

Centers for Medicare and Medicaid Services  
Rural Health  
Moderator: Jill Darling  
November 16, 2016  
3:00 p.m. ET

Operator: Good afternoon. My name is (Shannon) and I will be your conference facilitator today. At this time, I'd like to welcome everyone to the Centers for Medicare and Medicaid Services, Rural Health Open Door Forum.

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

Ms. Jill Darling, you may begin your conference.

Jill Darling: Thanks, (Shannon). Good morning and good afternoon or probably just good afternoon, everyone. My name is Jill Darling, CMS Office of Communications and thanks for joining us today for the Rural Health Open Door Forum.

Before we jump into the agenda, I just have two quick announcements. 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 inquiries, please contact CMS at [press@cms.hhs.gov](mailto:press@cms.hhs.gov).

And one new update we have regarding Open Door Forum, there is a little note on the agenda. We now will have podcasts for Open Door Forums so we'll have the transcript and an audio for you and any other of your colleagues who were not able to make today's call so it will be posted. We do have a link available on the agenda. We will also still have the encore

presentation which is available for two business days after the call. So that is our new update.

So now I'll hand the call over to our Co-Chair, John Hammarlund.

John Hammarlund: Great. Thanks a lot, Jill. And welcome everybody to today's open door forum call. On behalf of the co-chair of the call, Carol Blackford, myself, we're delighted to have you to join us today. We have a very, very full and rich agenda and so we want to get started on it pretty soon, however, you will probably note if you received the agenda that we had a slot for the acting administrator for CMS, Andy Slavitt to speak today. Unfortunately, we got word sort of the 11th hour that Andy was pulled away and is unable to participate in today's call. I know he sends his regrets. He very much wanted to be part of today's call and to also wish all of you a happy national rural health day which is occurring tomorrow but unfortunately he was pulled away.

In lieu of Andy, what I'd like to do to open the call is to be joined by Dr. Cara James who's the Co-Chair of the CMS Rural Health Council and Cara and I would like to talk to you little about some of the activities of the Council, the recent summit and some future activities that are going on and we hope that will be a good way to spend some of this time. But again, Andy sends his regrets and I will hope that we can bring him on to a future one of our calls.

So with that, I'm going to hand it over to Dr. Cara James, the Co-Chair of the Council and she and I will talk to you the next few minutes about some of the work that we're doing. So, Cara.

Cara James: Thank you, John. And welcome to all of you and thank you so much for joining us for the call today. I'm pleased to be back on to talk a little bit about some of the updates for the CMS Rural Health Council.

Before I do that, I just wanted to start off in recognition of National Rural Health Day tomorrow by thanking each and every one of you for all the work that you do every day to provide quality care to your patient. We, CMS, are

doing what we can but we know it takes all of the partnerships in the work that you guys bring to the table to help us get to where we want to be.

And speaking of the Council, we've been very busy this year doing a lot of engagement with roll stakeholders across the country, listening, learning and reflecting on what we've heard in a manner that informs the work that we're doing here at headquarters. So the Council is also helping to ensure that we view all of our policies and initiatives with the ruling and we're working to reduce the burden reduction where we can which is the trust of our recently launched initiative in CMS to engage with physicians regarding regulatory burden.

So as John mentioned, we recently held a Solution Summit, Rural Health Solution Summit in October. Some of you may have participated with that either here in person in Baltimore via Livestream or maybe even in one of our regional offices but we had more than 635 participants from 48 states in the District of Columbia, representing a wide variety of stakeholders. We had a lot of active discussion and participation through three breakout sessions that focused on essential health services in rural communities, increasing rural innovation in healthcare delivery and modernizing telemedicine.

We also had a really interesting presentation in session with local innovators, as well as remarks from various center directors here at CMS and leadership from CMS HRSA and the department. And these discussions that we have will continue in the session helped us to appreciate the barriers, best practices and opportunities relating to the delivery of care in rural America.

And I'm going to turn it over to John to talk about what we're doing with those lessons and learning and where were going next. John.

John Hammaerlund: Yes. Thanks, Cara. It was a real pleasure to participate in the Rural Solution Summit and I'm glad so many folks were able to participate from all over the country. So the next step is we're going to be taking our show on the road. So ever – over the next three months, a couple of sessions this month and then in December and January, the CMS regional offices in concert with CMS leadership, we're going to be holding a series of regional listening

sessions and they're going to – their design is sort of build on what we've learned so far from the summit and from other engagements we've had.

We're going to be diving a little deeper into some of the subjects that we the address of the summit and sort of understanding the nuances and differences in rural communities around the country and we're also going to be exploring common ground on some underlying principles for a 10-year vision for rural health care that will sort of define our path to improve access to quality care for rural Americans.

So we've started thinking a little about sort of a vision statement and the underlying principles for the future rural healthcare but we want all rural stakeholders to be part of that good thinking and help us build the vision statement. So that's some of what we'll be exploring during these listening sessions around the country. We hope ultimately to have posted a sort of a calendar of the various listening sessions that are taking place but at the moment we'll be relying on the regional offices that have a close connection with the stakeholders in the regions to get the word out about the sessions that will be taking place in their respective regions.

And on the policy front, well, you can see from today's agenda for this call that you know there's a lot going on, we're going to be addressing a lot of important and timely topics with you today such as the rurally relevant facets of the recently published outpatient prospective payment system, final rule and the physician fee schedule final rule so lots to talk about today and in the future.

And I just want to – I'll end with one thing, I noted that if Andy had been able to participate on today's call, one of the things he would have wanted to emphasize is that while there is going to be obviously a transition of an administration of administrations in the coming months that CMS's commitment to rural communities remain steadfast.

Cara and I as Co-Chairs of Rural Health Council see that as an enduring initiative. We're going to continue to work hard, to listen and learn and to

inform. Carol Blackford and I as Co-Chairs of these open door forum calls are going to continue to make sure that these calls reach out to you about every six weeks so we can get timely topics out there and we can hear your questions and concerns. So just know there's a lot of commitment from all of us at CMS to continue to be good partners with you in rural America.

So with that, we're going to now turn it back to Jill and she's going to go ahead and embark on the formal agenda of policy topics today. So Jill, take it away.

Jill Darling: Thank you, John. So up next or first, we have David Rice to start off with the Hospital Outpatient Prospective Payment System Final Rule.

David Rice: Thank you Jill. For calendar 2017, we are increasing the payment rate under the outpatient prospective payment system by factor of 1.65 percent. This increase factor is based on the hospital inpatient market basket percentage increase of 2.7 percent for inpatient services minus the multifactor productivity adjustment of 0.3 percentage points and minus 0.75 percentage point adjustment required by statute.

For the rural sole community hospital adjustment, we are continuing the adjustment of 7.1 percent to the OPPOS payment for rural sole community hospitals including essential access community hospitals. This adjustment applies to all services paid under the OPPOS excluding separately payable drugs and biological devices paid under the pass-through payment policy and items paid at charges reduced cost.

Additionally, in this final rule, we are finalizing policies to implement Section 603 of the Bipartisan Budget Act of 2015. Section 603 enacted November 2, 2015 amended the OPPOS part of the statute or Section 1833T and established that certain items and services furnished by certain off-campus outpatient department to the provider shall not be considered covered outpatient department services for purposes of OPPOS payment and shall instead be made under the applicable payment system beginning January 1, 2017.

I may discuss the payment to applicable provider based departments and then I'll pass it off to Elizabeth Daniel who will discuss which provider based department this provision will apply to. The proposed rule proposed to adopt the Medicare physician fee schedule as the applicable payment system for services furnished and non-accepted off-campus provider based departments because many of these services furnished an off-campus (PPDs) are identical to those furnished and freestanding physician practices where they'll be paid under the physician fee schedule at the non-facility rate. Under the proposed rule, the only payment made for non-accepted services would have been a payment for the practitioner at the non-facility rate as Medicare would do services provided at a freestanding facility.

We are finalizing our proposal to adopt the Medicare physician fee schedule as the applicable payment system for services furnished and non-accepted off-campus provider based departments. However, we received many public comments raising concerns with the proposal to implement the physician fee schedule as the applicable payment system without providing hospitals a method to bill for these items and services under the physician fee schedule in 2017. These concerns included that providing a non-facility payment to the practitioner had implications under the physician self-referral and anti-kickback statutes and existing incident to regulations.

Commenters noted that these concerns method might be difficult for hospitals and practitioners to reach arrangements on payment for non-accepted services. And if for certain non-accepted item and services, it would not be possible for either the practitioner or the hospital to receive payment.

After consideration of these public comments in conjunction with this final rule, we have issued an interim final rule with comment period to establish new physician fee schedule rate for non-accepted items and services furnished in an off-campus provider based departments for 2017. This will remit hospital to bill and be paid for items and services furnished in non-accepted off-campus provider based departments.

Under this interim final rule, CMS is establishing interim final site specific rates under the physician fee schedule for the technical component of all non-accepted items and services. Hospitals will be paid at this newly established physician fee schedule rate for non-accepted items and services which will be billed on the institutional claim and must be billed with the new claim line modifier PN to indicate that an item or service is a non-accepted item or service.

For 2017, the payment rate for these services will generally be 50 percent of the OPFS rate which we believe best approximate the difference in payment for the physician fee schedule services provided in other settings given the data available at this time. There's some exceptions that are spelled out in the IFC including that payment for separately payable drugs will not be reduced. Packaging and certain other policies will continue to apply in order to maintain a proper – appropriate relativity between the rates. Physicians furnishing such services will continue to be paid on the professional claim and we pay at the facility rate under the PFS consistent with current payment policies.

For physicians practicing in an institutional setting, as these are payments under the PFS, the PFS copayment rules. We estimate an implementation of Section 603 will reduce net part B payment by \$50 million in 2017 relative to a baseline with Section 603 is not implemented in 2017. We note that there will be a 60-day public comment period on the IFC and we are seeking public comments on the new payment mechanism and rates detailing the interim final rule with comment period. Based on these comments, we'll make adjustments as necessary to the payment mechanisms and rates through a rulemaking that could be effective in 2017.

At this point, I'll pass it off to Elizabeth Daniel who will discuss which TBD the provision will apply to.

Elizabeth Daniel: OK. Good afternoon. As Dave mentioned, Section 603 amended the part of the OPS statute that establishes that certain items and services furnished by certain off-campus departments of the providers shall not be considered – cover the outpatient department services for purposes of the OPFS payment

and challenge that be paid under the applicable payment beginning January 1, 2017.

We finalized several policies as proposed relating to which off-campus TBDs and which items and services are accepted from application of payment changes under this provision. We finalized that off-campus TBDs would be permitted to continue to bill for accepted items and services under the OPPTS. Accepted items and services are items and services furnished after January 1, 2017 by a dedicated emergency department as defined an existing regulation an off-campus TBDs that was billing for covered outpatient department services furnished prior to November 2, 2015 and has not impermissibly relocated or changed ownership and a TBD that is on the campus or within 250 yards of the hospital or a remote location of the hospital.

In response to public comments, rather than limit the definition of an accepted off-campus TBD to those that were billing for a covered outpatient services under the OPPTS furnished prior to November 2, 2015, we finalized that off-campus TBDs will be eligible to receive OPPTS payment as accepted off-campus TBDs for services that were furnished prior to November 2, 2015 and billed under the OPPTS in accordance with timely filing limit.

In addition, we propose that to limit the items and services that an accepted off-campus TBD could continue to bill under the OPPTS beginning January 1, 2017 to those items and services within a clinical family that were furnished and billed as of November 2, 2015. Under the proposal, additional items and services beyond those – within the 19 clinical families and services furnished and billed prior to that date will not be accepted items and services paid under the OPPTS.

In response to public comments on administrative burden and overall complexity and potential beneficiary access issues, we do not finalize this proposal. CMS will monitor expansion of clinical service lines by off-campus TBDs and continue to consider whether a potential limitation on service line expansion should be adopted in the future.

We also finalized our proposals that items and services must continue to be furnished and billed at the same physical address to the off-campus TBD as was used at November 2, 2015 in order for the off-campus TBD to be considered accepted from Section 603 requirement. The final relocation policy includes a notable change from the proposed rule to allow accepted off-campus TBDs to relocate temporarily or permanently without loss of accepted status due to extraordinary circumstances outside of the hospital's control.

Examples of these circumstances may include natural disasters or seismic building code requirement. Exception for extraordinary circumstances will be evaluated and determined by the applicable CMS regional office and we note that we expect that this request for exception to the – will be rare and for unusual circumstances.

And finally, we finalized our proposal to allow an off-campus TBD to maintain accepted status under the rules outlined in the final rule if the hospital has a change of ownership and the new owners accept the existing Medicare provider agreement from that prior owner.

And now, I will hand it off to (Lela Strong) to cover other highlights from the OPS final rule.

(Lela Strong): Thanks, Elizabeth. So I'll be speaking about the finalized comprehensive APC policies for 2017, as well as our refinements to our packaging policies for 2017. So a comprehensive APC or CAPC has an APC that provides for an encountered level payment for designated primary procedure and generally all exempted services provided in conjunction with the primary procedure.

Currently there are 37 CAPCs which mostly include procedures for the implantation of costly medical devices. For calendar year-end 2017, we are finalizing our proposal to create 25 additional CAPCs which results in a total of 62 CAPCs. These new CAPCs are primarily major surgery APCs within the various CAPC clinical family. We're also finalizing our proposal to establish three new clinical families to accommodate new CAPs. And those new clinical families include narrow procedures, excision, biopsy, incision and draining procedures, as well as airway endoscopy procedures.

We're also finalizing our proposal to develop a CAPC for bone marrow transplant, as well as a dedicated cost center and revenue code for donor acquisition cost related to bone marrow transplant. The creation of a new CAPC for bone marrow transplant or BMT would allow all the cost for the services on the same OPPS claim as BMT to be packet and to the right setting for BMT. This would also allow for the payment for the BMT to be representative of the payment for all services that are associated with the procedure including donor acquisition cost.

So I'll also be covering the refinements to our package services policies for 2017. For 2017, we're finalizing three policy refinement with respect to packaging. First, we are finalizing it for the proposal to align the packaging logic for all the condition of packaging status indicators so that packaging would occur at the claim level instead of based on the data service. This to promote consistency and to ensure that items and services that are provided during a hospital stay, they may spend more than one day our package according to OPPS packaging policy.

The second policy refinement in relationship to packaging is that in C.Y. 2014, we adopted a policy to exclude molecular pathology test from our laboratory packaging policy because these types have a different pattern of clinical use than more conventional laboratory tag which may make them less tied to a primary service in the hospital outpatient setting than the more common and routine laboratory test center package. We believe that this rationale would also apply to certain ADLTs and that's advanced diagnostic laboratory test so therefore we're finalizing our proposal to expand this laboratory packaging exclusion to ADLTs and the ADLTs have to meet that criteria of Section 1834A(d)(5)(A) of the Act.

So the last policy refinement in relation to packaging is the discontinuation of the L1 modifier and calendar year 2014, we implemented modifier L1 to allow for separate payment of laboratory test and under two circumstances, first laboratory test were the only services on the claim or when the laboratory tests were unrelated to other services on the claim meaning that the laboratory

test was ordered by a different physician for a different diagnosis than the other services on the claim.

In calendar year 2016, we implemented status indicator Q4 which allows for automatic separate payment for the laboratory test when these are the only services on the claim without the use of the L1 modifier. So for calendar year 2017, we're finalizing the proposal to discontinue separate payment for unrelated laboratory test and we will therefore discontinue the use of the L1 modifier.

Jill Darling: Next, we have (Grace Im) who will go over the HCAHPS Pain Management.

(Grace Im): Thanks, Jill. Good afternoon, everyone. And this topic is actually related to the hospital value-based purchasing program or VBP program which is a pay-for-performance program for inpatient hospital setting that is funded by 2 percent reduction from participating hospitals base operating BRG payment each year. In the calendar year 2017, OPPI, ASP proposed rule, we proposed to remove the pain management dimension of the hospital consumer assessment of healthcare providers and systems survey or the HCAHP Survey which is a patient experience care survey for purposes of the hospital VBP program beginning with the FY 2018 program year.

With the strong support we received for our proposal and the public comments, we are finalizing the removal of the pain management dimension as proposed from the hospital VBP program. We note that we are currently developing and field attesting alternative questions related to provider communication and pain in order to remove any potential ambiguity in the HCAHP survey and we will solicit comments on this alternative in future rulemaking.

And finally, for additional information on hospital VBP program requirement, please also refer to the FY 2017 IPPI which is inpatient prospective payment system and the LTCH PPS final rule published in the Federal Register back on August 22, 2016.

Jill Darling: Thank you, (Grace). Next, we have Kathleen Johnson who will go over the EHR Incentive Program.

Kathleen Johnson: Thank you, Jill. The EHR incentive program, we finalized for eligible hospital in (Inaudible) and dual eligible hospitals who are attesting the CMS. The removal of CDS and PPOE objectives and measures beginning in 2017 as well as the reduction of certain thresholds and measures for modified stage II in 2017 and for stage III 2017 and 2018. We've also added measure nomenclature for modified stage II and stage III objective and measures. We note that the changes are not applicable to Medicaid providers who are attesting to their state system. For all providers in the EHR incentive program, we finalized an any continuous 90 day EHR reporting period in both calendar year 2016 and 2017 at minimum. Providers may attest to longer EHR reporting period if they so choose.

We also finalized a 90-day reporting for CQMs for all providers that choose to report CQM by attestation in 2016. In addition, all providers that have not successfully demonstrate meaningful use in a prior year and are seeking to demonstrate meaningful use for the first time in 2017 to avoid the 2018 payment adjustment will be required to attest to the modified stage II objectives and measures.

Lastly, beginning in 2017 for all meaningful use measures unless otherwise specified, all actions in the numerator must occur within the EHR reporting period if that period is a full calendar year. If it is less than a full calendar year, within the calendar year in which the EHR reporting period occurs. Lastly, for new EPs in 2017, we have finalized a one-time significant hardship exception from the 2018 payment adjustment for certain EPs who are new participants in the EHR incentive program in 2017 and are also transitioning to MIPS in 2017. Thank you.

Jill Darling: Thanks, Kathleen. So next, we'll be going into the calendar year 2017 Physician Fee Schedule Final Rule.

Marge Wachorn: Hi. Good afternoon, everyone. Thank you, Jill. This is Marge Wachorn and I'll be speaking about the physician payment update in Physician Fee

Schedule. For calendar year 2017, I want to highlight three areas where we made changes and update the physician payment. First, in the area of primary care, we finalized several proposals to make separate payment for services relating to primary care and care management. Those services include behavioral health integration, the psychiatric collaborative care model, prolonged evaluation and management, the face-to-face and non-face-to-face services assessment and care planning for individuals with cognitive impairments such as dementia and chronic care management for patients who require greater complexity. We also finalized several proposals to reduce the administrative burden associated with furnishing and reporting chronic care management services.

The next area I want to highlight is Telehealth. I'm sure this is an area very much of interest to the rural providers. Specifically, we added several services to the list of services that are eligible to be furnished via Telehealth. Those services include ESRB related services for dialysis, advance care planning and critical care consultation furnished via Telehealth. We also added a new place of service code to be reported for services that are furnished via Telehealth.

And finally, I wanted to highlight the fact that we updated the geographic practice cost in disease which we use to adjust payments under the physician fee schedule to reflect local differences in the practice cost incurred by physicians and non-physician practitioners.

We update these every three years. The update for the (inaudible) will be faced in by statute over calendar years 2017 and 2018. And finally, we implemented a new locality structure for the state of California that was required under the Protecting Access to Medicare Act of 2014. And next, I'll turn it over to Corinne Axelrod.

Corinne Axelrod: OK. Thank you, Marge. We have several RHC and FQAC updates and so I'm going to actually have Simone Dennis start off by giving you some updates on the RHC and accuracy payment rate. Simone?

Simone Dennis: Hi. All right. This is Simone. So first I'm just going to start with FQHC market basket. So as of January 1, 2015, all the FQHCs are paid under the FQHC prospective payment system, Section 1834O of the Social Security Act requires that in the first year after implementation, FQHC base payment rate is updated by the MEI. It also requires that in subsequent years, the FQHC base payment rate is updated by the HQC market basket of goods and services or if such an index is not available by the Medicare economic index.

In the proposed – in the PFS proposal, we included a proposal to create a 2013 base FQHC market basket. We worked with our office of the actuary to develop the index using 2013 cost report. We selected 2013 as a base year because that was the most recent and complete set of cost report data available. In the proposal, we included a lengthy discussion of our methodology to develop the market basket. All the comments we received in our proposal were highly in favor of using the FQHC market basket instead of the MEI and a few commenters asked for technical clarification.

So for C.Y. 2017, we're finalizing that proposal to update the FQHC market basket, to update the FQHC base payment rate by the FQHC market basket and we are confident that the FQHC market basket more accurately reflects the actual cost and scope of services the FQHC is furnished compared to the MEI. Over time, the FQHC market basket produces slightly higher update compared to the MEI. We expect that to continue for the near future so therefore for C.Y. 2017, the FQHC market basket update is 1.8 which is 0.6 percent higher than the MEI 12 – 1.2 percent.

So related to the market basket, I want to talk about the FQHC payment rate update. So recently, MLN Article MM9831 has been published to the CMS website. Again, it's the article that describes the annual payment rate update for the FQHC PPS. So for C.Y. 2017, the rate is going to be updated by the market basket of 1.8 percent. So beginning on January 1, 2017, the base payment rate will be \$163.49.

Also, put in that article, it instructs contractors to adjust the grant by their tribal FQHC claims paid at the C.Y. 2015 rate of \$305. In 2016, to be paid at

the C.Y. 2015 rate of \$324. Provider action is not necessary for that adjustment.

And then for the RHCs, we also have an MLN article that's been published to the CMS website. It contains the RHC payment rate increase. So beginning on January 1, 2017, the payment limit for the year is \$82.30. I'm going to turn it back over to Corinne.

Corinne Axelrod: OK. Thank you, Simone. I'm going to talk first about CCM, chronic care management with the chronic care management and transitional care management supervision requirements. So in the 2017 physician fee schedule final rule, we finalized revisions to the supervision requirement so that beginning on January 1st of 2017, services and supplies furnished by auxiliary personnel incident to PPM or TPM services can be furnished under general supervision of the RHC or FQHC practitioner instead of under direct supervision of a RHC or FQHC practitioner.

We also made revisions to the CCM requirements effective again January 1, 2017. Some of them are that CCM must be initiated during AWV, an annual wellness visit, IPPE or comprehensive evaluation and management visit only for new patients or patients not seen within one year. This would replace the requirement that CCM could be initiated – that CCM could only be initiated during an AWV, IPPE or comprehensive ENM visit where CCM services were discussed. It still needs to be initiated during an ENM, AWV or IPPE visit but if the patient have had one of these visits during the past year, you can reference that visit to initiate the CCM services.

Another requirement that has been revised is that now there must be 24/7 access to a RHC or FQHC practitioner or auxiliary personnel with a means to make contact with a RHC or FQHC practitioner to address urgent healthcare needs regardless of the time of day or day of week. These replaces the requirement that CCM services be available 24/7 with healthcare practitioners in the RHC or FQHC who have access to the patient's electronic care plan to address his or her chronic care needs regardless of the day time, the day of the week or time of the day.

Another item that has been revised is that now the RHC or FQHC practitioner must document in the beneficiary medical record all – that all the elements of beneficiary consent were provided and whether the beneficiary accepted or declined CCM services. This replaces the requirement that RHCs and FQHCs obtain written – a written agreement that these elements were discussed and removed the requirement that the beneficiary provide authorization for the electronic communication of his or her medical information with other treating providers as a condition of payment for CCM services. The complete list of changes to the CCM requirement is on pages 80256 through 80257 of the final rule and we will be adding information in the next few weeks to the RHC and FQHC web pages on these revised requirements.

A couple of other related CCM items, we have received comments asking whether additional CCM codes that were added for practitioners billing under the physician fee schedule would also apply to RHCs and FQHCs. The only CCM code for RHCs and FQHCs is 99490, either billed alone or with other payable services on an RHC or FQHC claim. If you use any of the other codes for complex CCM, 99487, 99489, G0506, you will not get your CCM payment. As we explained in the proposed and final rule, we did not adopt these codes for RAs and FQHCs because payment for RHCs and FQHCs services are not adjusted for the length or complexity of the visit so that is on page 80257 of the final rule.

We were also asked if the new codes for psychiatric collaborative care management services which is G0502, G0503, G0504 and G0507 could be used by RHC and FQHCs. The eligibility requirement for CCM services are that the patient have two or more chronic condition that are expected to last at least 12 months or until the death of the patient and place the patient at significant risk of death, acute exacerbation, decompensation or functional decline. While CCM is typically associated with primary care condition, patient eligibility is determined by the RHC or FQHC practitioner and mental health conditions are not excluded. We invited comments on whether an additional code specifically for mental health condition is necessary for our RHCs and FQHCs that will include beneficiaries with mental health conditions in their CCM services. If you believe there is a need for a separate

CCM code for mental health conditions, please e-mail me, [Corinne.axelrod@cms.hhs.gov](mailto:Corinne.axelrod@cms.hhs.gov) and explain why the existing CCM code is not sufficient.

And finally the Medicare diabetes prevention program and the PT. We also got several questions asking whether RHCs and FQHCs can bill for MDPP services. So as you know, RHC and FQHC practitioners are statutorily defined as per – as services furnished by a physician, nurse practitioner, physician assistant, certified nurse midwives, clinical psychologist or clinical social worker and under certain conditions, an FQHC visit may be furnished by a qualified practitioner of outpatient DSMT and MMT. RHC and FQHC visits are medically necessary, primary health services and qualified preventive health services that are furnished face-to-face, location by a RHC or FQHC practitioner.

RHCs and FQHCs can enroll as MDPP suppliers if they otherwise meet the enrollment eligibility criteria but MDPP is not an RHC or FQHC service. If a clinic chooses to furnish MDPP services, the clinic must exclude all costs related to furnishing MDPP services from its cost report and instead submit claims for MDPP services under its separate MDPP supplier enrollment. RHCs and FQHCs must ensure that there is no co-mingling of RHC or FQHC resources in the cost report used to furnish MDPP services. So just to reiterate that, MDPP is not a RHC or FQHC service. If a clinic chooses to furnish it then all the cost must be carved out of the cost report and the RHCs, FQHCs must ensure that there is no co-mingling.

That's it. Thank you.

Jill Darling: Thank you, Corinne and Simone. Next we have (Terrie Postma) who will go over the Medicare Shared Savings Program.

(Terrie Postma): Thank you. Hi. This is (Terrie Posma), lead Medical Officer for the Medicare Shared Savings Program. As you likely know, the Medicare Shared Savings program, permit providers and suppliers to join together in what are known as the accountable care organizations or ACO to become accountable

for the total cost of care and quality of the fee-for-service beneficiaries assigned to them.

In the 2017 PFS final rule, we included several policies that modified the shared saving program regulation. I know that a lot of rural providers and suppliers are participating in shared savings program ACOs and we really appreciate your interest in the program.

So I'll go over some of those rule changes now. The first set of rule changes are really just some technical changes and clarifications that aren't meant to significantly modify our current policy operation. In the interest of time, we're just going to skip over those. You can read about them in the rule.

The one that I want to flag out for you are first, we established some beneficiary protection policies related to use of the SNF three-day waiver. You recall that in the June 2015 final rule, we finalized the policy to waive the SNF – the three-day inpatient requirement prior to admission to the skilled nursing facility or SNF. This SNF three-day rule waiver is available to ACOs that are participating in track three and is scheduled to begin on January 1, 2017. To use the waiver under certain conditions, a designated SNF affiliate can bill and receive payment for SNF for beneficiaries that are prospectively assigned to a track three ACO when such beneficiaries have not had the required three-day inpatient hospitalization.

In the June 2015 final rule, we indicated we continue to consider any additional beneficiary protection that were necessary and address them in future rule making. So 2017 PFS rule is that future rule making in which we're finalizing certain beneficiary protection specifically that there is a 90-day grace period for payment of SNF claims under certain circumstances for beneficiary that become excluded from the ACO's quarterly prospective list and that when a SNF affiliate claim is rejected for lack of the three-day stay for fee-for-service beneficiary that was not prospectively assigned that if they didn't qualify for use of the waiver then the SNF may not charge or attempt to charge the beneficiary for the day.

Next, I want to highlight some changes to our assignment algorithm that we finalized. The assignment algorithm is used to align beneficiaries to an ACO when the beneficiary designated and the modification we're making is to take into consideration information that a beneficiary shares with CMS that designates an ACO professional as responsible for their overall care. So currently, beneficiaries are assigned to ACOs based on a claim-based algorithm that assesses the plurality of primary care services furnished by certain provider types that are participating in the ACO.

In the June 2015 final rule, we gathered stakeholder feedback and incorporating beneficiary preference or attestation into the shared savings program assignment methodology. So in this PFS, we are 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 or beneficiary believe is most responsible for their overall care coordination and we're going to use that information to override the claims-based algorithm as long as a beneficiary is eligible to be assigned to the ACO and the beneficiary has selected an ACO practitioner of a type that is used on assignment.

Next, we finalized some updates to the ACO quality reporting standard including some changes to the quality measures that and the quality validation audit process. The changes that we made to the quality performance standard measures that align with the recommendations that were made by the secretary for quality measures collaborative and also align with the measures that were finalized for the web interface under the quality payment program or QPP final rule.

Additionally, we finalized the policy to retire two acute ambulatory sensitive conditions admission measures to reduce redundancies in the ACO measure stat that and we added it in their place one ambulatory sensitive condition acute composite measure. The net result of these changes to reduce the overall number of quality measures that the ACO have to report from 34 to 31.

We also finalized some improvements to the way we validate an audit, the quality data that's submitted by ACOs. Starting in spring of 2017, we'll perform a quality validation audit in a single step instead of the current multistep process. If an ACO fails the audit by having an overall audit match rate of less than 90 percent, the ACO's overall quality form will be adjusted proportional to the ACO's audit performance. As a result of the comments we received on the proposed rule, we retain the right 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 the poor audit performance.

Next, we made some updates to align with the quality payment program. First, we're finalizing some – we're finalizing the fund setting of our alignment with PQRS, the value modifier and the HER incentive program, all which are now I have subsumed under the quality payment program or QPP. Also, under the QPP, the ACO quality reporting is used to satisfy the quality performance category for eligible clinician that are subject to net participating in the ACO. So in 2017, PFS will finalize the policy under the shared savings program rules that requires ACOs to report quality measures through the web interface on behalf of the eligible clinician that are participating in that.

Additionally, we modify the title and specifications of the EHR measure or ACO 11. This measure is necessary for ACOs in track II and III to meet the QPP final rule alternative criterion for being designated as the plans to APMs. And therefore, under the shared savings program rule, each ACO participant 10 regardless of track must report the advancing care information or ACI category in the form and manner specified under MIPS. This measure is retained in the shared savings program measure set as double waded and will impact the ACO's quality performance, score as well each year saving.

In addition to – in addition, the data is going to be used under MIPS for those MIPS eligible – MIPS eligible clinicians that are participating and ACO track one.

Finally, we made some revisions that would permit eligible clinicians and ACOs to report quality measures apart from the ACO for purposes of PQRS and the quality payment program. Shared savings program rules aligned with

PQRS such that ACOs are required to report quality on behalf of the eligible professionals that participate in and it and similarly the eligible clinicians that are participating in it for purposes of QPP. Unfortunately, there have been a few instances when ACOs have failed to report quality in the recent years and in these cases, the ACO did not qualify the sharing understate – in any state saving under the shared savings program. But also because of our alignment with PQRS and the value modifier, the eligible professionals in the ACO, either received or were at risk for receiving a downward payment adjustment because of the failure to report such eligible – such professional had no remedy because they were prohibited by our shared saving program rule from submitting quality data apart from the ACO for purposes of those other programs.

We therefore have revised our program rule to permit eligible professionals that are part of an ACO to report quality apart from the ACO should they choose to do so. If the ACO fails to report, the data submitted independently by those participants could be considered for purposes of PQRS and in the future purposes of MIPS.

Note however that CMS will always use ACO's submitted data preferentially when it's present. We have some additional information about this in a special reporting period that EPs who's ACOs failed to report quality measures on their behalf in the 2015 performance year can take advantage of coming up this spring. So we have those facts available – we'll make them available to ACOs through the spotlight newsletter in the ACO portal and so watch for more information on that. Thank you.

Jill darling: Thank you, (Terrie). And last, we have (Katie Mucklow) who will go over the Provider Enrollment Medicare Advantage Program.

(Katie Mucklow): Hi. Thanks so much. This – the actual title is the Medicare Advantage Provider Enrollment Provision. This provision requires all network providers for Medicare Advantage to enroll in Medicare. Most of you have seen we've had a little progression towards enrolling more providers and suppliers into the Medicare program. A couple of years ago we issued the Part D prescriber enrollment requirement that required prescribers of Part D drug to enroll in

Medicare and there hasn't been – we haven't met any sort of enforcement data on that but we are aligning the enforcement of that particular will – with is one which should be effective January 1, 2019.

The requirement for this will also apply the pace program, cost plan, demonstrations and pilot. We're pretty close to actually having met the requirements of this rule since 93 percent all Medicare Advantage providers and suppliers are already enrolled in Medicare but we're just closing the gap on those providers and suppliers that we've assessed to be of a higher risk and they likely already meet our requirement anyway.

But to be clear, that doesn't just apply to Medicare – traditional Medicare part A and B services but also expands to supplemental benefit like dental benefit in particular but it would extend to lots of other items and services. So the type of individuals and entities that will need to enroll that's based on a statutory definition of provider and supplier and not cited several times throughout the rule still those providers and suppliers that are not categorically eligible to enroll and not required to meet the requirements of this rule.

So just like in the part D prescriber enrollment provision or rule that I just mentioned, pharmacists don't fit into the statutory three definition of that and therefore we don't require them to enroll. Well, they actually are not able to enroll. So we'll be issuing a lot more guidance in the future. We're still two years away from, you know, making this enforceable and the penalties will be a little bit different than they were in the part D prescriber enrollment. It won't be denial at the point of sale. We'll do the enforcement of this through intermediate sanctions or perhaps contract termination for the plan that will be required to help us enforce this requirement and that's all I have.

Jill Darling: Thank you, (Katie), and thank you to all of our speakers today. As you realize, I might have a minute away from 4 o'clock but we will take one to two questions from you all.

So (Shannon), we'll go into our short Q&A today.

Operator: Certainly. As a reminder ladies and gentleman, if you would like to ask a question, please press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Please limit your questions to one question and one follow-up to allow other participants time for questions. If you require any further follow-up, you may press star one again to rejoin the queue.

Your first question comes from the line of Jean Antonucci from Jean Antonucci MD. Your line is open. Please go ahead.

Jean Antonucci: Hi. Thank you very much. Jean Antonucci, Primary Care, Fellow Family Doctor in Maine. Two comments that we would like help with so no answers needed so it will be quick. One is complexity of programs, PQRS has reported an error and it's impossible to fix specifically stating that I reported only one measure for hypertension. My concern is if we go forward with new programs, the complexity and the errors are impossible to fix and there is no one to talk to. This impacts us. I know when I submitted but, you know, mistakes happen.

And that goes along with my second comment being brief, the chronic care codes. I really appreciate that you're trying to do well but rules are impractical for us to consider calendar months. And significantly, very severe diabetic who doesn't not have two conditions and to babysit transitional code for 30 days.

What we desperately need is no new code but simplification because we are overwhelmed with many rules to each code. Each code pays very little and when one is audited if I were to return \$32 per chronic care code I used correctly but some mistake misinterpreted. We have no voice and I urge simplicity because we can't adopt these potentially useful tools. There are many errors being made. There's no way to have a voice and we need to move toward simplicity. That's a lot but maybe you put top and under your hats because we have no one to speak to out here. Thank you.

Carol Blackford: We will certainly do that. Thank you very much for sharing those concerns with us. We've all been taking notes and if you have any additional concerns

that you would like to share, please feel free to send them to me. This is Carol Blackford and my e-mail address is Carol dot Blackford, B-L-A-C-K-F-O-R-D@cms.hhs.gov. Thank you.

Jill Darling: I think we have time for one more question.

Operator: Your next question comes from the line of Mark Lin from Healthcare Business. Your line is open. Please go ahead.

Mark Lin: Oh, yes. Hello, everybody. Hi. This is Mark Lin with Healthcare Business Specialist in Chatanooga. And I work with a lot of rural health clinics and we're having a big problem. I'm getting a report in all over the place that since the C.G. modifier went into effect on October 1st, a lot of clinics are not getting paid, a lot of the claims are not processing. I think they've been told by the MAC to just hold off and wait and the MAC will reprocess them and we're going on now six weeks into this and we're getting a lot of money built up into the system and making things simpler. You know, this complexity the C.G. modifier has caused, some of the MACs to not be able to pay them. A lot of people weren't aware of this and did not let the C.G. modifier on there.

And so if there's something we can do, if we can get out some type of interim payments to a lot of these RHCs. I mean of folks are telling me that they're going to have a hard time making payroll if this continues on. So that's what I want to relay to you guys. And along with same issue is pneumococcal vaccine, the Prevnar 23 is \$178 per shot. That's direct cost and it's the way that RHC comp report settle out. They basically get their money sometimes it's almost three years before they get better. If I do 200 pneumococcal, they have \$35,000, \$40,000 sitting there waiting to be paid, you know, three years later. And so it's becoming a real cash flow issue for me already. So that's what I have.

Corinne Axelrod: Thanks, Mark. So this is Corinne. So thank you for bringing those issues to our attention. Our understanding is that most of the people that have – the RHCs that have had their claims not paid are ones that actually did not have the C.G. modifier on their claims. So if you have any other specific examples,

please sent them to use. I don't think we really have time to get into this any further today or the vaccines but I know you've got my e-mail address.

Mark Lin: Oh, yes.

Corinne Axelrod: You wouldn't mind sending me your questions and issues then I'll make sure that we follow-up with you.

Mark Lin: Yes. It is – and I thought the same thing that it was just a C.G. – because we tell people how to fix this. You file a bill that's 717, you put in the – you put in the form locator 64, which is document number is. You put the condition code B9, and you put in remarks modifier. And we've told them that but they're saying that that's not even fixing the problem with so many. So absolutely, we will e-mail you with the issues. We certainly appreciate all the work you guys have been doing. It's certainly reflective in today's conference call.

Corinne Axelrod: Great. Thanks a lot, Mark.

Mark Lin: Thank you.

Carol Blackford: All right. This is Carol Blackford. And on behalf of John and myself, I wanted to just express my thanks for everyone for hanging in during our very meaty discussion. Lots of regulatory activity as you can tell. So hopefully you found the call and the information that we shared today useful.

As I say in every open door forum call that I participate on, please continue to share your thoughts and suggestions for how to make these calls useful and helpful for you. That is the purpose of the call so send us your thoughts, suggested agenda items to myself, Carol Blackford. And again, I'll share my e-mail address. Its Carol dot Blackford, B-L-A-C-K-F as in Frank, O-R-D@cms.hhs.gov.

And that concludes our call for today. So thank you very much for participating.

Operator: Thank you for participating in today's rural health open door forum conference call. This call will be available for replay, beginning at 5 P.M. Eastern Time today, November 16, 2016 through midnight on November 18th. The conference I.D. number for the replay is 44464022. 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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