

Centers for Medicare and Medicaid Services  
Safety-Net Providers  
Open Door Forum  
Moderator: Jill Darling  
August 10, 2017  
2:00 p.m. ET

Operator: Good afternoon. My name is (Kim), 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, (Kim).

Good morning and good afternoon, everyone. Thank you for joining us today for the Safety-Net Providers Open Door Forum.

Before I hand the call off to our chair members, I have one brief announcement for everyone. 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 enquiries, please contact CMS at [press@cms.hhs.gov](mailto:press@cms.hhs.gov).

So, now, I will hand the call off to our co-chair, Rita Vandivort.

Rita Vandivort-Warren: Thank you, Jill. I am Rita Vandivort. I work in the Office of Policy Analysis at HRSA. And I want to welcome all of the Safety-Net providers.

We work hard to try to identify new changes that you might be interested in and that might affect your work. And I want to give a big thank you to CMS for supporting this and utilizing their experts to come to you to explain new rules and guidances.

So, with that, I'd like to hand off to my co-chair, Corinne Axelrod, who is from CMS.

Corinne?

Corinne Axelrod: Thank you – thank you, Rita. Hi, everybody, I'm Corinne, and as Rita said, I'm at CMS. I'm on the Medicare side in the Hospital and Ambulatory Policy Group. And I also want to thank you all for being on the call - I know it is summer, it's vacation time, so, we do appreciate you being available, and I think we've got a really good agenda today. So, I just want to mention that, you know, this call is for you. And if there are other items that you would like us to put on for future calls, just please let us know. You can contact Rita or myself or Jill. We just want to make these calls as valuable to you as possible.

So, I will now turn it over to Jill.

Jill Darling: All right. Thanks, Corinne. Up first, we have Marge Watchorn, who has a few updates regarding the Physician Fee Schedule.

Marge Watchorn: Thank you, Jill. Good afternoon, everybody. My name is Marge Watchorn. I'm the deputy director at the Division of Practitioner Services, which is a part of the Hospital and Ambulatory Policy Group in the Center for Medicare.

I want to speak for a few minutes about some important update that we have for the Physician Fee Schedule in our proposed rule for calendar year 2018.

The proposed rule was published in July. So, it's open for public comment. Comments are due on Monday, September 11. You can information about how to submit public comments in – on the cms.gov webpage.

Under the Physician Fee Schedule, the overall update for calendar year 2018 would be an increase of 0.31 percent. This reflects a combination of a couple of different statutes that are at work here, the first being an increase of 0.5 percent – so, a half-percent increase – which is established under the Medicare Access and CHIP Reauthorization Act of 2015.

And that increase is reduced by 0.19 percent, which is attributed to the misvalued code target amount which was required on a – under a different piece of legislation, which is the Achieving a Better Life Experience Act of 2014, otherwise known as the ABLA Act.

Next, I wanted to tell you about an important change that we're proposing for some codes that are used in the treatment of opioid addiction. Specifically, we're proposing to make payment for services which describe the insertion and removal of buprenorphine hydrochloride drug implant. Right now, we have a code that's more general which address drug implants.

We felt that the valuation of the existing code was perhaps insufficient and did not recognize the cost of the particular drug implant. So, we're proposing a separate payment amount. And this is part of overall efforts on the part of the Department to address opioid addiction.

Next, I wanted to talk a little bit about some updates that we're proposing for Medicare telehealth services and remote patient monitoring. For calendar year 2018, we're proposing to add several codes to the list of Medicare telehealth services.

These codes include the following services – visit to determine low-dose computed tomography eligibility, a code representing interacted complexity, two codes for health risk assessment, one code for care planning for chronic care management and two codes for psychotherapy for crisis.

Additionally, in the proposed rule, we're proposing to eliminate the required reporting of the telehealth modifier for professional claims in an effort to reduce administrative burden for practitioners. And we're also seeking ways on how we can further expand access to telehealth services within our current statutory authority.

We're also seeking comment on whether we should make separate payments for several CPT codes that describe remote monitoring. We note that such services would not be considered Medicare telehealth services as defined by the statute.

Next, I wanted to tell you a little bit about an update to the payment rates under the Physician Fee Schedule for non-excepted items and services that are furnished by non-excepted off-campus provider-based departments of hospitals. And if you've been following a recent implementation, this is – comes out of the Bipartisan Budget Act of 2015, often known as Section 603.

For the current year, 2017, we finalized a policy where the Physician Fee Schedule is the applicable payment system for most of these items and services and that as of January 1 of this year, services provided by these provider-based departments are no longer paid under the Outpatient Prospective Payment System.

What we're proposing to change for next year is that we would reduce the current payment for these items and services by 50 percent. So, that would be a 50-percent decrease in payment.

Currently, we pay for these services under the Physician Fee Schedule based on a percentage of the OPSS payment rate. So, the proposal would change the payment from – which is – from the current payment rate, which is 50 percent of the OPSS payment rate – and that would be decreased to 25 percent of the OPSS rate. We believe that this adjustment would encourage fair competition between hospitals and physician practices by promoting greater payment alignment.

Next, I'd touch briefly on initiative that we're taking to reduce burden overall for providers not just under the Physician Fee Schedule but if you've tuned in to previous briefings on the other rules that we have published recently, the agency as a whole is looking for input and feedback from stakeholders to try to identify ways that we can reduce burden and simplify our rules.

So, within the Physician Fee Schedule, we've also included language to welcome those comments. We're looking for ideas that would cover regulatory actions that we could take, sub-regulatory policies that we could change, practices and procedural changes in order to accomplish our goals. So, again, we welcome all comments in response to the request for additional information.

And that's it. Thank you.

Jill Darling: Great. Thank you, Marge. And, next, we have Corinne, who will go over care management at RHCs and FQHCs.

Corinne Axelrod: OK. Thank you, Jill. So, as many of you know, RHCs and FQHCs can receive payment for chronic care management, 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, which is known as BHI, services, and are not authorized to bill FQHC services separately to the Physician Fee Schedule.

In the calendar year 2018 Physician Fee Schedule proposed rule, we have proposed to revise the CCM payment for RHCs and FQHCs and establish requirements and payment for general behavioral health integration, BHI, and psychiatric collaborative care management model services, which is known as psychiatric CoCM that are furnished in RHCs and FQHCs beginning on January 1 of 2018.

For the first part of the proposal revision – CCM payment for RHCs and FQHCs and adding requirements and payment for general BHI, we would establish a new general care management G code, GCCC1, and the payment

amount would be set at the average of the national non-facility Physician Fee Schedule payment rates for CCM code 99490, complex CCM code 99487 and general BHI code G0507. If we were to use the 2017 rates, the payment amount for general care management would have been approximately \$61.

The second part of the proposal is to establish a new psychiatric CoCM G code, GCCC2, for RHCs and FQHCs. Payment amount would be set at the average of the national non-facility Physician Fee Schedule payment rate for psychiatric CoCM codes G0502 and G0503. Using the 2017 rates, the payment amount for psychiatric CoCM for RHCs and FQHCs would have been approximately \$134.

These proposed new G codes are only for RHCs and FQHCs and could be billed alone or in addition to other services furnished during the RHC or FQHC visit. They could be billed once per month per beneficiary and could not be billed if other care management services are billed for the same period. There are specific requirements that must be met to bill the new G codes, and those are detailed in the proposed rule.

We did a special National Provider Call on August 1 and went over the proposals and the requirements in great detail. The slide presentation is – it's on the FQHC webpage. I just checked and, for some reason, it's not showing up on the RHC webpage.

So, after this call, I'm going to follow up on that and try to get that posted as well on the RHC webpage. It's also on the MLN website, and there'll be a transcript and recording available, probably next week, from the August 1 call.

So, I want to remind everybody to submit any comment on the proposed rule by September 11. There's a link on the webpage and there's also – you could go to regulations.gov website and it's also on the website that Marge mentioned just a few minutes ago.

So, that's it. Thank you. I'm going to turn this back over to you, Jill.

Jill Darling: All right. Thank you, Corinne. Next, we have Terri Postma, who will speak on the change for FQHC, RHC in beneficiary assignment through ACOs participating in the Medicare Shared Savings Program.

Terri Postma: (OK). Thank you, Jill. Hi, everybody. Thanks for having us here today and joining us.

The Shared Savings Program, you'll recall, was established in 2011 as a result of the passage of the Affordable Care Act. And it's a voluntary value-based purchasing initiative here at CMS that rewards accountable care organization, or ACO, participants for improving quality of care and reducing growth in cost for an assigned beneficiary fee-for-service population.

The act requires CMS to assign fee-for-service beneficiaries to an ACO participating in the Shared Savings Program based on the beneficiary's utilization of primary care services furnished by physicians participating in the ACO.

A beneficiary is eligible for assignment if the beneficiary has had at least one primary care service during the applicable assignment window furnished by a physician who is an ACO professional in the ACO, and who is a primary care physician or has a specialty designation used under our assignment methodology.

Once we determine the pool of beneficiaries that are eligible, we apply a two-step process to determine if the beneficiary has had enough primary care services identified as a specific set of HCPCS or CPT codes to hold the ACO accountable for the beneficiary's care for that performance year.

When we established the Shared Savings Program through rulemaking in 2011, FQHC and RHC stakeholders asked CMS to permit them specifically to be able to form an ACO and to include their beneficiaries on assignment.

However, at that time, RHC and FQHC claims contained very limited information concerning the individual practitioner or even the type of health

care professional who provided the – who directly provided the service to a beneficiary because this information was not necessary to determine payment for services in RHCs and FQHCs.

So, unlike Physician Fee Schedule claims, there was no direct way for us to determine if a claim was for a service furnished by a physician at the RHC or FQHC and, therefore, in the absence of special rules under the Shared Savings Program, we wouldn't have been able to establish an eligible pool of beneficiaries.

Therefore, we established special rules for ACOs that included FQHCs and RHCs so that their beneficiaries could be considered in some fashion under the assignment methodology.

Specifically, in order to include them, we required that at the time of application, as part of the ACO participant list, the ACO has to submit national provider identifiers (NPIs) of the physicians that provided direct patient care in FQHC and RHC settings.

We also used revenue center codes as proxies for primary care services because prior to billing rules that took effect in October 2014 and April 2016 in FQHCs and RHCs, they were not required to use CPT or HCPCS codes for billing purposes.

The special process that I just described imposed an additional burden on ACOs that wish to include or be formed by RHCs and FQHCs. So, in addition to operational complexities, program integrity screening and other issues, we permitted submission of NPIs on an annual basis.

And stakeholders told us that tracking NPIs across sites of care and the sheer number of necessary submissions was prone to error and could result in fewer claims being considered for purposes of Shared Savings Program assignment than would otherwise occur.

In part, to address these issues and a result of the lobbying efforts of FQHCs and RHCs, in December, Congress passed an amendment to the statutory language governing the Shared Savings Program assignment methodology in the 21st Century Cures Act.

The Act amends the Shared Savings Program provision to require the secretary to assign beneficiaries to ACOs participating in the Shared Savings Program based not only on their utilization of primary care services furnished by physicians but also on their utilization of services furnished by RHCs and FQHCs effective for performance years beginning on or after January 1, 2019.

The statute provides the secretary with broad discretion to determine how to incorporate services provided by RHCs and FQHCs into the Shared Savings Program beneficiary assignment methodology.

Therefore, as part of the Physician Fee Schedule rule, we are proposing the following starting in performance – or starting for performance year 2019.

First, we're proposing to remove the requirement for ACOs to identify and attest to the physicians who directly provide primary care services in each RHC or FQHC.

Second, we're proposing to use all RHC and FQHC claims to establish beneficiary eligibility for assignment.

Third, we're proposing to consider all RHC and FQHC claims as primary care services without regard to any HCPCS or revenue center codes.

These changes – these proposals, we believe, are appropriate to reduce operational burdens for ACOs that include RHCs or FQHCs as ACO participants and bring greater consistency to our – the Shared Savings Program - assignment methodology. We're looking forward to your comments on these proposals and which folks mentioned are due September 11.

Thank you very much for your attention and we hope that you'll find these proposals as exciting as we do, and I'm looking forward to your comments.

Jill Darling: All right. Thank you, Terri.

And, last on the agenda, we have Adam Richards, who has some Quality Payment Program updates.

Adam Richards: Great. Thank you. And thanks so much for having me here today to discuss the various aspects of the proposed rule for year two of the Quality Payment Program. So, that's 2018 program year. I am going to discuss at a very high level some of the proposed changes to both the Merit-Based Incentive Payment System and Advanced Alternative Payment Model tracks of the program.

This will not be an exhaustive review because we could certainly be here for quite a while. But, I am hopeful that some of these changes will resonate with each of you. And I'm glad to hear the topic of burden being discussed today as our focus is to continue to reduce burden within the Quality Payment Program as well so that clinicians can really concentrate on putting patients first.

I do hope that you all take the opportunity to submit comments – and I'll talk about that process shortly – really in an effort to help us strengthen the program as we move into year two and beyond.

Before jumping in, I do want to mention that if you are interested in additional information on the rule, I encourage each of you to visit [qpp.cms.gov](http://qpp.cms.gov) and view our comprehensive fact sheet on the rule as well as the rule itself.

We've also recently posted several of our previous webinars on the proposed rule if you are interested in listening to our policy subject matter experts explain some of the proposals in greater detail.

With that said, as I mentioned earlier, we are in the rulemaking period. And I certainly encourage each of you to review the proposed changes and officially

comment. Counting today, we have about 12 or so days left as the comment period officially closed on August 21, 2017. So, please mark your calendars and submit your comments as soon as possible.

We welcome all thoughts and feedback. So, guidance on how to submit comments can be found within the proposed rule as well as that comprehensive proposed rule fact sheet that I had mentioned earlier, both of which are available on [qpp.cms.gov](http://qpp.cms.gov).

So, for the Merit-Based Incentive Payment System track of the Quality Payment Program, we have a number of proposals. I am just going to touch on a few that may be of interest.

So, starting off, we are proposing to raise the low-volume threshold from its current level of \$30,000 in Medicare Part B allowed charges and 100 Part B beneficiaries to \$90,000 in Medicare Part B allowed charges and 200 Part B beneficiaries.

Our anticipation is that the proposed increase will exempt more clinicians, which may help to relieve existing burden by affording clinicians more time to potentially prepare for future program years.

Now, we have received quite a bit of feedback on allowing clinicians who are exempt to opt in to future program years. So, we are also proposing to allow clinicians to opt in to MIPS if they exceed one or two of the low-volume threshold components beginning in the 2019 performance year – so, that would be two years from now.

This is one area of the rule where we are eager to hear your feedback. And that is on whether we should allow the; opt in – the opt in option and what the threshold should be.

We are proposing to implement virtual groups as a participation option for year two. Now, very quickly, in order to keep us moving, the unofficial kind of general definition of a virtual group is a combination of two or more TINs

– taxpayer identification numbers – which can include solo practitioners or group practices with 10 or fewer eligible clinicians under the TIN.

We anticipate that virtual groups could provide those clinicians in smaller practices who may have limited resources with the opportunity to join other clinicians and practices in order to combine their resources to participate in the program. We – I will say that clinicians will have maximum flexibility to help encourage virtual group formation.

For the MIPS performance categories, many of the requirements will remain the same. So, just very quickly, those are Quality, Cost, Improvement Activities and Advancing Care Information. I do want to briefly touch on the Advancing Care Information performance category. So, for Advancing Care Information, we are proposing to allow clinicians to use either 2014 or 2015 certified EHR technology edition in year two.

However, we are proposing to provide a bonus for those who use the 2015 edition of CEHRT. We are proposing to add a de-certification hardship for clinicians whose EHR was de-certified over the year.

We are also proposing to add a new category of exception for small practices to reweight the Advancing Care Information performance category to zero and reallocating 25 percent weight to the Quality performance category.

Speaking of reweighting, we are also proposing that ambulatory surgical center-based eligible clinicians will have their Advancing Care Information performance category automatically reweighted to zero percent. One thing to note – that if this proposal is accepted, this will apply to the 2017 transition year.

So, it will apply to the performance year that we're currently in, 2017. One final note is that we are also proposing additional hardship exceptions under the Advancing Care Information performance category where that category would generally be reweighted in most instances to Quality.

So, moving beyond the Advancing Care Information, we are proposing new hardship extenuating circumstances category for the entire – for all of the MIPS performance categories, really. We do currently have this option available for the Advancing Care Information performance category.

But, we realized that extenuating circumstances – and when I say extenuating circumstances, I'm referring specifically to things like natural disasters – may exist that would apply for all of the performance categories. So, that extenuating circumstances would cover all of the performance categories.

We are proposing to reward clinicians who treat complex patients by adding a bonus to the MIPS final score. We will apply an adjustment of one to three bonus points based on the medical complexity for the patients treated using the average hierarchical conditions category risk score.

We are proposing to add five bonus points to any MIPS-eligible clinician or small group who is in a small practice or – I'm sorry – a group who is in a small practice and has at least submitted data on one MIPS performance category.

We are seeking comment on whether the small practice bonus should include rural practices as well. So, we are definitely interested in hearing some feedback on that.

Lastly, I do want to mention that we will continue a similar policy for clinicians practicing in rural health clinics and federally qualified health centers. So, services rendered by clinicians under the RHC and FQHC payment methodology will not be submit to MIPS payment adjustments.

However, clinicians in these settings have the option to voluntarily report on measures that are applicable to them through one of the numerous data submission methods that are available under MIPS. So, if you're interested in those methods, there is more information on [qpp.cms.gov](http://qpp.cms.gov) that outlines that data submission methods that are available.

Jumping over to Advanced APMs – and I'll just cover this quickly. I will point to one important proposal that may be of interest in reviewing. And that is the all-payer combination option.

So, MACRA created two pathways to allow clinicians to become what we like – what we call qualifying APM participants in an Advanced APM. So, there is the Medicare option and the all-payer combination option which will be available beginning in 2019.

So, the all-payer option allows eligible clinicians to achieve that qualifying APM participant status based on a combination of participation in Advanced APMs within Medicare and other Advanced APMs offered by other payers, which may include Medicaid, Medicare health plans such as Medicare Advantage, CMS multi-payer models and other commercial payers.

We are seeking comments on the various proposals under this all-payer combination option. Of course, there are a few other proposals included for Advanced APMs. So, I certainly encourage you to review the fact sheet that I have been mentioning today as well as the proposed rule for some additional information.

So, to wrap things up today, I just want to remind everyone that the official comments on the proposed rule for year two of the Quality Payment Program are due by August 21, 2017.

I think it is also important to remind or to remember that the program's first performance year is already under way and runs from January 1, 2017 to December 31, 2017, again, what we are calling the transition year. And it's not too late to participate.

So, in anyone out there is included in the program this year, there's still plenty of time left and we have a number of great options available to help support you in preparing and participating in the program.

So, with that, I'm going to turn it back over to Jill. Thanks, everyone.

Jill Darling: All right. Thank you, Adam. And thank you to all of our speakers today.

(Kim), we will go into our Q&A, please.

Operator: Thank you. As a reminder, ladies and gentlemen, if you would like to ask a question, please press star, then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your questions to one question and one follow up to allow other participants time for questions.

If you require any further follow up, you may press star, one again to rejoin the queue. And, again, if you would like to ask a question, please press star, then the number one on your telephone keypad.

And there are no audio questions at this time.

Jill Darling: All right. Well, I will hand the call back to Rita and/or Corinne for closing remarks.

Rita Vandivort-Warren: Corinne, do you want to start?

Corinne Axelrod: No. Go ahead.

Rita Vandivort-Warren: I just wanted to thank all the experts and CMS to bring all this information to us and also to all the participants. And if you found this useful, please share the word and have them join up by finding the Safety-Net Providers Open Door Forum on the CMS website. Thank you.

Corinne Axelrod: And I also wanted to thank everybody for joining the call. I know sometimes people are hesitant to ask questions because there's a lot of people on the call. But, it's a real opportunity - You've got some experts here in the room and, you know, either now or in the future, if you have questions, really don't hesitate to ask because that's what we're here for. And, again, if you have other topics you'd like to hear about, please let us know. You can email either Jill or Rita or myself.

And a final reminder about sending in comments. There's a separate link and date for the Quality Payment Program comments and, then, a different link and date for comment on the Physician Fee Schedule proposals.

So, please, if you have any comment, we always welcome them. We find them very helpful to know if you like what we are proposing or if you have other suggestions or even if you don't like it. I guess we want to hear that, too.

So, anyway, thank you, all, and I hope you all have a great rest of the summer.  
Jill?

Jill Darling: Thanks, Corinne and Rita. Thank you, everyone, for joining today's call. The next Safety-Net Providers Open Door Forum is to be announced. So, just be on the lookout for the next agenda. It should be about the next three months from now. So, look out in November. So, everyone, have a great day. Thank you.

Operator: Thank you for participating in today's Safety-Net Providers Open Door Forum conference call. This call will be available for replay beginning today at 5:00 p.m. Eastern through midnight on August 14.

The conference ID number for the replay is 60407836. The number to dial for the replay is 855-859-2056. This concludes today's conference call, and you may now disconnect.

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