

Centers for Medicare & Medicaid Services  
Rural Health  
Open Door Forum  
Moderator: Jill Darling  
November 14, 2017  
2:00 p.m. ET

Operator: Good afternoon, my name is (Amy) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services Rural Health 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, you press the pound key. I would now like to turn the call over to (Sheila Mulligan), you may begin.

(Sheila Mulligan): Thank you (Amy). Good morning, good afternoon everyone. My name is (Sheila Mulligan) in the CMS Office of Communications. Thank you for joining us today for the CMS Rural Health Open Door Forum. We apologize for the delay in starting. We are going to turn this over to John Hammarlund for opening remarks.

John Hammarlund: Well thanks so much. Well hello everybody, thank you very much for joining this special call today. We have a really robust agenda and I have all of my CMS colleagues who have joined us today to speak to these important topics.

Also want to thank the colleagues from the CMS regional health offices, the rural health coordinators for joining us today. I also want to say happy week of National Rural Health Day which as you all know is on Thursday, this Thursday November 16th.

And with regards to National Rural Health Day, I'm very pleased before I turn it over to the co-chair of this call Carol Blackford to turn the microphone briefly to Dr. Cara James who is the director of CMS's Office of Minority Health and co-chair of the CMS Rural Health Council for a special announcement. So Cara, take it away.

Cara James: Thank you John and welcome to everyone. I'm very pleased to be here today as we are kicking off celebrations for National Rural Health Day, week if we call it.

And one of the things that we wanted to share with you is an effort that we have been working towards and listening to you in terms of how we can help to put together information that is useful and easy to find.

So we are announcing our new rural health page where we are beginning to consolidate some of our resources related to rural health and healthcare here at CMS that can help you.

So that website is going to be [go.cms.gov/ruralhealth](http://go.cms.gov/ruralhealth) again that's [go.cms.gov/ruralhealth](http://go.cms.gov/ruralhealth). We have beginnings of that site up and running, we're going to be adding to that as we continue to develop new resources and to bring others in and information to help you in the work that you're doing.

So we're very excited about that and look forward to adding more to it and to getting your feedback on it. So without further ado, I'm going to turn it over to the other co-chair of the open door forum, rural open door forum Carol Blackford. Carol.

Carol Blackford: Thank you Cara. I just wanted to take a quick moment to thank everyone who submitted comments on all of our proposed rules this year. As John mentioned we have a very full agenda and we're going to walk through some of those payment rules today.

And I hope you will see that we've taken the opportunity to reflect the comments that were submitted in our, the final policy is included in the final rules.

I also want to thank everyone for taking the time to submit your thoughts and suggestions to the request for information around burden reductions that were included in our rules as well as other documents that have come out from the agency over the past year.

As you know CMS recently launched the patients over paperwork initiative which is a cross cutting collaborative process that evaluates and streamlines regulations with a goal towards reducing unnecessary burden, increasing efficiencies and improving the beneficiary experience.

Through the patients over paperwork initiative, CMS along with our partners and stakeholders are committed to removing regulatory obstacles that get in the way of providers spending time with patients.

We received a very healthy response to our request for information and we are still sifting through all of the feedback that we've received, but we are very much looking forward to a continued dialogue around this initiative and around ways that we can remove these regulatory obstacles in various forums over the course of the next year and certainly in our ongoing payments rules as well. So I just wanted to take a moment to thank everyone for taking advantage of that opportunity and providing that feedback to us.

And with that, let's go ahead and dive into the meat of our agenda. I think we're going to start out with the calendar year 2018 position fee schedule final rule and Ryan Howe is going to give us some of the payment updates that were included in that rule. Ryan...

(Ryan Howe): Great, thank you very much Carol and thank you to everybody on the call. At the risk of reiterating I wanted to note that as part of the physician fee schedule rule not only did we issue the request for information broadly about all the ways under which we might reduce regulatory burden as part of the putting patients first initiative in several sort of specific areas under physician fee schedule payment policy, we identified areas where we were seeking comment and received a lot of good information.

And we're still sifting through those related to documentation and coding for evaluation management visits, for Telehealth services and for our ongoing work in care, in paying for care management services.

So in all of those areas we were very pleased to receive the feedback that we did from the public and we continue to look at those areas in specific.

In terms of the particular provisions that I wanted to highlight in the physician fee schedule final rule, wanted to note that our ongoing work in the misvalued code (inaudible) identifying services that may be misvalued and altering payment rates so that the valuation is accurate as possible is ongoing.

And much of that work is associated with the CPT coding changes that happen annually under the physician fee schedule and this year's no different than any other. We proposed and finalized values for many of the new CPT codes.

This year was the last year of what's called the misvalued code target and that relates to measuring how many, how much the changes are for those misvalued codes and that affects what the overall update for the physician fee schedule payment is.

And combined with the update as specified under the macro law and the misvalued code target achievement, the update for 2018 for physician fee schedule spending overall is a positive 0.41 percent and that's mostly realized through a positive increase to the physician fee schedule conversion factor for 2018 which will move from \$35.89 to \$35.99 starting on January 1.

Of particular note I think to this audience, there were a couple of changes that we did propose and finalize related to Medicare Telehealth services, the first of which relates to those services that are ordinarily furnished in person but under certain circumstances can be furnished via audio, video, interactive communication technology.

We proposed and finalized adding several services to the list of eligible that can be furnished via Telehealth notably the visit to determine the low dose CT

scans as well as psychotherapy for crisis neither of which were previously on the Telehealth list. We also added a few other services to the Telehealth list that we hope will reduce some of the burden with reporting.

And then the other note that I wanted to mention regarding the area of communication technology enhancements in general isn't strictly speaking Medicare Telehealth services but we saw comment on and ended up finalizing payment for a currently existing CPT code for the collection and interpretation of data from a patient, for example blood pressure or glucose monitoring over time.

Specifically the code describes 30 minutes of professional time for the collection and interpretation of that data over a period of 30 days. So that code is CPT code 99091 and that's newly separately payable under Medicare for 20 – that will be for 2018.

We anticipate that that will be a step in the right direction in terms of recognizing the value that communication technology can bring to overall service of Medicare patients in particular in the areas of ongoing care management.

And I should also note that we anticipate additional CPT codes in the coming years for technologies like this and we will address the appropriate payment and rules regarding those services in the hopes of making them accessible as possible to Medicare beneficiaries as soon as those codes arrive.

The last thing I wanted to mention, we finalized a policy to improve payment for office based behavioral healthcare services for services like psychotherapy when they're furnished in the office setting and that's based on some concerns that we, that folks had brought to us regarding the payment rate for those services in particular.

And so for 2018 there'll be modest increases in Medicare payment rates for those services and we anticipate addressing any further increases that would be necessary through future rulemaking in subsequent years.

So for the benefit of everybody else I'm going to stop there but happy to take questions on any other payment revision that may be of interest.

Carol Blackford: Thanks. And I think we're going to switch over to Simone Dennis who is going to give us an update on care management and RHCs and FQHCs.

(Simone Dennis): All right, thank you Carol. Currently RHCs and FQHCs are authorized to bill for chronic care management using CPT code 99490 and the payment rate for the service is about \$42. It can be billed alone or with other payable services under RHC or FQHC claims.

However, RHCs and FQHCs are not currently authorized to bill for other care management services such as complex chronic care management, behavioral health integration known as BHI or psychiatric collaborative care model known as CoCM.

In the physician fee schedule proposed rule we propose to authorize billing of these other care management services BHI and CoCM for RHCs and FQHCs.

Our proposal was very well received and we are finalizing it as proposed for services for on or after January 1, 2018. I'm just going to provide a quick overview of what that finalized policy actually is and again it's effective January 1, 2018.

We created a new G code, G0511 known as general care management and it's specifically for RHCs and FQHCs only. The payment rate is set as the average of the care management and BHI codes under the CFS.

The rate for CY 2018 for G0511 will be about \$62. It is billed when the minimum requirement for a CCM or BHI have been met, that is when at least 20 minutes of care management services have been furnished. It is also billed once per month per a beneficiary. No other care management services can be billed during the same service period.

We also created another new G code G0512 psychiatric CoCM. The payment rate for this code is the average of the psychiatric CoCM codes under the PFS. That rate will be about \$145 for CY 2018.

It is billed when the minimum requirement for CoCM have been met. So that's when at least 70 minutes of CoCM services for initial patients or at least 60 minutes of CoCM services have been furnished for subsequent visits. It is also billed once per month per beneficiary.

No other care management services can be billed during the same period. G0511 and G0512 cannot be billed during the same service period together, and again they can be billed alone or with other standalone billable services on RHC or FQHC claims.

Until the new G codes become effective, RHCs and FQHCs can continue to receive payment for CCMs. RHCs and FQHCs can bill CPT code 99490 until December 31st, 2017.

Beginning with dates of service on or after January 1, 2018 RHCs and FQHCs will need to begin to bill G0511 for CCMs. The consent requirements are the same for CCM, BHI and CoCM.

These services are not subject to cop-insurance and or deductible and we do not have the statutory authority to waive them. Therefore it's important that the beneficiary is aware of the cost sharing associated with these services.

Patient eligibility requirement for these codes, for CCM a patient must have two or more chronic conditions present, for BHI and CoCMs any behavioral health or psychiatric condition including substance abuse disorders must be present.

We did receive a few questions regarding the members of the care team for CoCMs and CoCM requires a care team comprised a RHC or FQHC practitioner, a behavior and a psychiatric consultant.

The behavioral healthcare manager must have formal education or specialized training in behavioral health services such as social work, nursing, psychology and must have a minimum of a bachelor's degree in a behavioral health field.

This person can also be a clinician with behavioral health training including RNs and LPNs. The psychiatric consultant must be a medical professional trained in psychiatry and qualified to prescribe the full range of medications.

On FQHC web pages we have posted information regarding these services, we have a link to the PFS final rule. The rule includes a complete discussion of our finalized policy and the requirements for the services.

Additionally on the web we have a FAQ document with an addendum that also describes the requirements of the services. That's the end of my discussion on the new care management codes G0511 and G0512 for RHCs and FQHCs only. Again we have more information on these codes, on the web thank you for listening.

(Sheila Mulligan): Well thank you (Simone). The next topic is (EY) 2018 outpatient prospective payment rule and overview and I will hand it over to Carol Blackford and she's going to be speaking of patients over work, patients over paperwork initiative and also the 340B. Thank you.

Carol Blackford: Thank you. So as everyone on the call I'm sure knows, the calendar year 2018 of PPS and ASC rule was released on November 1st and there are a lot of topics that are covered in that rule some of which our program experts are going to highlight for you in a bit, but there are a couple of topics that I wanted to highlight as well.

So as we've talked about, the patients over paperwork initiative is a CMS priority and we are working along with our partners and our stakeholders to take a look at ways to remove regulatory obstacles that get in the way of providers spending time with patients.

The PPS payment system final rule includes a number of items that we hope will reduce regulatory burden including a reinstatement, reinstating of the

non-enforcement of direct supervision requirements for outpatient therapeutic services for critical access hospitals and small rural hospitals having 100 or fewer beds for calendar year 2018 and 2019.

We also finalized the removal of three ambulatory surgical center quality reporting program quality measures for the calendar year 2019 payment determination and subsequent years.

Removal of these measures would alleviate maintenance costs and administrative burdens to the ASCs resulting in a burden reduction of over 1,000 hours and saving over \$48,000 in calendar year 2019.

We also finalized the removal of six hospital outpatient quality reporting program quality measures resulting in a burden reduction of over 450,000 and saving \$16.7 million in calendar year 2020 for hospitals.

Next I want to highlight an important provision with respect to how Medicare will pay for certain drugs acquired under the 340B program which is a drug discount program administered by HRSA. Under this program certain drugs may be purchased by eligible hospitals and other entities at deeply discounted rates.

Currently Medicare pays hospitals more than the average sales price for drugs acquired under the 340B drug discount program which is more than what hospitals pay to purchase those drugs. And because the cost of patients is based on what Medicare pays hospitals to administer the drug, patients are paying a higher rate for the drugs as well.

In order to lower drug prices for Medicare beneficiaries, CMS is finalizing paying for drugs purchased through the 340B program and provided to Medicare patients in hospital outpatient settings at the average sales price minus 22.5 percent rather than the current payment of average sales price plus six percent. Drugs not purchased under the 340B program would continue to receive ASP plus a six percent payment.

In addition, this payment change does not apply to vaccines or drugs receiving pass through payments. Children's hospitals, PPS except cancer hospitals and rural sole community hospitals will be accepted from these drug payment reductions for calendar year 2018. In addition, critical access hospitals are not affected by this policy since they are not paid under the OPSS.

We've received a few questions about how to identify a rural ACH. So in nutshell, rural ACHs receive a 7.1 percent add on adjustment under the OPSS.

These providers meet the definition of an ACH under the regulations at (4/12/92) or an essential access community hospital which is considered to be an ACH under section (1886 D iv-D iii) roman numeral III of the act and are located in a rural area as defined under section (412-64B) of the regulations, or are treated as being located in a rural area under section (412-10) of the regulations.

The redistribution of estimated savings from adopting the 340B drug payment policy is being reallocated across all non-drug services that are paid under the OPSS.

We estimate that the reduction in drug payments due to this policy including beneficiary co-payment will be approximately 1.6 billion in 2018. Medicare beneficiaries would share in the discounts hospitals received under the 340B discount program saving an estimated \$320 million on drug costs in calendar year 2018.

Now I want to take a quick moment to talk a little bit about the modifiers that were proposed and finalized in the OPSS rule.

After considering the administrative and financial challenges associated with providers reporting the modifier as described in the proposed rule, and in order to reduce regulatory burden we are reversing our position on how the modifiers will be used by providers to effectuate the payment adjustments for 340B purchased drugs.

Now for the sake of time I'm not going to walk through the specific details of the modifiers. I will direct everyone to the discussion included in the final rule.

I will reiterate as we stated in the final rule, we do expect to issue additional sub-regulatory guidance about the use of these modifiers and I would encourage everyone to take a look at that guidance once it is released. So at this point in time I'm going to turn it over to (Josh McFeeters) who is going to walk through some additional provisions in the OPSS rule.

(Josh McFeeters): Thank you Carol. I'd like to now go over the physician supervision enforcement structure for critical hospitals those rural hospitals. Direct supervision is required for hospital outpatient therapeutic services covered and paid by Medicare that refers to hospitals as well as in provider based departments of hospitals.

In the final rule we finalized our proposal to reinstate the enforcement instruction for outpatient therapeutic services versus furnished in (COGS) in small rural hospitals having 100 or fewer beds for calendar year 2018 and 2019.

To get these (COGS) in small rural hospitals, more time to comply with the supervision requirements for outpatient therapeutic services and to give all parties additional time to submit specific services to be evaluated by the (hot) panel for recommended change in supervision level.

The enforcement instruction gives these hospitals more time to comply with the direct supervision requirements and to identify additional services that could be reviewed by the advisory panel to consider a change in the supervision levels. A question that many stakeholders have is what will happen with enforcement for 2017?

While we do not have in place an enforcement instruction to our contractors for calendar year 2017 directing them not to enforce the direct supervision requirements or patient therapeutic services first in (COGS) as well rural hospitals, we anticipate that our limited audit and enforcement resources will

be directed towards other higher priority matters during the year. And with that, I'm going to turn over the discussion to Lela Strong.

(Lela Strong): Thank you Josh. I'll be discussing changes to the inpatient only list for calendar year 2018. The Medicare inpatient only list includes procedures that are typically only provided in the inpatient setting and therefore are not paid under the OPPS or the outpatient prospective payment system.

Every year CMS uses established criteria to review the inpatient only list and determine whether or not any procedures should be removed from the list. For calendar year 2018 CMS is removing total knee arthroplasty for CKA from the inpatient only list as well as five other procedures.

As a reminder, the removal of a procedure from the inpatient only list does not require the procedure to be performed only on an outpatient basis, rather the removal of a procedure from the inpatient only list allows for the payment of the procedure in either the inpatient setting or the outpatient setting.

In addition, CMS is precluding the recovery audit contractor the RACs from conducting patient status or "site of service reviews" of outpatient total knee arthroplasty procedures for a period of two years.

We received several comments during the comment period that noted that the physician should be the final arbiter of the site of service for the Medicare beneficiary but requested that CMS establish patient selection criteria for outpatient TKA.

We know that while we expect providers who perform outpatient TKA on Medicare beneficiaries to use comprehensive patient selection criteria to identify appropriate candidates, we believe that providers and medical specialty societies who perform outpatient TKA and present specialized clinical knowledge are most suited to create such guidelines.

CMS does not expect to create or endorse specific guidelines or content for the establishment of providers' patient selection protocols for outpatient TKA.

Lastly, CMS is also adding one procedure to the inpatient only list in response to public comments. And with that, I'll turn it over to (Craig Dobyski).

(Craig Dobyski): Thank you (Lela). I will be providing a brief summary of CMS's revised laboratory date of service policy.

In the calendar year 2018 OPPS final rule, CMS addressed comments regarding the laboratory date of service policy and its impact on billing for molecular pathology tests and certain advanced diagnostic laboratory tests or ADLTs that are ordered less than 14 days following a hospital outpatient discharge.

After considering the public comments received on this topic, we added an additional exception to the current laboratory date of service regulations effective January 1st, 2018.

This new exception to the laboratory date of service policy specifies that in the case of a molecular pathology test or a test designated by CMS as an ADLT under criterion A, the date of service must be the date the test was performed only if the test was performed following a hospital outpatient's discharge from the hospital outpatient department, the specimen was collected from a hospital outpatient during a hospital outpatient encounter,

it was medically appropriate to have collected the sample from the hospital outpatient during a hospital outpatient encounter, the results of the test do not guide treatment during the hospital outpatient encounter and the test was reasonable and medically necessary for the treatment of an illness.

This new exception to the laboratory date of service policy will enable laboratories performing criterion A ADLTs and molecular pathology tests excluded from the OPPS packaging policy to bill Medicare directly for those tests instead of requiring them to seek payment from the hospital outpatient department. That concludes my summary of the revised laboratory date of service policy. Thank you.

(Sheila Mulligan): Thank you (Craig). We're now going to turn over the call to (Lois Serio), she's going to be giving an update on the new Medicare card.

(Lois Serio): Hi everyone, thank you so much for letting me join all of you for today. We're just trying to get the word out and make sure that all the rural health community and the providers are aware of this important change coming.

So just to give you a little background, the health insurance claim number otherwise known as the HICN is a Medicare beneficiary's identification number and it's been used for processing claims and for determining eligibility for services since the inception of the Medicare program.

It's used with the Social Security administration, the Railroad Retirement Board throughout the states, Medicare providers and health plans.

Back in 2015 the Medicare Access and CHIP Reauthorization Act mandated the removal of the Social Security number based HICN for Medicare cards to address the current risk of beneficiary medical identity theft.

So the legislation requires that CMS mail out new Medicare cards with a new Medicare number which we're also calling the Medicare beneficiary identifier or MBI by April of 2019. So the Social Security number removal solution must provide the following.

So first of all, CMS needs to generate this new Medicare number or MBI for all beneficiaries. That's including our existing, our currently active as well as the deceased and or archived and any newly enrolled beneficiaries.

We will also be issuing new redesigned Medicare cards and these new cards will contain the new number to existing and new beneficiaries. And thirdly and probably most importantly, we need to modify our systems, all systems and business processes that currently use and accept the current number.

We need to require updates to accommodate the receipt and the transmission, display and processing of the new number. So CMS will use an MBI

generator to assign 150 million MBIs or new Medicare numbers in the initial enumeration.

That's 60 million active and 90 million deceased archive and generate a unique MBI as I said for every new Medicare beneficiary that will be aging into the system. We also will generate a new MBI for a Medicare beneficiary whose identity has been compromised.

So just to give you a little more background on this new number it's going to have the following characteristics, it will be the same number of characters as the currently HICN 11 but it will be visibly distinguishable from the old number.

It will contain upper case alphabetic and numeric characters throughout the 11 digit identifier. It will occupy the same field as the HICN on transactions and this is important, is unique to each beneficiary so a husband and wife will have their own number.

It will be easy to read and limits the possibility of letters being interpreted as numbers. For example alphabetic characters are upper case only and will exclude S, L, O, I, B and Z.

It will not contain any embedded intelligent or special characters and it will not contain inappropriate combinations of numbers or strings that may be offensive. So again, we also anticipate that this new number it will not be changed for an individual unless the MBI is compromised. So, once the beneficiary receives this new number that is their new number.

So just a little bit about our transition period, so starting in January of 2018 CMS will activate this MBI generator and then starting in April of 2018 this coming spring we will start the transition period and we will start mailing the new cards out to beneficiaries through phased mailing approach, and from April 2018 through April 2019 the mailings will continue.

During this period of time also we can, we will accept and process both the HICN and the MBI on transactions. So actually we're giving everyone a 21 month transition period whereby either number will be accepted.

So starting April 2018 when the new cards start being mailed out all the way until December 31st, 2019 either number will be accepted. But starting January 2020, the HICNs will no longer be exchanged with beneficiaries, providers, plans and other third parties with some limited exceptions.

So we also have pictures for those of you if you got our slide deck on my slides, we have pictures of what the new Medicare card will look like as well as what the new Railroad Retirement Board card will look like because Railroad Retirement Board beneficiaries will also be receiving the new Medicare number.

So we will be providing outreach and education through April 2019 to 60 million beneficiaries, their families, advocacy groups, care givers, health plans, the provider community. We've also this past September sent out an all provider letter and fact sheet on this coming change to all Medicare providers.

And we have quarterly provider open door forums that talk about this change and what providers need to do to get ready. We are working very closely with the states and the territories and all of our business partners including vendors, business practice management programs.

So we're really trying to get the word out coming to the open door forums that people allow us to squeeze into. So, we want to get the word out that this is coming and that people are ready to receive this new number.

So we're also going to be telling beneficiaries once they receive their new card we'll be providing them instructions on how to safely and securely destroy their old Medicare cards and how to keep the new Medicare number confidential. We're also working to develop a secure way for beneficiaries to be able to access their new Medicare number when needed.

So some of our education and outreach resources, we're trying to help all of you communicate with people who have Medicare on our website and that is [cms.gov/newcard](https://www.cms.gov/newcard).

And on that website we have all the information needed for providers, plans. All the information I'm talking to you today is on that site. We also have areas where you can print and order special materials.

We have a flyer that you can distribute, we have a poster for providers' offices, conference cards for beneficiaries and tear off cards for patients for the doctors' offices. So please we can't encourage you enough to go to again [cms.gov/newcard](https://www.cms.gov/newcard) to get all this information.

Some key points we'd like to reinforce with all of you and for the providers to reinforce with their patients is to understand that mailing everyone a new card will take some time. So for beneficiaries they may receive their card at a different time than their friends or neighbors.

We want to make sure that beneficiaries' addresses are up to date so we encourage them to make sure and if they need to correct their address to contact Social Security or go online to (my FFA) their account.

Again we want to also for fraud make sure that people are aware that Medicare will never contact the beneficiary to ask for personal or private information in order to get the new card and number.

Again just some key points we wanted to reinforce for everyone to be aware, so providers, all providers need to be ready by April 1st, 2018.

Business processes and systems need to be ready to accept the new cards starting in April because new beneficiaries and folks receiving their card in the mail will start using it. There will be that 21 month transition period I spoke about from April 1st, 2018 through December 31st, 2019.

Providers will have three ways to get the new number; patients will present the card at the time of services, providers can receive it through the remittance

advice and providers can also obtain it through a secure web portal with their MAC.

So again we have resources to help you providers talk to the people with Medicare that I stated earlier. And again that is on our [cms.gov/newcard](https://www.cms.gov/newcard) and it's under the partner and employers tab. So I really wanted to thank you for allowing me this time to talk about this initiative.

We're really asking that if you have any suggestions for reaching out to the rural health community for us or if you have any particular concerns that we should address as it relates to the rural health community in making sure that everyone is ready to accept this new number to please reach out to us.

We have a mailbox and that is one word [newmedicarecardssnremoval@cms.hhs.gov](mailto:newmedicarecardssnremoval@cms.hhs.gov). Again [newmedicarecardssnremoval@cms.hhs.gov](mailto:newmedicarecardssnremoval@cms.hhs.gov). So again thank you all so much for letting me join you and please go to our website for any additional information.

(Sheila Mulligan): Well thank you so much (Lois). I will now hand the call over to (Carlye Burd) and she's going to talk about the Medicare diabetes prevention program overview.

(Carlye Burd): OK, thank you so much. My name is (Carlye Burd) and I'm the program lead for the Medicare diabetes prevention program.

And what I'm going to do is provide a very brief and high level overview of the rule that was just finalized in the physician fee schedule, and I also will try to provide a bit of context for some of these final policies given that we've had two rule making cycles now.

So for those of you who aren't familiar, the Medicare diabetes prevention program was borne out of a DPP model test that was run out of the innovation center here at CMS between 2013 and 2015.

And since that model test was proven to be effective among Medicare beneficiaries it has since been expanded nationwide to be accessible and covered as a Medicare preventive service as of April 1st, 2018.

So last year's rulemaking established the basic policy framework for this new service and this year we delve deeper into the payment policy as well as policies for the providers which are called the MDPP suppliers who will furnish the service starting in 2018.

So what I'm going to do is actually go through the fact sheet which is linked on the agenda, there's also some other links on the agenda for this call that you should definitely check out if you're more interested in finding out details.

And I'll also put a plug in for a conference call that we are having on December 5th that will review this final rule as well as provide additional details on last year's rule in more comprehensive depth.

So very quickly I know we don't have that much time, as I mentioned this new service will become available on April 1st, 2018 and the enrollment processes for this new supplier the MDPP suppliers will begin on January 1st, 2018. So that's coming right up around the corner here, suppliers will begin enrolling and services will begin starting in April of next year.

In this final rule we made some modifications to both the service and eligibility policies. Last year we had established the eligibility criteria for this service and those basically require a beneficiary to have an indication of pre diabetes in order to enter the program and that is based on their blood test results. In this final rule we finalize that individuals who develop diabetes during their service period can remain in the model.

So that was part of stakeholder feedback that we received over the course of the last year and in last year's rules so we did finalize that policy that beneficiaries who develop diabetes while receiving MDPP services can stay eligible.

We also finalized a one year limit on what are called the ongoing maintenance sessions. And this is the one year following the first core year of MDPP services.

In last year's rule we established that the MDPP program would include one year core services and those services include coaching sessions typically held in a group setting in a community based organization and that beneficiaries would have eligibility to attend maintenance sessions. And then this final rule we finalized that those maintenance sessions would be capped at one year.

We also finalized the payment structure for MDPP. We finalized a performance based payment structure which ties payment to attendance and weight loss goals. And if you would like more information on those specific amounts I will refer you to the fact sheet that is included in the invite.

But the main take home message is that suppliers can receive up to \$670 per beneficiary if they achieve all the attendance and weight loss performance goals over the course of the two year services period.

We also finalized several policies related to the MDPP suppliers the first of which is regarding which suppliers will be eligible to enroll in Medicare to furnish these services. We are requiring that all organizations that enroll as an MDPP supplier have CDC recognition.

[Organizations must have] at least MDPP preliminary or full recognition. So we've gotten a lot of questions about existing providers that are already enrolled in Medicare, those providers will have to obtain the CDC recognition which is about a one year process and it could take longer to meet the CDC standards before enrolling into Medicare as an MDPP supplier.

We finalized several policies around the supplier standards. So last year we had finalized that MDPP organizations would enroll as an MDPP supplier which is a new type of healthcare provider that we established last year and this year we established several compliance standards that these suppliers have to meet in order to maintain their enrollment in Medicare. We also established policies around beneficiary engagement incentives.

So the suppliers that are offering MDPP can choose to provide in kind patient engagement incentives to the beneficiaries who are in the program to assist the supplier in engaging that beneficiary in the behavior change that leads to either meeting an attendance goal or a weight loss goal.

We did finalize some conditions around those incentives as well, in particular some conditions around the amounts of items of technology that can be furnished.

And finally, we did finalize a policy to allow makeup sessions including a limited number of virtual makeup sessions for MDPP suppliers to furnish to beneficiaries who miss a regularly scheduled session.

I'll stop there. If you want more information, again I would encourage you to go to [go.cms.gov/mdpp](http://go.cms.gov/mdpp) or we have a mailbox as well you can email [mdpp@cms.hhs.gov](mailto:mdpp@cms.hhs.gov). Thank you so much.

(Sheila Mulligan): Thank you Carlye and all the speakers. We will now go into our question, answer session. (Amy), please let the callers know how to ask the questions. Thank you.

Operator: As a reminder ladies and gentlemen, if you would like to ask a question please press star then one on your telephone keypad. If you would like to withdraw your question, you may 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 again press star one to rejoin the queue. Your first question today comes from the line of (Annette Fern) of Brookwood Baptist, your line is open.

(Annette Fern): Yes, I have a question on the 99091. That is a collection and interpretation of what?

(Ryan Howe): It is interpretation of physiologic data. So generally that's going to be data collected from a patient through some kind of device and then sent via communication technology to the practice or the practitioner?

(Annette Fern): So that will be paid like none rules?

(Ryan Howe): I'm sorry that would be paid?

(Annette Fern): Would that be paid like non-rate like fee for service?

(Ryan Howe): Right, right.

(Annette Fern): OK fee for service, OK. OK.

Operator: And again, and again to ask a question please press star then the number 1 on your telephone keypad. Your next question comes from the line of (Rachel Shyer) of Peoples Health, your line is open.

(Rachel Shyer): For rural health to be able to bill for labs that are approved to be paid outside of the rural health pricing type all inclusive rates, they are to still bill the location of the rural health and the servicing provider of the provider doing the actual lab?

(Simone Dennis): Hi, this is (Simone Dennis). If I understand your question the RHC or FQHC should use non-RHC or FQHC place of service codes when billing for laboratory services because those are not considered RHC or FQHC services.

(Rachel Shyer): OK. So even though that the lab was done at the same place that say the (E&M) or whatever else they were doing it turns from that 50 or 72 into 11 for the labs being billed?

(Simone Dennis): So again, lab services are billed by the lab entity. I can't specify what those codes would be but you would use those non-RHC or FQHC codes and use those laboratory entity codes.

(Rachel Shyer): Perfect. Is there somewhere that describes that that I could find on any CMS website?

(Simone Dennis): We do have a discussion of this in the RHC and FQHC manual chapter 13 that's linked on our webpage if you're familiar with the RHC or the FQHC page.

(Rachel Shyer): Yes I am but I had searched and hadn't found anything that I could communicate to my providers who are arguing with me that they couldn't bill the location 50 say with the lab Q codes.

And I'm just you know we're going back and forth and I was looking for documentation from CMS that I could quote to them and I have been all over that site and I've been on the, you know you all do that FQA little paper frequently asked questions type thing it's not anywhere in that. So I was just hoping maybe there was some, so you're saying in the chapter there might be something that would state more appropriately what I'm saying?

(Simone Dennis): Yes, there's a section for non-RHC and FQHC services where it speaks to that.

(Rachel Shyer): Yes, I've seen that. But it doesn't really speak to which place a service should be billed and that's their argument to me.

Carol Blackford: So this is Carol Blackford. Why don't you go ahead and send the question to me and then we can respond with a specific link and citation so that you have that reference. And my email address is carol.blackford, B-L-A-C-K-F-O-R-D, @cms.hh.gov.

(Rachel Shyer): Cms.hms ...

Carol Blackford: HHS like Health and Human Services.gov for government.

(Rachel Shyer): Carol is with a C?

Carol Blackford: Carol with a C, Blackford ...

(Rachel Shyer): C-A-R-O-L Blackford@cms.hhs.gov.

Carol Blackford: Correct.

(Rachel Shyer): I got it. Thank you so much.

Carol Blackford: You're welcome.

Operator: And there are no further questions in queue at this time.

(Sheila Mulligan): Yes. I will hand the call back to Carol for closing remarks.

Carol Blackford: Well I want to thank everyone for taking the time today to join us. I know it was a very meaty agenda with a lot of information. So thank you for hanging with us and for asking questions.

If you have any thoughts on potential topics for future rural health open door forum calls, please send those suggestions to me. Again my email address is carol.blackford B-L-A-C-K-F-O-R-D @cms.hhs.gov.

We want these calls to be as helpful and useful to you as possible so we appreciate getting feedback on or suggestions on potential topics for future calls. So with that, I want to thank everyone again for participating and wish you all a happy Thanksgiving. Thank you.

Operator: Thank you for participating in today's Rural Health Open Door Forum conference call. This call will be available for replay beginning today at 5 pm eastern through midnight on November 17th.

The conference ID for the replay is 61720919. The number to dial for the replay is 855-859-2056. This concludes today's conference call, you may now disconnect.

END