

Centers for Medicare and Medicaid Services
Safety-Net Providers
Open Door Forum
Moderator: Jill Darling
November 06, 2017
2:00 p.m. ET

Operator: Good afternoon. My name is (Mariana) and I will be your conference operator 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 that time, please press star followed by the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you. I would now like to turn the call over to Jill Darling. You may begin your conference.

Jill Darling: Thank you (Mariana). Good morning and good afternoon everyone. I'm Jill Darling in the CMS Office of Communication. And thank you for joining us today for the Safety-Net Providers Open Door Forum.

Before we get into today's agenda, one brief announcement from me. 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 do have any inquiries, please contact CMS at press@cms.hhs.gov. So now I will hand it off to our Co-Chair, Corinne Axelrod.

Corinne Axelrod: Hello everybody. This is Corinne Axelrod. And on behalf of the Centers for Medicare and Medicaid Services, I really want to thank all of you for taking the time to call in today. We appreciate your time and your interest.

And these calls are hopefully helpful to all of you. And if there are topics that you would like to see on future calls, please let us know. You can always e-mail me, corinne.axelrod@cms.hhs.gov.

And I'm going to turn it over to Rita, who I think will also be happy to get out her e-mail address. And if you have any suggestions, you can contact either myself or Rita. Thank you. Rita?

Rita Vandivort-Warren: Yes. Thanks Corinne. I just want to welcome everyone. I'm Rita Vandivort-Warren. I work in the Office of Planning, Analysis and Evaluation here at HRSA.

And we're very pleased to help co-sponsor this so that we can try to bring you the latest information around changes in healthcare financing. And I am always open to suggestions.

My e-mail is a little more; tricky than Corinne's. It's rvandivort-warren@hrsa.gov. And we'd love to hear from you about what you would like to hear about. And we will do our best to try to bring that here. With that, I think I'll turn this back to Jill.

Jill Darling: Thank you Rita. First up, we have Marge Watchorn, who has an update on the 2018 Physician Fee Schedule Final Rule.

Marge Watchorn: Thank you Jill. Hi everybody. This is Marge Watchorn. I'm the Deputy Director of the Division of Practitioner Services here at CMS.

I wanted to go over some of the highlights from the Calendar Year 2018 Physician Fee Schedule Final Rule, which went on display last Thursday, November 2nd, scheduled for publication in the federal register I believe on November 15th.

So for 2018, we have our annual update for rates that are paid under the physician fee schedule. It's a combination of the statutory update of an increase of 0.5 percent, reduced slightly by 0.9 percent, which reflects what's known as the misvalued code target recapture amount.

This is a statutory provision that was first put in place by the Medicare Access and Chip Reauthorization Act of 2015, also known as MACRA. The 2018 is the last year of the misvalued code target. So what the final calendar year 2018 increase is an increase of 0.41 percent.

Also, I wanted to let you know that the conversion factor that we used to calculate rates under the PSS went up by 10 cents. So the conversion factor for 2017 currently in effect is \$35.89 and it goes up to \$35.99 for the following calendar year.

As we do in every year in the Physician Fee Schedule, we have updates to the Medicare Telehealth Service, which I'm sure as you all know, are services that can be provided via Telehealth in rural areas.

This year, we added seven CPT codes and HCPCS codes to the list of services that can be provided via Telehealth.

And those services include a visit for low-dose computed tomography or low-dose CT, interactive complexity, two codes to address health risk assessment, one code for care planning for chronic care management, and two codes for psychotherapy for crisis.

I also want to point out that in response to public comments that we received, we decided for next year to make separate payments for a CPT code that describes from a patient monitoring.

This is important because it's really part of our overall strategy to increase access to telehealth services or services that are not provided face-to-face.

We – again, we received an overwhelming number of comments saying that those codes should be made payable for 2018. So the code is CPT code 99091, which describes from a patient monitoring requiring a minimum of 30 minutes of time from the physician or other qualified health professionals.

And then another service I wanted to highlight that we're making improvements for is an improvement in the way the Physician Fee Schedule pays for office-based behavioral health services with the patient. We believe that these services in general, perhaps, had been undervalued.

So we changed the way we value those services in an effort to improve payment under the physician fee schedule. The expectation is that these are services that serve a variety of needs, but in particular, can also be used in the treatment of opioid addiction.

Along those lines, we also are finalizing payments for several codes to describe the insertion and removal of buprenorphine hydrochloride drugs which is a drug implant system.

We were making separate payments for these codes because, again, we received an overwhelming number of public comments that said that this would improve Medicare's overall payment and strategy for treating opioid addiction.

This particular drug is indicated for the treatment of opioid addiction. So again, this is part of our overall strategy to address the opioid epidemic, specifically through improvements to the Physician Fee Schedule. And that was all I had.

Jill Darling: Great. Thank you Marge. We have Corinne Axelrod, who will go over Care Management in RHCs and FQHCs.

Corinne Axelrod: Thank you Jill. As most of you probably know, RHCs and FQHCs currently can receive payment for CCM, chronic care management services, when CPT code 99490 is billed alone or with other payable services on an RHC or FQHC claim.

The payment amount has been about \$42, which is the rate paid in 2017 to practitioners billing under the Physician Fee Schedule. RHCs and FQHCs have not been authorized to bill for any other care management services or to bill these services separately to the Physician Fee Schedule.

In the 2018 Physician Fee Schedule Proposed Rule that was published in July, we proposed revising the payment methodology and rate for CCM furnished in RHCs and FQHCs and establishing requirements and payment for two additional care management services – general behavioral health integration, BHI, and psychiatric collaborative care model, COCM services.

We have now finalized the proposals for CCM, general BHI, and psychiatric COCM services furnished on or after January 1st 2018. Yay. Here's how it will work.

To bill for CCM or general BHI, RHCs and FQHCs will use a new general care management G code, G0511, which we created specifically for RHCs and FQHCs.

Some of you may recall that in the proposed rule, we refer to this as GCCC1, which was a placeholder code. But now we have G0511 which is a permanent code.

The payment amount is set at the average of CPT codes 99490, 99487, and 99484, which are the CPT codes for CCM, complex CCM, and general BHI. I don't have the exact rate yet for 2018, but it will be about \$62 for 20 minutes or more of CCM or general BHI services per month.

The general care management G code, G0511, can be billed once per month per beneficiary regardless of how many minutes of services beyond the 20 minutes have been furnished. And it cannot be billed if any other care management services are billed during the same period.

To bill for psychiatric COCM services, RHCs and FQHCs will use a new psychiatric COCM G code, G0512, which was also created specifically for RHCs and FQHCs.

And this was GCCC2 in the proposed rule. The payment amount is set at the average of CPT codes 99492 and 99493, which are the codes for initial and subsequent psychiatric COCM.

Again, I don't have the exact rate yet for 2018 but it will be around \$145 for either 70 minutes or more of initial psychiatric COCM services or 60 minutes or more of subsequent psychiatric services.

It can be billed once per month per beneficiary regardless of how many minutes of services beyond the 70 or 60 minutes have been furnished, and cannot be billed if any other care management services are billed during the same period.

Both G0511 and G0512 can be on a claim either with or without a billable service, and you can bill G0511 or G0512 but not both for the same patient during the same month.

If you are currently furnishing CCM services, you would continue to use CPT codes 99490 on a claim for services furnished through December 31st of this year. For services furnished on or after January 1st of 2018, you must use G0511 or G0512.

Payment is based on the date of service. So for CCM services furnished before January 1st, use CPT code 99490; and for CCM services furnished January 1 or after, use G0511.

On the CMS RHC and FQHC webpages, the first item under spotlight is new care management services. And we have a link to both the final rule and to FAQs for RHCs and FQHCs.

The version of the final rule that is posted is the display copy, and the care management provisions for RHCs and FQHCs are in pages 515 through 550 of this version. Once the rule is actually published, the page numbers will change.

Also note at the back of the FAQ document, in the addendum, which have a chart of CCM, general BHI, and psychiatric COCM services and their requirements, you can see on this chart that the initiating visit and the

beneficiary consent requirements are the same for CCM, general BHI, and psychiatric COCM.

For CCM, patients must have two or more chronic conditions that are expected to last at least 12 months, or until the death of the patient and place the patient a significant risk of death, acute exacerbation or decompensation, or functional decline.

For both general BHI or psychiatric COCM, patients must have a behavioral health or psychiatric condition being treated by the RHC or FQHC practitioner, including substance use disorders that in the clinical judgment of the RHC or FQHC practitioner, and this the primary care practitioner, warrants general BHI or psychiatric COCM services.

The billing requirements and service element requirements are different for all three of these services. I'm not going to go through all the different requirements, but just want to note a couple of things.

First, care management services are subject to the same copayment requirements as any other services. We do not have the authority to waive the copayment.

And fees are typically non-face-to-face services and not visible to the payment. It is especially important to explain both the benefits of the services and the cost sharing responsibilities when getting payment consent.

We also got several questions regarding the qualification of the behavioral healthcare manager and the psychiatric consultant or psychiatric COCM services.

The behavioral healthcare manager is a designated individual with formal education or specialized training in behavioral health such as social work, nursing, or psychology with a minimum Bachelor's degree in a behavioral health field such as clinical social work or psychology or via the clinician with behavioral health training.

The psychiatric consultant for psychiatric COCM services must be a medical professional trained in psychiatry and qualified to prescribe the full range of medications.

The person can be a psychiatrist but is not required to be a psychiatrist if they meet these qualifications. So a person such a psychiatric mental health nurse practitioner, for example, would meet these requirement.

As I mentioned earlier, a link to the final rule is on the CMS RHC and FQHC web pages. And that's where you'll find all of the comments we received to the proposed rule and our responses, many of which we then included in the FAQs that are also posted on the web pages.

There will been an MLN article coming later and an update later to Chapter 13 of the CMS Benefit Policy Manual. And when those are available, we'll post them on our website as well. I will stop now and will take questions at the end of the presentation. Thank you.

Jill Darling: Thank you Corinne. And next we have -- our next and final agenda topic will be from Mimi Toomey, who will go over the Request for Information from the CMS Innovation Center.

Mimi Toomey: Thank you Jill. Yes. Hi. My name is Mimi Toomey. And I'm the Deputy Director of our Policy and Programs Group at the CMS Innovation Center, otherwise known as CMMI.

Back about a month ago, we issued a Request for Information to collect ideas on the path forward for the Innovation Center. And we want to let you know what we have in that Request for Information and request that you provide comment and input as well.

We are seeking broad input related to the new direction for the Innovation Center that will promote patient-centric care and has market-driven reform that empower beneficiaries as consumers, provide price transparency, increased choices, and competition to drive quality and improved outcomes.

Our goal going forward is to increase flexibility by providing more waivers under our authority in the Innovation Center from current requirements as necessary to test different innovation models.

Healthcare providers should be competing for patients in a free and dynamic market and creating incentives to increase quality and reduce cost. We're looking to launch new demonstrations in several areas.

I have a list that are – were not limited to this list but includes direct primary care arrangement in which CMS pays primary provider networks directly without the involvement of an insurance intermediary, lowering the cost of prescription drugs, especially those that are high cost therapies, models to encourage innovation in the Medicare Advantage space, including modernizing the bidding process for Medicare Advantage plans, state-based and local innovation models including models focused on the dual eligible, more models for specialists including those that could qualify -- should be in advance alternative payment model under the quality payment program; and mental and behavioral health models, including ones that are directed towards the opioid crisis.

We know that there's a lot of great ideas out there. We have always solicited comments from stakeholders as we develop models. This is just really putting more pen-to-paper and requesting more feedback.

We want to hear from people on the frontline. We are going to be reviewing ideas and submissions, and then from that, launching transformative models, new models.

We want to encourage you and your organization to submit your ideas and feedback through the Innovation Center website. And we are taking comments through November 28th.

Jill, I appreciate you giving us the opportunity to talk to this group today. And really, strongly encourage participants on this call to look at the Request

for Information and provide comments using the provide feedback online or via e-mail.

Or if you have specific questions or clarifications, feel free to reach out to me. And I am mimitoomey@cms.hhs.gov. And that is all I have. Just to wrap I really, really and strongly encourage people to engage with the RFI process. Thank you.

Jill Darling: All right. Thank you Mimi, and to Corinne and Marge. So (Mariana), we'll go into our Q&A please.

Operator: At this time, I would like to remind everyone, in order to ask a question, please press star and then the number one on your telephone keypad.

We'll pause for a brief moment to compile the Q&A roster. Again, it is star-one on your telephone keypad to ask a question. There are no questions at this time. I will turn the call back over to the presenters.

Corinne Axelrod: Hi. This is Corinne Axelrod. So again, we just want to thank all of you for joining in the call. I know some of you really do have questions and maybe don't want to ask them in front of everybody else.

So if you have any questions, please look at our materials, let us know. And again, if there's any topics you would like us to cover for the next Safety-Net Open Door Forum, please let us know. Thank you.

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

END