



Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session

Moderated by: Nicole Cooney
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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 sessions. This call is being recorded and transcribed. If anyone has any objections, you may disconnect.

I will now turn the call over to Nicole Cooney. Thank you. You may begin.

Announcements & Introduction

Nicole Cooney: Thank you. I'm Nicole Cooney from the Provider Communications Group here at CMS, and I will be your moderator today. I'd like to welcome you to this Medicare Learning Network listening session on the Physician Fee Schedule Proposed Rule: Understanding Three Key Topics.

Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL, go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

At this time, it is my great pleasure to introduce our CMS administrator, Seema Verma, who will provide opening remarks. Administrator Verma?

Presentation

Seema Verma: Thank you. And Good Afternoon. And I appreciate everybody joining today's call. And we are going to be covering three main topics – streamlining E/M payments, advancing virtual care and improving the Quality Payment Program. We will spend most of our time today, however, on the E/M payment.

So, I'd like to start with a discussion of the proposed changes to E/M payment and Physician Fee Schedule proposed rule. Our technical experts are on the line to walk through the details of the proposal and to address any clarifying questions. But, before I turn it over to them, I wanted to take a moment to walk through the reasons that we proposed the overhaul in this rule.

Those of you that have followed CMS know that one of my priorities from the moment I got here was to put patients first. And this is why we launched the Patients Over Paperwork initiative, which is about reducing provider burden to get government out of the way of doctors taking care of their patients. We are very serious about this. And this effort is a genesis of the reforms we are proposing related to evaluation and management, or E/M, codes.

We have heard frustration from clinicians and too many stories about provider burnout. And it has become clear to me that if we are going to improve quality and access for our patients, we have to address the concerns of providers on the front line.

As I toured the country talking to doctors over the last year, the amount of time it takes to document information in patient charts in order to bill Medicare came up time and time again as a source of frustration. This is also an issue we heard about repeatedly in comments submitted when we asked about ways we could reduce burden in a request for information that we put out last year.



In response to this input, we are taking action in the Physician Fee Schedule proposal to reduce the burden associated with billing for E/M visits. Our intention is to increase the amount of time physicians have with their patients by streamlining documentation requirements for physician services.

Evaluation and management visits make up around 40 percent of all Medicare payments under the Physician Fee Schedule. Documentation guidelines have not been updated since 1997, and they have not been updated to consider the advent of electronic health records.

Close to three-quarters of a million clinicians use these codes all across America. When we hear consistent and significant complaints about the unnecessary burden that is impacting patient care, we cannot just accept the status quo. Our proposal would streamline both payment and documentation for office E/M visits.

The proposal must be budget-neutral, meaning this proposal is not intended to impact the budget – the federal budget. In combining code levels, we recognize that adjustments are needed to address the fact that some visits take more time. And this is why, as part of the proposal, we are introducing new add-on codes to account for patient complexity. The rule would also give clinicians options beyond the 1995 or 1997 E/M documentation guidelines.

We have analyzed the impacts of the proposal and found that most specialties would see financial impacts up or down in the 1- to 2-percent range from the proposal. And we believe that any negative payment adjustments would be outweighed by the dramatic reduction in administrative burden, allowing clinicians to spend more time with their patients. And the reduction in burden is significant. If you add up the amount of time saved for clinicians across America in one year from our proposal, it would come to more than 500 years of additional time available for patient care.

I hope today's call will help to address some of your questions and concerns. For example, providers have asked when new add-on codes could be billed under the proposal and whether these add-on codes could be used in combination.

Our program experts will get into more. But, I'll tell you up front the add-on codes would be available as soon as any other changes took effect, and the add-on codes could be used in combination.

And switching topics, very briefly before I turn this over to our experts, I also want to make sure providers were aware of our proposal for Medicare to start paying for virtual check-ins, meaning patients can connect with their doctors by phone or video chat. We are trying to modernize Medicare to leverage the latest technology to increase access to care and deliver better outcomes.

Many times, this type of check-in will resolve patient concerns in a convenient manner that gets them the care that they need and avoids unnecessary cost for the system.

This is a big issue for our elderly and disabled populations where transportation can be a barrier to care as well as for caregivers. Now, we are not intending to replace office visits but, rather, to augment them and create new access points for patients.



Another priority area of ours that I'd like to highlight is our Meaningful Measures initiative. CMS is conducting a holistic, across-the-board review of all of our quality measures that providers have to report, including in the Quality Payment Program. If we are going to require that providers take the time to report a measure, it is incumbent on CMS to make sure that the measure has a meaningful impact on patient care.

And, more broadly, we want to focus on measuring outcomes and get out of the business of micromanaging processes. Therefore, as we identify measures that are outdated, duplicative or overly burdensome to report, we are proposing to remove them in order to ensure a focus on the measures that genuinely promote quality and ensure safety as well as program integrity.

I believe these proposals collectively present big wins for providers and for patients and demonstrate our commitment to supporting doctors and other providers as we put patients first. Now, this is a proposal. So, we are looking forward to your question, inputs and suggestions and working with us to make this effort successful.

I'm going to turn it over now to Emily Yoder to start to walk through more specifics related to the E/M codes and the physician experience. And thank you for your time and participation today.

Documentation Requirements and Payment for Evaluation and Management (E/M) Visits

Emily Yoder: Thank you so much, Administrator Verma. And thanks to everyone for joining the call. We really look forward to telling you about our proposals and hearing your questions and comments.

So – and we are on slide 8 right now. So, as you know, documentation is crucial for patient care and also important for the purposes of accurate reimbursement. Medical documentation includes information about a patient's health and their history, and medical professionals rely on medical records when evaluating a patient and developing a plan of care.

As Administrator Verma highlighted, we have heard that the current documentation requirements for E/M services do not support patient care, and completing medical documentation consumes time that a clinician could be spending with their patients.

So, slide 9. Currently, E/M documentation is derived from either the 1995 or the 1997 E/M documentation guidelines. When selected the correct code, practitioners and billing staff consider the criteria highlighted in the slide. So, you have the patient type, new versus established, the setting of service – so, outpatient or inpatient – and the level of E/M service performed.

So, this proposal focuses on the 10 office outpatient E/M codes. There are five codes for new patients and five for established patients. Within the new or established patients, the codes are further stratified based on history, examination and medical decision making. For visits consisting of 50 percent or more counseling and/or coordination of care, time may also be used to determine the level of visits.

In addition to the burden of medical documentation, we have also heard that the codes themselves do not accurately reflect crucial differences in the resource cost between types of visits such as primary care or specialist visits.



So, to improve payment accuracy and simplify documentation, we proposed new, single-blended payment rates for new and established patients for office outpatient E/M levels two through five visits and a series of add-on codes to reflect resources involved in furnishing primary care and complex non-procedural services as well as an additional 30-minute prolonged services code.

As a corollary to this proposal, we proposed to apply a minimum documentation standard where Medicare would require information to support a level two office visit code for history, exam and/or medical decision making in cases where practitioners choose to use the current framework or, as proposed, medical decision making or time to document E/M levels two through five visits.

So, this change is important – and I'm on slide 12 now – because we believe that the proposed changes will reduce the burden associated with documenting to standards that the medical community has indicated are clinically outdated and do not provide the most clinically meaningful information about patient complexity or care and are frequently filled with redundant information.

Furthermore, revised documentation standards will reflect crucial changes in technology, particularly advances in EHRs, and changes in the delivery of care such as a growing emphasis on team-based care, management of chronic conditions and behavioral health care services.

We proposed to allow practitioners to choose to document office outpatient E/M visits using medical decision making or time instead of applying the current 1995 or 1997 E/M documentation guidelines. Or, alternatively, practitioners could continue to use the current framework.

We are also proposing to expand current options by allowing practitioners to use time as the governing factor in selecting visit level and documenting the E/M visit regardless of whether counseling or care coordination dominate the visit.

For practitioners choosing to support their coding and payment for an E/M visit by documenting the amount of time spent with the patient, we propose to require the practitioner to document the medical necessity of the visit and show the amount of time spent by the practitioner with the patient.

We are seeking public comment on ways to measure time, including whether to use the times associated with the current E/M visit levels to determine the level of visits reported or whether to use a single time associated with a single PFS rate for E/M visit levels two through five or whether to use the times associated with typical time for the CPT code that is reported, which is also the typical time listed in the AMA CPT code for that code or we are also seeking comment on alternatives to any of those options.

So, on slide 14, there is a chart with the proposed payment for the office and outpatient E/M-based visits under our proposal.

On slide 15, we have heard from stakeholders that the current valuation of the E/M visit does not reflect many of the resource costs associated with furnishing primary care or services requiring additional complexity. We are, therefore, proposing three add-on codes to recognize these resource costs. The add-on codes can be furnished by practitioners that are providing the type of E/M visit described by the add-on codes. And the add-ons are not limited to specialty – by specialty designation.

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The first of the add-on codes is for primary care visits. This code would be billed every time a primary care visit is furnished. While we expect that the add-on code for primary care would mostly be utilized by primary care specialties, we understand that certain specialists such as OBGYN and cardiologists function as primary care practitioners. And, so, we want to recognize that other specialties could use the code when providing primary care services.

On slide 16, we are proposing an add-on code for visit complexity that, like the primary care add-on, will be billed within every E/M office outpatient visit requiring additional resources beyond those accounted for in the blended two through five payment rates. While the code descriptor does include specific specialties, these are meant to be illustrative of the kinds of work accounted for by this add-on. We are not limiting the code by enrollment specialty.

We are also proposing a 30-minute prolonged services code that could be billed in addition to the primary care or complexity add-on when 30 minutes of additional time is spent.

We note that in modeling the impact of the proposals, we did not model the primary care and visit complexity add-on code billed together. But, we welcome public comment on whether there are clinical circumstances where it would be appropriate to bill both codes.

So, in summary – on slide 17. This slide is a summary of the changes we are proposing to the documentation requirements for E/M visits. For payments, in addition to the two HCPCS code add-on codes for resource cost associated with different kinds of visits and the 30-minute prolonged services code, we are also proposing the application of a multiple procedure payment reduction, or MPPR, to the office outpatient E/M visit.


In the case where an E/M visit is furnished with other services billed on the same day by the same practitioner for the same patient, the lower-priced services would be subject to a 50-percent reduction in payment.

To operationalize this reduction, we are using the surgical MPPR as a template where we would apply multiple procedure indicator two to the 10 office and outpatient-based E/M visit codes and the codes for podiatric visits as well. So, now, we would like to open the lines for questions.

Question & Answer Session 1: Clarifying Questions on the E/M

Nicole Cooney: Yes. Thank you. Before we get started on the Q&A, I'd like to set a few ground rules for today's session. We do have a lot of folks on the line with us. And in an effort to take as many questions as we possibly can, we are going to spend a maximum of three minutes on each question and answer. We would like to be able to get to as many folks as possible, and we felt this was the best way to accomplish that.

I also would like to draw everyone's attention to slide 6 and remind you that verbal comments on today's call do not take the place of submitting formal comments on the rule. And the process for doing that is outlined in slide 6 of today's presentation. And as a reminder, today's session is being recorded and transcribed. We will now take those clarifying questions on the E/M topic. There will be an opportunity to get in the queue after the other topics. So, please limit your questions to E/M for this session. All right, Dorothy, we are ready.



Operator: To ask your 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 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.

Please hold while we compile the roster.

Please hold while we compile the roster.

Your first comment comes from the line of Ronald Hersch.

Ronald Hersch: Hello there. I was wondering when you were discussing picking an E/M code based on time or medical decision making or using the old system and then the blended payment system, they seem to be inherently linked.

Would you consider adopting one but not the other? And, also, have you been in discussion with the many other payers that would have to make this change or would need to consider making this change? Thank you.

Emily Yoder: Yes. Thank you for that. And as – so, to answer your first question, that is a great thing to put in the public comment. We are actually interested in that very topic, what you know– what things could be implemented versus – you know- other parts of the proposal.

For your second question, we are certainly interested in feedback from private payers. But, we have not been in any conversations with them as we were developing this proposal.

Ronald Hersch: Thank you.

Operator: Your next comment comes from the line of Mitch Harris.

Mitch Harris: Hi. I have two questions. One, are the codes available yet – the add-on codes? And, two, do you know what they will be priced at?

Emily Yoder: Yes. The codes – there are placeholder codes for the HCPCS G-codes in the proposed rule currently. And I believe on slide 18 there is a summary of the codes and their proposed payment rates.

Mitch Harris: Thank you.

Emily Yoder: That information is also in the text of the proposed rule itself.

Mitch Harris: Okay.

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Operator: Your next comment comes from the line of Jim Blakeman.

Jim Blakeman: Have you considered the impact of the flattening of codes on a redistribution of office visits to other settings, particularly the emergency department?

The \$14 difference doesn't make up for the change from \$104 for an office visit, yet 14 doesn't even get you to the level four and the level five. And we suspect that physicians will defer high-acuity patients to the emergency department in much higher-cost setting. What has CMS considered in that regard?

Emily Yoder: Thank you. That's a really good question. So, as we were developing this proposal, while the proposal itself is limited to the 10 office and outpatient E/M codes, we were cognizant of the fact that the blended payment rate for level two through five may not account for all of the resource cost associated with performing a visit, especially for patients with complex needs.

And, so, in addition to the add-on code which you mentioned for complexity, that's – we also have the 30-minute prolonged services code, which pays around ...

Lindsey Baldwin: Sixty-seven.

Emily Yoder: ... \$67. And we really hope that practitioners will utilize this code in order to provide care to patients with more complicated needs.

Operator: Your next comment comes from the line of Maria Tiberend.

Maria Tiberend: Hello. My name is Maria Tiberend with BJC Healthcare. My question is around the proposed medical decision making or time as the basis to determining appropriate levels.

Regarding medical decision making, if a provider chose to use that as their driving factor versus the '95 or '97 guidelines, what definitions or criteria will be used to determine the level of medical decision making? And will that – have that impact on those levels of E/M on the two through five?

Emily Yoder: So, yes, thank you for that question. So, the proposal states that if you were to use medical decision making as the basis for the level of E/M code selected, you would only need to document medical decision making to a level two visit, and you would receive that blended two through five payment rates.

Maria Tiberend: Okay. Thank you.

Operator: Your next comment – your next comment comes from the line of Mary Kay Johnson.

Mary Kay Johnson: Hi. I'm calling from Scott A Fleischer and Associates. I am looking for the impact that it would have on psychiatric services and where psychotherapy is involved with an office visit, if we can use the add-on codes or if there is some sort of basis for psychotherapy along with an E/M code.



Lindsey Baldwin: Hi. Yes. Thanks for that question. Must like the existing prolonged services code, the newly-proposed G-code for 30 minutes of prolonged services could be added on to an E/M visit or a psychotherapy session.

Mary Kay Johnson: So, you can also use psychotherapy but then there would be a reduction for 50 percent?

Lindsey Baldwin: No, no, the multiple procedure discount that I think you are referring to – that would not apply to psychotherapy services.

Mary Kay Johnson: Okay. Thank you.

Operator: Your next comment comes from the line of Karen Latham.

Karen Latham: Hi. On slide 18, I just want to make sure I'm understanding this. On the proposed \$5 add-on payment for primary care services, did you state that that's not limited to primary – PCP-type providers or by specialty type? It could be applied to specialists as well? And with the \$14 add-on payment that's proposed, that's just limited to specialties? Can you just clarify that?

Emily Yoder: So, none of these add-on codes are limited by Medicare enrollment specialty. They are really designed to capture different types of visits. So if, say, a cardiologist is furnishing a primary care visit, which we know happens, that cardiologist could bill the primary care add-on code.

And that same cardiologist, if they are furnishing a cardiology-focused visit or more complex visit, then they could bill the complexity add-on code for that patient. So, we are really not interested in limiting these add-on codes by enrollment specialty.


Karen Latham: Thank you.

Operator: Your next comment comes from the line of Abelina Odel.

Abelina Odel: Hi. Good morning. I want to start by saying thank you. It's very clear from the beginning of this presentation that you have had a keen listening to the sentiments of the medical community and that you have deployed a ton of thoughtfulness and care in trying to strategize a reasonable and affordable solution. So, I want to thank you very much for that.

And just to sort of piggyback on the previous question, so, for example, if a primary care provider is doing a Bredesen protocol for cognitive decline or perhaps managing a chronic illness related to autoimmune disorder but handling that in a primary care capacity, in theory, they would be able to bill the primary – the specialist and the 30-minute, which might come into play particularly in something like a Bredesen context. Am I understanding this correctly?

Emily Yoder: First of all, thank you so much for your kind words. And your question is a good one. So, as it stands right now in the rule, the primary care add-on code or the complexity add-on code can be billed in addition to the prolonged services code.



And we are seeking comment on whether or not there are situations – and I believe you actually described some – where the primary care code and the complexity add-on code could be billed at the same time for the same patient. So, that would be really helpful information for us to have in the comments.

Operator: Your next comment comes from the line of Paula Ziemski.

Paula Ziemski: Hi. My name is Paula Ziemski. I'm calling from UPMC in Pittsburgh. And although I've got a million comments, I've got a couple that I'll put at the top. The first question that I have is in reading through the Federal Register, it appears that the payment rate would be the same – the new blended payment rate would be the same for a physician and a non-physician practitioner. Is that correct?

Nicole Cooney: Give us one second.

Paula Ziemski: Okay.

Emily Yoder: Hi. Thanks for hanging on there.

Paula Ziemski: Sure.

Emily Yoder: So, yes, the payment rate would be the same regardless of who the practitioner is furnishing the service in terms of the RVUs that are assigned to that service. But, for those practitioners who have that statutory – a separate percentage applied, for example, like 85 percent, then that would apply to this like it would to any other service.


Paula Ziemski: Okay. That – I think that was the second part of my question. Is how is this going to impact any current incident two rules, say, when a nurse practitioner sees a physician – or sees a new patient under the supervision of the physician? So, those rules, it sounds like, are not changing. So, the rate is reduced then.

Emily Yoder: Right. There is – there would be no effect on incident two rules.

Paula Ziemski: Okay. I do not think that that is clear in the documentation that's been released so far. Everything that I am reading is showing the same rate. So, you know, we'll certainly comment on that. But, I just wanted to make sure that there are some attentions paid because I think that — that could lead to multiple issues.

One is it does make things more complex. But, on the other hand, if the physicians and the non-physician or the APPs are being paid at the same rate, that could also lead to the devaluing, I think, of physicians' education and expertise.

The other comment that I just wanted to make is whether or not CMS has considered instead of just applying these new rules to a certain set of locations, office and outpatient – the term is “simplification.” That's what you are looking for in exchange for reduced payment.



But, in my estimation, it's really not simplifying things when physicians have to know other sets of rules for other locations and other settings. So, we will be sending in our comments. But, I just wanted to make sure that I have an opportunity to have this heard.

Nicole Cooney: Thank you very much.

Paula Ziemski: You are welcome.

Operator: Your next – your next comment comes from the line of Shan McDaniel.

Shan McDaniel: Hi. I'm Shan McDaniel with Medtron/MedData Service Billing. My question is a little bit related to the place of service issue, meaning are we going to receive a reduction if the place of service, even if it's one of the 10 codes in question, not like the ER visit earlier but just simply at an outpatient setting or a different setting than that of your office, is the site of service differential coming into play?

And the second question is if you are imposing the multiple procedure payment adjustment, if there are more than one procedure that – procedures that have the multiple indicator two, as I appreciate, those all will be reduced in half or just the lowest one will be reduced in half related to the 25-modifier usage?

Nicole Cooney: Give us one second.

Emily Yoder: Thank you for waiting. So, in terms of your first question, the site of service differential will continue to apply for these codes. And, then, for your question about the MPPR, under the MPPR, the first procedure is paid at – or the most expensive procedure is paid at 100 percent. And, then, the less expensive procedures are paid at 50 percent.

Shan McDaniel: All of the less expensive that have indicator – multiple indicator two, what I thought I heard you say, are subject to 50-percent reduction?


Emily Yoder: That is correct.

Shan McDaniel: That's a little bit extreme. Going back to the site of service, can you ask that they indicate what the rates for the new E/M primary care and complexity and each one of the add-ons in addition to the new flat fees or the blended fees – what those are rather than – I guess I'm presuming that what you posted is the office place of service. Right? Can you ask that they share with us what's the site of service rate will be in all of the scenarios?

Emily Yoder: Yes, we can – we can do that.

Shan McDaniel: Is it typically in your mind just to present right now or – that's not what I've experienced, but maybe.

Lindsey Baldwin: Yes. So, these services are priced in both the facility and the non-facility setting. And the public use files that are posted along with the rule – they provide the RVUs for both settings.



So, you can access that information there to calculate those payments. But, we are – we are also happy to provide that.

Shan McDaniel: Great.

Emily Yoder: Thank you

Nicole Cooney: Thank you.

Shan McDaniel: And do you reduce the RVUs of the multiple add-on procedures when you knock them down by 50 percent or we still get the RVUs? How does that ...

Lindsey Baldwin: The MPPR would apply to the total payment.

Shan McDaniel: Total payment and the RVU (inaudible).

Nicole Cooney: Thank you. We've – thank you. I'm sorry we've exhausted our time on this question. I have to move on to the next person. Thank you so much.

Shan McDaniel: Thank you.

Operator: Your next comment comes from the line of Beverly Hutchison.

Beverly Hutchison: Hi. This is Beverly Hutchison. We are an outpatient provider-based physician's clinic within the hospital setting. Will the add-on codes – will we be allowed to use the add-on codes as well?

Emily Yoder: Thank you for that question. And the answer is yes.

Beverly Hutchison: Thank you.

Operator: Your next comment comes from the line of Mary Jane Sifmer.

Mary Jane Sifmer: This is Mary Jane of Family Care Partners. We are a family practice clinic. And from going through the information, it's my understanding even with the blended fee schedule we will continue to bill the 99212, 3, 4 and 5. But, I'm just questioning the add-on payment and the prolonged.

So, if we are looking with the time element associated with those four codes, we would have to go for the, one, 30 minutes beyond that code and, then, how do we determine the additional resources? I mean, we have a lot of things as far as staff doing referrals and prior authorizations and other things for those patients. Can you give an example?

Emily Yoder: Hi. So, to answer the first part of your question, so the new prolonged services code – it describes 30 minutes of additional time spent beyond the typical time of the visit. So, with the current prolonged services code, CPT time rules apply where the practitioner needs to go one minute beyond the midpoint. So, we are seeking comment on that point.

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If we were to apply the CPT time rules, then this new G-code could be billed when 16 minutes of time are spent beyond the typical time associated with that level of visit. And, then, I'm not sure I caught the second part of your question about prior authorization. Would you mind repeating that part?

Mary Jane Sifmer: Well, when we are looking at the additional payment codes, the add-ons, the ones as to recognize additional resources to address inherent complexity in E/M visits associated with the primary care services, I'm just not real clear how we would – what the determining factor is to use that code.

Emily Yoder: Yes. I mean, I think the determining factor would be time. But, we are absolutely happy to hear all of those comments in a formal public comment letter, which we will consider for the final rule.

Mary Jane Sifmer Thank you.

Operator: Your next comment comes from the line of Sandy Dixon.

Sandy Dixon: Thank you. My name is Sandy Dixon from Metrolina Nephrology Associates in Charlotte, North Carolina. I've got a question followed by just a general comment. I'm just – I've been following this project or this movement for a while now and I'm trying to figure out how this is less burdensome to physicians and practices from an administrative standpoint or otherwise. It seems to me it's getting real confusing.

I think physicians – I think I speak for all physicians and I know I speak for nephrologists that, you know, definitely, a revising of the documentation guidelines is absolutely necessary. But, I don't think any of us anticipated a blended payment. We are an extremely large nephrology practice.

For those of you out there that don't know much about nephrology, it's largely Medicare. We have upwards of 20,000 active patients. Blending a payment for us is going to be a reduction in pay overall annually or greater than 10 percent. So, that's going to lead into my first question but also, I'm trying to figure out where this part came from as far as this blended payment.


And, my first question is just really where did – where did CMS get the math that this would affect specialists 1 to 2 percent either way? That's maybe based on a benchmark productivity profile of a level three visit, which for a nephrology practice is not very common.

And, we're talking about patients over paperwork but, again, keeping – bearing in mind that we personally have 20,000-plus patients. Where is all this time coming from? Because we have already figured out that to negate the impact – the negative impact financially, we are going to have to see more patients.

And I have to believe that many other specialists out there are going to have to as well. So, it really accomplishes nothing for us as far as that goes. And if practices out there haven't taken the time to figure out how this is going to impact them financially, they need to.

So, the time – the time – prolonged services – who has an additional 30 minutes to spend with a patient when you are already seeing four patients an hour sometimes just to get everybody seen? I guess – I guess the math is my main question.

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Where did – where did CMS – I think we'd all like to see some numbers and some data about the – where they took into consideration every specialty out there – cardiology, neurology, nephrology, oncology – and plugged it into this benchmark that shows a 1- to 2-percent reduction in payment. You know, we are still catching up from the 2010 no more consults and then of the payment cuts to excess procedures in the last couple of years and, now, we are being faced with this. So, any comment there would be – would be great. Thanks.

Emily Yoder: Thank you so much for that. And I hope that you include all that in a public comment. This three minutes is almost up, but I will say that we based our analysis on five years' worth of claims data.

Sandy Dixon: For what specialty?

Emily Yoder: Across Medicare specialties.

Sandy Dixon: Okay. Well, (inaudible).

Nicole Cooney: Okay. I'm sorry do don't really have time on this one. We have to move on. But, thank you so much. Dorothy, next question, please.

Operator: Your next comment comes from the line of Tamara Johnson.

Tamara Johnson: Hi. I work for a cardiologist, single provider. And I have – regarding the complexity add-on code, will there be certain diagnosis codes required in order to bill that? For example, a cardiomyopathy or a CHF patient. My second question is for the multiple procedure, if that's – if the indicator twos will be added on to other services that are not currently on the indicator two listing such as EKGs.

And, then, the third question would be regarding the use of these codes in the hospital setting because, as you know, as alluded to previous caller, the consult codes were taken away. So, there are instances when a cardiologist is called to the hospital to do a new patient consult on a Medicare patient and suddenly you can't use the initial services code because the hospital has used it, so you have to use a new patient code.

And when you are seeing a patient for elevated troponin, it just seems like there should be whether or not a fourth add-on code to indicate place of service severity or something along those lines. But, it really— is going to impact us negatively. And I'd just like to know about your comments on those things.

Emily Yoder: Thank you so much. Those are really good questions. So, for your first question about diagnosis codes, no. Right now, we have not made any proposals about limiting the add-on codes to specific diagnosis codes. We would – of course, if that is something that people perhaps think that we should do, we would really appreciate that information in a public comment.

Lindsey Baldwin: Yes. And for the second part of your question, you asked about the MPPR and how that will be implemented. We – as proposed, we proposed to change the indicator from zero to two on the 10 office outpatient codes. And we would also sign the multiple procedure indicator or two to the two podiatry G-codes that are proposed. But, it would be limited to those 12 codes and nothing else would be changed under this proposal.



Emily Yoder: And, then, would you mind stating your third question again?

Tamara Johnson: Because the consult codes were taken away, occasionally we are asked to see a Medicare patient in consultation in the hospital setting, the hospital code it is and the outpatient or observation. The hospital has just already used the initial services or the initial visit code. So, then, we either have to use new patient or establish that we are already familiar with that patient in the course of the last three years.

And I am wondering if there is any sort of plan to – obviously, if we are seeing a patient in the hospital setting, it's of a more severe nature and we could use the add-on codes for that. But, because of the place of service, that automatically is indicative of a more complex or serious visit level than in an office setting. And I'm wondering if that – there are any plans to address that in regards to the new blended payment.

Emily Yoder: So, right now, we do not have – we have not proposed anything along those lines. We would be really interested in public comments from you about that.

Tamara Johnson: Thank you.

Operator: Your next comment comes from the line of Luana Ciccarelli.

Luana Ciccarelli: Hi. This is Luana Ciccarelli from the American Academy of Neurology. Part of my question was already answered. It was specific to the prolonged service add-on code. You stated that it could be billed in addition to the complexity add-on code when 30 minutes of additional time is spent.

And my question was if the midpoint rule applied to this, meaning it could be reported 16 — excuse me — or if the full 30 minutes must be spent. It sounds like that hasn't been finalized. But, maybe if you could confirm that.

And, also, if an E/M visit is being reported with the add-on, prolonged and the complexity, what's the time threshold for that? Is – do you need to add in what the typical time is for the complexity code, which I believe is 8 minutes? So, we're just wondering what that math looks like.

Emily Yoder: Okay. So, on your first question, you are asking whether the CPT time rules would apply for the newly-proposed 30-minute prolonged services code.


Luana Ciccarelli: Correct. Yes.

Emily Yoder: That is something that – yes. We're definitely open to comments on that. As I mentioned before, the midpoint rule does apply to the currently-existing prolonged services code. And, so, we are certainly open to comment on that.

And, then, your second question I think related to time on the complexity add-on G-code.

Any time there is just a reference to sort of the typical time, we would assume. But, there is not a time requirement to bill that code.

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Luana Ciccarelli: Okay. Great. And, then, going back to the prolonged, so in order to add the – if you were going to add the prolonged service, and let's say you already have the E/M and the complexity, their time isn't the factor. It's just beyond what the typical time is for the E/M. Is that correct?

Emily Yoder: Yes. That's right.

Luana Ciccarelli: Okay. Thank you.

Operator: Your next comment comes from the line of Donna Reeves.

Donna Reeves: I'm sorry. I didn't know how to take myself out of the queue. My question has been answered.

Operator: Your next comment comes from the line of Barbara Olsen.

Barbara Olsen: Hi. This is Barbara Olsen from Baltimore. I have an auditing question. When you – when you pull a record to audit or if we pull a record to audit, do we still use the same scorecards that we use – that we currently use? I know we only get paid the same between two and five.

But, we're still going to bill two through five. Right? We're going to bill a 212 or a 21345 based on what we did in the visit. So, how is an auditor to go back and review this? Are we using '95, '97 just looking at MDM, just looking at time? How are we judging the code level?

Emily Yoder: Hi. Thank you for that. That's a really good question. And those are all good things to put in your public comment. I think that we are really interested in sort of the nuts and bolts of how this would get implemented. So, thank you for that.

Operator: Your next comment comes from the line of Vicky Gaour.

Vicky, your line is open.

Your next comment comes from the line of Elizabeth Fuentes.

Elizabeth Fuentes: (Inaudible) Fuentes, and I work for an ophthalmologist's office. And my question is since we do have ophthalmology codes 92004 and so on, will those be also in this proposal or is just for the E/M? Because, we can – since it's ophthalmology, we can use both, either the E/M or the I code. So, is there anything happening with the I codes?

Emily Yoder: Hi. Thank you for that comment. We are not making any proposals related to the ophthalmology E/M codes.

Elizabeth Fuentes: Okay. Thank you.

Operator: Your next comment comes from the line of Angela Simmons.

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Angela Simmons: Hi. Thank you for taking my call. I - On page 35841, the Federal Register, under the section on the MPPR – it describes in the middle column the reduction of 50 percent for the procedure or visit that is the least expensive if there are two in the same day. It says physician or a physician in the same group practice.

And I wanted to find out for those that have a very large multi-specialty group practice if a physician who was a cardiologist in the morning did a procedure and then later in the afternoon, a dermatologist in the same group practice were to have an E/M visit, is that second or that less expensive one going to get a reduction even though they are completely unrelated because they are in the same group practice? That's my first question. And I have a second question.

Emily Yoder: Yes. We are applying the existing rules for the MPPR. So, there would be no changes from the current guidelines on that.

Angela Simmons: Okay.

Emily Yoder: Do you have another question?

Angela Simmons: Yes, I do. My second question is you mentioned earlier that the GCGOX visit complexity code was open to all specialties. On page 35842, it indicates that it's limited to endocrinology, rheumatology, hem-onc, urology, neurology, OBGYN, allergy, otolaryngology, cardiology and pain. I wanted to confirm if it was only available to those specialties or if everyone can use the visit complexity code.

Emily Yoder: So, the specialties that are listed in the code descriptor are – those are the specialties that we use for the purposes of our impact analysis. And they are also the kind – those specialties are sort of – they illustrate the kinds of visits that the complexity add-on code would apply to.

It's not meant to be a comprehensive list. And we certainly are not limiting billing of the complexity add-on code by Medicare enrollment specialty.

Angela Simmons: Okay. Thank you.

Nicole Cooney: Thank you so much. In the interest of time and getting to folks, we need to move on. Thank you. Dorothy, next question.

Operator: As a reminder, if you would like to remove yourself from the queue, press the pound key. Your next comment comes from the line of Bradley Dykstra.

Bradley Dykstra: Hi. This is Bradley Dykstra from Atlanta Allergy and Asthma Clinic. I believe you may have answered it already, but does this apply to the Medicare Advantage plans and would it also apply to the Medicare railroad plans? Thank you.

Emily Yoder: This proposal is limited to fee-for-service.

Bradley Dykstra: Okay. Thank you.



Nicole Cooney: Thank you. Dorothy, I can take one more question before we move on to our next topic.

Operator: Your next comment comes from the line of Jodie Helman.

Jodie Helman: Hi. Yes. Jodie Helman from Marquette, Michigan. I am wondering how this is going to impact the relative value units. Many of our physicians are paid on RVU. And if they are billing a level five and you are giving us a blended rate, as it were, are you also going to blend the RVU?

Emily Yoder: Yes. So, the payment rates is – so, the payment rates starts out in RVUs. So, the blended rate is actually a blended RVU. And, then, the various adjustments are applied like, for example, the geographic adjustments. So, yes, it is derived from a blended RVU.

Presentation (Continued)

Nicole Cooney: Okay. Thank you so much, everyone, for your questions on E/M. Up next, we have Lindsey Baldwin from our Center for Medicare to discuss advancing virtual care. Lindsey?

Advancing Virtual Care

Lindsey Baldwin: Thanks, Nicole. So, going back to the slide presentation, we will start back on slide 21. In the CY 2018 Physician Fee Schedule proposed rule, we sought comment on how CMS could support technological developments in virtual health care. We received feedback from stakeholders supportive of CMS expanding access to health care practices that incorporate innovation and technology in managing patient care.


Through our proposals in the CY 2019 PFS proposed rule, we are aiming to increase access for Medicare beneficiaries to physician services that are routinely furnished via communication technology. We have proposals that describe a discrete set of services that are defined by and inherently involve the use of communication technology as well as proposals that expand Medicare telehealth.

Moving on to slide 22. We have proposed two new distinct services that would not fall under the restriction that apply to current Medicare telehealth services. The first is to pay clinicians for a virtual check-in. These are brief, non-face-to-face assessments conducted via communication technology.

Practitioners could be separately paid for brief communication technology-based services when they check in with beneficiaries via telephone or other telecommunications devices to decide whether an office visit or other service is needed. This would increase efficiency for practitioners and convenience for beneficiaries.

The second is to pay clinicians for remote evaluation of patient-submitted photos or video that is pre-recorded and submitted by the patient that would allow practitioners to assess whether a visit is needed.

Additionally, we proposed to pay Rural Health Clinics and Federally Qualified Health Centers for communication technology-based services and remote evaluation services that are furnished by an RHC or FQHC practitioner when there is no associated billable visit.



Also, under our annual process of adding services to the Medicare telehealth list, we are proposing to expand Medicare telehealth services to include prolonged preventive services.

And, lastly, I also want to mention that we are also proposing to implement the requirements of the Bipartisan Budget Act of 2018 for telehealth services related to beneficiaries with end-stage renal disease who receive home dialysis as well as telehealth services for beneficiaries with acute stroke.

Both of those provisions are effective by law on January 1, 2019. And with that, we are happy to answer any questions on these proposals.

Question & Answer Session 2: Clarifying Questions on Advancing Virtual Care

Nicole Cooney: Thank you, Lindsey. We are now ready to take your clarifying questions on advancing virtual care. Please limit your questions to this topic. And remember, in the interest of taking as many questions as possible, we will spend a maximum of three minutes on each question and answer.

And as another reminder, verbal comments on today's call do not take the place of submitting formal comments on the rule as outlined on slide 6 of today's presentation.

Dorothy, we are ready for our first caller.

Operator: To ask your question, press star followed by the number one on your touch-tone phone. To remove yourself from the queue, press the pound key. Once your line is open, state your name and organization.

Please hold while we compile the roster.

Please hold while we compile the roster.

Your first comment comes from the line of Tara Martin.

Tara Martin: Hi. This is Tara Martin from Holy Redeemer Health System. I was wondering if annual wellness visits or behavioral health psychotherapy sessions would ever be covered virtually.


Lindsey Baldwin: So, I believe most – almost all of the existing psychotherapy CPT codes are on the Medicare telehealth list that can be furnished currently. And the new proposals for the virtual check-ins – I think that if so long as the requirements that are described at the service are met, they could be billed. And, so, that could be done in the context of mental health care as well.

Emily Yoder: We are also – I mean, we are interested in comments as to different ways that we could expand the use of telecommunications technology for other types of services, including, the ones that you mentioned. So, if you would include that in a public comment, that would be really helpful.

Tara Martin: Thank you.

Operator: Your next – your next comment comes from the line of Susan Rehill.

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Susan Rehill: Hi. Thank you so much. This has been so informative. This is great. So, I would like to know can you define communication technology for me, please? It seems like phone calls are kind of a no-brainer. But, would that include like email, chat? What is communication technology, please?

Lindsey Baldwin: So, we are currently defining communications technology for the purposes of the virtual check-in as two-way audio communication or video communication. It doesn't necessarily have to be audio and video. For the purposes of the asynchronous service, that does not need to be – I mean, it's two-way communication. But, it doesn't have to be synchronous.

Susan Rehill: (Inaudible) with the audio...

Lindsey Baldwin: We have – we really – yes. We wanted to avoid being too specific in terms of the kinds of technology that these services refer to in part because technology changes so rapidly and we don't want to be overly prescriptive in light of that.

Susan Rehill: That makes sense. Thank you so much.

Lindsey Baldwin: Thank you.

Operator: Your next comment comes from the line of Toni Sitzman.

Toni Sitzman: Hi. This is Toni. Family Health Care of Siouxland in Sioux City, Iowa. And on the second bullet regarding Rural Health Clinics, would that actually be for the use of the room then?

Nicole Cooney: Give us one second.

Simone Dennis: Hi. My name is Simone Dennis. Do you mind repeating your question one more time, please?

Toni Sitzman: Yes. The second bullet where it says that you would pay Rural Health Clinics or FHQCs for communication-based services furnished by an RHC or FQHC when there is no billable visit – so, what you would be paying the Rural Health Clinic for? Would it be for the use of the room and the services that you are allowing the patient come in to use?

Simone Dennis: So, we developed the proposal for RHCs and FQHCs who has a new G-code, which is going to be blended from the two codes under the PFS. And it would be for the professional service time for furnishing this service.

Toni Sitzman: Okay. So, it would – there really wouldn't be a face-to-face visit with the provider there. But, the patient would come in to use the facility, so they could see a physician remotely.

Simone Dennis: No. I think there is just a slight misunderstanding. So, it would still be communication technology-based. So, the patient could possibly initiate it through a text or an email. But, it would still be the time spent talking on the phone or via Skype via non-face-to-face communication.

Toni Sitzman: Okay. Thank you.



Simone Dennis: Thank you.

Operator: Your next comment comes from the line of Cindy Wilson.

Cindy Wilson: Hi. Yes. My name is Cindy Wilson, and I am with Advanced Practice Providers and I just have a couple of questions on the virtual care. I was wondering if – first, if you could define clinician. Is that providers, you know, physicians or is that advanced practice providers as well?

And then, also, is there any limitation when you can be doing this and billing for it if the person is also getting remote monitoring that month or potentially on chronic care management that same time period? Are there any codes that can't be billed at the same time if you are doing this, you know, advancing the virtual care type of services? Thank you.

Lindsey Baldwin: Hi. Thank you for your question. So, to answer your first question, I think it was which practitioners or which clinicians could furnish this service. It would be any practitioner who concurrently bill an E/M service.

And, then, I think the second part of your question was asking if they are also billing chronic care management or doing remote monitoring, can they also bill this code. Yes, they could. We did not limit that it had to be one or the other just so long as the time is not counted twice.

Cindy Wilson: Got you. Thank you.

Lindsey Baldwin: Sure.

Operator: Your next comment comes from the line of Mark Gilbert.

Mark Gilbert: Yes. Mark Gilbert, Department of OBGYN at Upstate here in Syracuse, New York. I think my question was answered. It was really the second bullet about the rural health or Federally Qualified Health Centers, would it be the host site and whether a specialist can, you know, have consults where the patient is at the Rural Health Clinic, but the physician is in an urban setting, say.

Simone Dennis: So. So, you suggested that the patient is in the clinic, but the provider is in another setting. Is that correct?

Mark Gilbert: Correct. That they are a specialist, right, and performing ...

Simone Dennis: I just want to make sure that we are not confusing telehealth with this new proposal.

Mark Gilbert: That could be.

Lindsey Baldwin: I think maybe that is the point of confusion. So, RHCs and FQHCs are paid for the originating site where the bene is located but they are not designated to be distant site providers of telehealth.

Mark Gilbert: Okay.



Nicole Cooney: Thank you. Dorothy, I will take my final question on this topic.

Operator: Your final comment comes from the line of Jill Robinson.

Jill Robinson: Good afternoon. Thank you so much for taking my call. My question is related to the last question that was asked. Our – we would like to see the geographic restrictions taken away just like they will be taken away for tele stroke and dialysis patients so that urban hospitals can provide services to people that live in rural areas or people that have mobility or stroke problems that keep them from coming to – coming to a facility.

If they have had a traumatic brain injury, it's going to hard to get them to come so on and so forth. So, could the geographic restrictions be lifted for other services so we can be of better service to our patients?

Lindsey Baldwin: Thank you for that question. Unfortunately, for the purposes of Medicare telehealth, the originating site restrictions, which are the geographic restrictions, are specified in statute. So, we don't have any leeway there from a regulatory perspective.

For the – but, we would note that the virtual check-in and the remote asynchronous service are not Medicare telehealth. And, so, those can be furnished regardless of where the beneficiary is located.

Jill Robinson: Thank you very much for clarifying. I appreciate your answer very much.

Lindsey Baldwin: No problem. Thank you.

Presentation (Continued)

Nicole Cooney: Okay. For our final topic. We have Molly MacHarris from the Center for Clinical Standards and Quality and Corey Henderson from the Center for Medicare and Medicaid Innovation to discuss continuing to improve the Quality Payment Program to reduce burden and offer flexibility to help clinicians successfully participate. We will start with Molly.

Quality Payment Program

Molly MacHarris: Thanks, Nicole. And thank you, everyone, for being here today. I am going to go ahead and start on slide 25 to go over the MIPS proposal under the Quality Payment Program. So, the first piece I wanted to note is that we did make proposals this year for the third year of the program to expand out our eligible clinician types.

So, those who are currently eligible to participate for the first two years of this program include physicians, physician assistants, clinical nurse specialists, certified registered nurse anesthetists and nurse practitioners. We have also proposed to expand out those who could be considered MIPS-eligible to clinical psychologists, physical therapists, occupational therapists and clinical social workers.

Moving on to slide 26. We do still have a number of exclusions from the MIPS program. Those include if you become newly enrolled to Medicare during the performance period as well as if you become a QP or partial QP



under the Advanced APM track of the Quality Payment Program. We also still have our low-volume threshold exclusion.

We proposed a number of changes to this exclusion in the third year. Specifically, the first change that we proposed is to maintain compliance with the recently-passed Bipartisan Budget Act. The Bipartisan Budget Act asks us to only apply the low-volume threshold based off of covered professional services as opposed to prior to the passage of the Bipartisan Budget Act, we took into consideration all Medicare Part B allowed charges.

The second proposal that we made for the low-volume threshold for the third year is to expand out the element that we could consider. So, the way that the low-volume threshold works today is we assess it based off of a number of allowed charges, specifically 90,000 in billings.

We also assessed to see how many beneficiaries or patients a clinician sees. As it stands today, it's 200 patients. We also have proposed new for the third year to also take into consideration the number of services that a clinician has. We proposed that threshold at 200 services.

And, then, the last piece that we proposed regarding the low-volume threshold is the ability for certain types of clinicians who meet one or two of the three elements I just described but not all three. They would have the ability to opt in to participate in the MIPS program. If a clinician chooses to opt in, they would be considered MIPS-eligible, which means they could receive a positive, negative or neutral adjustment.

Moving on to slide 27. A couple of changes that we've proposed here regarding the performance category weights. As folks will recall, under the MIPS program, we assess clinicians' performance on four performance categories, including quality, cost, improvement activities and promoting interoperability, which deals with the usage of certified EHR technology.

For the third year of the program, we've proposed to have quality count for 45 points, cost to count for 15 points and improvement activities and promoting interoperability to still count for 15 and 25 points, respectively.

Moving on to slide 28. Just a few other changes I wanted to share with you all today. As part of the quality performance category, we have made proposals to incorporate in the Meaningful Measures initiative. We've proposed to remove a number of measures that are low-bar measures or have met our topped-out criteria.

We also have proposed to move the small practice bonus that is available for clinicians in the second year of the program to fall within the quality performance category. Under the cost performance category, we do still have the Medicare spending for beneficiary and total per capita cost measures. But, we also have proposed to add eight new episode-based measures.

We also have made some proposals regarding our facility measurement option, specifically expanding the number of clinicians who would be able to participate in this option and then, also, the way that this option would work where clinicians would not need to make an election. Instead, we would only use this option if it would benefit the clinician as part of a burden reduction effort.

For the improvement activities, we have made a few refinements to the inventory. We have added a few new activities and we have made some proposed changes to some of the existing activities. And for the promoting



interoperability performance category, we have completely overhauled this performance category to align the clinician policies with the hospital policies.

We have reduced measures from – or we’ve reduced the number of measures that a clinician would need to perform under this performance category. And we have also changed the scoring to be focused on performance.

Moving on to slide 29. In relation to where we proposed to set the performance threshold and the total amount of payment adjustment that could be distributed in the third year of the program, in the third year we’ve proposed the that performance threshold would be at 30 points.

Remember that the performance threshold is the number that we would look at in relation to a clinician’s final score. If the clinician’s final score is above the performance threshold, they would get a positive adjustment. If it’s below the performance threshold, they would get a negative adjustment. And if their final score is at the performance threshold, they would be neutral adjustment.

We have also proposed to increase the exceptional performance bonus from 70 points, from where it’s been at for the first two years, to 80 points. And the total amount of payment that’s at risk in the third year of program as required by law is 7 percent.

And, then, moving on to slide 30. I also just wanted to flag a couple of items that we are looking for your feedback. We really want to hear from all of you on this. We are interested in new approaches that we could take for the quality performance category.

We’ve heard a number of concerns from folks that this category is overly complex and there are a lot of rules and requirements that can be confusing. So, we really want folks’ input on ways that we could really transform that performance category.

We also are interested in folks’ feedback on ways that we could create more alignment across the performance categories, meaning where we could have measures or activities that fall into other categories.

We are also looking for feedback on expanding out our facility measurement option and also the ability for certain types of groups to further subdivide. So, at this point, I’m going to go ahead and turn the presentation over to Corey to talk through the APM proposals. Corey?

Corey Henderson: Thank you, Molly. Let’s move to slide 31. I just want to give enough time for everyone to be able to ask a few questions. But, I would just touch on the proposals for the Advanced Alternative Payment Models. And these proposals are for year three of the program, which is performance year 2019.

Under the general section of Advanced Alternative Payment Models, we are updating the Advanced APM CEHRT threshold so that an Advanced APM must require that at least 75 percent of eligible clinicians in each APM entity use CEHRT. We are also proposing to extend the 8-percent revenue-based nominal amount standard for Advanced APMs through performance year 2024.



And for MIPS APMs and the APM scoring standard, we are clarifying the requirements. The MIPS APMs will assess performance on quality measures and cost utilization. And we are also proposing to update the MIPS APM measure sets that apply for purposes of the APM scoring standard.

If we go to slide 32. Under the Advanced Alternative Payment Model – so, again, for the proposals for year three, performance year 2019, we’re going to focus on the all-payer combination option. Here, we are looking increase flexibility for the all-payer combination and other payer Advanced APMs for non-Medicare payers to participate in the Quality Payment Program.

First, we are proposing to establish a multi-year determine process where payers and eligible clinicians can provide information on the length of the agreement as part of their initial other payer Advanced APM submission and have results and determination be effective for the duration of the agreement.

Additional flexibility will be allowing QP determinations at the TIN level in addition to the current options for determinations at the APM entity level and the individual level and these are – and since it is where all clinicians who bill under the TIN participate as a single APM entity.

And additional flexibility is being proposed by moving forward with allowing all payer types to be included in the 2019 payer-initiated other payer Advanced APM determination process for the 2020 QP performance period. And, finally, we are streamlining the definition of a MIPS comparable measure in both the Advanced APM criteria and other payer Advanced APM criteria.

Now, I hand it back over for question and answers.

Question & Answer Session 3: Clarifying Questions on the Quality Payment Program

Nicole Cooney: Thank you, Corey. We are now ready to take your clarifying questions on the Quality Payment Program portion of our session. If you could please limit your questions to this topic keeping in mind our three-minute maximum. And, also, as a reminder, verbal comments received on the phone do not take the place of formal comments submitted as outlined in the directions on slide 6.

Dorothy, we are ready for our first question.


Operator: To ask your question, please star followed by the number one on your touch-tone phone. To remove yourself from the queue, press the pound key. Once you line is open, state your name and organization.

Please hold while we compile the roster.

Please hold while we compile the roster.

Your first comment comes from the line of Anne Marie Cunningham.

Anne Marie Cunningham: Hi. Yes. Thanks for taking my question today. This is a question in regards for – are the MIPS and AMP reporting applicable to the facility outpatient setting since we bill under a single NPI?



Molly MacHarris: Sure. This is Molly. So, to be eligible for the Quality Payment Program, typically we would need to be able to identify a specific clinician associated with the TIN, a tax identification number, and an individual rendering NPI.

Anne Marie Cunningham: So, then, to clarify, then, in the proposed rule, should that MIPS move forward then the outpatient facility would be excluded from the required reporting. Correct?

Molly MacHarris: It would depend on the specific of how you bill into Medicare. So, for this particular question, I recommend that you send this to us as part of the formal comment process. We also do have a service center that you could reach out to, and we can work through that in more detail on the specific scenarios of your circumstance and whether or not you would be considered MIPS-eligible.

Anne Marie Cunningham: Okay. Thank you.

Nicole Cooney: Thank you.

Operator: Your next comment comes from the line of Colleen Sifuentes.

Colleen Sifuentes: Hi. My name is Colleen Sifuentes and I work for a family medicine group. I have a question on the year two payment adjustment. I spoke with QPP representative, and he had said that since CMS was not expecting so many physicians and groups to do that well, that 100 percent is still only going to get a 2 percent, like no one will get higher than a 2 percent for this year one.

Is that correct? You said that the targeted review wouldn't help.

Molly MacHarris: Sure. This is Molly. So, for the first year of the Quality Payment Program, we will be issuing payment adjustments beginning in 2019. We did recently release feedback reports to folks in July.

We also have released previously some information regarding the Quality Payment Program that we did have record levels of participation. We have 91 percent of eligible folks participate in the program, which we are very happy about.

For your issue that you could have a really high final score and a relatively smaller payment adjustment, that is accurate. When you think about the MIPS program, one of the things that's important to remember is that it must be – all the payment adjustments must be issued in a budget neutral manner.

So, we would have to ensure that the number of folks that are getting the negative payment adjustments offsets the number of folks that would be getting the positive adjustment. So, we have seen that for this year where people have had really high final scores and a lower payment adjustment. So, I hope that helps explain what you've been seeing. Thank you.

Colleen Sifuentes: Well, it does – it's just a little bit – I mean, it's a little bit concerning when, I mean, if, you know, you hope to get the percentage and then you don't get it and you do all the work for it just because the other physicians didn't get a negative.



And, then, the – when we turn in – like some physicians turned in for 90 days and then some turned – like we turned in for a year. Was that – I mean, would that have helped us in getting the higher payment adjustment and all? Or just no one gets higher than 2 percent?

Molly MacHarris: What we've seen based off of our data results is that people who are having really high final scores such as yourself, that their maximum adjustment is around that 2 percent, again, keeping in context that we have had such a high amount of participation in the first year of the program that has impacted the total amount of positive adjustments that we can distribute.

Colleen Sifuentes: Okay. And do you just ...

Nicole Cooney: Thank you so much. Sorry. I'm so sorry.

Colleen Sifuentes: Thank you.

Nicole Cooney: But, in the (inaudible) many folks ...

Colleen Sifuentes: That's Okay.

Nicole Cooney: Yes. Thank you so much for understanding. Next question, please, Dorothy.

Operator: Your next comment comes from the line of Sherie Reeves.

Sherie Reeves: Good afternoon. I just wanted to ask in the – in the process of trying to align with the hospital and the clinician in the policies, is there any look at aligning Medicaid with the Medicare so that we don't have disparate reporting requirements between a Medicare and a Medicaid physician?

Elizabeth Holland: Yes. We did actually look at aligning Medicaid. But, unfortunately, the Medicaid EHR Incentive Program, which is now the Medicaid Promoting Interoperability Program, is phasing out. And, so, we are paying fewer and fewer clinicians in hospitals.

And, so, because the attestations are handled at the state level and the territory level, there's actually 54 systems and they're just aren't the resources available to update all those systems to accommodate the change.

So, we – ideally, we would have done that. But, we just lack the resources to enable that to happen.

Sherie Reeves: So, the burden is back on the physicians – us to have the resources to be able to do that.

Elizabeth Holland: You are certainly welcome to submit a comment. Thank you.

Operator: Your next comment comes from the line of Melanie Robin.

Melanie Robin: Hi. I'm from the University of Maryland in Baltimore. My question is really more of a clarification. I think you touched on it but I just want to confirm. If we have facility-based providers, if we



submit data for them and that score is better than what they would have gotten if you were just looking at their facility claim, then you are going to look at what we've submitted. Is that correct?

Molly MacHarris: Yes. So, the way that the facility measurement option works is that specifically for the quality and cost performance category, we would first look to see if someone meets our facility-based definition, which has a number of place of service codes associated with that. Apologies I don't recall them off the top of my head.

Then, we would look to see for that facility-based clinician – is there a hospital under that HVBP program that we could associate that clinician with what we would do then if we would take that hospital's total performance score and apply that to the clinician's quality and cost performance category scores.

If that is more beneficial to the clinician, meaning if they would have higher performance using the HVBP toward the performance score rather than their other MIPS submission, that's what we would use for their quality and cost performance categories. Or at least that's the proposal. But, again, I would recommend that you submit a comment to us through the formal process on your thoughts and feedback there.

Nicole Cooney: Thank you.

Melanie Robin: Okay. Thank you.

Operator: Your next comment comes from the line of Jall Hughes.

Jall Hughes: Hi. I'm calling from Level One University Health Care in Southern California. First, I would like to thank you so much for taking the time to review this with us today. It's been very helpful.

My question relates to slide 27 and there's two parts to it. The first part is what goes into adjusting the category weight percentages? And the second part of the question is do you see quality and cost coming to parity? Thank you.

Molly MacHarris: Sure. So, the performance category weight that we have for year three are 45 percent for quality and 15 for cost. To take your second question first, yes, we are required by law under the Bipartisan Budget Act amendment to the MACRA status that beginning in year six of the Quality Payment Program, quality and cost must both contribute 30 points towards a clinician's final score.

For our first question, when we took a look at where we should set or where we should propose to set these performance category weights this year, we did take a look at where we've had it for the first two years as well as where we ultimately need to land at that 30 and 30 mark.

So, that's where we have come up with our proposals for this year. But, again, I would highly recommend that you submit a comment to us on this issue.

Nicole Cooney: Thank you.

Jall Hughes: Thank you.



Operator: Your next comment comes from the line of Janet Brier.

Janet Brier: Pardon me. Hello. I have and – but I just have a quick question about the telehealth. And I know you don't want to talk about that now. But, does the patient portal count with one of the telehealth encounter (inaudible) two-way communication with the patient portal?

Molly MacHarris: This is Molly. Nicole, I think that – so, one, we didn't completely hear the question in the room, but we think it may actually be for the telehealth issue. But, Nicole, I'll defer to you.

Janet Brier: Yes. The question was “does the patient portal count as a telehealth encounter when it's a two-way encounter”?

Nicole Cooney: Just give us one second.

Lindsey Baldwin: I'm sorry. Could you provide a little bit of clarification? What do you mean by patient portal?

Janet Brier: We have various communication vehicles that the patients can communicate with us via the Internet basically. So, they can communicate with our practitioners through a portal, a patient portal, and we can communicate back to them the same way.

Lindsey Baldwin: Great. Okay. Thank you for clarifying.

Janet Brier: Rather than instead of phone encounter.

Lindsey Baldwin: Yea. Got you. Yes. I think that what you're describing – that sounds like it would meet the description for the remote pre-recorded service that describes the asynchronous going forward, but it wouldn't for the virtual check-in that requires interactive two-way communication.

Janet Brier: Okay. Thank you. And I apologize for asking that question out of turn. Thank you.

Lindsey Baldwin: No problem. No worries.

Nicole Cooney: Dorothy, I'll take my final question.

Operator: Your final comment comes from the line of Teresa Beck.

Teresa Beck: Hi. This is Teresa Beck from Baker Medical Group. And my question is looking at the proposal in 2019 to add further providers, especially physical therapists and occupational therapists, how – if they are not owned under our physician group but are owned via the hospital or their own plan, will the quality payment structure come through the hospital setting or would there not be any accountability for them?

Molly MacHarris: Sure. This is Molly. I think you're getting at some of the different ways that clinicians can bill into Medicare. So, I'd recommend using – one, I'd recommend that you submit to us a formal comment through the process so we can respond to it there.



Under the quality payment program, again, we identify clinicians based off of their unique TIN, of their tax identification number, and their NPI, their individual rendering NPI. We do understand, however, that there are certain billing arrangements that clinicians can have as part of their organization which can limit our ability to identify the clinician as part of the Quality Payment Program.

There's a lot of nuances there. So, I think what would be best is if you can submit a formal comment to us. And if you would like additional information in the meantime, I can direct you to our website, qpp.cms.gov. We have a lot of factoids and fact information out there as well as our service center where they can work through this issue in the interim. I hope that helps. Thank you.

Teresa Beck: Thank you.

Additional Information

Nicole Cooney: Thank you, everyone. I wanted to let everyone know that we do have several resources available that we feel would be helpful to those of you on the call or anyone interested in the topic. But, rather than read the long URLs here on the phone and have everyone scramble to write them, I will be sending them in a follow-up email to all registrants later today, tomorrow, within the next 24 hours. So, be on the lookout for that email.

We will have an audio recording and written transcript for today's session. That will be available in about 7 business days on our call webpage. We will also announce the availability in the MLN Connects newsletter. And, again, my name is Nicole Cooney.

I'd like to thank our presenters today, our administrator and also thank you for participating in today's Medicare Learning Network listening session on the Physician Fee Schedule proposed rule. Have a great day, everyone.

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