Preventative Benefits

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Operator: Good day ladies and gentlemen and welcome to your Preventative Benefits conference. At this time all participants will be in a listen-only mode but later we will conduct a question and answer session which instructions will be given at that time. If anyone should require audio assistance you can press * then 0 and an audio Operator will assist you and as a reminder, today's conference is being recorded.

And now I would like to introduce your host for today, Janet Miller.

Janet Miller: Thank you John. Good afternoon and to those joining us from the west coast, good morning. My name is Janet Miller and I am on staff in the Partner Relations group in CMS' Office of External Affairs.

As many of you know, some of the key provisions in the Affordable Care Act relate to changes in Medicare's preventative benefits and these changes could be a major step toward improving the health status of beneficiaries particularly those with disabilities or chronic health conditions.

So I'm very happy to welcome you to this special teleconference. Now to help frame today's call to prepare you to listen you should know we are going to be covering five areas of conversation. We'll begin with a quick review of where we are with preventative services including the Welcome to Medicare visit and then go on to review aspects of the new and your wellness visits. From there we're going to review how these policies impact beneficiary co-pays and deductibles and then we will move on to talk about materials CMS has developed to educate both beneficiaries and providers on these important changes and then we will conclude in the final area will be a question and answer session with our staff.

So to begin the call it is my pleasure to welcome our first speaker, Dr. Jamie Schaeffer. Dr. Schaeffer is a Division Director in the coverage and analysis group, or CAG, and for those of you who are not familiar with CMS speak, this is the group that uses evidence based medicine principles to help us develop national coverage policy for the Medicare program. Dr. Schaeffer has over ten years of primary care experience and is Board certified in family practice and occupational and environmental medicine. She also holds a Masters in Public Health, has done doctoral work in cognitive aging and has an undergraduate degree in chemical engineering. Welcome Dr. Schaeffer.

Dr. Jamie Schaeffer: Janet, thank you very much. Good afternoon. As many of you know, historically Medicare has focused on the evaluation and treatment of medical illness. This stems principally from the Social Security Act back in 1965, Section 1862 A1A which states, "No payment may be made for items or services which except for items and services described in the preceding subparagraph are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member." So, preventive services were not interpreted at that time to be part of coverage meaning they were not necessary to treat disease.

It took a number of years for Congress to add the screening benefits of mammography, colon cancer screening, bone densitometry, and diabetes screening. Now fast forward to

the Medicare Modernization Act of 2003 which provided for prevention visits that occurs within the first 12 months of obtaining Part B. This exam includes a review of your health, education and counseling about the preventative services you need like certain screenings and shots and referral for other care. Your doctor will check to make sure that you are up to date with preventive screenings and services such as cancer screening and shots and depending on your general health and medical history, further tests may be ordered if necessary.

For example, a person at risk for abdominal aortic aneurysm may get a referral for a one time screening ultrasound at their Welcome to Medicare physical exam. Your doctor will give you advice to help you prevent disease, improve your health, and to stay well. You will also get a written plan such as a checklist when you leave, letting patients know which screenings and other preventive services you should get.

Now, I'm going to define the seven required elements of the initial preventive physical examination which is also called the Welcome to Medicare visit.

Number one is a review of the individual's medical and social history with special attention to modifiable risk factors for disease detection. Number two is a review of the individual's potential risk factors for depression or other mood disorders. Number three is a review of the individual's functional ability and level of safety. Number four, a physical examination to include measurement of the individual's height, weight, body mass index, blood pressure, a visual acuity screen, and other factors as deemed appropriate by the examining physician or qualified non-physician practitioner. Number five, end of life planning as defined in regulations upon agreement with the individual. Number six, education, counseling, and referral as deemed appropriate based on the results of the review and evaluation services described in the previous five elements and the last element, education, counseling, and referral including a brief written plan such as a checklist provided to the individual for obtaining an EKG as appropriate and the appropriate screening and other preventive services that are covered as separate Part B benefits.

Janet Miller: Thank you Dr. Schaeffer. That was very thorough. Our next speaker is Dr. Joseph Chin who also works in the Coverage and Analysis group and is the Medical Officer in the Division of Medical and Surgical Services. He specializes in preventive medicine. Welcome, Dr. Chin.

Dr. Joseph Chin: Thank you Janet. I'm going to briefly describe the annual wellness visit and present some additional insight into how we see the visit formalizing over the next few months.

As described in the Affordable Care Act 2010, section 4103, the annual wellness visit is a new service that's available beginning January 2011 for beneficiaries who have Part B and who have not had an initial preventive exam as Dr. Schaeffer mentioned, within the past 12 months.

In the final rule that's on display on the CMS website there are several elements of the annual wellness visit that we had listed. It includes the detection of cognitive impairments, assessing individual risk factors, developing a personalized prevention plan and voluntary advanced care planning. I won't read through all of these other elements. They are on display on the website starting from pages 739 to 799 of CMS document 1503.

Next I would like to describe in more detail the health risk assessment component of it which is not currently a required element of the annual wellness visit but it is featured prominently in the Affordable Care Act not only in sections 4103 but also in section 4004

which is primarily a CDC, the Centers for Disease Control and Prevention section that they're focusing on.

In the statute there is a fall 2011 deadline for the Secretary to develop an evidence based guideline and standards for the health risk assessment so that's one of the reasons why the health risk assessment is not a required element of the annual wellness visit at this time since those are not available but we envision that once we have some more information coming out from those activities that in the future, HRA will be actually a prominent part of the annual wellness visit as mainly I think we believe Congress intended it in the way it was written in the statute.

Right now we also, CMS also has a number of other activities that have focused on health risk assessments. There is an ongoing demonstration that looks at health risk appraisals that's based on telephone and internet type of assessments.

When we have a standard model and evidence based guidelines available we believe that the annual wellness visit really will be focused on the health risk assessment. For example, if the health risk assessment that's conducted either during the visit or prior to visit by the beneficiary, if the assessment indicates or in some way identifies some particular risk factor, for example, cardiovascular disease, then the annual wellness visit can focus on evidence based interventions and the U.S. Preventive Services Task Force recommendations to reduce those risks. That may include for example, the use of aspirin for cardiovascular disease, the use of intensive behavioral therapy for diet and exercise and other recommendations from the task force.

So I think that once we have the health risk assessment available that the annual wellness visit will really focus on the results of the health risk assessment to really further tailor the visit to the individual beneficiary's needs and risks and I think that's how we see it going forward, thank you.

Janet Miller: Thank you Dr. Chin. We started today's call with pretty much policy information because policy determines payment. Our next speaker is Stephanie Freeling (ph). Stephanie works for the Division of Practitioner Services in hospital and ambulatory payment group in the Center for Medicare Management. Stephanie has a BS in Political Science, an MBA and MPH and is a staff currently assigned to prevention of Stephanie-authored section 4104 in both the proposed and final rules. Welcome, Stephanie.

Stephanie Freeling: Thank you Janet. It's a pleasure to be here. We're very excited to be discussing section 4104, the removal of barriers to preventive services in Medicare. We believe that a thorough implementation of this provision can really increase utilization for beneficiaries.

I'd like to bring to your attention as Dr. Chin did as well that earlier this month we did release our Medicare physician fee schedule final rule for calendar year 2011 and I want to encourage our listeners to review the final rule which can be found on the federal register website, www.ofr.gov/inspection. Section 4104 is also in the 1503 pages as are many of the provisions for the Affordable Care Act that were implemented via this rule.

In particular, section 4104 removes the barriers for beneficiaries who seek preventive services in Medicare and the legislation accomplished three things. It authorized an amended definition of preventive services allowed in Medicare. It removed cost sharing requirements for many but not all of those preventive services and the legislation in particular recognized colorectal cancer screening examinations that turned diagnostic in the same clinical encounter and it will extend the waiver for deductible in such cases but co-insurance will continue to apply for the diagnostic procedure.

The definition of preventive services has been amended to include the initial preventive physical examination that Dr. Schaeffer spoke of, the annual wellness visit that is authorized by the Affordable Care Act Section 4103 that Dr. Chin addressed, and for those which continue to be identified by Section 1861 WW2 of the Social Security Act and I will go ahead and mention those here today because there is some confusion about what Medicare considers to be a preventive service and what the United States Task Force recommends for prevention.

So the first is pneumococcal, influenzal, and Hepatitis B vaccinations, screening mammography, screening PAP smears with pelvic exams, colorectal cancer screenings, outpatient diabetes self management trainings, bone mass measurements or bone density, glaucoma screenings, medical nutritional therapy, cardiovascular disease screening, diabetes screenings, ultrasound screening for abdominal aortic aneurysms, and additional services identified through the national coverage determination process and as of 2010, HIV testing was added in May and smoking cessation for asymptomatic patients was added in August of this year.

So that is the definition of preventive services allowed in Medicare and those are the services that are subject to the waiver. So the second provision, addressing the waiver, is that the policy change for deductible and co-insurance requirements for preventive services allowed in Medicare so the section authorized Medicare to make 100% of the payments for the IPPE, the annual wellness visit, and for those preventive services recommended by the United States Preventive Service Task Force with a grade of A or B for any indication or population and that is appropriate for the individual. Not all Medicare preventive services have a grade of A or B and some preventive services are simply not rated. For example, the IPPE Welcome to Medicare and the annual wellness visit are not rated services by the United States Task Force but these services are subject to the waiver because they're specifically addressed and recognized and the waiver of cost-sharing requirements for these services.

Diabetes self-management training and colorectal cancer screening with barium enema are preventive services that are not rated by the United States Task Force and therefore the co-insurance and deductible will continue to apply for these services.

Prostrate cancer screening has a United States Preventive Service Task Force rating of a D and glaucoma screening has a rating of I. These services don't meet the statutory requirements for the waiver and therefore co-insurance and deductible will continue to apply for these services as well.

For a complete list of the preventive services and cost-sharing requirements for 2011, please refer to the final rule. It's Table 65 and it's titled, "CY2011 Deductible and Co-Insurance for Preventive Services under Section 1861 DDD3A of the Act."

The final provision of Section 4104 extended the waiver of deductible services for services furnished in connection with or in relation to a colorectal cancer screening test that becomes diagnostic or therapeutic. Section 4104C waives the Part B deductible for a colorectal cancer screening test that becomes diagnostic. Providers and practitioners will append a new HCPCS modifier PT, colorectal cancer screening test converted to a diagnostic test, to the diagnostic procedure code that is reported instead of the screening colonoscopy code. The claims processing systems would then respond to the modifier by waiving the deductible for all surgical services reported in the same clinical encounter as the screening test. The co-insurance again will continue to apply to the diagnostic procedure.

I wanted to take this opportunity to maybe address some notes that Janet has forwarded to me that have come in and maybe even from some callers here, that are on the line here

today. One issue in particular came around the assignment, Medicare assignment issue and I wanted to confirm that we, right now the statute only is waiving the co-insurance for those physicians that do take the Medicare assignment so if a limiting charge applies meaning that a beneficiary pays the physician for these services directly, then they will be subject to a co-insurance penalty when the claim is submitted. We don't know that that will be our policy going forward. It's something that we're currently reviewing now.

The other thing is is that we don't want to attribute the waiver of co-insurance and deductible to all preventive services that are allowed in Medicare and I think that it's important to note that clinical laboratory tests and immunization drugs are actually not paid under the Physician P Schedule. They're paid under other fee schedules and co-insurance and deductible didn't apply to these services prior to the Affordable Care Act and so there's been no policy change there.

Another item that I wanted to mention was around the colorectal cancer screening that becomes diagnostic. There are several codes if you review the table. Any of those codes, the PT modifier code would work for waiving the deductible in those cases so it doesn't have to be a specific screening code. It could be any of those codes that are available.

For more details regarding Section 4104 again please read the final rule. You can also find in our rule a discussion of public comments that we received and a table again identifying preventive services and their status for cost sharing in comparison to 2010 to 2011. I think this tool is very helpful and when I get questions on how the Affordable Act has changed benefits, I like to refer you to that table.

Janet Miller: Well Stephanie, thank you for that very thorough and very good explanation. We started today's conference call with policy because policy drives payment and now we want to shift direction a bit and focus on education outreach and what it is that we are doing to get information to both beneficiaries and to the provider network with so also with us today are Ms. Jeannie Wilkerson and Ms. Mary Loan. Jeannie works in our Creative Services group and works with beneficiary outreach and Mary is a Technical Advisor in the Provider Communications group and that group has responsibility for national provider education, getting products developed, and dissemination of information and most of what comes out from Mary's group is branded under the Medicare Learning Network and I think we will begin with Jeannie to talk a bit about what we are doing to educate our beneficiaries.

Jeannie Wilkerson: Thanks Janet. Good afternoon everyone. As Janet said, my name is Jeannie Wilkerson and I work in the Creative Services group (inaudible). Our division develops most of the Medicare beneficiary publications including the Medicare and You Handbook. I am one of the writers for the handbook as well as the preventive services materials. We update our publications as new legislation is passed or when we need to clarify the language to improve comprehension. For the handbook, we actually start this process very early. Our materials go through many levels of review including subject matter experts, CMS leadership, Office of Legislation, and our Office of General Counsel and depending on the product, some are even reviewed by external partners. For example, for the handbook we asked for early input from the SHIPS and other partners to find out their experiences using the handbook during open enrollment.

In order to meet our statutorily mandated deadline we weren't able to include all of the details of the new preventive services that were included in the Affordable Care Act in the handbook. Our plan is to update the current publication, "Your Guide to Medicare's Preventive Services and Staying Healthy" with this information once all of these details for the services are finalized. The Medicare and You 2011 is available now and the other products I mentioned are currently being revised and can be found on Medicare.gov later

in December. The preventive services materials will be printed and available on Medicare.gov and by calling 1-800-MEDICARE, thanks.

Janet Miller: Jeannie, thank you very much. A very important component to these new benefits is going to be making sure that healthcare providers understand when and how to recommend them to our patients and that's where Mary's component comes in. Mary, welcome.

Mary Loan: Thank you. At the provider communications group we recognize the crucial role that healthcare professionals play in promoting, providing, and educating Medicare patients about potentially lifesaving preventive services and screenings. We are taking significant steps to reach out and educate the provider community about the array of preventive services and screenings now covered by Medicare. We always ask for providers' help to get the word out to their patients and their caregivers regarding Medicare covered preventive services and screenings.

In order to encourage healthcare providers to order, refer, and provide the preventive services to their patients we have produced a variety of educational products for providers. They are intended to help providers understand the coverage, coding, and payment policies related to preventive services and as Janet had mentioned, all of these products are available on the Medicare Learning Network website which is a website that we have developed in our group mainly for the Medicare fee-for-service providers and within that website we've maintained because we have so many preventive services products now, we have dedicated a preventive services educational products page on that website and right now unfortunately, those products have not yet been updated with the new information. We unfortunately are at the mercy of the systems folks and we have to wait for them to notify the contractors to get their payment systems in place. Then we are ready and set though to update them as soon as all of that information is officially released to our Medicare contractors. So we have a variety of products on the website right now for providers and hopefully they will make good use of that.

Janet Miller: Mary, thank you very much. John, I think we're about ready for questions and if you want to engage that process that would be very nice and while you're setting this up I want to take the opportunity to let listeners know that in addition to the speakers you just heard we have a couple of other folk with us in our office and these are the CMS version of the lifeline and that would be Mr. Bill Larsen and Ms. Jamie Hermanson. Both work in CAG's division of medical and surgical services. Bill has been with the federal government for about 42 years, primarily working on Medicare coverage and payment issues and so Bill knows a lot and he is one of our primary contacts for the public on prevention and other coverage issues and Jamie also provides subject matter expertise on a variety of areas including prevention and kidney dialysis and so John, when you are ready to queue people in, we're ready.

Operator: Okay, so ladies and gentlemen at this time if you have a question or comment press the * then 1 key on your touchtone telephone to queue up for a question. So again, if you have a question or comment press the * then 1 key on your touchtone telephone.

We'll give it a few minutes for attendees to queue up.

Okay and our first question is coming from Ilana Raskin.

Ilana Raskin: Hi, this is Ilana calling from the Medicare Rights Center. Thank you everyone for letting us know about all of these changes. It's great so we can share this with our clients. This question is for Jeannie and Mary. You had some great advice on the new materials that you're writing up and how these are going to be up and available both through the website and by calling Medicare. I was just wondering if in terms of beneficiaries and

providers you're going to be doing any mailings out to people or any kind of proactive outreach in place of people having to look online or to call Medicare themselves.

Jeannie Wilkerson: For the beneficiary population we will not be doing any mailings.

Mary Loan: And that would be the same for the providers. What we do with the providers though we do have an extensive marketing messaging effort underway and we have a lot of national provider associations that we partner with and whenever we update any of those products they will get that message. The word will get out to them that way.

Janet Miller: And Ilana, this is Janet Miller speaking. I appreciate your point which is one of the reasons we are so happy to have this call and if you would like to send us suggestions as to how we might be able to work with organizations such as yours to enhance our communications either through additional calls or webinars or getting information to you that you can send out to your chapters, I would appreciate that.

Ilana Raskin: That's great, thank you so much. I really appreciate that.

Janet Miller: Our pleasure.

Operator: Okay, so again ladies and gentlemen if you have any questions press the * then 1 key on your touchtone telephone.

And our next question is coming from Vicki Gottlich. Vicki, please go ahead.

Vicki, are you there for a question? Your line is open if you still have a question.

Okay, assuming she is unable to ask a question, again ladies and gentlemen if you have any questions press the * then 1 key on your touchtone telephone.

And we'll take our next question from Abigail Morgan.

Abigail Morgan: Hi, yes, thank you. I have a question for Dr. Chin regarding the health risk assessment component and the plan for getting beneficiaries to complete the health risk assessment prior to the annual wellness visit. Is there any plans for partnering with local community based organizations to help seniors get the health risk assessment completed correctly and in a timely manner before the annual wellness visit and is there an ability for these organizations to receive some reimbursement for their time or is it a paid service and how do you envision that working?

Dr. Joseph Chin: That's a very good question. At this point, basically the way the statute has looked at how to provide the risk assessment part of it is through the internet or a web based version or through, on the telephone or through really the provider's office. Right now I think the physician, the visit is a physician focused visit so the mechanism would actually be through the physician's office or a link to that place of service. I don't, I can't comment on how other groups could be involved in that. I think that's more of a payment issue I believe but I don't believe there's a mechanism to include non-Medicare providers in the service at this point.

Operator: Okay, thank you and our next question is coming from Leslie Freed. Leslie, please go ahead.

Leslie Freed: Okay good, thank you. I just want to say before I ask my question that I kept trying to hit my *1 and so I don't know if there's a problem with the system but I'm glad I got through.

I actually have a couple of questions also about outreach to beneficiaries and to doctors. We are thrilled to have the, that the assessment for detection of cognitive impairment is included in the annual visit. I'm calling on behalf of the Alzheimer's Association so my question is how do doctors really find out about it? Are there any sub-regulatory documents that are going to be out there providing guidelines as to what they should be doing or how they should be doing every annual visit, what's required, and we're also very interested and excited that the voluntary advanced care planning piece is included in the annual visit and sort of what kind of information is going out both to beneficiaries and to providers about that?

Janet Miller: Leslie, this is Janet speaking and we're getting ready to answer the question but we are having a little bit of a discussion here.

Leslie Freed: Oh okay, thank you, versus just silence.

Janet Miller: Alright, "the assessment of an individual's cognitive function will be by direct observations with due consideration of information obtained by the way the patient reports, concerns raised by family members, friends, caretakers, or others." I think we've –

Leslie Freed: Right, I've read the reg.

Janet Miller: Right, we've answered that in the reg.

Leslie Freed: So you don't anticipate any further assessment or testing at the annual visit?

Dr. Joseph Chin: Well, there are – there is a provision in the statute that allows for modification of the visit when there's evidence for that so for example, if there's, right now there isn't one specific screening tool or assessment tool for impairment that's recommended by the Task Force, for example. That's one entity, the U.S. Preventive Services Task Force which is a group that's actually focused on –

Leslie Freed: I was just thinking that, I'm a patient, you're the doctor. I'm getting my annual wellness visit and so is your expectation that just the doctor is going to say, you know, ask a few questions or notice through the exam that there might be some cognitive issues?

Dr. Joseph Chin: There a couple of, probably a number of different ways to make that diagnosis or detection. One of them is as mentioned, I think physicians if they're using a different tool that they're comfortable with that could be also continued use. For example, the mini-mental status questionnaire which is fairly quick, this is one tool that physicians –

Leslie Freed: Yes but many docs don't use that anymore because of the patent requirement.

Dr. Joseph Chin: Right, true and I think that's why really there hasn't been one that's specifically recommended at this point.

Leslie Freed: Is it your expectation – okay. Is it your expectation that possibly during the annual wellness visit, some of that might go on?

Dr. Joseph Chin: Yes and it's also possible that if the Task Force does develop a recommendation for one screening tool, that could be incorporated also.

Leslie Freed: Okay, I'm really not trying to be difficult although it might sound like I am. I'm just trying to get a sense of real world in the doctor's office.

Dr. Joseph Chin: Sure, I understand.

Leslie Freed: So like starting January 1st, in theory people could call and make a doctor's appointment for the annual wellness visit so I'm trying to get a sense of, because we too will provide some materials for, on the websites and try to educate beneficiaries about what their expectations can be.

Bill Larsen: This is Bill Larsen. All the elements, all the required elements should be documented in the patient's medical record so that the doctor may not say an awful lot but there should be something, regular documentation requirements that we require for all Medicare evaluation and management services and this is an evaluation and management service that just happens to be focused on prevention, identifying modifiable risk factors, documenting what the findings are, and then providing lots of education, counseling, and referral for covered, for other additional services, preventive or otherwise.

Leslie Freed: Okay, thank you and can you – what about the second piece, the whole voluntary advanced care planning. Is there, are there more materials that are going to be going out or will there be a Med Learn article about that specific piece because as we know, there have been a bunch of studies that say sometimes doctors don't have those discussions with their patients and even though it's voluntary it might take some nudging.

Dr. Joseph Chin: Right, I think we recognize that and, which is probably one of the reasons why it was continued in the annual wellness from the initial visit, allowing for another opportunity to discuss that over time.

Leslie Freed: Yes, I think it's great. I just, it might be a good source of a Med Learn article at some point in the future, just a suggestion.

Janet Miller: Yes, thank you very much. I think that's an excellent idea.

Operator: Okay thank you and if there are any further questions press the * then 1 key on your touchtone telephone to queue up for a question.

Okay and we have one more question or actually a couple more questions now. Our next is coming from Vicki Gottlich.

Vicki Gottlich: Hi, thank you all very much for the information. Stephanie, I was the person who raised the question about assignment so could you please go over that again so I make sure that I can advise people correctly?

Stephanie Freeling: Yes and it's a pleasure to talk with you in person because I've been using your question and I have brought an example. I was hoping you'd be on the call.

Vicki Gottlich: Okay, good.

Stephanie Freeling: Okay so as you probably know, a non-participating physician chooses on a claim by claim basis whether or not to accept assignment unless they're required to do so by law so if the non-participating physician does not accept Medicare assignment then Medicare pays the beneficiary directly and the non-participating physician, they bill the beneficiary up to the limiting charge so the limiting charge can be 115% of the published fee schedule amount. So the non-participating physician, they get paid 95% of the fee schedule amount so they're penalized for not adhering to our fee schedule.

So for example, I'm going to use some generic numbers but I've made my notes here so if there was a service that was provided and say the fee schedule amount was $100.00 so that's the beneficiary's, the beneficiary's Part B deductible is waived for the provision, right? So that doesn't apply but Medicare would pay the beneficiary $76.00, okay? So

that's 95% of 80%, right? That's how you get to the – so you take, right? Are you following me?

Vicki Gottlich: Right.

Stephanie Freeling: Okay, so the non-participating physician can collect $109.25 for the service.

Vicki Gottlich: Okay.

Stephanie Freeling: Okay? So that means that the beneficiary in this case, they are subject to cost sharing and they're going to pay $33.25 out of pocket for those services.

Vicki Gottlich: Okay.

Stephanie Freeling: So it's an important distinction and it's something that we were aware of before the rule but obviously you're not the only person to raise this question of how we're going to deal with it going forward and so that's something that we're still discussing because this, not taking assignment is really not, it's not the direction we wanted to go to promote these preventive services.

Vicki Gottlich: Right, okay, thank you.

Stephanie Freeling: Sure.

Bill Larsen: This is Bill Larsen again. You might be aware that you can go to Medicare.gov if you're interested in finding a physician who accepts assignment. That's something new that's up on our website now under Medicare.gov and wherever you are in the country you should be able to find a listing of physicians who do accept assignment in your locality. I just learned about it myself just in the last week or so, so that's an interesting development.

Stephanie Freeling: And Vicki, if you feel the need please contact me directly.

Vicki Gottlich: Okay, I will. Thanks so much.

Stephanie Freeling: Sure.

Operator: Thank you and we'll take another question coming from Leslie Freed.

Leslie Freed: Sorry, there was one other thing I wanted to raise in that I noticed in the final rule you decided again not to have annual screening after the first annual visit for depression based on I guess the same reason you had it in the proposed rule but is that something that you all will be reconsidering because there's a lot of evidence of depression in older adults and probably younger adults with disabilities but I think the annual wellness visit actually is a perfect opportunity for primary care providers to really get a sense of whether there's some depression and make an appropriate referral.

Dr. Joseph Chin: It's not a required element as you noticed but it could be that the annual wellness visit could be, it actually should be really based on individual risk and then tailored to individual beneficiaries so if it's used in the initial visit and the beneficiary is more or less identified as being at risk for depression due to chronic conditions then there is an opportunity to continue that. Although it's not a required element it could be conducted during the annual wellness visit I think.

Leslie Freed: I guess I just feel like it's a real lost opportunity having worked with seniors most of my professional life and in fact recently was at a senior center and there was discussion about how nobody in the room thought that seniors got depressed yet when they a couple weeks

later decided to have some support groups for depression, they had an overflowing group. I mean, they had lots of people show up and so I just think that with the annual wellness visit is a good – even if it's just a question or two to sort of get someone thinking about, especially a provider maybe making a referral. So that's just my two cents.

Janet Miller: Right Leslie. We have to keep in mind also that the health risk assessment which is not part of the annual wellness yet would lead us to believe when we finally have that model in place that certainly patients at risk for depression will be identified and the health risk assessment will parse that out so patients will be identified.

Leslie Freed: Good. I mean, it's not out yet so I hope that there will be some –

Janet Miller: Right, we fully anticipate that though to happen.

Leslie Freed: Oh good, thank you.

Operator: Thank you and I'm showing no further questions in the queue at this time. I'd like to turn the – actually, we do have one last question coming from Ilana Raskin.

Ilana Raskin: Hi, thank you. This is just a quick follow up and you may have already said it but what was the timeframe for the HRA coming out and being incorporated?

Dr. Joseph Chin: The deadline is actually a year from when the enactment, a year and a half – a year for the, some guidelines, from the enactment of the Affordable Care Act and then 18 months for a model so it was I believe in March that it was, the Act was actually signed in law so roughly from there we're talking in the fall of 2011.

Ilana Raskin: Okay, okay great, thank you.

Operator: Thank you and our next question is from Tom Smith.

Tom Smith: Hello there. I have a quick question and I'm worried you probably already answered at least part of it before but the wellness visits seem to be sort of related to the primary care providers but how would it relate to people who have sort of chronic conditions and require a specialist? I mean, basically their chronic condition is outside of the scope of sort of the average primary care provider.

Dr. Joseph Chin: There is a primary care focus since, given it's a wellness type visit so the other E&M services for other chronic conditions performed by a specialist I think may be a different track than the annual wellness visit and although it could be done by a specialist I think we envisioned that most of the interest will be from primary care providers that are I think more able to deal with general screening and wellness visits.

Tom Smith: Great, thanks.

Janet Miller: However, we do recognize that certain people with chronic problems are followed by specialists and that the specialists actually do provide what we would consider primary care so it would seem that this, in these circumstances would be very applicable.

Dr. Joseph Chin: It really I guess boils down to availability of time to look at some of these preventive services and which provider would have the ability to work that into their schedule for the individual, I think.

Tom Smith: Okay great, thanks.

Operator: Okay, there are no further questions. I'd like to turn the conference back to Janet for any concluding remarks.

Janet Miller: Thank you John and I certainly want to thank our speakers, Drs. Schaeffer and Chin, Stephanie and Jeannie and Mary and our (inaudible), Bill and Jamie for their help and I also want to let you know if there are any questions that you think of a little bit later you can send them to a special mailbox that we've set up and we're going to keep the mailbox open for a week. The mailbox address is CMSEPO@mscgnic.com. I'll repeat that. It is CMSEPO@mscgnic.com. We're going to keep it open for a week from today's call. The contractor will send any questions or comments to us and we will compile answers and send them to everyone on the call provided you gave us your contact information when you dialed in and at that time we could also send you links to some of the training materials that we might have established for preventive services and maybe links to Med Learn articles and the websites that Stephanie referenced.

John, I thank you for your assistance and thank you all for your participation. John, we can sign out.

Operator: Okay ladies and gentlemen this does conclude your conference. You may now disconnect and have a great day.