

CENTERS FOR MEDICARE & MEDICAID SERVICES

Low Income Health Access Open Door Forum

Moderator: Jill Darling

November 30, 2016

2:00 p.m. ET

Operator: Good afternoon, my name is (Heidi) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Low Income Health Access Open Door Forum.

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

Ms. Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Heidi). Good morning, good afternoon, everyone. Thanks for joining us today for the Low Income Health Access Open Door Forum. I'm Jill Darling in the CMS Office of Communications.

So before we jump into our agenda, two quick announcements from me. This Open Door Forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you do have any inquiries, please contact CMS at [press@cms.hhs.gov](mailto:press@cms.hhs.gov). And a new update for these open door forums, we will now have podcasts available for all Open Door Forums.

So on the agenda, there was a link that will take you to all of our Open Door Forum podcasts for transcripts and audio. So with this being the first one, give us a week or so, some time to get it up there. So we just wanted to let

everyone aware of this new update. I will hand the call off to our Co-Chair Rita Vandivort-Warren from HRSA.

Rita Vandivort-Warren: Thank you very much, Jill. You're always so helpful with your assistance in this. I want to just tell everyone that I'm very pleased that Corinne Axelrod from CMS has offered to be Co-Chair with me. You may know Corinne, she is known, at least here at HRSA, as a wonderful expert around FQHC and RHC matters.

We call her to get her help, so I'm so pleased to have her help me in identifying the best topics that would be most useful for you all. Corrine, would you like to say a few words?

Corinne Axelrod: Thank you, Rita, for those kind words. I really appreciate it. And welcome, everybody. CMS and HRSA have a long history of working collaboratively together. I'm really pleased to join you Rita in co-hosting this call and hopefully we can continue the tradition.

Before I turn it back over to Rita, I also wanted to mention that Rita and I have been discussing the name of this call, which is Low Income Health Access Open Door Forum. And we were wondering if another name might better reflect the target audience for this call. There's always some overlap among our various open door forum calls, but this one is particularly trying to reach safety net providers.

One possibility would be to call it the Safety Net Provider's Open Door Forum call. But we'd be interested in getting your feedback. After the presentations, when we open the call up for questions, please let us know if you have any thoughts or suggestions on this. And we'll mention it again. Anyway, thank you again, Rita, and I'll turn it back over to you.

Rita Vandivort-Warren: Thank you. We have quite a few items on our list here. We'll jump right in. First, we want to talk about new requirements on essentially most, if not all – and I'm going to get myself in trouble – the experts are coming to give you the facts on emergency preparedness requirements. And Jacqueline Leach with Janice Graham will provide you that information.

Jacqueline Leach: Hi, there. I'm Captain Jacqueline Leach and I work in the Clinical Standards group at CMS and we are responsible for the health and safety standards for CMS. And for the Emergency Preparedness Rule, although I am not the author, I'm going to give a quick overview and give you just some brief details.

And then you can refer to the FAQ link in the e-mail that was sent out earlier this morning, that may be able to help you if you have any more questions or for clarifications. The Emergency Preparedness final rule was published on September 15th of this past year.

And the final rule establishes consistent emergency preparedness requirements for healthcare providers and suppliers that participate in Medicare and Medicaid. The basis of the rule, the purpose of the rule, is to increase patient safety of course, during emergencies so that facilities are adequately prepared; establish a more coordinated response to all types of disasters, both natural and man-made.

And these requirements are additions to the conditions to the participation and coverage that apply to 17 Medicare, Medicaid participating providers and suppliers. Basically, what we did, as with most areas, we reviewed the current Medicare emergency preparedness regs that we had on the books already for both providers and suppliers.

And we found a lot of the requirements were not comprehensive enough to basically address the whole spectrum of emergency preparedness, the complexity of it all for the coordination. Like, for example, a lot of the requirements didn't address the need for coordinating with other systems that pair within their town, their city, their state or whatever communicating with them.

And then contingency planning; like Plan A, what if it doesn't work, where do you go to Plan B, Plan C, et cetera. And then, the third thing, the training of personnel because if your staff, people are not trained, if it's not addressed before hand, they're not got to put into action when there is an actual emergency. And we do know that.

After the proposed rule, we considered all the stakeholder comments and the final rule basically boils down to the facilities required to meet four common, well-known industry standards. And those four are the facilities must develop an emergency plan. And in order to get to that emergency plan, it's based on a risk assessment.

And the risk assessment looks at the whole spectrum of the capacity of the facility, the capabilities that are there, and how they know they respond to emergency and disasters specific to their location of the facility. For example, if they're in a mountain area what kind of utilities or emergency equipment can get there versus on the coast or in the desert.

That's kind of what that speaks to. And then, in addition, number two, providers and suppliers have to develop and implement policies and procedures based on that emergency plan and the risk assessment which is pretty much common sense, using those two things in order to develop their own facility policies.

And so, third, providers and suppliers must develop and maintain a communication plan. And of course, this has to comply with federal and state law to be sure that the patient care is coordinated with the facility across other healthcare providers that are local to the facility, with the different state and local health departments, and of course emergency systems like EMS, fire department, that type of thing.

And then lastly, the facilities have to develop and maintain training and testing programs. Like we talked about before, if you kind of don't practice it, they're not going to put it into use when an emergency does happen. And of course, that would include your initial training, then annual training. And also, if there is an actual incident that can be counted as part of an annual training and they just have to evaluate that and do an evaluation and see how they actually responded to the incident.

And just as an aside, because this rule affects 17 different types of Medicare and Medicaid providers, all the standards have been adjusted based on the

characteristics of the different facilities. For example, if you're an outpatient like an RHC, FUHC, or an ASC, you wouldn't be required to have policies and procedures for the provision of (subsistence). So, I know this sounds like a lot and it's a lot to do especially for those (in rural).

It's (possibly new areas) and policies and procedures to develop but it's not something that's going to be due in the next 60 days implementation. Providers and suppliers have a full year to comply and implement these regulations so that's on November of 2017. And so, we anticipate conservative guidance for this final rule to be published probably in the Spring of 2017. So, in the interim, we have set up a FAQ Web Site and I believe Ms. Darling sent that out.

Everybody should have that. If you don't, you can e-mail us. It's an FAQ link on our Web Site, frequently asked questions, and also we have an e-mail if you have any questions or you want some clarification on specific areas, you can e-mail us and that e-mail was also sent this morning in that e-mail. But other than that, I believe that's all I have to say. Yes, so I think that's it.

Rita Vandivort-Warren: Thank you, Jacqueline. Next, we have Simone Dennis who will go over the FQHC market basket.

Simone Dennis: Thank you. So, as of January 1, 2016, all FQHCs are paid out of the FQHC prospective payment system. Section 1834(o) of the Social Security Act requires that in the first year after implementation of the FQHC PPS, the FQHC base payment rate is updated by the Medicare Economic Index or MEI. The act also requires that in subsequent years the FQHC base payment rate is updated by the FQHC market basket of goods and services or, if such an index is not available, by the MEI.

In the physician fee schedule proposal, we included a proposal to create a 2013 base FQHC market basket to work with our office of the actuary to develop the index using 2013 (cost report) data. We selected 2013 as the base year because that was the most recent and complete set of (cost report) data available. In the proposed rule, we included a lengthy discussion of our

methodology to develop the market basket and we used a similar methodology as we used to develop other market baskets.

All of the comments we received were in favor of using the FQHC market basket instead of the MEI. A few commenters asked for a technical clarification and for CY 2017, we are finalizing our proposal to update the FQHC base payment rate by the FQHC market basket. We are confident that the FQHC market basket more accurately reflects the actual costs and scope of services that FQHCs furnish compared to the MEI. Over time, the FQHC market basket produces slightly higher updates compared to the MEI.

We expect that to continue for the near future. So, therefore, for CY 2017, the FQHC market basket update will be 1.8 percent which is 0.6 percent higher than the MEI of 1.2 percent. I also want to share some information about the annual FQHC and RHC payment rate (CR). So, MLN article MM9831 has been published to the CMS Web Site and the FQHC Web Site. That is the MLN article describing the annual payment rate update for the FQHC PPS.

For CY 2017, the rate will be updated by the market basket of 1.8 percent and from January 1, 2017 through December 31, 2017, the FQHC PPS base payment rate will be \$163.49. That MLN...

Rita Vandivort-Warren: Great.

Simone Dennis: Also instructs contractors to adjust the grandfather tribal FQHC claims paid at the CY 2015 rate of \$305 so that it – for CY 2016, they're paid at that rate which is \$324. No provider action is necessary for that adjustment to take place. So now, moving on to the RHC payment update, that MLN article is MM9829 and that also is published on the CMS Web Site and the RHC Web Site so effective January 1st, 2017 through December 31st, 2017, the RHC payment limit for CY 2017 is \$82.30.

And that's all I have. Thank you.

Rita Vandivort-Warren: Thank you very much, Simone. And next we're going to look at the chronic care management and RHC and FQHCs and a few other matters that Corinne is going to enlighten us on. Corinne?

Corrine Axelrod: Thank you Rita. So I'm going to talk about chronic care management, CCM, and transitional care management, TCM. In the 2017 physician fee schedule final rule, we finalized revisions to the supervision requirements for both of these programs. So that, beginning on January 1st, 2017 services and supplies furnished by auxiliary personnel (interested in to) CCM or TCM services can be furnished under a general supervision of a RHC or FQHC practitioner instead of under direct supervision of a RHC or FQHC practitioner.

And these changes will be updated in the regulations in 405.2413 and 405.2415. In terms of the CCM requirements, we also finalized revisions to the requirements for RHCs and FQHCs effective January 1st, 2017. Some of the revised requirements are that CCM be initiated during an annual wellness visit, initial prevent a physical exam 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 during a AWV, (IPPE) or comprehensive E&M visit when CCM services were (discussed). It still needs to be initiated during an E&M, AWV or (IPPE) visit, but the patient has – that's had one of these visits during the last year, you can reference that visit to initiate (these) CCM services.

Another requirement that's been changed is there must be 24/7 access to a RHC or FQHC practitioner or auxiliary personnel with (a) means to make contact with (the) RHC or FQHC practitioner to address urgent healthcare needs, regardless of the time or day – time of day or day of the week. This 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 urgent chronic care needs regardless of the time of day or day of the week.

One more is that the RHC or FQHC practitioner must document in the beneficiary's medical record that all the elements of beneficiary consent were

provided and whether the beneficiary accepted or declined CCM services. This replaces the requirement that the RHCs and FQHCs obtain a written agreement that these elements were discussed and removes 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 requirements is on page 80256 through 80257 of the final rule. And we will also be adding information in the next few weeks to the RHC and FQHC webpages on this. Also in the final rule, we received comments asking – comments actually to the proposed rule.

We received comments asking whether the additional CCM codes that were added for practitioners billing under the physician fee schedule would also apply to RHCs and FQHCs.

So, I want to clarify that the only CCM code for RHCs and FQHCs at this time is CPT 99490 which is either billed alone or with other payable services on an RHC or FQHC claim. If you used any of the other codes for complex CCM, and those codes are 99487, 99489 and GO 506, you will not be paid for those. They're not authorized.

As we explained in the proposed and final rule, we did not adopt these codes because payments for RHCs and FQHC services are not adjusted for the length or complexity of the visit. So, there's a discussion about that on page 80257 in the final rule. We also were asked if the new codes for psychiatric collaborative care management services, and those are GO 502, GO 503, GO 504, and GO 507, could be used by RHCs and FQHCs.

We stated in the final rule the eligibility requirements for CCM services are that the patient has two or more chronic conditions and those chronic conditions 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.



So, while CCM is typically associated with primary care conditions, 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 conditions is necessary for RHCs and FQHCs that want to include beneficiaries with mental health conditions in their CCM services. If you believe there is a need for separate CCM code for mental health conditions for RHCs and FQHCs, please e-mail me.

My e-mail address is [Corinne.axelrod@cms.hhs.gov](mailto:Corinne.axelrod@cms.hhs.gov). It's c-o-r-i-n-n-e-a-x-e-l-r-o-d@cms.hhs.gov. And please explain why the – why you believe the existing CCM code is not sufficient. And finally, I also want to mention that we got several questions asking whether RHCs and FQHCs can bill for the Medicare Diabetes Prevention Program services, its MDPP, Medicare Diabetes Prevention Program. So, as you probably know, RHC and FQHC practitioners are statutorily defined as services furnished by a physician, nurse practitioner, physician assistant, certified nurse midwife, clinical psychologist, or clinical social worker.

And under certain conditions an FQHC visit may be furnished by a qualified practitioner of outpatient DSMT and MNT. RHC and FQHC visits are medically necessary. Primary health services and qualified preventive health services that are furnished face-to-face to a patient by RHC or FQHC practitioner. The MDPP is a structured behavioral change intervention that aims to prevent the onset of type II diabetes among Medicare beneficiaries diagnosed with pre-diabetes. It consists of a series of group sessions led by a coach to help people lose weight and make other behavioral changes.

MDPP is not an RHC or FQHC service. RHCs and FQHCs can enroll as an MDPP supplier if they otherwise meet the enrollment eligibility criteria but if the 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 using a separate NPI. RHCs and FQHCs must ensure that there's no co-mingling of RHC or FQHC resources in the cost report used to furnish MDPP services.

So I know that's a lot of information. I'm going to stop here and I think at this point I'll turn it back to Jill and I think...

Jill Darling: Yes.

Corrine Axelrod: ... ready for questions. And again, I'll just remind you questions about what we talked about but also if anybody has any feedback on our interest in perhaps changing the name of this call, please address that as well. Thank you.

Jill Darling: Thanks Corinne and thanks to Simone and Jaqueline. (Heidi), we'll go into our Q&A please.

Operator: Thank you. I'd like to remind our ladies and gentlemen, if you would like to ask a question, please press star then one on your telephone keypad. If you would like to withdraw your question, 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. We'll pause for a moment to compile the Q&A roster. Again, that's star then the number one to ask a question. And there are currently no questions in the queue.

Female: All right, well thanks everyone. I will pass the call to Rita or Corrine for any closing remarks.

Rita Vandivort-Warren: Well, we hope this has been useful information to you and as they noted, some information was sent out with links earlier today that may provide the details if not everything's clear but we really appreciate your attending. Corrine, any last thoughts?

Corinne Axelrod: So I would just like to give out my e-mail address again. It's Corrine, [corinne.axelrod@cms.hhs.gov](mailto:corinne.axelrod@cms.hhs.gov) and please feel free to e-mail either myself or Rita if you have ideas for future calls, if you have questions about anything we talked about or anything else because we really want to make these calls as useful to you as possible.

Rita Vandivort-Warren: Absolutely.

Corinne Axelrod: So Rita, do you want to just give out your e-mail as well?

Rita Vandivort-Warren: Yes, I have an impossible name but at least it's on the (list thing). So my e-mail is RVandivort-Warren. That's V-A-N-D-I-V-O-R-T-Warren, W-A-R-R-E-N, @hrsa, H-R-S-A.gov. At least that (ended) short. But we would love to hear from you if you have suggested topics. I really want to underscore that and if you have any opinions, I think Corinne and I have discussed perhaps calling this safety net open door forum so we'd be interested if you find that a more useful or descriptive title.

And with that, I think our time together is done. Jill?

Operator: Thank you for...

Rita Vandivort-Warren: Oh, go ahead.

Operator: Thank you for participating in today's Low Income House Access Open Door Forum Conference Call. This call will be available for replay beginning at 5:00 p.m. Eastern time today, November 30, 2016, through midnight on December 2. The conference ID number for the replay is 44796292. 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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