cms.hhs.gov.

Deepak Adhikari: Yes. I have version 3 and version 4.50. So, for example, if the revenue center code is 0521, so how much amount am I supposed to put as allowed charges for that particular claim?

Dr. Terri Postma: You don't put anything. We get this all internally from our claims system. We know what the charges are.

Deepak Adhikari: For example – yes. Okay.

For example, if I want to mimic the way it was done in our data because we are just trying to do that mimicking how it was done or how the processes are done for assigning issues, I was trying by myself, and because I have institutional claims from CMS which doesn't report allowed charges and my sensitivity is a little bit off especially due to this FQHC and RHC issue.

Dr. Terri Postma: Yes.

Deepak Adhikari: And so, like – maybe there is a – some like – some number there for those kind of revenue center codes where I can translate that as allowed charges.

Dr. Terri Postma: I see. Okay. It would be really great if you could submit that question and exactly what you are trying to do to our program – our subject matter experts at aco@cms.hhs.gov. And we should get – be able to get you a more specific answer.

Deepak Adhikari: Okay. Thank you so much.

Dr. Terri Postma: That's – sure. That's aco@cms.hhs.gov.

Deepak Adhikari: Okay. Thank you.

Dr. Terri Postma: Thanks.

Operator: Your next question comes from the line of Coleen Ruddy.

Coleen Ruddy: Yes. I had a question on the 24/7 coverage. Can that be provided by physicians that are in the ER if they have access to the electronic health record within the clinic?

Corinne Axelrod: I'm sorry. So, you are referring to care management services, I assume. And so – and your question is whether a physician in an ER could provide the 24/7 coverage. Is that right?

Coleen Ruddy: Right. So, it says access to care – ensure 24-hour, 7-day-a-week access to care management services providing the patient with the means to make timely contact with health care practitioners in their practice.

I mean, how are you expecting that to happen? I'm just wondering, you know, if the patient has a concern, if they call in, is it okay if the physician that's covering the ER at that time takes care of that concern or...?

Corinne Axelrod: So I would say that's a good question to submit. I don't think we have any guidance on that at this time. So if you wouldn't mind submitting that as a question, then we'll look into that.

Coleen Ruddy: Okay. And where does that get submitted again?

Corinne Axelrod: There is a link on the slide presentation for comments.

Coleen Ruddy: Okay.

Hazeline Roulac: That's on slide 40.

Coleen Ruddy: All right. Thank you.

Corinne Axelrod: Thank you.

Coleen Ruddy: And then, I have another question. Is it all billed with a Rural Health Clinic type of bill and it's on a UB?

Simone Dennis: This is still in regards to care coordination, correct?

Coleen Ruddy: Correct.

Simone Dennis: Yes, it's billed on the UB 04.

Coleen Ruddy: Okay. And the providers aren't required to track their time separately for the services provided here versus in the Rural Health Clinic. Correct?

Corinne Axelrod: So, I'm not sure that we're kind of on the same page here. So, the RHC or FQHC practitioner would furnish the initiating visits for care management and would oversee the care coordination. But the actual care coordination is typically furnished non–face-to-face by...

Coleen Ruddy: Okay.

Corinne Axelrod: ...other personnel.

Coleen Ruddy: Okay. Yes. I got that. Thank you.

Corinne Axelrod: Okay. All right. Thank you.

Operator: As a reminder, to ask a question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, press the pound key.

Your next question comes from the line of Denise Seratosley.

Hazeline Roulac: Hi, Denise. Are you there?

Denitrias Seratosley: I'm not sure if that's Denise or it's Denitrias. But, this is Denitrias with Azalea Health. I'm the Care Manager Coordinator. Can you hear me?

Hazeline Roulac: Yes, Denitrias, we can hear you. You can go ahead with your question.

Denitrias Seratosley: Okay. My question is regarding the CCM services. As far as the 20 minutes of care management, does that have to be a face-to-face visit or does it – can it be telephonic?

Corinne Axelrod: Hi. This is Corinne. And it does not have to be face-to-face. The initiating visit, obviously, has to be face-to-face. And if you're doing psychiatric CoCM services, the behavioral health care manager has to be available to provide face-to-face services.

But for care coordination services in general, those are typically not done face-to-face and could be done over the phone. Those services are coordinating with other providers, checking in with the patient – things like that. So I would assume most of that actually would be done over the phone.

Denitrias Seratosley: Okay. That was my question. Thank you.

Hazeline Roulac: Thank you.

Operator: Your next question comes from the line of Debra Morrison.

Debra Morrison: Hi. My question is about the psychiatric Collaborative Care Model and referencing slide number 33, that the behavioral health care manager needs to be available to contact the patient outside of regular RHC or FQHC hours. Can you talk a little bit more about that? It seems – it sounds like this person needs to be available 24/7, and that feels a little bit unrealistic for this kind of a role.

Corinne Axelrod: So I think that's a good question. If you'd like to submit that in a comment, that would be good. I don't really have any information as to how that requirement was determined. The psychiatric CoCM model is a structured model. And so, I'd have to go back and see if there's any additional information on the – what it actually means to be available outside of RHC and FQHC hours.

I agree with you it sounds like it's 24/7. But that is consistent with care management that there has to be somebody available 24/7 for both the care management CCM, BHI, and CoCM. So, if you would send in a comment, then maybe we can clarify that either in the final rule or in subregulatory guidance.

Debra Morrison: Okay. Great. Thanks a lot.

Corinne Axelrod: Yes. Thanks.

Operator: Your next question comes from the line of April.

April Head: Hi, ladies. This is April Head from Hermann Hospital. And I had a question in regards to the 20 minutes that would be with a patient documented. Could that be a phone conversation with a patient's family that had concerns about that family's health or, to your knowledge, does that have to be directly with the patient?

Corinne Axelrod: So it's another good question. Does the – care management does not have to be directly with the patient because it's managing the patient's care. And so, I would assume that would include family members. But, again, I would want to verify that before saying it for sure.

April Head: Okay. Thank you for your advice.

Corinne Axelrod: Yes. Thank you.

Hazeline Roulac: Hi, Dorothy. We have time for one more question, please.

Operator: Your final question comes from the line of Jackie Burczyk.

Jackie Burczyk: Hi. I was just going to request that perhaps for the case managers under the behavioral health component, you could also include the specifics of what types of providers would be allowed. We have licensed behavioral specialists in our State here. And so, I wanted to make sure that that would also be an acceptable care manager for behavioral issues.

Corinne Axelrod: Great. Thank you.

Jackie Burczyk: Thank you.

Additional Information

Hazeline Roulac: So, thank you for your comment.

Unfortunately, that's all the time we have for your questions today. If we did not get to your question, you can email it to the address listed on slide 40.

If you missed any information presented today or would like to review again, an audio recording and written transcript of today's call will be posted to the MLN National Provider Calls and Events webpage, the same webpage where you downloaded the slide presentation. We will place an announcement in the MLN Connects newsletter when these resources are available.

On slide 42 of the presentation, you will find information and a URL to evaluate your experience with today's call. We hope you will take a few moments to evaluate your experience.

Again, my name is Hazeline Roulac. I would like to thank our presenters and thank you, our participants, for participating in today's Medicare Learning Network call on New Proposals for RHCs and FQHCs on Care Management Services and ACO Assignments. Have a great day, everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect.