

Centers for Medicare & Medicaid Services
Physicians, Nurses & Allied Health Professionals Open Door Forum
Moderator: Jill Darling
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3:00 p.m. ET

Operator: Good afternoon. My name is (Lindsey) and I will be your conference facilitator today.

At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services Physicians and Allied Health Professionals 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. Ms. Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Lindsey). Good morning and good afternoon, everyone. My name is Jill Darling in the CMS Office of Communications. Thanks for joining us today for the Physicians Open Door Forum. Before we get into the agenda, a 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 have any inquiries, please contact CMS at press@cms.hss.gov. And I will hand the call off to Dr. (Rogers).

(Dr. Rogers): Thanks, Jill. This is always one of our most avidly followed calls of the year. We're going to talk about the physician rule and as things are changing so dramatically in the way we do business. I'm sure that a lot of you are tuned in and going to be hanging on every word. We put together a great panel of

subject matter experts and we're going to try to walk through this in the most clear way possible.

So, Jill and (Marge), let's go for it.

Jill Darling: Thank you. So today, we'll be going over the portions of the Physician Fee Schedule final rule. Up first, we have Ryan Howe, who will go over the Physician's Payment.

Ryan Howe: Hi. Thank you, Jill. And thank you Dr. (Rogers), appreciate the opportunity to talk about a few of the payment provisions in this final Physician Fee Schedule Rule for 2017. And I'll cover several areas but be available for questions if there are payment areas that I don't have the opportunity to address, but it's – there was a – it was a kind of hefty rule this year for us. So, I'm sure many of you may have some questions as well.

So, I wanted to first point out that like last year, 2017 will be a year where the conversion factor and the payments under the PFS are affected by the updates as mandated by the MACRA legislation. And for 2017, the physician update is 0.5 percent. And, so, in calculating the rates for the services paid under the PFS, there's an overall increase of 0.5 percent that is offset by several other statutory provisions. So it's not quite a full half of 1 percent.

In terms of the conversion factor which many of you are probably interested in, the – a current – the 2016 conversion factor is \$35.80. And the 2017 conversion factor will be \$35 and about \$0.89. So, the – that reflects the overall positive update to the PFS.

There's several different provisions that affect the way that we calculate the conversion factor as well as the (RVUs), and in the broadest term, that includes the half percent update as mandated by the law, adjustments that are made to maintain the payment and coding to be overall budget neutral which is also mandated by law, as well as to account for changes in evaluations from misvalued codes. And, their statutory provision that set a certain amount that Medicare needed to make reductions in misvalued codes. And if that amount

was not met, then adjustments to the overall payment update would need to be made in order to make up the difference.

All of those results – it's a relatively complicated formula, but results overall in a positive update and update to the conversion factor of just under \$0.09.

And in terms of several particular payment policies that we would like to highlight and give you some information about, but first has to do with the – an ongoing work that the agencies undertake into pay more accurately for primary care services and care management services. What we recognize as well as many others, of course, over a long period of time is that given the Physician Fee Schedule coding system and payment system, there's an overall emphasis on procedures and tests and sometimes that leaves payment specificity for visits and other cognitive services and care management services in particular, somewhat less specific than is optimal.

So over several years, we've undertaken efforts in collaboration with the CPT Editorial Panel through the AMA to identify and define services that best reflect the resource cost associated with primary care and care management services.

Several years ago, we began making payment for what I'd call transitional care management services. This is the care management that happens over the 30 days following patient's discharge from a facility. And then two years ago, we began making payment for chronic care management services. This is in per calendar month non-face-to-face care management work that physicians furnish to patients who have multiple chronic conditions and several other qualifying attributes.

In the 20 – in last year's rulemaking, we saw a comment on other ways that we might recognize the services that are being furnished by physicians who – and other practitioners who focus on the care management and other kinds of primary care services. And we specifically saw information about models of care that integrate behavioral health care expertise into the primary care setting, and whether or not coding and payment changes might be helpful in making sure that accurate payment is made for those services in particular.

As a response in great part to the common solicitation and all of the comments that we received during last year's rulemaking, as well as our ongoing collaboration with the AMA and the CPT Editorial Panel, we made several proposals, many of which we finalized for 2017 to pay more accurately for primary care services.

We want to highlight a few, we finalized payment policies to make separate payment for certain existing CPT codes that described non-face-to-face prolonged evaluation and management services. These are the kind of circumstances where a physician or other practitioners spending significant amounts of pre or post time following or prior to a discrete patient visit based on the needs of that particular patient.

Those codes have existed for sometime and for 20 – starting January 1, 2017, will be separately billable under Medicare.

We also proposed in the finalized proposal to make separate payment for comprehensive assessment and care planning for patients with cognitive impairment. This is a code where what we believe largely is happening, our folks are reporting an E&M visit code, but we think that this assessment in care planning will more specifically identify the kinds of services that are being furnished. And it's a code that has been approved for CPT for 2018, but will be available for use under Medicare starting January 1st, 2017 using a G-code.

That's similar to series of codes that – for which we finalized payment to describe behavioral health integration services that I mentioned earlier, specifically under what's called the psychiatric Collaborative Care Model. This is a model of care where a primary care practice focuses on the behavioral health needs of their patients by collaborating with psychiatric consultant and a care manager specifically for those patients with those particular needs.

Like the chronic care management code, the – these codes are described per calendar month services that is – and any combination of non-face to face as

well as in-person care that wouldn't otherwise be separately reportable focused on the care management of patients with those conditions.

There's four codes for behavioral health integration overall, three of which described the Collaborative Care Model specifically and a fourth that describes other kinds of approaches to behavioral health integration services.

Finally, in terms of the chronic care management codes, which I mentioned earlier, we've made payment for the single code for chronic care management services as of January 1st last year. And for 2017, we'll be expanding that by using the existing CPT codes that describe chronic care management services to patients with greater needs, as well as an additional code that describes the assessment in care planning for CCM services and that will be an add-on code to the visit that initiates the CCM care.

We've also proposed and finalized several changes that we believe will minimize or help to reduce the administrative burden associated with our billing for chronic care management services when they're being furnished, including allowing patients to receive the services if they've seen that physician within a – or other practitioner within a year as opposed to requiring and initiating visit, as well as requiring – or no longer requiring that written documentation be signed for patient consent but rather that the medical record at least reflect the conversation where the patient consented to receiving the service has been made.

So we believe that these policies was finalized, will be helpful in promoting the overall health as well as recognizing the resource cost that are currently ongoing by practitioners focusing on caring for beneficiaries in these ways.

And we look forward to ongoing collaboration with the community to not only identify other services that might be identified, but also to give us feedback about how the rules are billing the codes, might be better communicated and where they need to be changed so that beneficiaries can get access to the services to improve overall health.

Several other policies I wanted to mention, one is, excuse me, for over several years of rulemaking, we've noted that for services for which we're valued with moderate sedation being inherent in the procedure, so I'll say a good example is colonoscopy services. The way that that service as well as many other services on the fee schedule have been valued has been to assume that their practitioner who's furnishing those procedures is also furnishing a sedation services to the patient at the same time. And so they've been valued with payment for that sedation automatically built in.

What we found over several years of claims analysis is that, on an increasing basis, for some of the services, anesthesia professionals are separately reporting anesthesia services for those patients during that encounter. And so, we've identified that issue over several years and CPT created a new code to identify separate reporting of moderate sedation services for 2017. And we made proposals related to evaluation not only in the moderate sedation services, but also for the procedures for which the moderate sedation was inherently or previously considered to be part of the payment.

And so we made proposals and finalized those proposals and those codes will effective for January 1, 2017.

The one wrinkle there is that, there's some stakeholder concern about the appropriate evaluation of the moderate sedation relative to GI services in particular. And so we proposed and finalized making payment using a Medicare G-code for moderate sedation services when furnished during GI procedures that's separate from the CPT coding, that sort of augments the CPT coding for moderate sedation and that'll be effective for January 1.

Another issue that some folks are probably interested in is Medicare telehealth services. These are services that are typically furnished in person and designed – and described as in-person services but under certain conditions as established by law can be paid by Medicare and furnished via remote communication technology.

For 2017, we've added several services to that list of codes that can be reported that way. Those are ESRD related services, advance care planning

services, and we've, using G-codes, created payment for critical care telehealth consultation to patients needing them.

Just a few more issues quickly, for 2017, CPT changed the coding for services describing – or – I'm sorry, for mammography services, and over – there are several changes to the coding structure under CPT, including eliminating the distinction between digital and film and like other imaging services, just reporting a single code to describe the imaging itself, as well as elimination of the add-on code for computer-aided detection. These are significant changes to that – the coding for these services. And what we proposed to do in the proposed rule is to adapt the CPT coding but maintain the current level of payment in order to, over several years, make really significant changes to important services.

Unfortunately, what we found as we prepared for to implement the new coding structure is that due to some claims processing issues, we're not able to use in the CPT codes for Medicare for 2017. And so, we will adapt as proposed the policies related to the coding structure, but rather than implement the new CPT code numbers, we'll be using G-code numbers, but we will use the policies and the code descriptors associated with the new CPT code structure. So hopefully, that will mean and allow for a relatively seamless switch for 2018, although we're not quite there yet.

So, hopefully, there won't be a lot of confusion and we'll do our best to communicate effectively about that change.

2017 is a routine update in the geographic adjustments under the PFS. And most of the significant changes take place in California due to statutory provision as well, there's a change for Puerto Rico. And I direct you to the final rule if you're interested in reading about those changes.

Finally, we made a proposal in the proposed rule to – based on a statutory provision that required us to collect data to determine what services are furnished during global periods, the global surgery periods of both 10 and 90 days. We made a robust proposal to use eight separate G-codes for reporting to us about what services are being furnished during those global periods in

order to help improve the value, the accuracy of the evaluation for those services.

We heard a lot during the comment period that our proposal would have forced providers and practitioners to deal with a lot of administrative burden that the particular reporting requirements were owners. And we certainly seriously considered those concerns and made significant revisions to our final policy.

Unlike the proposed policy there, the final policy relies on the reporting of a single existing CPT code, that CPT code 99024 to describe a patient encounter and visit in the post-operative period for 10 and 90 days, so that's a single code as opposed to the (AT) codes. We're also only requiring reporting from a smaller sample of practitioners, specifically those in practices of 10 and more practitioners and only in nine specified states. And finally, only for the 10 and 90-day global periods for a certain high volume, high cost procedures nationally.

All other practitioners are able to report voluntarily, which we think might be helpful in terms of helping identify the most appropriate resource use and evaluation for the services. And I should also note that the – you know, our final policy, we're not requiring reporting until July 1st but starting January 1st, reporting will be voluntarily collected through the claims system, through that single CPT code. And then, for those practitioners that meet all of the criteria I just mentioned, reporting will be required for July 1st.

And that's all I have, which was a lot. So, yes.

Jill Darling: Thanks, Ryan.

Up next, we have Carlye Burd who will go over the Medicare Diabetes Prevention Program Model Expansion. Carlye.

Carlye Burd: Thank you so much.

Hi, everyone. My name is Carlye Burd. I am the team lead for the Medicare Diabetes Prevention Program and I'm really happy to talk to all about our

exciting programs today, and the elements of the final rule that are laid out in the MPFS. And also, what has been deferred to future rulemaking.

So the final rule does finalize the proposal to extend the duration and scope of the additional DPP, Diabetes Prevention Program Model test. And, we now will refer to this expansion as the Medicare Diabetes Prevention Program Expanded Model.

We received several comments, we received over 700 pieces of correspondents from all sorts of stakeholders and we really took a lot of the comments to heart and we also will be using some of those comments in future rulemaking.

Because the expanded model will be implemented over two rounds of rulemaking, in this rule, we've finalized aspects of this model expansion that will enable organizations that are interested in furnishing MDPP services to prepare for enrollment.

And this includes finalizing the framework for expansion and finalizing details of MDPP benefits beneficiary eligibility criteria, MDPP supplier eligibility criteria and certain enrollment policies. But we will be using future rulemaking to propose additional supplier enrollment requirement as well as the payment structure and program integrity policies.

So I'm going to go over some of the major policies that were finalized in this benefit for the expanded model and then also the proposals that were deferred to future rulemaking.

So the MDPP core benefit was finalized as an additional preventive service, meaning it will be available to eligible beneficiaries at no cost sharing. And that was the point on – of clarification that many commenters requested and also had advocated for.

So, that is clarified and finalized in this rule.

We are also finalizing that the core benefit is 12 consecutive months and consist of at least 16 weekly core sessions over the first six months and at

least six monthly core session over the second six months furnished regardless of weight loss.

That means anyone that is eligible to receive this benefit can receive the benefit in its entirety, 12 months.

We also finalized the beneficiary eligibility criteria and you'll see the details in the rule, beneficiaries must be enrolled in Part B, they have to present one of three blood tests indicating abnormal blood glucose. And they have to have a BMI over 25 and 23 for self-identified agents, American.

Eligible beneficiaries, we've finalized that they will have access to ongoing maintenance sessions after the core benefit if they achieved and maintained the required minimum weight loss of 5 percent. And we are also clarifying what a maintenance session bundle is, it's a three-month session and three months of monthly sessions that is and maintenance of weight loss to provide clarity around how you know if someone is eligible to go on to those ongoing maintenance sessions.

We are revising – in response to commenters, we've revised our definition of CDC-approved curriculum. We removed the specific curriculum topic names. There was a lot of commenters that suggested CDC does approve alternate curricula. So we've adjusted that definition to account for any curricula that is approved by CDC under their recognition program.

We've also revised in response to commenters this session duration requirement to specify that any session must be of approximately one hour in length and that was in response to commenters who were concerned about the precise precision of exactly one hour.

We are also finalizing our proposal that the beneficiaries do not have to have a physician referral. So we are finalizing this as proposed that beneficiaries can self-refer, they can get a community referral or their provider can refer them into the program.

Now, I'm going to go over some of the supplier requirements and then enrollment policies that we discussed in the final rule.

So the organizations that will be enrolling in Medicare will be enrolling at suppliers. And a prerequisite to that enrollment is to have CDC recognition. And CDC administers the Diabetes Prevention Recognition Program, and that is the recognition body for lack of a better word that Medicare will rely on for the purposes of enrollment.

We've finalized that the – that organizations enrolling must have either – must have full recognition and we had proposed a preliminary recognition standard, but we are deferring that proposal to future rulemaking so that we can seek comment on the specific standards around preliminary recognitions that were not initially proposed. And we got a lot of comments and a lot of confusion on that so we decided to take that back and we'll be proposing and seeking comment on that in future rulemaking.

We have also finalized our proposal to require that suppliers undergo high-screening level as a condition of enrollment. And we've also finalized a – our proposal to require coaches to obtain national provider identifiers as part of their enrollment on applications. And, in addition, we finalized our requirement, the DPP organizations will submit a roster of their coach MPIs and other coach information – identify an information upon enrollment.

There is some nuance here with the enrollment policy that you'll see if you read this section of the rule. We have not finalized specifically the actions that will be taken using that roster. So we will – we intend to propose those actions in future rulemaking and seek comment on those and that will allow us to finalize supplier enrollment.

So, given the – this rule, what we were able to finalize did not get us to – on – to the unlocking of supplier enrollment, we will have to wait for future rulemaking in order to finalize remaining policies around the use of this roster.

We have modified an original proposal regarding a moment of existing providers. We are requiring that all DPP organizations regardless of their

existing enrollment in Medicare (on) role in Medicare as an MDPP supplier in order to furnish MDPP services.

And I know there was a lot of concern from commenters on this and I'm happy to go in more detail during the question and answer period on this one. But, essentially what we lay out in the final rule is ultimately the burden around ramification if that is – if that's (inaudible) we can isolate the enrollment to existing providers to this MDPP supplier enrollment and not the entire enrollment.

Now, I'm going to briefly go over some of the policies that we are deferring. We do not have enough information in our – based on the proposal and the comment period and decided that it would be pertinent to defer our proposal on DPP control providers for those providers that are DPP virtually or through remote technologies and we will be addressing and proposing specific policies around these DPP organizations in future rulemaking.

We are also deferring certain policies that we do not specifically propose but to comment on in the rule, such as our payment policy and our program integrity policies. As I mentioned, we are deferring the use of the coach information during enrollment for future rulemaking. And we now (pulled) out specific policies regarding monitoring and enforcement actions that can occur during the entire enrollment in future rulemaking.

Because we are not implementing these requirements in full, we can't begin to enroll organizations until our next round of rulemaking is complete in 2017. And, we intend that's prior enrollment starts before the model expansion goes live January 1st, 2018, and we hope that the information that is in the final rule can help prepare for that enrollment.

So we look forward to comments again next year, the payment structure, these – the virtual providers and program integrity in our future rulemaking critical. Thank you so much.

Jill Darling: Thank you, Carlye.

Up next, we have Terri Postma who will go over the Shared Savings Program.

Terri Postma: Hi, thanks. Thanks everyone for joining us today.

I'm going to just go over the final policies that were implemented as part of the 2017 PFS for the Shared Savings Program. As I'm sure you're aware, the Shared Savings Program was established to promote accountability for a patient population, coordinate items and services under parts A and B Medicare and also encourage investment and infrastructure and redesign care processes for high quality and efficient service delivery through provider and supplier participation in what are known as accountable care organizations or ACOs.

The 2017 PFS rule includes the final – several final policies specific to certain sections of the Shared Savings Program regulations.

First, we finalize various technical changes and clarifications. These are not meant to significantly modify any of our current policy or operation, so I'll just mention them briefly.

One is that we clarified the merged and acquired TINs are not expected to remain Medicare enrolled once they're defunct. But they had to have been Medicare enrolled when they were billing Medicare for services rendered to the fee-for-service beneficiaries.

Second, we clarified how ACOs and tracks two and three that fall below 5,000 assigned beneficiaries would be financially reconciled.

And finally, we can clarify their regulatory language regarding the use of our terms quality performance standard and minimum attainment.

So again, those are just technical changes and clarifications that are not significantly meant to modify any of our current policy or operations.

Next, we established beneficiary protection policies related to the use of track three ACO's use of the SNF three-day waiver. In the June 2015 final rule, we – you'll remember that we finalized the policy to waive the three-day inpatient requirement prior to admission to a skilled nursing facility or SNF. This SNF

three-day rule waiver is available to ACOs participating in track three and is scheduled to begin January 1st, 2017. To use the waiver, under certain conditions, a designated SNF affiliate of the track three ACO may bill and receive payment for a SNF stay for beneficiaries that are prospectively assigned to the ACO when such beneficiaries have not had a three-day inpatient hospitalization.

Also in the June 2015 final rule, we indicated that we continue to consider what additional beneficiary protections were necessary to implement this waiver and address them in future rulemaking.

That future rulemaking is the 2017 PFS final rule. And, in which we're finalizing the following beneficiary protection policies. First, a 90-day grace period for payment of claims under certain circumstances for beneficiaries that are excluded from an ACO's prospective list on a quarterly basis.

And second, that when a SNF affiliate claim is rejected for lack of a three-day stay for a fee-for-service beneficiary that was not prospectively assigned to the ACO, the SNF may not charge or attempt to charge the beneficiary for that stay.

The ACO for whom the SNF affiliate is associated may be required under those circumstances to submit a corrective action plan and the SNF affiliate is responsible for the charges for that stay because the SNF affiliate is required under our rules to validate and ensure the beneficiary is eligible for the SNF three-day waiver prior to admission to the SNF.

Next, we made some modifications to the assignment algorithm to assign beneficiaries to an ACO when a beneficiary has designated an ACO professional that is used in the assignment, as responsible for their overall care coordination.

Currently, beneficiaries are assigned to ACOs based on a claims-based algorithm that assigns the plurality of primary care services furnished by certain provider types participating in the ACO.

In the June 2015 final rule, we gathered stakeholder feedback on incorporating beneficiary preference or attestation into the Shared Savings Program assignment methodology.

In the 2017 PFS then, we're finalizing a methodology to collect and use beneficiary information to modify the claims-based assignment algorithm. Specifically, we're going to gather information directly from beneficiaries through MyMedicare.gov, which is a patient portal on what practitioner the beneficiary believes is most responsible for their overall care coordination.

This information will be used to override the claims-based algorithm in the Shared Savings Program as long as the beneficiary is eligible to be assigned to an ACO. If the beneficiary is eligible for assignment and selects an ACO practitioner of a type that have used an assignment to ACOs, then we'll prospectively align that beneficiary to the ACO regardless of track and regardless of whether or not the beneficiary would have been assigned based on claims.

If a selected practitioner is not participating in an ACO, the beneficiary will be excluded from an ACO's assignment list even if based on claims, we would have assigned the beneficiary to an ACO.

ACOs will begin to see these changes in our 2018 assignment list.

Next, we made some updates to ACO quality reporting including changes to the quality measure set in the quality validation audit process. For the quality measure set, we've finalized several changes. In the quality measure set, you'll recall, has been – are the measures that the ACO is responsible for reporting at the end of each year.

These proposals align with recommendations made by the Core – by the secretary of Core Quality Measures Collaborative and they align with the measures finalized for the web interface under the QPP final rule.

Specifically, we finalized a revision to the measure for medication reconciliation. We added a measure of imaging utilization for low back pain. And we retired three measures, screening for high blood pressure, beta

blocker therapy for LVSD and ACE or ARB for patients with coronary artery disease and diabetes mellitus or (LVES) of less than 40 percent.

Additionally, we've retired two AHRQ ambulatory sensitive conditions admission measures to reduce redundancies in the measure set. And added in its place an ambulatory sensitive condition acute composite measure, which is currently used in the physician value-based payment modifier.

Finally, to align with the QPP final rule, we modified the title and specifications of the EHR measure, that's ACO 11. The measure is necessary for ACOs and track two and three to meet the QPP final rule alternative criteria for being the designated advanced APMs. Therefore, under the Shared Savings Program rules, each ACO participant TIN, regardless of track, must report the advancing care information or ACI category in the form and manner specified under MIPS. That data is going to be used by us to calculate the ACO 11 measure, the EHR measure under the Shared Savings Program, it – where it remains double weighted and will impact the ACO's overall quality score and the ACO shared savings.

In addition to the AP – in addition, the data reported under the ACI category under track one will impact the APM entity group score in the ACI category under MIPS.

The net result of – the quality measures that changes that we made, the net result of those changes is to reduce the overall number of quality measures from 34 to 31 and to better align with CMS quality programs and with the recommendations made by the secretary of Core Quality Measures Collaborative.

We also finalized improvements to the way that we validate and audit the quality data submitted by ACOs. Starting in 2017, starting this spring, we'll perform quality validation audits in a single step instead of a multi-step process. So if an ACO fails the quality audit by having an overall audit match rate of less than 90 percent, the ACO's overall quality score will be adjusted proportional to the ACO's audit performance.

For example, if the ACO's quality score is 75 percent and the ACO's audit match rate is 80 percent, the ACO's audit adjusted quality score would be 60 percent. We retained the right in this final rule not to make an adjustment to the ACO's overall quality score if there are unusual circumstances outside the ACO's control that led to poor audit performance.

Additionally, we made some updates to align with the Physician Quality Reporting System and the Quality Payment Program beyond what I just discussed about the EHR quality measure.

So as finalized in the recently published QPP final rule, PQRS, the value modifier and the EHR Incentive Program are being sunset. And instead, replaced by their Quality Payment Program or QPP. Because the Shared Savings Program ACO reporting rules say that reporting satisfy certain requirements for these sunsetting programs, we updated our rule to address that change.

Under the QPP, the ACO's quality reporting will be used to satisfy the quality performance category for eligible clinicians participating in it that are subject to MIPS.

We finalized the policy under the Shared Savings Program that requires ACOs to report quality measures on behalf of the eligible clinicians participating in it for purposes of MIPS.

Finally, we made some revisions that would permit eligible professionals in ACOs to report quality measures apart from the ACO. As I noted previously, the Shared Savings Program rules align with PQRS currently such that ACOs are required to report quality on behalf of the eligible professionals that participate in it, and the ACO's quality submission is used by PQRS and the Value Modifier Programs to determine whether the eligible professionals participating in the ACO get an incentive or downward adjustment.

The Shared Savings Program rules previously did not permit eligible professionals to report quality apart from the ACO for purposes of PQRS or the value modifier.

There have been a few instances recently when an ACO has failed to report quality in – as required on behalf of their EPs. In these cases, the ACO did not qualify the (sharing) any savings that may have generated under the program. But also, because of our alignment with PQRS and the value modifier, the eligible professionals in the ACO either received or at risk of receiving a downward adjustment under the PQRS and the value modifier.

Such EPs had no remedy previously because they were prohibited by our Shared Savings Program rules from submitting quality data apart from the ACO for purposes of PQRS and the value modifier.

We therefore finalized the policy under the Shared Savings Program rules to permit eligible professionals that are part of an ACO to report quality apart from the ACO should they choose to do so.

And this means that for ACO's EPs that failed to report previously in 2015, the EPs that – or affected have an opportunity to take advantage of a special reporting period under PQRS to satisfy those reporting requirements for the 2017 payment adjustment year.

Please for those of you who are ACOs or participating in the ACOs, please watch for the Shared Savings Program spotlight newsletter in the ACO portal for more information about the special reporting period for the eligible professionals whose ACO failed to report quality measures on their behalf for the 2015 performance year.

We're going to be posting some facts that are available to you through that mechanism. So, EPs, those of you who are listening that might be affected, and who are participating in ACOs, contact your ACO leadership to access those facts. And we're also looking to make those facts publicly available but they're going to be available to your ACOs a little bit sooner.

And then, there are speakers from the value modifier here today who can outline some more details.

Jill Darling: Thank you, Terri.

Kim Spalding Bush: Hi, this is Kim Spalding Bush and I am going to pick up where Terri left off about the special reporting period. So she just mentioned we removed the prohibition of EPs who are part of an ACO participant TIN from reporting outside of their Shared Savings Program ACO.

And, we also finalized in this rule some conforming changes to the Value Modifier Program to account for that new reporting, because the Value Modifier Program keys off of PQRS reporting. We made a special reporting period that we will allow Shared Savings Program participant TINs that were in ACOs that in 2016 did not successfully report PQRS in order to avoid that 2017 PQRS payment adjustment. And then, the – consequently, the 2017 value modifier automatic downward payment adjustment.

So, these groups and fellow practitioners will be able to avoid the automatic downward adjustment under the 2017 value modifier if they report 2016 PQRS data during the secondary reporting period and meet the criteria to avoid the 2018 PQRS payment adjustment. And they can do this either as a group using one of the group registry, QCDR or EHR reporting option, or if at least 50 percent of the eligible professionals in the group meet the criteria to avoid the 2018 PQRS payment adjustment as individuals. And they can do that using the individual options of registry, QCDR or EHR reporting.

And if they do, then we will classify their quality composite as average quality and their cost composite as average cost.

This secondary reporting period will coincide with the 2016 PQRS reporting period for those methods. So that is the first quarter of 2017.

Then for the 2018 Value Modifier Program, we finalized the policy that if a Shared Savings Program ACO does not successfully report quality data on behalf of their EPs in order to avoid the 2018 payment adjustment, then we will use the data that the EPs report to PQRS outside of the ACO for 2016 performance in order to determine whether the TIN would avoid the automatic downward adjustment under the 2018 value modifier.

We finalized that these groups and fellow practitioners would avoid the automatic downward adjustment under the 2018 value modifier if they report to 2016 PQRS data and meet the criteria to avoid the 2018 PQRS payment adjustment, again, either as a group or if at least 50 percent of their eligible professionals meet the criteria to avoid that PQRS payment adjustment.

And then if they do, then under the quality-tiering methodology again, we would classify their quality composite as average quality and their cost composite as average cost.

So, also in this final rule, we finalized a couple of – or some additional policies around the informal review process. We established how the quality and cost composites under the value modifier will be affected for both the 2017 and 2018 payment adjustment periods under certain circumstances.

We described four different scenarios and we finalized how the quality and cost composites would be impacted for groups and fellow practitioners under the value modifier as a result of those informal review decisions.

Jill Darling: All right, thank you, Kim.

Up next, we have Robin Usi who will go over Open Payments.

Robin Usi: Hi, I'm Robin Usi, director for the Division of Data and Informatics in the Center for Program Integrity. You know, thanks for the opportunity to speak to you today regarding the Open Payments Program solicitation for comments that was a writer on the proposed Physician Fee Schedule.

I know we are very short on time and I guess the most important point here is that this was simply a solicitation for comments regarding several areas of the Open Payments Program. At this point, we are not implementing any rule changes, these comments are simply an effort for us to gather additional information for potential future rulemaking for the program.

I guess the one thing that I'd like to add for those who are not familiar with open payments is that it is a program that creates transparency around the nature and extent of relationships that exist between drug device, biological

and medical supply manufacturers, and physician and teaching hospitals and physician owners or investors.

The rule was, you know, since the initial publication and implementation of the final rule, and the subsequent changes that were part of the 2015 Physician Fee Schedule, you know, we've had various stakeholders provide us feedback and – on the program and this was – we took this as an opportunity to more widely solicit feedback from those interested in the program.

So again, in an effort to allow time for speakers who do have changes to the rule, I just want to thank those of you who may have submitted comments and that we are reviewing these comments for, again, potential future rulemaking.

Thank you. And I guess I will leave it at that since there are other speakers to go today.

Jill Darling: Thanks, Robin.

Robin Usi: Sure.

Jill Darling: Up next, we have JoAnna Baldwin who will go over the Appropriate Use Criteria.

JoAnna Baldwin: Hi, everybody. Today, I'm going to give you very high-level overview of the Appropriate Use Criteria Program, what it is and what its impacts will be.

So, every practitioner that orders advanced imaging services, so that's MRI, C.T., positron emission tomography and nuclear medicine. Every practitioner that orders will have to, in the future, consult an electronic tool. That tool will communicate appropriateness information back to the ordering professional. That information will have to make its way to the furnishing professional, so in many cases, the radiologist, because information about appropriateness for that order will have to come in on the furnishing practitioner's claims.

So that information is going to have to go from the ordering practitioner who actually consults the clinical decision support for appropriate use information, it's going to have to make its way to the furnishing professional, to the

radiologist, and then it's going to have to go on their claims to come into Medicare.

So, eventually, when this program kicks off, which we have said, maybe as early as January 1st, 2018, but will not be before that, that consultation will have to occur for every advanced imaging service orders. There are like everything, (are) few exceptions, so we're going to have exceptions for hardship where we'll have some overlap with the EHR Incentive Program and then we'll have an exception for emergency services. So just to be clear, that's not an exception for the emergency department, but there will be some exceptions for emergency services.

So, I think probably the most important information that I'd like everyone to take away today is that, CMS laid out in this year's final rule the requirements for this clinical decision support tool, they have to apply to us, they will have to become qualified and we are expecting that the first list of qualified tools will be posted to the CMS website by the end of June 2017. So at that time, you will want to go on our website and look for which tools became qualified.

Around that same time, we will be issuing the Physician Fee Schedule proposed rule for next year, and that will include a lot more information, more details about this program, getting down a little bit more about implementation, claims processing. We'll get more into the nuances of it next year, so stay tuned for more of that information. But, today, I just want you to take away that this program is coming, it impacts a lot of practitioners, its new information that has to be collected and go on the furnishing professional's claim. But more information will be coming.

So we want everyone to be on the lookout for that. We will do a lot of provider education when we get to the point where this program, you know, when the switch of this program actually gets turned on and folks have to begin reporting and consulting.

So I think I'm going to leave it at that for now since we are just about out of time.

Jill Darling: Thank you, JoAnna.

So folks on the phone, we do have two more topics which we will go over. And just to let you know, we will be taking about two to three questions afterwards. So, we will be going over our timeframe.

So up next, we have Katie Mucklow who will go over the Provider Enrollment Medicare Advantage Program.

Katie Mucklow: Hi. Thanks, I'm glad I don't have to get this done in 30 seconds, but I'll do my best.

This is the Medicare Advantage Provider Enrollment Provision, this provision requires Medicare Advantage providers and suppliers to enroll in Medicare. The requirement also applies to the PACE program, cost plan, (inaudible) as well. About 93 percent of all Medicare Advantage providers and suppliers are already enrolled in Medicare. So this is just sort of closing that gap to require all network providers and suppliers to enroll.

And to be clear, this doesn't just apply to Medicare services, but it also extends to supplemental benefits like dental services. And, the types of individuals and entities that will need to be enrolled is based upon a statutory definition that's covered pretty clearly in the rule. But it's the statutory definition of provider and supplier that we typically cite in our provider enrollment rules.

So the providers – so those providers and suppliers that are categorically eligible to enroll will be required to enroll. And then ones that are outside of what we've determined to be a category of provider supplier that does not need to enroll would be like a pharmacist, that was something that we specifically excluded in the Part D prescriber enrollment rule that we issued a couple of years ago.

So this requirement will be effective January 1st, 2019. And I can say now, based on an HPMS memo that was issued several weeks ago, that the Part D prescriber enrollment requirement and this Medicare Advantage provider

enrollment requirement are going to line up together for that January 1st, 2019 date.

And that's all I have.

Jill Darling: Thanks, Katie.

And last, we have Kim Glaun who will go over the Billing Qualified Medicare beneficiary for medical – I'm sorry, for Medicare Cost Sharing.

Kim Glaun: OK. Hi, thanks for staying tuned. I'll be very brief. But I'm going to discuss the final rules, reminder to Medicare providers about an existing provision of law, which prohibits providers from billing beneficiaries who are enrolled in the Qualified Medicare Beneficiary Program for Medicare cost sharing. And that program is also known as (Quimby) or the QMB Program. And today, I'm just going to refer to them as (Quimby).

And just quickly, a brief background, the (Quimby) Program is a Medicaid program that pays Medicare premiums and cost sharing for low-income Medicare beneficiaries. Those individuals typically have incomes at around \$12,000 a year. Nationwide, there are about 7 million beneficiaries who enrolled in (Quimby).

And the proposed – as in the proposed rule, the final rule, really is just reiterating current law which is that federal law, like I said, is prohibiting – does prohibit Medicare providers from charging those enrolled in (Quimby) for Medicare cost sharing, so that's sort of the takeaway. The takeaway is just to clarify too that this prohibition applies to all Medicare providers, even to those that don't accept Medicaid so that's a clarification that we want everyone to understand.

Inappropriate billing is a violation of the Medicare provider agreement, so that is also something to keep in mind. And we have found just to – as background that there is a lot of confusion and we understand there has been a lot of confusion on the ground about the rules, and that's why we're trying to clarify them. But we also know that inappropriate billing is a persistent problem, a study that we did in 2015 showed this.

So given this, we – in the final rule, we're advising Medicare providers to take steps to reeducate themselves and their staff about the (Quimby) billing rules and to implement procedures to make sure they exempt individuals to Medicare cost-sharing billing and related collection efforts. And we know that just lastly that we – in the comments to the proposed rules, we got a lot of support for our efforts. There is acknowledgment that there is confusion and a need for greater understanding of the rules, but providers did ask us to do more to help them identify the (Quimby) status of their patients.

And we have noted, we did note in response that we are actively exploring administrative mechanisms to assist providers in this regard. And as an initial step, just wanted to let you know that starting next month, the Medicare Administrative Contractors will conduct targeted outreach to providers. They'll send a letter to providers who (Quimby) individual has reported as persisting inappropriate billing.

A provider, MLN, Medicare Learning Network, article went out last week regarding this new process. And it's – and then 9817, and we can probably provide that link to folks after the call today, too. And, there is more that we're doing internally on these issues, so stay tuned on that.

Jill Darling: Thank you, Kim. And thank you all of our speakers for today. We do appreciate everyone for sticking around. I know that we're past the hour mark, but like I said earlier, we will be taking just two to three questions because of the time.

So (Lindsey), we'll open up the Q&A, please.

Operator: 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, 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 join the queue.

Your first question comes from the line of Betsy Nicoletti. Your line is open.

Betsy Nicoletti: Hi, thank you. I'm lucky to have my call answered.

I have a question about the G-code for moderate sedation G0500, is it used in place of the CPT codes or an addition to the CPT codes for those colonoscopy, GI procedures?

Male: So, it's used in place of the single CPT code that describes the practitioner furnishing the moderate sedation him or herself, but only for the GI services. So it's – so think of it as a ...

(Crosstalk)

Male: Right. It's in place of and more specific.

Betsy Nicoletti: Thank you.

Operator: Your next question comes from the line of (Greg Lindberg). Your line is open.

(Greg Lindberg): Hi, I was just wondering about the changes that you described to the quality measures when those would be taking effect. And then if you could just also just review quickly the ambulatory condition, sensitive composite measure. Thank you.

Terri Postma: Hi, this is Terri. I think you're asking about the changes to the Medicare Shared Savings Program quality measure set. And, the quality measures – there's a really nice table in the 2017 PFS final rule that you can find on the Federal Register, it's posted there now. And, that table outlines the quality measures that we established through this rulemaking for the 2017 performance year.

So – and the measure specifications we intend to post prior to the performance year, and we typically do that in around December, maybe early January timeframe. So, be watching the – our website for those. And then you had a

question about the ambulatory sensitive measure. (Ruby), do you have a response for that?

(Rubia): Yes. So this is (Rubia), I come from the Shared Savings Program.

In the PFS rule, we did make some changes in terms of retiring the two individual PQIs that we had in our measures and introduced the PQI ambulatory sensitive condition acute composite. And like Terri said, that would be part of the 2017 performance year.

We are releasing the measure information form. We're hoping to get that, as Terri noted, end of December or early January, the specifications. But we are – the specifications are aligned with the AHRQ version. So you can view that online. We are just changing the attribution for it to be an ACO level. And we are – we did introduce more a robust risk adjustment methodology that will include (ACCs) and comorbidities. So it's beyond the AHRQ specification for just age and gender.

(Greg Lindberg): Thank you.

Jill Darling: And (Lindsey), we'll take one more question, please.

Operator: Your next question comes from the line of (Randy Fing). Your line is open.

(Randy Fing): I had a quick question regarding the MSP program for – particularly reporting for ACI to the participants and the ACO have to individually report, or does measure 11 in the quality reporting (cover it)?

Terri Postma: Yes, this is Terri Postma again with the Shared Savings Program. Appreciate the question and the chance to clarify.

So, the Shared Savings Program rules, as you noted, the quality performance standard includes ACO 11. ACO 11 takes the information that eligible clinicians, MIPS eligible clinicians, reported in ACI category under the Quality Payment Program takes that data and uses it to calculate an ACO measure, ACO 11.

So, each ACO participant TIN, regardless of track, must report under ACI according to the form and manner required under MIPS. So that's number one.

And then number two, we take that information, use it to calculate the ACI category score for MIPS ECs participating in ACOs. But we also take that data and use it to calculate the ACO 11 measures. So it's two separate things, but one reporting. One reporting, the ACO participant TIN, each of them has to report ACI in the form and manner requiring a MIPS, but then we use that data in two different ways. Is that clear?

(Randy Fing): OK. So the TIN will individually attest, is that correct?

Terri Postma: The – each ACO participant TIN, yes, must report for the ACI category. However, MIPS requires that reporting to be done. The ACO does not report that category.

(Randy Fing): OK.

Jill Darling: Thanks everyone for joining today's Physicians Open Door Forum. We do greatly appreciate you sticking around after the hour timeframe. And I know probably there were some other questions, but we'll will – if you can – if you want to shoot me an e-mail, please don't bombard my e-mail. It's jill.darling@cms.hhs.gov. And I can forward it along to those specific speakers.

So thank you all for joining today's call. And the next Physicians Open Door Forum is to be determined. So thanks everyone. Have a great day.

Operator: Thank you for participating in today's Physicians and Allied Health Professionals Open Door Forum conference call. This call will be available for replay beginning at 5:00 p.m. Eastern time, today, November 15th, 2016 through midnight on November 17th.

The conference ID number for the replay is 8513026. 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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