

Centers for Medicare and Medicaid Services
Physician, Nurses and Allied Health
Open Door Forum
Moderator: Jill Darling
November 29, 2017
2:00 p.m. ET

Operator: Good afternoon. My name is (Tiffany), and I will be your conference operator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services, Physician, Nurses and Allied 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 would like to ask a question during this time, simply press star, then the number one on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Jill Darling, you may begin your conference.

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

So before we get into today's agenda, I have one brief announcement. 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 and A portion of the call.

If you do have inquiries, please contact us at press@cms.hhs.gov. And I will hand it off to our chair, Marge Watchorn or Dr. Gene Freund for opening remarks and then we'll get right into the agenda, if you have any opening remarks.

Marge Watchorn: Gene, I'll be speaking quite a bit about the Physician Fee Schedule, so I'll give you an opportunity if you had anything you wanted to share with the group today.

Gene Freund: I don't have any particular announcements to this point. I'm excited about today's conference call.

Jill Darling: All right. Thanks, James. So I'll just hand it off to Marge to go over some items under the Physician Fee Schedule.

Marge Watchorn: Great. Thank you so much, Jill. This is Marge Watchorn. I'm the deputy director of the Division of Practice Nurse Services here at the CMS. I'm very pleased and relieved to announce that we published our calendar year 2018 Physician Fee Schedule final rule. The rule went on display on November 2nd and was formally published in the federal register on November 15th. You can find that on the CMS website under Physician Fee Schedule.

So I wanted to share a little bit with you about some of the physician team and provisions. And then, we have about four other speakers will be following me and sharing about some of the other provisions that were in the final rule.

So first, a little bit of background on the Physician Fee Schedule. Payment is made under the fee schedule for services that are promised to Medicare patient by physicians and other practitioners in all sites of services. These services includes but they're not limited to visit, surgical procedures, diagnostic test, therapy services, and specified preventive services. In addition to physicians, payment is made under Physician Fee Schedule to a variety of practitioners and entities including nurse practitioners, physician assistant, and physical therapist, as well as radiation therapy centers and independent diagnostic testing facilities.

In this final rule, we included an announcement launching the patient's over paperwork initiative, which is an exciting cross-cutting collaborative process that evaluates and streamlines federal regulations, with an overall goal to reduce unnecessary burden. The goal is also to increase efficiencies and to

improve the beneficiary experience. The effort emphasizes a commitment to removing regulatory obstacles that really, we still get in the way of providers and practitioners and physicians, spending time with their patients.

In this final role that we're talking about today includes a couple of initiative that are a part of that overall initiative. One is the reduction in reporting requirements and also removing downward scheme and adjustments based on performance for practices that make minimum quality reporting requirements.

So, with regards to payments for physicians and non-physician practitioners, as we do every year in the Physician Fee Schedule, we have an annual update to the rates and for calendar year 2018, that it will be an increase of 0.41 percent. Now, how do we get to that number? It reflects a couple of different statutory provisions. First is the statutory increase of 0.5 percent, which was established under the Medicare access and CHIP Reauthorization Act of 2015. And then that figure is reduced by 0.09 percent which is due to the mis-valued code target recapture amount which was required under the Achieving a Better Life Experience Act of 2015.

When we applied these adjustments and then we factor in the budget neutrality adjustment to account for the changes in the relative value units that are used to establish rates under that Physician Fee Schedule, the final calendar year 2018, Physician Fee Schedule conversion factor is \$35.99, which has an increase of 0.10 cents over the conversion factor that's in effect for 2017.

One of the major policies that we implemented in the final goal is a change in the way, in the payment amount for items and services provided by non-accepted off campus provider-based hospital departments that are paid under the Physician Fee Schedule. We established the policy in 2017 whereby these departments are no longer paid under the Outpatient Prospective Payment System and we established that the Physician Fee Schedule is the applicable payment system for many of the items and services provided by this set, subset of off-campus departments.

Currently in 2017, these departments are paid a rate which is equal to 50 percent of that Outpatient Perspective Payment System rate or the OPSS rate. And for 2018, we finalized a decrease to the payment which will go down to 40 percent of the OPSS rate. So currently, these departments are paid 50 percent of the OPSS rate in 2017. What we finalized for 2018 is 40 percent of the OPSS rate.

With the goal in mind to create a more level playing field for competitions between hospitals and physician practices by promoting greater payment alignment.

Next, I wanted to talk a little bit about some of the changes and improvements we're making for Medicare Telehealth Services. As we do every year, we consider additions to the list of services that can be provided via telehealth under the Medicare program. This year, we're adding seven codes to that list and they are HCPCS Code G0296, which is the visit to determine low-dose computed tomography eligibility or low-dose CT. CPT Code 90785 for interactive complexity. Two CPT Codes, 96160 and 96161 for health risk assessment. HCPCS code G0506, which is care planning for chronic care management. And two CPT Codes that described psychotherapy for crisis and that's CPT code 90839 and 90840.

Also, in the final role, we're finalizing our proposal to eliminate the requirement to report the telehealth modifier GT on professional claims. And again, this is part of our goal to reduce administrative burden. In calendar year 2017, we finalized the new place of service code or POS code for telehealth. So we felt that having the claim be required to have two different pieces of information, essentially to communicate the same thing to CMS was duplicative and not necessary. So we're removing the requirement to report the modifier again on professional claims.

In the area of remote patient monitoring, we sought comment in our proposed rule about whether to make separate payments for CPT codes that describe remote patient monitoring or other codes that describe the extensive use of communication technology. After consideration of the comments, we did

design to go ahead and finalize separate payments for CPT code 99091, which described collection and interpretation of physiologic data and other information. And it specifically requires a minimum of 30 minutes of time spent by the physician or another qualified healthcare professionals.

We also included a number of information that we received regarding a number of comment solicitations. In the proposed rule, we requested specifically comment on evaluation in management visit codes or E&M visits and documentation requirements that support those E&M visit codes. We received a number of really good comments. We begin to – so those comments, we summarized them at a high level. And we intend to continue to take a look at this area in the future rule making.

Next, I wanted to shift from specific physician team provisions and I wanted to share an update on payment policy that we're finalizing for biosimilar biological drugs. Currently, the policy that we have in place for 20s – that went into place in 2016 and is also in effect for 2017 is that we established payment for biosimilar products by grouping together biosimilar products that had the same reference product.

In our proposal, we included a comment solicitation broadly about our biosimilar payment policy and whether the agency should consider making any changes to our existing policy. After consideration of the comments that we received, we decided to change the payment policy where we will be separately coding and paying for biological biosimilar products under Medicare Part B.

So in other words, for newly-approved biosimilar products, we will not be grouping biosimilar drugs together even if they have the same reference products for the purpose – purposes of coding and payment.

And that was all I had to share, so I'll pass it back to Jill, to introduce our next speaker.

Jill Darling: Sure. Thank you, Marge. Next, we have Sabrina Ahmed who speaks on the Value Modifier.

Sabrina Ahmed: Thank you, Jill. Good afternoon everyone. In the 2018 Physician Fee Schedule final rule, we finalized all of the policies as proposed for the 2018 Value Modifier. These policies will allow us to better align incentives and also provide a smoother transition to the new Merit-based Incentive Payment System under the Quality Payment Program.

We finalized the following policies for the 2018 Value Modifier. First, the automatic downward payment adjustment for not meeting minimum quality reporting requirement will be reduced from negative four percent to negative two percent for physician groups with 10 or more eligible professionals; and from negative two percent to negative one percent for physician and non-physician solo practitioners, physician groups with two to nine eligible professionals, and groups consisting only of non-physician eligible professionals.

We also finalized that all physician groups and physician solo practitioners who met minimum quality reporting requirement will be held harmless from downward payment adjustments for performance under quality-tiering.

Lastly, we finalized that the maximum upward payment adjustment amount for all physician groups and physician solo practitioners will be set to two times the Value Modifier adjustment factor in 2018.

The 2016 Annual Quality and Resource Use Reports that were released on September 18 reflect all of these final policies. I will be talking more about these reports later in this call.

That's all I have on the Value Modifier. Back to you, Jill. Thank you.

Jill Darling: Thanks, Sabrina. Up next, we have JoAnna Baldwin who will go – who will talk about the Appropriate Use Criteria.

JoAnna Baldwin: Hi, everyone. Thanks for joining the call today. So I'm going to talk about the appropriate use criteria program for advanced diagnostic imaging. And just as a – for some – a little quick review and background information. So

when we're talking about advanced diagnostic imaging under this program we're talking about CTs, MRIs, positron emission tomography or PET and nuclear imaging.

This program came about in 2014 through the PAMA legislation and CMS has been working year after year through the Physician Fee Schedule to implement this program and kind of stand it up piece by piece before it begins and is completely rolled out for ordering professional participation in the program.

So, this program is where ordering professionals, so if someone orders advanced diagnostic imaging services for a Medicare beneficiary, at the time of that order, the ordering professional will be required to consult an electronic tool called a clinical decision support mechanism. The ordering professional enters information into this tool and the tool provides feedback regarding the appropriateness of the imaging service for that particular patient.

So ordering professionals must provide this consultation information then to the furnishing professional for their claim. So the information about the consultation is used by the ordering professional. It is then provided to the furnishing professional. So in these cases, we're talking about the radiologist or the outpatient imaging center that performs the test. Information about the consultation then must be appended to the claim for the radiologist, the claim for the outpatient imaging center.

So CMS currently has a list of qualified clinical decision support mechanisms posted to our website. And we also have a list of qualified provider-led entities. These are the organizations that are authorized by CMS to develop the appropriate use criteria that is then populated within qualified clinical decision support mechanisms.

So in this year's final rule, we established the timeline for the program. So first, there will be a voluntary participation period and that will begin July 2018 and it will run through 2019. And during this portion of the program, it is truly voluntary, ordering professionals that use clinical decision support

mechanisms, can consult, they can provide the information through the furnishing professional and we will have a way for the furnishing professional to append information to their Medicare claim to say that they received information about appropriate use criteria consultation from the ordering professional.

We're going to – during the voluntary period, really simplify that reporting. So, we intend to have a single modifier, HCPCS modifier that will be for use on the claim and that we are working on our educational materials and our educational plan so that we can begin communicating information to all of our stakeholders in time for the July 2018 rollout of the voluntary participation period.

Then the program will begin in January 2020. This first year will be an educational and testing period. So in other words, while the program will have started in this year, we will not apply payment penalties. So CMS will continue to pay claims even if appropriate use criteria consultation information is not correctly appended to the claims. And we're allowing for this because we received feedback from our stake holders during public comment periods. And they expressed to us it is important to be able to practice.

It is important for them to have time to get accustomed to giving this information from the ordering professional to the furnishing professional for them to be able to practice with correctly appending this information to the claim form. And our stakeholders wanted more time to be able to look at qualified clinical decision support mechanisms, to be able to look at them very closely, vet them carefully and select the one that is best for them, best for their practice, best for their electronic health record technology that they use.

So we will continue to implement this program through next year's Physician Fee Schedule because we have to keep moving the program forward toward the prior authorization component. So the program – the final component of the program is prior authorization for ordering professionals that are not adherent to appropriate use criteria. And that will be discussed next year and

in future rule making cycles so that we have the opportunity to receive feedback from stakeholders through public comments.

Jill, that's all I have for a summary of the appropriate use criteria program.

Jill Darling: All right, thank you, JoAnna. Up next, we have (Kari Vandegrift) who will speak on that Medicare Shared Savings Program.

(Kari Vandegrift): Hi everyone. For the Medicare Shared Savings Program, we have finalized multiple modifications to the rules for accountable care organizations. These modifications are designed to reduce burden and streamline program operations. The first one is in response to the 21st Century Cares Act. We have made revisions to the assignment methodology for ACOs that include FQHC and RHCs. We've eliminated the requirement to enumerate each physician working in an FQHC or RHC on the ACO participant list. This will get rid of the attestation list and reduce a lot of burden for our ACOs.

We have also reduced burden for ACOs when submitting an initial shared savings program application or the application for using the skilled nursing facility. Three-day rule waiver, we have fewer narratives that ACOs will need to provide to us when applying for the waiver or for the shared savings program.

So lastly, we have also added three new chronic care management codes and four behavioral health integration codes to our definition of primary care services used in the ACO assignment methodology.

Jill Darling: All right, thank you, (Keri). And last for under the Physician Fee Schedule is (Crystal Kellam) who will speak on the PQRS.

(Crystal Kellam): Good afternoon. As you'll recall in July 2017, CMS issued the calendar year 2018 Medicare PFS proposed rule which also includes a proposal – included a proposal that will reduce the number of measures that must be satisfactorily reported for the 2016 PQRS to avoid the 2018 downward payment adjustment. We have finalized the proposal that would change the current 2016 PQRS program policy that requires reporting of 9 measures across 3 National

Quality Strategy domains to only require reporting of 6 measures with no domain requirement. We have accounted for these proposed policies in the PQRS feedback reports and the payment adjustment letters that you will be hearing more about today.

Feedback reports provide detail on the individual EPs and PQRS group practices, reporting and performance and whether or not they are subject to the downward payment adjustment. The PQRS feedback reports that were recently issued to each ten and each NPI combination that reported PQRS data in 2016, reflects the policy change for 2016 in the summary page of the report.

Payment adjustment letters were set beginning on September 18th, 2017. If you receive a payment adjustment letter, you will see the following statement. Our records show that you did not meet the 2016 quality measures report (inaudible) criteria finalized in the calendar year 2016.

Medicare included physician fee as your final rule, in order to meet the proposed, more lenient criteria outlined in the calendar year 2018 Medicare Physician Fee Schedule proposed rule. These criteria were proposed to cover the 2016 reporting period and help clinicians avoid the 2018 PQRS downward payment adjustment. If these criteria are not finalized as we proposed, we will issue a revised letter. That's all I had, Jill.

Jill Darling: All right, thanks, (Crystal). So next on the agenda, we have Dr. Dara Richardson-Heron, who's a Chief Engagement Officer of the All of Us Research Program at NIH. So Dr. Richardson?

Dara Richardson-Heron: Great. Thank you so much. Thank you for the opportunity to join you today for the CMS open door forum. I am Dr. Dara Richardson-Heron and I am very excited to talk to you about our wonderful research program. I want to thank my gracious CMS colleagues for allowing me to spend some time with you today. The efforts we're taking to advance precision medicine span the entire federal government and success really does depend on our coordination and cooperation. And today is really a great example.

Now, I understand each of you were given a link with a copy of our slide presentation. So, I will give you the cue to change slides as we move forward. I'm really excited that you chose to spend a few minutes learning about our program today.

As a physician myself, I'm always excited to speak with the health care provider of a community. We really do view you and your relationship with your patient as a critically important component of our ultimate success in the All of Us Research Program.

If you move to the next slide, entitled, "What is Precision Medicine," I just want to start with a bit of context and talk a minute about a concept that I know many of you are aware of and that's precision medicine, which is an approach to improving health, treating disease, and finding a cure. And you know, it really acknowledges that each of us is unique, our habits, our environments, and our biology, and that the interaction of these factors really does impact our health.

You know, ultimately, precision medicine, we hope will produce much more accurate diagnoses, earlier detection, and better prevention strategies and treatment choices for all of us.

If you move to the next slide entitled, "Precision Medicine Initiative." Now, some of you may recall that the Precision Medicine Initiative was launched in January 2015 with an overall goal of accelerating and moving forward the promises of precision medicine. Now, PMI actually refers to the entire federal initiative, which include other activities conducted by the Food and Drug Administration, the office of the National Coordinator for Health IT, the Veterans Affairs, the Department of Defense, the Office of Civil Rights, and many other federal agencies. The cornerstone of PMI is run by the National Institute of Health and that's our program, the All of Us Research Program.

Next slide.

Now, our program is a landmark longitudinal research effort that aims to engage one million or more United States participants to improve our ability to prevent and treat diseases based on individual differences.

Now, our mission is to accelerate health research and medical breakthroughs, enabling individualized prevention, treatment, and care for all of us. And we have three main objectives. One, we aim to create a new model of research based on collaboration among researchers, providers, and participants which requires nurturing these relationships.

Secondly, we want to deliver a hugely valuable resource of data, which will be accessible in really unprecedented ways. And finally, we want to catalyze a robust ecosystem of researchers and funders that are really eager and hungry to use and support this ecosystem.

Next slide.

Now, in order for us to succeed in our mission, our three main objectives, we're aiming to achieve what we call quadruple diversity. And that's diversity of people, geography, health status, and data types. And the National Institute of Health is committed to ensuring that all communities, especially those who have been historically underrepresented in biomedical research, have the opportunity to both participate in and benefit from this initiative. And this includes both healthy and sick individuals from all walks of life and socioeconomic backgrounds and from all regions of the country.

And we also aim to collect a variety of data from surveys to electronic health records, to bio-samples like blood and urine, to data from wearable devices, to create a truly rich dataset that can facilitate new discovery.

Next slide.

We also have a transformational approach to participation. Of course, achieving this diversity will not be easy. And as we engage communities to establish authentic and lasting partnerships, we fully understand that many minority groups just don't trust biomedical research because of a series of

historical transgressions, including testing on vulnerable populations who really never reap the benefits. So, in order to overcome these barriers, we really must clearly communicate our new model of participation and biomedical research in which we view our participants as full partners in our efforts.

Next slide.

Now, we also have a transformational approach to data access. Over time, we will build one of the world's largest datasets for health research. And this data set will be accessible to researchers, providers, and citizen scientist to accelerate scientific breakthroughs with appropriate safeguards, of course. And we're using the highest standards of privacy and data security to protect participant data and information. And we just want to make sure that we have diversity among the researchers also, who can use the data.

Our goal is to make as much de-identified data as possible available to all researchers, from all backgrounds, including citizen scientists, as I mentioned before. Now, as it relates to our program data, in order to build this data set, we're going to ask participants in a program to share many different kinds of information over time. We'll start by collecting a limited set of standardized data from sources that will include, as I mentioned, participant surveys, electronic health records, physical measurements, and bio-samples such as blood and urine. And the data types that we collect will grow and evolve with both science, technology, and also with trust.

Next slide.

Now, we're going to – All of Us is going to advance research and really equip healthcare providers with better and more powerful data to help tailor healthcare to individual patients. And this slide, entitled, "Selected Scientific Opportunities," outlines some of the breakthroughs that we really do believe are possible with our program.

Next slide.

Now, so you may be asking; how are we going to get there? Well, this slide outlines our engagement strategy which aims to attract and engage participants in three ways. One, through our healthcare provider organizations which are Regional Medical Centers, Federally Qualified Healthcare Centers and VA Medical Centers with an outreach and engagement plan that is actually specific to their communities.

Two, we have a, what we call, a direct volunteer campaign, and partners and this team is responsible for engaging individuals who are not connected to a funded healthcare provider organization. And then thirdly, we have provider, patient, community, state, and civic group engagement partners and we're working with a robust set of organizations that reach potential participants and we made a number of partnership awards to date. In fact, just a couple weeks ago, we announced that we're partnering with seven provider organizations including the American Medical Association, the American Association of Family Physicians, and the American Association of Nursing Colleges to help us educate their membership about All of Us. And in fact, today, we just announced a partnership with the National Library of Medicine.

We're really excited as providers learn more about the program to help extend additional opportunities to support our efforts. Next slide, and this slide just shows a look at the geographic reach of some of our partners. We also have in All of Us mobile unit which takes the All of Us Research Program education into hard to reach communities. And you can learn more about our program of course, on our website which is joinallofus.org. So, this brings me to our plans for launch and beyond which is the next slide.

Right now, we're in what we're calling the beta testing phase, early testing phase and really in limited numbers of people testing and retesting our infrastructure and our strategies and our messages, but we really do have ambitious plans to scale up as soon as we are ready and to launch and get ready to launch in 2018. Over time, we anticipate the program evolving as our capacity evolves, bringing on new technologies, protocols, governing different aspects of the program in clinical tests to derive new data from participant information. And we are 100 percent committed to providing

transparency and open access to our protocols to enhance interoperability with other cohorts. And you can view our first protocol online. It's again on our website, joinallofus.org, and we will be posting much more as information is approved.

So, in closing, I really am excited to continue building our partnerships. On the last slide, you'll see where you can sign up for updates. You can feel free to reach out to me or our partners working with a variety of communities to get more information, contact information for our engagement counselor Elizabeth Lee is on this slide. But we really do hope that you'll do whatever you can to learn more about the program because we absolutely need our providers to be involved and engaged in order for our program to be successful.

So, with that, I'd like to say thank you so much for the opportunity to speak to you today and I'd really be happy to take questions at the appropriate time.

Jill Darling: All right, thank you.

Dara Richardson-Heron: You're welcome.

Jill Darling: Up next, we have (Amy Hammonds) who will speak on Open Payments.

(Amy Hammonds): Hi everyone! This is (Amy). I am over here in the Center for Program Integrity and work on the Open Payments Program. I just have a very brief reminder for everyone that records that were published in 2017, so that's open payments records for program year 2016 are still available for review and if necessary, dispute through the end of this calendar year. So, physicians and teaching hospitals have until December 31st, 2017 to review any of that reported data. And if you need any information for registering in the open payment system and how to review the data, that's available on our resources page which is at cms.gov/openpayments.

So that's just our brief reminder for everyone. And if anyone has any questions, we're happy to answer them at the right time.

Jill Darling: Thank you. And last, we have Sabrina Ahmed. Again, you heard Sabrina early on the call who will speak on the 2016 PQRS Feedback Report.

Sabrina Ahmed: Thank you, Jill. On September 18th, we released the 2016 Annual Quality and Resource Use Reports, also called the QRURs. At the same time, we also released the 2016 Physician Quality Reporting System (PQRS) feedback reports.

The 2016 QRURs show how groups and solo practices, as identified by their Medicare-enrolled Taxpayer Identification Number, performed in 2016 on the quality and cost measures used to calculate the 2018 Value Modifier.

The QRURs also indicate whether physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified registered nurse anesthetist in the practice will receive an upward, neutral, or downward Value Modifier adjustment to their payments for items and services rendered under the Medicare Physician Fee Schedule in 2018.

The 2016 PQRS feedback reports show individual eligible professionals and group practices their 2016 PQRS reporting results and indicate if they are subject to the 2018 PQRS downward payment adjustment.

Groups and solo practitioners may request an informal review of perceived errors in their 2016 PQRS results and/or their 2018 Value Modifier calculation during the informal review period that began on September 18th and will be ending on December 1st, this coming Friday, at 8:00 p.m. Eastern Time.

Eligible professionals can also submit an informal review request until December 1st, 8:00 p.m. Eastern Time, if they believe they were incorrectly subject to the 2018 PQRS downward payment adjustment.

Information about the 2016 Annual QRURs and how to request a Value Modifier informal review is available on the 2016 QRUR and 2018 value modifier web page. Information about the PQRS informal review process is

available on the PQRS Analysis and Payment web page. Both of these web pages were included in the agenda for this call.

Both of these reports can be accessed on the CMS Enterprise Portal with an Enterprise Identity Management (EIDM) account with the appropriate role. To find out if there is already someone from your practice who can access these reports, you can contact the QualityNet Help Desk at 1-866-288-8912. Instructions for signing up for an EIDM account with the correct role and instructions for accessing both of these reports are available on the How to Obtain a QRUR web page. The link to that website was also included in the agenda.

For additional assistance regarding EIDM or PQRS feedback reports, you can contact the QualityNet Help Desk. If you need assistance with the QRUR or have questions about the Value Modifier, then you can contact the Physician Value Help Desk. Both help desk contact information are available on the How to Obtain a QRUR website.

If you go to that website and scroll all the way to the bottom, you will see the contact information for both help desk. They are both available from 8:00 a.m. to 8:00 p.m. Eastern Time, Monday through Friday.

That's all I have. Back to you, Jill.

Jill Darling: All right. Thank you, Sabrina, and thank you to all of our speakers today. But we will be going into our Q&A now. (Tiffany)?

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, 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 key to rejoin the queue.

Your first question comes from the line of Ronald Hirsch with R1. Your line is open.

Ronald Hirsch: Hi there. Hi, Jill. So my question is about the initial observation care codes used by physicians 99218 to 99220. WPS just put out a bulletin that they had spoken with CMS and that they will only be paying observation initial codes for the physician who actually orders observation and performs the initial observation service.

Now, this is totally different than what's done with in-patient admissions where one physician can give the order, but another one can do the actual H&P and bill for the initial in-patient service. So is there any logic why CMS is requiring the same physician to order and perform the service, and do they not realize that physicians are not available 24 hours a day and one may order the service and another perform it?

Marge Watchorn: Thank you, Dr. Hirsch. I appreciate you raising that issue. Unfortunately, I don't know that we necessarily have the right folks on the room. If you wouldn't mind – if you could send me an e-mail and definitely include the information about the code, I think you said it was something that had come out from WPS.

Ronald Hirsch: Yes.

Marge Watchorn: If you send me an e-mail, I'll make sure that it gets to the right folks and my e-mail is Marge, marge.watchhorn@cms.HHS.gov.

Ronald Hirsch: OK. I will do that. Thank you, Marge.

Marge Watchorn: Yes.

Operator: Your next question comes from the line of (Joe Patel) with (MGMA). Your line is open.

(Joe Patel): Thank you very much. This is wonderful. My question was for the Physician Fee Schedule part of the presentation. And my question is, when does CMS intend to make the use of MACRA patient relationship modifiers mandatory?

Did you receive that?

Marge Watchorn: Yes, sorry. Thank you, we were on mute, my apology.

(Joe Patel): OK. That's OK.

Marge Watchorn: I don't know that we necessarily – again, I'm sorry, I have the right folks on the line. So please feel free to go ahead and send that question to me by e-mail and I will make sure it gets to the right folks. Again, it's marge.watchorn@cms.hhs.gov.

(Joe Patel): And how do you spell Watchorn, I'm sorry.

Marge Watchorn: Sure. I'll spell it again, but it's also on the agenda if you don't get a chance to right down quickly at, W-A-T-C-H-O-R-N.

(Joe Patel): Wonderful, thank you so much.

Marge Watchorn: All right.

Operator: As a reminder to ask a question, that is star hold by the number one on your telephone keypad.

Your next question comes from the line of Judith Warren with Health Care for All. Your line is open.

Judith Warren: Hello, this is for Dara Richardson in the All of Us program. If we are unable, it looks like I won't be – I won't find the availability to join All of Us in the early enrollment round, can you tell us what test are you going to be taking? And so that we can do it privately and then in the future, add it to your library of humans or database?

Dara Richardson-Heron: Well thank you for the question. So just to clarify, you know, everyone with the exception of prisoners and those who are decisionally-challenged are eligible to participate in the program when we launch sometime in 2018.

So, you know, I'm not sure what you meant when you said, you know, since you won't be able to join in the early round. Everyone is eligible to participate with very minimal disqualifiers as it relates to the type of information that we will be collecting. Essentially, we will be asking individuals to complete a questionnaire, several questionnaires actually about lifestyle, biology, health; environment.

And then once individuals are selected to participate in collection of a biospecimen, they will be either assigned to go to a regional medical center, federally-qualified health center or with our direct volunteer partner sites such as Walgreens or Quest. They're one of the labs that open up once we launch in 2018. And they'll give a blood and a urine specimen.

So those are the samples that we'll be collecting initially right out of the gate. Did I answer your question?

Judith Warren: Yes. You did.

Dara Richardson-Heron: OK. Thank you.

Judith Warren: And we would sign up online, correct?

Dara Richardson-Heron: Yes. So initially, you'll sign up online. Again, as I said, right now we're only at the beta testing phase. So that's through our regional medical centers and our federally-qualified health presenters and through our code-based testing system, because we're testing the system. But when we launch nationally in 2018, anyone will be able to go on online to our website joinallofus.org, you'll be able to signup, you will be able to complete your questionnaires, of course complete your informed consent. And then be assigned to go and have a physical measures and biospecimens taken.

Judith Warren: Thank you very much.

Dara Richardson-Heron: You're welcome. Thank you.

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

Marge Watchorn: Great. Well, thank you again everybody so much. We know that your time is extremely important and we appreciate the fact that you take that time to dial in and listen to the speakers that we gather every six weeks or so. So thank you again and thank you especially for all the speakers who prepared their information.

And we are always looking to present the information that's important for you, for our audience. So please feel free to reach out to me or Jill or Dr. Freund. And we'll be happy to do our best to include those topics that are of interest to you.

Jill Darling: Thanks, everyone. Be on the lookout, the next Physician ODF will be January 2018. So everyone, have a wonderful new year.

Operator: Thank you for participating in today's Physicians, Nurses, and Allied Health Open Door Forum conference call. This call will be available for replay beginning today at 5 p.m. Eastern through midnight December 1st. The conference ID number for the replay is 61734711. The number to dial for the replay is 855-859-2056.

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

END