

Centers for Medicare and Medicaid Services  
Safety -Net Providers  
Open Door Forum  
Moderator: Jill Darling  
April 19, 2017  
2:00 p.m. ET

Operator: Good afternoon. My name is (Heidi), and I will be your conference facilitator today. At this time, I would like to welcome, everyone, to the Centers for Medicare and Medicaid Services Safety -Net Providers Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Heidi). Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communication. Thank you for joining us today for the Safety-Net Providers Open Door Forum. And always, we appreciate your patience and getting started with the call – it started a little late. So, we, you know, are waiting for more folks to dial in.

So, before we get into today's agenda, I have one brief announcement. This open door forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at [press@cms.hhs.gov](mailto:press@cms.hhs.gov).

And now, I will hand the call up to our co-chair for Corinne Axelrod.

Corinne Axelrod: Thank you, Jill. Hi everybody. I just wanted to thank everyone for joining the call today. There's a pretty diverse group of providers and others on this call, so, if there are any topics that you'd like us to include in future calls, we really encourage you to let us know. You can send an e-mail to me, corinneaxelrod and that's C-O-R-I-N-N-E dot Axelrod, A-X-E-L-R-O-D – @cms.hhs.gov or you can also send one to Rita.

I'm in the CMS Center for Medicare, Rita is in HRSA. So, let me turn it over to Rita who also just wanted to say a few words.

Rita Vandivort-Warren: Thank you, Corinne. Hi. This is Rita Vandivort-Warren. I am in the Office of Policy Analysis and Evaluation at HRSA working on crosscutting issues and I welcome all of you. I hope that you all like the name change that Corinne and I advocated for from low-income ex – no, low-income access to a safety-net provider. So, we thought that would be more descriptive and more engaging.

So, please tell others about this opportunity and we will welcome them on our next call. My e-mail along with my difficult name is rvandivort-warren, which is on your agenda, @hrsa.gov. So, I'd be very open to any suggestions also or any comments for follow up.

With that, I'll turn it over to Jill and we'll get to the meat of today's call. Thank you.

Jill Darling: Thanks, Corinne and Rita. So, first off, we have Monica Kay, who will go over the Social Security Number Removal Initiative.

Monica Kay: Thank you, Jill and welcome, everyone, on the call. I wanted to bring information to you about the Social Security Number Removal Initiative that we've been actively working on for the last several months. In terms of background, the health insurance claim number is a Medicare beneficiary's identification number and it's used for paying claims and determining eligibility for services across multiple MCs such as the Social Security Administration, Railroad Retirement Board, State Medicare Providers and Health Plan.

With the passing of the Medicare Access and CHIP Reauthorization Act, MACRA of 2015, that mandated the removal of the Social Security Number-Based HICN, which is the Health Insurance Claim Number from the Medicare card to address the current risk of beneficiary medical identity theft. That legislation requires that CMS must mail out new Medicare card with the new Medicare Beneficiary Identifier or MBI by April of 2019.

Some our program goals in doing the Social Security Number Removal Initiative is to decrease the Medicare beneficiary's vulnerability to identity theft. By removing that SSN-based HICN from their Medicare identification card and replacing that HICN with a new Medicare Beneficiary Identifier or MBI. In doing this, we want to minimize the burden for beneficiary, providers, Medicare operation, and provider solution for our business partners that allows the usage of HICN and MBI for our business critical data exchanges, and then of course, we have to manage the cost, scope and schedules with the project.

So, this involves complex IT system that affects you as a provider, our partners, as well as beneficiary, so along with our partners, CMS will address the complex systems changes for over 75 systems. We will also conduct expenses outreach and education activities and analyze the many changes that will be needed to our systems and business processes. The effects to stakeholders include our federal partners, state, beneficiary, providers and plans, as well as other key stakeholders such as our billing agencies, advocacy groups and data warehouses. And we have been closely working with our partners and stakeholders to implement the SSNRI removal initiative.

So, let's talk a little bit about the solution concept that new MBI or Medicare Beneficiary Identifier. The solution for this program must provide the following capabilities. We have to generate new Medicare Beneficiary Identifiers or MBIs for all beneficiaries. This includes existing currently active, deceased or archived, as well as new beneficiaries coming into our program. We must also issue those new redesign Medicare cards to our existing and new beneficiary.

We also need to modify our systems and business processes and any items or systems that require update to accommodate the receipt, transmission, display or processing of that MBI. CMS will use the MBI generate – generator to assign over 150 million new MBIs in the initial enumeration, this includes 60 million active and 90 million deceased or archives, as well as generate a new unique MBI for each new Medicare beneficiary. We will also generate a new unique MBI for any Medicare beneficiary who's identify had been compromised.

The next thing I would like to talk to you about is just the differences between the old HICN or Health Insurance Claim Number and the new MBI number. The Health Insurance Claim Number or HICN is the primary beneficiary's account folder's Social Security Number, SSN, plus the beneficiary identification code or BIC. It's a nine bite SSN plus a 1 or 2 byte BIC. And the key positions 1 through 9 are numeric. The new Medicare Beneficiary Identifier or MBI will be a new non-intelligent unique identifier.

It will also be 11 bytes and the key positions of 2, 5, 8 and 9 will always be alphabetic. It will also have the following characteristics. The MBI will have the same number of characters as the current HICN which is 11 but will be visibly distinguishable from the HICN. It will contain alphabetic and numeric characters throughout the 11-digit identifier. It will also occupy the same field as they HICN on transaction.

The biggest point to note is that it will be unique to each beneficiary, the husband and the wife will have their own MBI. It will also be easy to read and limit the possibility of letters being interpreted as numbers, and it will exclude the letters S, L, O, I, B and Z. It will not contain any embedded intelligence or special characters nor will it contain any inappropriate combinations of numbers or strings that may be offensive.

CMS anticipates that the MBI will not be changed for individual unless the MBI is compromised for some other limited circumstances that are still undergoing review by CMS.

Now, let's talk about our transition period in this implementation. CMS will have a transition period where they will start April – January 2018 through January of 2019 where we will begin to activate our MBI generator and translation services. April 2018 is when our official transition period begins, and between; April 2018 through May 2019, we will be conducting that phased card issuance to our beneficiary.

From April of 2018 through December of 2019, you as a provider will be able to accept and process both the HICN and the MBI on your transaction. And a point of note, as – after December 31st of 2019, HICNs will no longer be exchanged with beneficiaries, providers and plans and other third parties with some limited exception. So, that 21-month period allows the provider to be able to capture that new MBI, as well as ask for it from their beneficiaries and we'll talk a little bit more about that transition period.

CMS will complete a systems and process update to be ready to accept and return the MBI as of April 1st of 2018, which is our anticipated start date of the mailing of our new card. All stakeholders to submit or receive transactions containing the new Health Insurance Claim Number or the HICN must modify their processes and systems to be ready to submit or exchange the MBI by April 1st because that is when beneficiaries will start receiving their new card. Stakeholders may submit either the MBI or the HICN during that transition period.

CMS will accept and use for processing and return to the stakeholders either the MBI or the HICN whichever is submitted during that transition period. And in addition, beginning in October 2018 through the end of our transition period when a valid and active HICN is submitted on a Medicare fee-for-service claim both the HICN and the MBI will be returned on the remittance advice. The transition period will run, again, from April 2018 through December 31st of 2019, and as of January 1, 2020, we will no longer be sharing the HICNs with providers.

Let's talk about some of those exceptions after the transition period. We know that there are some business processes that may still need the use of the HICN after that January 1, 2020 date. So, in these situations, you'll still be

able to use the Health Insurance Claim Number or HICN. Appeal, if you are processing appeals and request and related forms, you will still be able to submit with either a HICN or MBI.

Report whether they're incoming reports to CMS or outcome – outgoing report to CMS, you will still be able to use that HICN or MBI. We will also be able to use the HICN for retroactive enrollment and span-date claim and that includes the 11X inpatient hospital, 32X home health and 41X religious non-medical health care and those are the institutional claims with a from date prior to the end of the transition period which is 12/31/19.

You will be able to use a HICN for adjustment and these are adjustments where you originally submitted a HICN on the claim and this includes PBEs, risk adjustment and encounter data. You will also be able to use the HICN for incoming information request and this is – for example, our Medicare secondary payer information request and request for medical documentation.

And then lastly, you will also be able to use a HICN for incoming premium payment and this is in related to the payments that are made by beneficiaries for Part A Premium, Part B Premium, Part D Income Related Monthly Adjustment Amount and others. And again, we will be using HICN on the reports until further notice.

So, let's talk a little bit about our card issuance. CMS will begin issuing new Medicare card for existing beneficiaries after the initial enumeration of MBIs which is roughly 60 million beneficiaries. As a point of note, the gender and signature line will be removed from the new Medicare card. The Railroad Retirement Board will also issue new card to their RRB beneficiary with the new Medicare Beneficiary Identifier, and we will work with states that currently include the HICN on their Medicare card to remove them to replace it with either a new Medicaid ID or replace it with an MBI.

And then CMS will conduct intensive education and outreach to all of our Medicare beneficiaries and their agents to help them prepare for this change. That outreach in education includes 60 million beneficiaries, their agents, advocacy groups and caregivers. It also includes health plans, the provider

community such as yourself, based in territories and other key stakeholders, vendors and partners.

CMS will ensure that we involved all of our stakeholders in our outreach and education efforts through existing vehicles for communication such as open door forums like this, HPS – HPMS notices and conferences.

In terms of health plan specific information, if you are a plan, please continue to review the HPMS memo that are sent out on a frequent basis. The last SSNRI-related memo was sent out on April 13th, also participated in our open door forum.

And then lastly, if you have any information, please go to our website where we keep it updated constantly and that is <http://gov.cms.gov/ssnri> for information.

I wanted to thank you for participating in this discussion today. We know it's a lot of information to digest and if you have any comments or questions, we ask that you submit them to us on our team mailbox at [ssnremoval@cms.hhs.gov](mailto:ssnremoval@cms.hhs.gov).

Thank you. Jill, turning it back over to you.

Jill Darling: Thanks, Monica. Up next, we have Adam Richards, who will go over the QPP, the Quality Payment Program Small, Underserved, and Rural Support Initiative.

Adam Richards: Great. Thanks, Jill and thanks to everyone for being here today. It's a pleasure to be on this call. I wanted to just take a step back quickly to kind of just talk context and where the Small, Underserved, and Rural Support came from. We realized that practices with 15 or fewer clinicians, specifically those in the rural and health professional shortage areas, they really are a crucial part of the health care system.

And therefore, we the Quality Payment Program, we've designed this program so that it provides flexible options really to make it easier for smaller practices

to actively participate in the transition year of the program, as well as beyond in later years. So, just talking about some of those flexibilities at the high level, we have flexible participation option, the ability to choose measures to the various performance categories, we have flexibility with submission options, and reporting methods, which is individual versus group reporting - however a clinician wants to report during the transition year.

And we've also focused on what we can do to include more small practices in alternative payment models and advanced alternative payment models, but one of the bigger flexibilities and what I'm here to really discuss with you today is the technical assistance and specifically technical assistance for the small practices which was kind of aptly named Small, Underserved, and Rural Support.

And this was actually an award that was made about two months ago on February 17th. It is a five-year technical assistance program that was authorized under MACRA. It's comprised of 11 local experienced and community based organizations that were awarded contracts as a result of an open and – of an open and competitive national procurement process. I do want to reiterate that the awards were made to organizations. I think there was a little bit of confusion about who receives the \$100 million allotted for technical assistance. So, that is the funding that will go to fund these organizations to help small practices kind of prepare for and participate in the Quality Payment Program.

And in case you didn't have a chance to see the press release or the infographic, those 11 organizations include Healthcentric Advisors, IPRO, Quality Insights, Alliant GMCF, QSource, Altarum, TMF, HSAG, Telligen, the Network for Regional Healthcare Improvement, and Qualis. And the Small, Underserved, and Rural Support is really designed for practices with 15 or fewer eligible clinicians. In just a few minutes, I'll talk about some of our other support branches for bigger organizations. And this, it really includes small practices in rural locations, health professional shortage areas and medically-underserved areas.

And the goal is to provide on the ground to support to eligible clinicians by assisting in the selection reporting of appropriate Merit-based Incentive Payment System or MIPS Quality Measures and Improvement Activities, optimizing health information technology within the various practices, supporting change management and strategic planning, and evaluating each practice and really the clinicians options for joining an advanced alternative payment model in the future.

Another thing that I will say, this list is not all inclusive. There is a lot of building flexibility and I think that's kind of the keyword here is flexibility for customization. So, each one of these organizations is able to meet the needs of the clinicians and the practices by changing the way that they approached the technical assistance. This support is available immediately like I said we launch this on February 17th and it is at no cost to clinicians and small practices.

The Small, Underserved, and Rural Support really adds an additional layer to the multilevel outreach effort that we've created to help eligible clinicians understand, prepare for and participate in the Quality Payment Program. So, now this serves or the Small, Underserved, and Rural Support really completes the picture of our integrated technical assistance which now includes the Quality Innovation Networks and Quality Improvement Organization or QIN-QIOs, the Small, Underserved, and Rural Support or SURS, our Transforming Clinical Practice Initiative or TCPI with the support of the Practice Transformation Networks, the APM Learning Systems and just generally the Quality Payment Program -

So, our service center, as well as the Quality Payment Program website, [qpp.cms.gov](http://qpp.cms.gov). They (clinicians) may be asking kind of where do – how do all these branches where they lie, how do they fall, who do they really help. So – and the available forms of a technical assistance really depend on how clinicians participate in the Quality Payment Program.

So, for example, clinicians that are participating in advance to APM and are considered Qualifying APM Participants or QPs. They would receive their

support through the APM Learning Systems. Now, clinicians participating in MIPS may receive support as part of the Transforming Clinical Practice Initiative through their Practice Transformation Network.

Alternatively, there are two additional options for MIPS specific assistance for clinicians who are not enrolled in a PTN or maybe not even interested in TCPI. Of course, these include the Small Underserved and Rural Support as I mentioned earlier if they are in a practice of 15 or fewer clinicians.

And then there's also the Quality Innovation Networks and Quality Improvement Organizations who are out there to support larger practices, so those practices that have greater than 15 clinicians. And finally, as I mentioned, clinicians who are part of APM or an advanced APM – or I'm sorry, just part of an APM and are required to still participate in MIPS are eligible to receive technical assistance through either the QIN-QIOs or the Small Underserved and Rural Support, again, depending on their practice size.

So, just to wrap things up here, all of these technical assistance branches have a shared goal of ensuring 100 percent of eligible clinicians have access to technical assistance, and we've also created a framework whereby if a clinician reaches out to anyone of these branches, we've created what are calling warm hand-offs so that we're able to take that clinician, answer any questions they may have right off the bat and then make sure they get to the right support network that's right for the size of their practice.

To wrap things up here, I will say, we have a resource available at [qpp.cms.gov](http://qpp.cms.gov) underneath the Education and Tools Section. It is called (Support for Small Practices)– it's just a general fact sheet for small practice that gives a list out of all of the organizations that I mentioned earlier, as well as the contact information for this organizations, as well as the general contact information for our central support contractor just in case if you – if you're not sure which organization might benefit you the most, you can always just reach out to our central support and they'll get you connected to where you need to go.

I'll also say for clinicians in small practices, not just the support for small practices fact sheet, but there are a lot of additional educational resources on [qpp.cms.gov](http://qpp.cms.gov). One area that I certainly will point you to is a tab under the Education and Tool Section. It's called the Webinars and Educational Programs, and if you click on that tab and scroll to the bottom, we've just actually uploaded some on what we're calling micro-videos. So, these are short videos generally 10 to 15 minutes or less.

But we've just uploaded seven videos that are specific to clinicians and small rural and underserved practices just to give them a high-level idea kind of what the Quality Payment Program is and how to really get started with the program for the transition year.

So, with that, I will turn it back over to Jill. Thank you.

Jill Darling: Thank you, Adam. Up next, we have Simeon Nile to cover the Accountable Health Communities model.

Simeon Nile: Thanks, Jill and hi, everyone. Glad to be on the line with you. Last year, CMS released the funding opportunity announcement for applications to the Innovation Center Accountable Health Communities Model. As a reminder, the model is a five-year model where CMS will implement and test the AHC model to empower local communities in addressing the health-related social needs of community dwelling Medicare and Medicaid beneficiaries.

These communities will bridge the gap between clinical and community service providers to address those beneficiaries health-related social need. When we think about social needs, we're talking about those things that help a beneficiary to obtain and maintain their optimal level of health and those include housing, food – access to food, meeting utility needs interpersonal safety and transportation needs.

To implement the model, we will be funding or we have funded bridge organizations within each of these communities to serve as hubs in these communities to form and coordinate relationships among the consortia of participants. Part of these responsibilities entail identifying and partnering

with clinical delivery sites to conduct systematic health-related social need screenings of all such beneficiaries and to make referral those community services that may be able to address those identified health-related social needs.

When you think about clinical delivery sites, we're talking about physician and practices, behavioral health providers, clinics and hospitals. Those bridge organizations are also responsible for coordinating and connecting beneficiaries to community service providers through community service navigation. In one of our particular tracks of the model, bridge organizations are also responsible for aligning model partners to optimize community capacity, to address health-related social needs.

Funds for this model will support infrastructure cost and staffing needs of bridge organizations and their partners and will not directly pay or will not pay for directly or indirectly any of the community services.

On April 6, 2017, CMS announced the participants for two of the tracks, the assistance and the alignment tracks of the Accountable Health Communities Model. By addressing the critical drivers of poor health and high secure – high health care cost, this model aims to reduce avoidable health care utilization, impact the cost of health care, improve high – improve health and quality of care for Medicare and Medicaid beneficiaries.

The awarded organizations in the Assistance Track will provide the person-centered community service navigation services to assist the high risk beneficiaries with accessing those needed services. Organizations awarded to the alignment track will also provide community service navigation services, as well as encourage community level partner alignment to ensure that needed services and supports are available and responsive to the beneficiary's needs.

CMS received many applications from all across the U.S. received applications for the Assistance and Alignment Tracks from a variety of organizations in May 18, 2016. After a review process, we selected 12 Assistance Track and 20 Alignment Track bridge organizations representing both rural and urban communities across 193 counties and existing in 23

states. Of those 12 Assistance Tracks and 20 Alignment Track bridge organizations, they vary in type and size and location and beneficiary demographics.

Some awardees were county governments, hospitals, universities and health departments, as well as community-based organizations with capacity to make relationships with other entities in the community and also address the local needs of that community. The Assistance and Alignment Tracks of the model will begin implementation on May 1, 2017 and there will be a five-year performance period.

To reiterate, the key innovations of the model is, one, this is one of the first CMMI models. It's one of the first Innovation Center models that are designed specifically to test building community capacity to address the needs of a geographically defined population of beneficiaries. Also, this is one of the few models, the first models to implement systematic screening of all Medicare and Medicaid beneficiaries to identify the unmet health-related social needs of those beneficiaries.

The model evaluation strategy includes randomization – a randomized evaluation – randomized evaluation design to understand – of community service navigation services, to provide assistance of beneficiary in accessing those services. Should you – if you would like more information about the model or any of the Innovation Center models, you can visit the Innovation Center website at [innovation.cms.gov](http://innovation.cms.gov).

Thank you so much for taking the time to learn more about model and I will turn it back over to Jill. Thank you.

Jill Darling: Thank you, Simeon, and that link is on the agenda for today. So, next we have Michelle Oswald, who will go over the Chronic Care Management Toolkit.

Michelle Oswald: Great. Thanks, Jill. So, I want to talk to everyone today about a new initiative that we just launched a few weeks ago called Connected Care to support chronic care management services. As a background, chronic care

management is defined as at least 20 minutes of non-face-to-face services provided by a physician or non-physician practitioner and the clinical staff for calendar month for Medicare beneficiaries with two or more chronic conditions expected to last at least 12 months or until the death of the patient and that placed the patient at significant risk of death, acute exacerbation, decompensation or functional decline.

In 2015, Medicare began paying separately under the Medicare physician fee schedule for chronic care management services furnished to Medicare patients living with multiple chronic conditions. In January of 2016, rural health clinics and federally-qualified health centers have been able to receive additional payment for the cost of chronic care management services that are not already captured in the RHC all-inclusive rate for the FQHC respective payment system for CCM services.

RHCs and FQHCs can bill for CCM services when an RHC or FQHC practitioner furnishes a comprehensive evaluation and management visit and your wellness visit or initial preventive physical examination to the patient prior to billing the CCM service and initiates the CCM service as part of this visit.

As of January 2017, some additional chronic care management codes have been added for performing more complex chronic care management services but RHCs and FQHCs are still only eligible to bill for the one code which is 99490 at this time.

The CMS Office of Minority Health along with HRSA's Federal Office of Rural Health Policy have partnered to design and implement a chronic care management campaign. This campaign has two interconnected audiences, health care professionals, as well as patients. The health care professional audience is focusing on practitioners and suppliers who are eligible to bill for chronic care management services with an emphasis on reaching health care professionals who practice in underserved rural areas and in areas with higher numbers of racial and ethnic minorities.

The patient audience includes Medicare beneficiaries, as well as dual eligibles who have two more chronic conditions with the focus on reaching racial and ethnic minorities and individuals in rural areas. This is a national campaign. So, we are striving to reach every state. We are targeting outreach in four specific states Georgia, New Mexico, Pennsylvania and Washington State with even further efforts in one rural county and one city within each of those states.

We have some new chronic care management products with this initiative to include a health care professional toolkit which may be helpful for you. This toolkit includes how to get started with chronic care management links to chronic care management fact sheets and resources for health care professionals to better understand and implement CCM in their practices. We also have educational materials to share with patients to include a patient flyer and a poster. And for those of you who are interested in partnering, we have a partnership toolkit available as well.

All of these materials are available to download from our website which is [go.cms.gov/ccm](http://go.cms.gov/ccm). The website includes links also to past webinars and presentations and it is also included in your agenda as well. If you have follow-up questions about chronic care management or the new chronic care management materials or if you're interested in partnering with us on the campaign, we encourage you to please contact us at [ccm@cms.hhs.gov](mailto:ccm@cms.hhs.gov).

Thank you and I will turn it back over to Corinne Axelrod who has some additional announcements.

Corinne Axelrod: Thank you, Michelle, and I just want to reiterate some things that Michelle said in terms of RHCs and FQHCs, that RHCs and FQHCs can receive payment for CCM when CPT code 99490 is billed alone or with other payable services on an RHC or FQHC claim. RHCs and FQHCs are not currently authorized to bill for any other CCM or behavioral health integration codes and other codes should not be used.

We have gotten questions about whether RHCs and FQHCs can bill the CCM codes to the physician fee schedule and the answer to that is no. RHCs and

FQHCs cannot bill the physician fee schedule for RHC or FQHC services.

So, I just wanted to reiterate that and, again, if there are any questions we will be happy to address them.

So, Jill?

Jill Darling: Thank you, Corinne and to all of our speakers today. All right. Thank you, everyone. I'll hand it off to Corinne for – and Rita for any closing remarks.

Corinne Axelrod: OK. Thanks, Jill, and thanks everybody for joining call. Again, if there are any topics that you would like us to cover, please let us know my e-mail address is corinne, C-O-R-I-N-N-E dot axelrod, A-X-E-L-R-O-D @cms.hhs.gov. Thank you.

Rita Vandivort-Warren: Hi. Thank you, Corinne, and we thank everybody for joining us today and we hope it was a kind of information you were seeking and let us know, as Corinne says about future topics that you'd like to hear about. My e-mail is rvandivort, V-A-N-D-I-V-O-R-T – warren, W-A-R-R-E-N @hrsa.gov, and we'd be happy to hear from you. Thanks very much.

Jill?

Jill Darling: Thanks, Rita and Corinne. Everyone, the next open door forum is to be announced so just be on the lookout your e-mail for when our next one will be roughly in the next three months. So, thanks, everyone. Have a great day.

Rita Vandivort-Warren: Thank you.

Operator: Thank you for participating in today's Safety-Net Providers Open Door Forum. This call will be available for replay beginning April 19 at 5:00 P.M. Eastern through April 21st at midnight. The conference ID number for the replay is 57715647. The number to dial for the replay is 855-859-2056.

This concludes today's conference call. You may now disconnect.

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