Centers for Medicare & Medicaid Services

Hospital/ Quality Initiative Open Door Forum

February 8, 2022

2:00 pm ET

Coordinator: Welcome, and thank you for standing by. At this time, all participants are in a listen-only mode until the question-and-answer session of today's conference. At that time, you may press Star 1 on your phone to ask a question. I would like to inform all parties that today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the conference over to Jill Darling. Thank you. You may begin.

Jill Darling: Great. Thank you, Courtney. Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications, and welcome to today's Hospitals Quality Initiative Open Door Forum. Before we dive into today's agenda, I have one brief announcement.

This Open Door Forum is open to everyone, but 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. And I will hand the call off to Emily Forrest.

Emily Forrest: Thanks, Jill. This is Emily. Hello, everyone. It's been a day. Anyway, good afternoon. This is Emily Forrest. Thank you for joining us today. We have a full agenda today. We'll be providing an update and an overview on a couple of different policies. First and foremost, the part two of the fiscal year 2022 IPPS PPS final rule with comment period, along with a wage index update.

If anyone has any COVID-related questions, we're also happy to answer those to the extent that we're able on today's call. So, feel free to ask those questions when we turn to the Q&A portion of the agenda today. So, without further ado, we'll begin our agenda.

And first on the list is CMS policies for administering COVID-19 monoclonal antibodies. So, I wanted to highlight to everybody on the call that we have been publishing updates regarding COVID-19 monoclonal antibodies, payment for those products, the administration of those products on our COVID-19 provider toolkit.

The web address for those particular toolkits is www.cms.gov/COVIDvax-provider. That's COVID, C-O-V-I-D V-A-X dash provider. And from there, you can navigate to several different pages on that toolkit for vaccines, but also monoclonal information as well.

The second from the last bullet on the left-hand toggle, is for monoclonal antibodies, and that is our monoclonal antibody toolkit. On that particular toolkit, you can provide - you can find, excuse me, payment information, encoding information, billing policies, as well as dates for those specific codes for the administration of those products in healthcare settings, as well as the home, and then some details about the specific payment policies for the home payment as well.

So, Medicare continues to only provide payment for monoclonal antibody products that sites purchase. And then Medicare also continues to provide

payment for administering those products purchased by sites, but also products distributed by the government at no cost to those entities.

So, for the most up-to-date information of those billing codes, effective dates, payment allowances, would really encourage folks to take a look at that toolkit. From there, that toolkit does provide a link to two different tables, one of which is providing - and again, these billing codes payment allowances are for vaccines, for COVID vaccines, and also monoclonal antibodies. Just want to highlight that you can transition from that one toolkit to additional information.

Medicare will continue to pay for monoclonal antibodies under the Medicare Part D vaccine benefits until the end of the year, in which the public health emergency ends. I wanted to also note, in terms of oral and infused antiviral products such as paxlovid and remdesivir, these are paid like other Part D as in dog, and Part B as in boy, drugs.

So, you can find some additional information about how these are handled on our emergency Web site, but also through standard reporting that we do for those drugs as well. So, with that, I will turn it over to Joe Brooks, for some information regarding the IPPS final rule comment period.

Joe Brooks: Thank you, Emily. This is Joe Brooks, as Emily mentioned, and I'll be discussing the FY 2022 IPPS final rule with comment period as it relates to Section 126 of the Consolidated Appropriations Act of 2021. On December 17th, CMS issued a final rule to implement the legislative changes to direct graduate medical education, and indirect medical education payments to

teaching hospitals that were included in Sections 126, 127, and 131 of the Consolidated Appropriations Act of 2021.

In this final rule, we are also seeking comment on specific aspects of the implementation of Sections 126 and 131. For the implementation of Section 126, we are seeking comment on how to account for healthcare provided outside of a HPSA, to HPSA residents, and feasible alternatives to HPSA scores as a proxy for health disparities in the prioritization of additional FTE cap slots.

For the implementation of Section 131, we are seeking comment on how to handle reviews of data from older cost reports. To be assured consideration, comments on this final rule with comment period must be received by February 25th, 2022. In commenting, please refer to file code CMS 1752-FC3.

Section 126 makes available an additional 1,000 Medicare-funded full-time equivalent resident cap slots phased in at a rate of no more than 200 slots per year beginning in fiscal year 2023. The law requires that in order to receive additional slots, a hospital must qualify in at least one of four categories, hospitals in rural areas, or treated as being located in a rural area under the law, which means the hospital is reclassified as rural, category two hospitals training a number of residents in excess of their GME cap.

Category three, hospitals in states with new medical schools or branch campuses. And category four, hospitals that serve areas designated as health professional shortage areas. We defined category four as serving a geographic

HPSA. A hospital qualifies under category four if it is training residents in a program, where at least 50% of the training time occurs at sites in the geographic HPSA.

Additionally, the law requires that at least 10% of the slots go to hospitals in each of the four categories, and that no single hospital can receive more than 25 slots. In addition to implementing the statutory requirement that a hospital receiving cap slots must fall into at least one of four qualifying categories, CMS is prioritizing the distribution of cap slots based on the HPSA score of the HPSA served by the residency program for which the hospital is applying.

What this means is that hospitals applying for programs where at least 50% of the training occurs in HPSAs with higher HPSA scores, are prioritized. For this prioritization, HPSAs used include primary care and mental health-only geographic HPSAs, as well as population HPSAs.

An applicant hospital also has to demonstrate and attest that it will be using the additional cap slots to expand an existing program, or start a new program within five years of receiving the cap slots. So, essentially, eligibility for distribution of Section 126 slots is a three-step process.

The first step is for a hospital to determine if it meets one of the four qualifying categories. If it is considered a qualifying hospital, the next step is the prioritization criteria. The hospital determines whether, for the residency program for which it is applying, at least 50% of the training occurs in training sites in the geographic or population HPSA.

If the hospital does not meet this 50% prioritization criterion, this doesn't mean the hospital is ineligible for slots, but it receives a lower priority for distribution of slots. Finally, the hospital has to demonstrate that it will be using the cap slots they are applying for to expand an existing program or start a new program within five years of receiving the cap slots.

The cap slots awarded for a specific fiscal year for Section 126, are always effective July 1st of that fiscal year. For example, slots awarded under the fiscal year 2023 round, are effective July 1st, 2023. In terms of how many cap slots each hospital can apply for, commenters expressed concerns about the requirement that the applicant hospital be physically located in a HPSA, and the proposed award limitation of one FTE per hospital per fiscal year.

We responded to these concerns by finalizing a policy that the hospital - that the applicant hospital is not required to be physically located in the HPSA, but rather that hospital participates in training residents in a program where at least 50% of training time takes place at scheduled training sites in the HPSA.

In addition, under our final policy, hospitals may receive up to five FTE cap slots per hospital per year. The maximum award amount for each application is contingent on the length of the program for which the hospital is applying, with up to one FTE being awarded per residency program year, not to exceed a program length of five years or five FTEs.

For example, if a general surgery - since general surgery is a five-year program, a hospital applying for a general surgery program can apply for up to

five FTEs in a single application map. If a hospital is applying for family medicine, which is a three-year program, it can apply for up to three FTEs in a single application round.

In order for hospitals to be considered for increases in their FTE resident caps, each qualifying hospital must submit a timely application. The Section 126 application is an online application, and included as part of the Medicare Electronic Application Request Information System, also known as MEARIS.

The online application does not need to be submitted in a single session. The system will allow you to save your progress, and you can resume your application from where you left off at another time and/or date as you prefer. The application deadline for the first round of implementation of Section 126 is March 31, 2022.

In accordance with the statute, CMS will award the first round of 200 FTE resident cap slots under Section 126 in fiscal year 2023. And these cap slots will go into effect July 1st, 2023. CMS will notify hospitals of fiscal year 2023 FTE resident cap slot distributions by January 31rd, of 2023.

Hospitals can view information about what's required to complete the application by accessing the Paperwork Reduction Act document, which is associated with the application. We also hope to have a list of frequently asked questions regarding the Section 126 application available online later this month.

For more information regarding Section 126 to include the final rule

preamble, online application system, and Paperwork Reduction Act document mentioned earlier, please go to our Direct Graduate Medical Education Web site. A link to this Web site is available on the Hospitals Open Door Forum Web site.

We encourage you to review the application itself, as well as the various information that has been made available online. If you have questions, please reach out to us through the MEARIS resources page for Section 126. And now, I'll turn it over to my colleague, Renate Dombrowski, who will discuss Sections 127 and 131. Thank you.

Renate Dombrowski: Thank you, Joe. I'm going to start with Section 127, which focuses on residency training in rural areas. Section 127 is related to what CMS has historically referred to as rural training tracks, which are now referred to as rural training programs.

Historically, to encourage the training of medical residents in rural areas, the Social Security Act provided additional cap slots to an urban hospital that established a separately accredited rural training track. These programs, accredited in family medicine only, required that the first year of training will be spent at the urban hospital, and the second and third years at a rural hospital.

While the urban hospital could receive additional residency cap slots, the law did not provide for additional cap slots to the rural hospital. Section 127 made several changes to these programs to support the training of residents in rural areas.

First, along with the urban hospital, the rural hospital may receive additional resident cap slots when participating in a rural track program. Secondly, the urban hospital and rural hospital may also receive more resident cap slots whenever a rural training site is added to an already existing rural track program.

And thirdly, the urban and rural portions of the rural track program, need not be separately accredited. Instead, residents are required to spend greater than 50% of the entire program training in a rural area. The removal from the law of this separately accredited requirement, allows hospitals to create rural track programs in any specialty, not just family medicine.

Next, I will provide some highlights on Section 131. Section 131 provides an opportunity for certain hospitals with very low direct GME PRAs or caps, to reset those per-resident amounts and caps based on starting a new residency program. We posted on our Web site an extract of Medicare cost reports from HCRIS going back to 1995, to assist hospitals in determining their eligibility for a cap or PRA reset.

We explained in the recently issued final with comment that hospitals are responsible for reviewing the HCRIS posting to determine if they are eligible for a PRA and/or cap reset. We stated that MACs will not reach out to hospitals to inform them of eligibility, nor will MACs review requests to confirm eligibility.

We further stated in the final rule that if a hospital sees that the HCRIS

posting indicates that there is either no PRA or cap, or there is a PRA or cap and that they are based on amounts of not more than three, then that hospital is eligible for a PRA and/or cap reset. Then no further review is required.

We emphasized, there's no need to contact the MAC, nor will the MAC do any further review for such a hospital. Rather, the law indicates that hospitals eligible for a reset, may start a new program in the five-year period after enactment, December 27th, 2020, through December 26th, 2025.

Only at that time will the hospital tell the MAC they started a new program, and they are eligible to get a new PRA and/or a cap, based on the new program. However, if a hospital reviews the HCRIS posting and the posting indicates PRA or caps set based on more than three FTEs, that means the hospital is not eligible for a PRA or cap reset.

But if the hospital believes that the HCRIS posting is incorrect, and in fact its PRA and caps are based on not more than three FTEs, then the hospital has a one-time opportunity to dispute the HCRIS posting. That is only hospitals that disagree with what the HCRIS posting shows have the one-time opportunity to prove to the MAC that they are eligible for a reset.

Such a hospital must submit complete documentation proving recent eligibility to its MAC by July 1st, 2022. For example, HCRIS shows caps of four and the hospital believes that its not correct and wants to show the MAC documentation that its caps are less than three.

This hospital must submit documentation to the MAC by July 1, proving that

its caps are less than three. We reiterate that the July 1st deadline is only for hospitals that disagree with the posting and want to prove their eligibility for a PRA or cap reset. If a hospital agrees with what the posting reflects, it would not reach out to its MAC by July 1.

Rather, as we stated, hospitals eligible for a reset, will first reach out to their MAC at the time they start a new program between December 27th, 2020, and December 26th, 2025. MACs will not review general requests for confirmation of reset eligibility. That is all we have for GME. So, I will turn it over to (Tehila) for a wage index update. Thank you.

Tehila Lipschutz: Thanks, Renate. This is Tehila. I'm going to give an update on the fiscal year 2023 wage index timetable. On January 28th, we released the revised FY 2023 wage index and occupational mix data as public use files on the CMS Web site.

February 15, in exactly one week, is the deadline for hospitals to submit requests, which includes supporting documentation for corrections to errors in the January PUFs due to CMS or MACs mishandling of the wage index data, or revisions of DAC review adjustments to their wage index data, as included in the January PUFs.

MACs must receive any requests and supporting documentation by this date, by February 15th, 2022. No new requests for wage index and occupational mix data revisions will be accepted by the MACs at this point, as it's too late in the process for MACs to handle data that is new in a timely manner.

So, we encourage hospitals to look at that data on our Web site, to look over their wage index data and occupational mix data before February 15th. Thank you. I'm going to turn it back to Jill.

Jill Darling: Great. Thank you, Tehila, Joe, Renate, and to Emily. Courtney, we will open the lines for Q&A, please.

Coordinator: Thank you. We will now begin the question-and-answer session. If you would like to ask a question, please press Star 1 and record your name. If you need to withdraw your question, press Star 2. Again, to ask a question, please press Star 1. Our first question comes from Kristi Hall. Your line is open.

Kristi Hall: Yes, good afternoon. I'm calling because I have a question about the monoclonal antibodies that are administered during the COVID-19 pandemic. My question is, a patient is receiving a monoclonal antibody, and after four minutes has a reaction. The administration is then discontinued, and the patient is sent to the emergency room for treatment of that reaction. My question is, how do we report that administration to CMS?

Emily Forrest: Thanks, Kristi. So, I just want to make sure I'm understanding. Are you asking about the reporting requirements that are required to have an understanding of what types of reactions are happening with the administration? Or are you referring to billing Medicare for that particular patient?

Kristi Hall: I'm referring to - I know you have to report that the patient had a reaction, and that goes into the database, but they want to know how they bill for the

administration of that, because the patient - technically it's not an infusion if it stopped after four minutes. And there is a lot of prep involved in getting ready to administer that - to that patient.

And of course, the observation afterwards, which, you know, I don't know if that's rolled into whether the patient has treatment because of a reaction or not. Does that make sense?

Emily Forrest: Yes, that's helpful. Thank you. So, in terms of the reporting itself, I would have to loop with my - link-up with my colleagues in the department who are closer to the reporting requirements. So, I can follow up with them and then touch base with you regarding that aspect of your question.

When it comes to the administration of monoclonals, the payment for administering monoclonals in a healthcare setting, do include payments for the monitoring that's required for that administration based on the EUA. The specific scenario that you're referencing about the stop and start, I would want to dig into that further. So, I don't want to provide you with misinformation on this call.

Kristi Hall: Okay, because, I mean, some people have suggested a push, but it's not - you can't report - you're not supposed to report the monoclonal antibody. And if you're reporting a push, I don't think it goes to the same area as the - I mean, the administration codes are very specific for the monoclonal antibody. So, I don't think the push is the answer.

Emily Forrest: Right. Yes, and I want to follow up with you on the specifics here, because I think there's a couple of different components that I want to make sure that I'm getting accurate for you.

Kristi Hall: Okay.

Emily Forrest: Yes. If you shoot us an email, and I'm blanking on it, Jill, but the hospital_ODF@cms.hhs.gov, I think we can follow

Kristi Hall: Okay. And should I direct it to a specific person or?

Emily Forrest: Yes. You can direct it to me, Emily Forrest.

Kristi Hall: Okay, thank you very much.

Emily Forrest: Yes. And there's also a COVID therapeutics inbox as well that might be helpful. I'm trying to pull it up. That email is also COVID19.therapeutics, with an S, at HHS dot gov.

Coordinator: Our next question comes from Kerry. Your line is open.

Kerry: Hi. Yes, I'm calling in regards to the 126, expanding the slots. And I just wanted to confirm that under the demonstrated likelihood criterion number two, if we're trying to expand an existing residency program, from my understanding, the ACGMEs next meeting to approve full-time slots is after the deadline of when the application is due.

So, I just want to confirm that it is okay to attach the approval that we're requesting in an expansion of slots to the ACGME, to the CMS 126 application, and that is sufficient enough documentation.

Joe Brooks: Hi. This is Joe Brooks. Thank you for that question. Yes. So, one of the components of the demonstrated likelihood criterion is that you're communicating with ACGME regarding your plans for the program, regarding your planned expansion.

So, if you have documentation already in hand, then definitely attach that to the application, and, you know, we'll go ahead and review that and determine if it meets the requirements. But right - under DLC-2, it's documentation that demonstrates your intentions for expansion with that program.

Kerry: Okay, thank you.

Coordinator: I'm showing no further questions, but as a reminder, please press Star 1 if you have a question.

Jill Darling: Hi, everyone. Its Jill Darling. We'll just give it a minute if there are any more questions in the queue.

Coordinator: Our next question comes from Beth. Your line is open.

Beth: Hi. Good afternoon. I have a question regarding the additional 20% payment that's made for hospital inpatient services rendered to COVID-19 patients. The

requirements right now are that we have a positive COVID test that occurred within 14 days in order to receive that additional 20%. I'm wondering about home tests, whether they qualify to meet that requirement.

So, for example, if the patient did a home test 10 days ago that was positive, does that qualify for us to receive the additional 20% payment? And how would we document that home test?

Emily Forrest: This is Emily. I would want to refamiliarize myself with that specific policy before answering the - whether the home test would count, unless others on the phone have more information. So, we can move back with you with that specific information.

Beth: Okay, thank you.

Coordinator: Our next question comes from Luke Nelson. Your line is open.

Luke Nelson: Good afternoon. My question is regarding the Section 126 application for new residency positions as well. Under demonstrated likelihood criteria, my understanding is that if your new residency program is starting before July 1, 2023, you wouldn't be able to apply under these criteria. Is that correct?

Joe Brooks: Okay. So, this is Joe Brooks. Thank you for that question. So, under the demonstrated likelihood criteria number one for new programs, and looking at the preamble, that's where I would direct you to first to get some clarification information. It's going to be on page 73422.

But - so it has to do with the fact that, you know, the program is going to begin training at any point within the hospital's first five years, beginning on or after the date the increase would be effective. So, I think that should answer your question as far as the new program is concerned.

But I also have my colleague on the line here, Renate, who could also, you know, either confirm what I'm saying, or add some more context if she prefers.

Renate Dombrowski: Sure. Thanks, Joe. So, from this first round, calls are effective July 1, 2023, the new program would need to start training residents at any time within five years, starting on July 1, 2023, not prior to.

Luke Nelson: Okay. So, if it has a 2022 start date, it wouldn't be - it wouldn't fall under these criteria.

Renate Dombrowski: Correct.

Luke Nelson: Okay. Thank you.

Coordinator: Our next question comes from Kelsey. Your line is open.

Kelsey: Good afternoon. I am calling to - on the mortalities and hospital-acquired complications that are connected with COVID. And I want to know if CMS will be including the COVID patients in these measures.

Emily Forrest: This is Emily Forrest. I'm having a hard time hearing this specific caller. Were you asking if whether or not CMS was going to be taking into account COVID hospitalizations and specific measures? Is that correct?

Kelsey: Yes, ma'am.

Emily Forrest: What specific measures are you referring to?

Kelsey: Mortality and the hospital-acquired complications.

Emily Forrest: Okay. I can

Kelsey: With the COVID patients.

Emily Forrest: Right. Okay. Yep, I can reach out to our colleagues and provide that information for you at a later date. But if you can email the hospital ODF inbox, we can get back with you. We don't specifically have those colleagues on the line at the moment, but we do appreciate the question.

Kelsey: Thank you.

Coordinator: Our next question comes from Steve. Your line is open.

Steve Bernstetter: Hi. My name is Steve Bernstetter, BJC Healthcare in St. Louis. I'm calling in regards to Section 126 GME slot distribution, specifically identifying eligible HPSA areas. The final rule mentions the fine shortage areas module on the HRSA Web site. And when we plug our academic hospitals addresses into

that module, it shows that both are located in a primary care and mental health HPSA.

However, you guys also published with the final rule, a supplemental file number 13 on the Web site, health professional shortage area public IDs and scores. And when we look those HPSAs up on that list, they do not show up there. So, my question is really, which is the correct source and why, if you have any idea, might they be different? Thank you.

Joe Brooks: Thank you for that question. This is Joe Brooks. So, that's correct. We have the document on the Web site there that provides the HPSA scores as of a cutoff date that we're using for this round. It's my understanding - I'm not the person who works directly with the health professional shortage area numbers and scores, but it's my understanding in reading the information about it from the HRSA Web site, that HRSA is in contact with state representatives throughout the year regarding the information that delineates certain HPSA scores for certain areas.

So, that would be the reason why you see changes there. I would refer to the document though. The document is going to be what you need to use to fill out the application. When you start going through the online application, you'll get to a certain point where you actually have to, you know, enter the address.

You have to enter the HPSA public ID into the window of your application online, and then a score will automatically populate based on that public ID. And that public ID and scoring information is directly from that document that

you referred to that's located online. So, hopefully that helps to answer your question.

Steve Bernstetter: It does. Thank you very much.

Coordinator: Our next question comes from Liz. Your line is open.

Liz: Thank you. I'm calling in regards to hospital outpatient billing for services when a physician normally practices in the hospital setting and is in the hospital clinic, and they're providing a telephone call to a patient in their home, and that home has been made a provider-based department of the hospital. The question is, can the hospital still bill that GO463 when it's a telephone call versus a tele - you know, a video visit or anything else?

Emily Forrest: Thank you for the question. I think were going to follow up with you on this as well. If you can give me - if you can email the hospital_ODF mailbox, that would be helpful. Its Hospital_ODF@cms.hhs.gov.

Liz: Hospital - would you just repeat it one last time? I'm sorry.

Emily Forrest: Yes, no problem. Yes, sorry, I talk fast. Hospital_ODF@cms.hhs.gov.

Liz: Okay, I will do that. Thank you so much.

Jill Darling: And reminder, that email is on the agenda. it's always on the agenda in case you need to send an email in.

Liz: Great. Thank you.

Coordinator: Our last question comes from Devon. Your line is open.

Devon: Hi. My question is in regard to Section 126 for doing a cap increase under number two, training residents in excess of our GME cap. I was just wondering - it sounded - I just want to confirm that. It only sounds like it's applicable for expanding our current programs, or if we're creating a new program, but if we're already above the cap where - and just want to increase that number, we wouldn't be eligible, correct?

Renate Dombrowski: Hi. This is Renate. Yes. So, applying for cap relief will not be allowed under the Section 126 application process, because the law requires that a hospital expand/or start a new program by the number of slots that it is awarded. So, using the award for cap relief would not be permissible.

Devon: Okay, thank you so much.

Coordinator: Our next question comes from Lisa. Your line is open.

Lisa: Hi, yes. My question is regarding the monoclonal COVID antibody infusions. Is there still no patient responsibility on those infusions or - this year or lately? Is there now - are the patients responsible for the 20% after the 80% Medicare payment?

Emily Forrest: Thanks, Lisa. This is Emily Forrest. So, in terms of monoclonal antibody products that are infused in Medicare patients, the Medicare beneficiary has a

zero co-pay or co-insurance associated with those monoclonal antibodies. I do want to note that that is different for products that are not considered monoclonal. I just wanted to highlight that difference there.

Lisa: Okay, thank you.

Coordinator: I'm showing no further questions at this time.

Jill Darling: Okay, great. Thanks, Courtney. I'll pass it to Emily for closing remarks.

Emily Forrest: Thanks, Jill, and thanks, everyone, for your participation on today's call. As we mentioned throughout the call, if you have any further questions, please do reach out to us via the Hospital ODF email. It's on the agenda, but I'll repeat it again. It's Hospital_ODF@cms.hhs.gov, and we will work to get you an answer to your question that you either provided today or after this meeting.

So, with that, that concludes today's call. Thank you for joining us, and hope you have a great rest of your afternoon.

Coordinator: That concludes today's conference. Thank you for participating. You may disconnect at this time.

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