Centers for Medicare & Medicaid Services
Hospital Open Door Forum
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Webinar recording:
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Passcode: 5=Dc27AN

[not recorded] Joseph Brooks: *Thanks for your patience. Okay. Karen, can you please begin recording?*

Automated voice: *Recording in progress.*

Joseph Brooks: Thank you. Thank you, everyone, for your patience in waiting for us to begin the Hospital Quality Initiative Open Door Forum. I'm going to start my video now. Hopefully folks can see me. I'm Joe Brooks, the Chair of this Open Door Forum. Welcome. Before we get into today's agenda, I have a few announcements. This webinar is being recorded. The recording and transcript will be available on the CMS Open Door Forum podcast and transcript webpage. The link is on the agenda. The Open Door Forum is open to everyone. If you are a member of the press, you may listen in; however, please refrain from asking questions during the webinar. If you have any questions, please email press@cms.hhs.gov. All participants are muted upon entry. For those who need closed captioning, a link was provided in the chat function of the webinar, so please use that link for closed captioning. There are no slides, just the agenda you see on the screen. And we'll be taking questions at the end of the agenda today. You may use the raise hand feature at the bottom of the screen, and we will call on you when it's time for Q&A. When the moderator says your name, please unmute yourself on your end to ask your question and one follow-up question. We'll do our best to get to your questions.

During today's Open Door Forum we'll be providing an overview of the final policies in the FY2024 IPPS and LTCH Final PPS Rule, which was issued on August 1, and the final policies in the FY24 IPF Final Rule, which was issued on July 27. We'll also be discussing the availability of HCAHPS podcast that updates to HCAHPS survey module adjustments, Hospital OPD prior authorization, facet joint interventions, and providing guidance on National Provider Identifier Enumeration. I also wanted to note that the comment period for calendar year 2024 OPPS and ACS proposed rule has a comment period that closes on September 11.

And also, the CY23 Physician Fee Schedule, PFS, proposed rule, which includes Medicare Shared Savings Program proposals—the comment period for the CY24 Comment Proposed Rule also closes on September 11. We encourage folks to get their comments in to us as early as possible to aid in our review of these comments, which also helps us get the responses and the final rule out as timely as we're able.

Again, we'll be reserving time at the end for questions on issues presented today. So, with that, I'll turn it over to Don Thompson to begin with discussing the FY24 IPPS LTCH PPS Final Rule. Don?

Donald Thompson: Thanks, Joe. I'm going to start talking about the increase and the payment rates under the IPPS and then the LTCH PPS and then a little bit about some of the wage index changes.

So, first of all, under the IPPS, the increase in the operating payment rates for general QCOR hospitals that are paid under the IPPS and also who successfully participate in the Hospital and Patient Quality Reporting Program and are also meaningful electronic health record users is 3.1%, and that represents the IPPS hospital market basket of 3.3% reduced by a statutory required 0.2 percentage point productivity adjustment.

That update reflects the most recent available forecast for the price proxies that go into the market basket and included projected increases in compensation.

Those—the increase in the operating as well as the capital IPPS payment rates will generally increase hospital payments by about $2.2 billion in fiscal 2024. We project that Medicare disproportionate share hospital payments as well as Medicare uncompensated care payments combined will decrease in fiscal 2024 by approximately $957 million. That change reflects our actuary use of updated estimates in data in its projections. We also estimate the additional payments for inpatient cases involving new medical technologies will decrease by about $364 million in fiscal 2024, and that is primarily driven by the expiration of some new technology add-on payments for several technologies.

In terms of the payment rates under the LTCH PPS, we expect the LTCH standard payment rate to increase by 3.3%. And the LTCH payments for discharges paid under the LTCH standard payment rate to increase by approximately 0.2%, or $6 million. That is due primarily to a projected 2.9% decrease in high-cost outlier payments as a percentage of total LTCH PPS standard rate payments.

After considering the public comments that we received on the proposed rule, we did make some modifications to the methodology that we use to determine the LTCH PPS high-cost outlier threshold for the discharges that are paid using the LTCH standard payment rate, and that outlier threshold is notably lower than it was in the proposed rule.

Switching gears to the wage index, we did continue the Low-Wage Hospital Policy. It’s a temporary policy that we started in fiscal year 2020 to address wage index disparities affecting low-wage hospitals, including many rural hospitals. This time we only have one year of relevant data, from fiscal 2020, due to the lag in the availability of data in the cost report, the wage data from the cost report. We only have one year of relevant at that time available to us to evaluate

any potential impacts of the policy. So, we are continuing the policy for fiscal 2024.

Another wage index change of note is that we made some changes in the rural wage index calculation methodology. We had proposed to do that, and we finalized those changes in the final rule, and that changes the calculation, in particular how we treat hospitals—urban hospitals, geographically urban hospitals—that reclassify to rural under 42 CFR 412.103. And so, we changed the calculation with respect to how those hospitals are treated, and that did change the rural wage index which also had implications for the rural floor.

With that, I'm going to turn it over to Renate to talk a little bit about a GME change that we made.

Renate Rockwell Dombrowski: Thanks. I'm going to give a summary regarding the Rural Emergency Hospital Graduate Medical Education Provision. This provision finalizes CMS's proposal to support residency training in rural areas by considering REHs as allowable training sites for Medicare Graduate Medical Education payments. This provision provides similar flexibilities to REHs that are provided to critical access hospitals when it comes to residency training. Specifically, effective October 1, an REH can be considered a non-provider site, which means another hospital can send residents to train at the REH and be paid for training if that other hospital pays the resident salaries and benefits, or, the REH can be paid directly at 100% of reasonable cost for the training cost incurred in training the residents. That's all I have. And I'm going to turn it over to Allison Pompey.

Allison Pompey: Thank you. I'll discuss the New Technology Add-on Payment Policy proposal that we finalized. So, to increase transparency and improve the efficiency of the NTAP program, or the New Technology Add-on Payment program, as well as its application process, CMS finalized its proposal to, one, require that NTAP applicants for new technologies that are not already FDA market authorized to have completed—to have a complete and active FDA market authorization application request at the time of their NTAP application submission. And two, to move the FDA approval deadline from July 1st to May 1st, beginning with applications for fiscal year 2025.

Our analysis has demonstrated that historically, NTAP applicants who submit an application prior to submitting an FDA marketing authorization request are rarely granted FDA approval or clearance before July 1st or even May 1st, again, the new NTAP FDA approval timeline, and CMS believes that these policy changes would improve the completeness of submitted NTAP applications, allow for a fuller analysis, and improve the ability for CMS to identify eligibility concerns for the proposed rule, and allow the agency and the public to more knowledgeably analyze applications and supportive data to inform a final decision.

And with that, I will turn it over to Andrea Hazeley to discuss Social Determinants of Health.

Andrea Hazeley: Good afternoon. For IPPS payment, this may be based on the use of hospital

resources and the treatment of a patient's severity of illness, complexity of service, and/or consumption of resources. Generally, a higher severity level designation of a diagnosis code results in a higher payment to reflect the increased hospital resource use. After review of our data analysis of the impact on resource use generated using claims data, CMS finalized a change to the severity designation of the three ICD-10 CM diagnosis codes describing homelessness—unspecified, sheltered, and unsheltered—from noncomplication or comorbidity to complication or comorbidity based on the higher average resource cost of cases with these diagnosis codes compared to similar cases without these codes.

This action is also consistent with the Administration's goal of advancing health equity for all, including members of historically underserved and under-resourced communities, as described in the President's January 2021 Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government.

As these SDOH diagnosis codes are increasingly added to build claims, CMS plans to continue to analyze the effects of FCOH on severity of illness, complexity of services, and consumption of resources. I will now turn it over to Meredith Larson.

Meredith Larson: Thank you. I will be discussing today changes finalized in the FY 2024 IPPS Rule related to the Physician Self-Referral Laws, specifically related to physician-owned hospitals. As a reminder, the Physician Self-Referral Law prohibits a physician from making a referral for certain designated health services to an entity with which the physician or immediate family member of the physician has a financial relationship. In addition, the entity is prohibited from billing Medicare or any other party for designated health services that it furnishes pursuant to a prohibited referral. For a hospital to submit claims and receive Medicare payment for services referred by a physician owner or investor, or a physician whose family member is an owner or investor, the hospital must satisfy all of the requirements of either the whole-hospital exception or the rural provider exception to the Physician Self-Referral Law. In most instances, to use the rural provider or whole-hospital exception, a hospital may not increase the aggregate number of operating rooms, procedure rooms, and beds above that for which the hospital was licensed on March 23, 2010, unless CMS has granted an exception to the prohibition on expansion.

A hospital may request an exception to the prohibition on expansion of facility capacity using the process established in the calendar year 2021 Hospital Outpatient Prospective Payment System Rule, an Ambulatory Surgical Center Payment System Final Rule. In FY 2024, IPPS Final Rule, CMS made changes to its regulations to improve transparency and to be in compliance with the expansion exception process. Specifically, CMS revised the regulations to clarify that CMS will only consider expansion exception requests from eligible hospitals, clarify the data and information that must be included in an expansion exception request, identify factors that CMS will consider when making a decision on an expansion exception request, and revise certain aspects of the process for requesting expansion exception.

In addition, CMS reinstated, with respect to hospitals that meet the criteria for high Medicaid facilities, program integrity restrictions on the frequency of expansion exception requests, maximum aggregate expansion of a hospital, and location of expansion facility capacity that were removed in the CY 2021 OPPS ASC Final Rule.

And with that, I will pass the discussion on to Julia Venanzi.

Julia Venanzi: Thank you. Myself and a number of colleagues are going to cover updates to some of our Quality Reporting and Value-Based Payment Purchasing programs. I'll start first with a cross-program modification that we made to a number of programs, including the Hospital Inpatient Quality Reporting program, the PPS Exempt Cancer Hospital Quality Reporting program, and then the Long-Term Care Hospital Quality Reporting program. In those three programs, we adopted a modified version of the COVID-19 vaccination coverage among health care personnel measure. That measure was modified in order to align with the CDC's update in their language to go from full vaccination course to up-to-date vaccination in order to include booster doses in the measure.

So I'll go next to updates that are specific to the Hospital Inpatient Quality Reporting Program. As a reminder, that is the Hospital Pay-for-Reporting Quality Program for acute care hospitals. This year, we finalized adding three new measures to the program. All three are electronic clinical quality measures, or ECQMs, related to patient safety. All three are being added to the list of ECQMs from which hospitals are required to self-select three to report beginning with the calendar year 2025 reporting period. The three ECQMs are the hospital harm pressure injury ECQM, which measures the portion of inpatient hospitalizations for patients 18 and older who develop a new stage 2, 3, 4 deep tissue or unstageable pressure injury. The second new ECQM is the hospital harm acute kidney injury measure, which measures the proportion of inpatient hospitalizations for patients 18 and over who have an acute kidney injury that occurs during the hospital admission. And then lastly is the excessive radiation dose, or inadequate image quality for diagnostic CT, which measures the percentage of eligible CT exams that are out of range based on having either an excessive radiation dose or inadequate image quality relative to evidence-based thresholds based on the clinical indication for that exam.

Moving now to removals. We also finalized the removal of three measures from the program. First is the PC-01 measure, or the elective delivery prior to 39 weeks of gestation measure. We're removing this measure because it is topped out. We previously had not proposed to remove it since we did not have other measures related to maternal health, but last year, in the FY23 IPPS Rule, we finalized the addition of two new maternal health measures, so we are now finalizing the removal of PC-01 now that those two measures have been added.

The next two removals—the Medicare spending for beneficiary and the total hip or knee risk standardized complication rate measure—we are—we finalized removing these measures due to the statutory requirement we have to publicly report measures for one year in the Hospital IQR Program before being able to move them into the Hospital Value-Based Purchasing Program. So,

basically, whenever we want to modify an existing Hospital Value-Based Purchasing Program measure, we have to first put the updated version back into the Hospital IQR Program, publicly report it for a year, and then move it to Hospital VBP. So, for those two measures, we are now removing them from IQR as the modified versions have been finalized in the Hospital VBP program.

Lastly for Hospital IQR, we did make two more measure modifications in addition to the update to the COVID-19 vaccination measure. We modified the hybrid Hospital-Wide Readmission Measure and the hybrid Hospital-Wide Mortality Measure to include Medicare Advantage patients.

So, I'll now turn it over to Ora to cover the PCH QR program.

Ora Dawedeit: Thank you, Julia. I will be reading updates on the PCH program. We have finalized four new measures for the program: facility commitment to health equity, screening for social drivers of health beginning with voluntary reporting in the fiscal year 2026 program and mandatory fiscal year 2027, the screen-positive rate for social drivers of health, and the last one is the documentation of goals of care discussions among cancer patients beginning with the fiscal year 2026 program.

And I think I'm turning it over to Heidi.

Heidi Magladry: Thank you, Ora. I'll be providing updates on the LTCH QRP provisions. The LTCH QRP is a pay-for-reporting program. LTCHs that do not meet requirements are subject to a two-percentage-point reduction in their annual payment update. In the fiscal year 2024 IPPS LTCH rule, CMS is finalizing the addition of two new measures, one measure modification, and two measure removals. We'll start with the new measures beginning with the fiscal year 2026 LTCH QRP. CMS finalized the adoption of the COVID-19 vaccine percent of patient residents who are up to date. This measure reports the percentage of stays in which patients in an LTCH are up to date with their COVID-19 vaccinations per the latest guidance of the CDC. Data would be collected using a new standardized item on the new LCDS.

The measure has the potential to increase COVID-19 vaccination coverage of patients in LTCHs. Beginning in the fiscal year 2025, LTCH QRP, CMS finalized the adoption of the discharge function score measure. The assessment-based outcome measure assesses functional status by assessing the percentage of LTCH patients who meet or exceed an expected discharge function score and uses mobility and self-care items already collected on the assessment tool.

The adoption of this measure will replace the topped-out process measure application of functional assessment and care plan.

As Julia mentioned, beginning in the fiscal year 2025 LTCH QRP, we also finalized the update to COVID-19 vaccination coverage among health care personnel measure in alignment with the

Hospital IQR and the PCH QR programs.

Moving on to removals, beginning with the fiscal year 2025 LTCH QRP, we finalized the removal of the application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function measure.

Our regulations describe eight factors we consider for measure removal from the LTCH QRP, and CMS finalized this measure's removal for two reasons. First, this measure meets the conditions for measure removal factor 1—that it has become topped out. Second, the measure meets measure removal factor 6—as there is an available measure that is more strongly associated with desired patient functional outcomes, which is the new discharge function score measure. Secondly, beginning with the fiscal year 2025 LTCH QRP, we finalize the removal of the percentage of long-term care hospital patients with an admission and discharge functional assessment in care plan that addresses function. CMS finalized this measure's removal because it meets the conditions for measure removal factor 1—it is topped out.

Another proposal, policy proposal, is beginning with fiscal year 2026 LTCH QRP. CMS finalized to increase the LTCH QRP data completion thresholds for the LCDS data items. CMS finalized that LTCHs must report 100 % of the required quality measure data and standardized patient assessment data collected using the LCDS on at least 85% of the assessments they submit through the CMS-designated submission system. Any LTCH that does not meet the finalized requirement that is 85% of all LCDS assessments submitted contain 100 % of required data items will be subject to a reduction of 2 percentage points to the applicable fiscal year APU beginning with fiscal year 2025.

And, finally, a public reporting proposal beginning with the September 2024 Care Compare refresh, CMS finalized the public reporting of the transfer of health information to the provider measure and the transfer of health information to the patient measure. These measures reporting the percentage of patient stays with a discharge assessment indicating that a current reconciled medication list was provided to the subsequent provider and/or the patient family caregiver at discharge or transfer.

And with that, I will pass it back to Julia for the Hospital VBP updates.

Julia Venanzi: Thanks, Heidi. Just two updates to share from the Hospital VBP program. First, we finalized a change to the scoring methodology that allows hospitals the opportunity to gain up to 10 bonus points based on their performance on the existing 13 Hospital VBP measures and the proportion of patients they serve that are dually eligible. This policy is aligned with policies that were recently finalized in the SNF VBP program as well as the Medicare Shared Savings Program. In alignment with that finalized policy, we also finalized an increase to the maximum total performance score a hospital can achieve—finalized changing that from 100 to 110 to account for those 10 additional points.

The second update is we finalized adding the Severe Sepsis and Septic Shock Management Bundle Measure to the Hospital VBP program. This measure measures the percent of patients who receive a certain sepsis protocol within three hours of presentation of severe sepsis.

I'll note that this measure is also in the Hospital IQR program, and that data is only collected once across the two programs. By finalizing it in the Hospital VBP program, the measure gets added to the existing pay-for-performance scoring methodology, which we believe will further incentivize improvement on this measure.

That's it for me. I believe I'm passing it over to the IPF PPS Rule team, to Nic Brock.

Nicolas Brock: Hi. Thanks, Julia. Good afternoon. So, I'll provide an overview of the fiscal year 2024 Inpatient Psychiatric Facilities Prospective Payment System. This payment system applies to about 1,500 psychiatric facilities, and this is the payment system associated with covering—furnishing covered inpatient psychiatric services, including services in psychiatric hospitals, as well as excluded psychiatric units of an acute care hospital or critical access hospital.

The four main topics we'll address today are the FY 2024 payment rate updates for the IPF PPS, as well as the rebasing and revision of the IPPS market baskets. In addition, we'll talk about changes to the regulation for excluded psychiatric units, and, lastly, the IPF PPS data collection and revisions required by the Consolidated Appropriations Act of 2023.

First, about the payment rate updates for FY 2024: we're updating the IPF PPS payment rates by 3.3% based on the final market basket increase of 3.5% plus a 0.2 percentage point productivity adjustment. We are finalizing our proposal to rebase to a 2021 base year for the IPF PPS market baskets. The final 2021 base market basket is used to calculate the 3.3% updates to the IPF PPS payment rates for fiscal year 2024. And my colleague David will talk a little bit more about that rebasing at the matter basket in just a moment.

In addition, we are updating the outlier threshold for the IPF PPS, so the estimated outlier payments remain at 2% of total payments. We estimate that this update will result in a 0.9-percentage-point decrease to aggregate payments.

Now I will hand it over to my colleague David to talk about the IPF PPS market basket.

David Pope: Thank you, Nic. Since the IPF PPS was implemented, the market basket used to update IPF PPS payments has been rebased and revised to reflect more recent data on IPF cost structures. CMS last rebased and revised the IPF market basket in the fiscal year 2020 IPF PPS Final Rule, where a 2016-based IPF market basket using Medicare cost report data for both Medicare participating freestanding psychiatric hospitals and hospital-based psychiatric units was adopted. For fiscal year 2024, we adopted a 2021-based IPF market basket and finalized changes to the market basket cost weights, price proxies, the market basket percentage increase, and labor-related share.

As a result of the rebasing and revising of the IPF market basket, the final fiscal year 2024 labor-related share is 78.7%, which is a 1.3-percentage-point increase relative to the fiscal year 2023 LRS of 77.4%.

This higher labor-related share is primarily due to the incorporation of the 2021 Medicare cost report data, which increased the compensation cost rate by 0.9 percentage point compared to the 2016 based IPF market basket.

Next up I'll discuss the modification to the regulation on excluded units paid under the IPF PPS. In response to increased behavioral health needs nationwide, including the need for availability of inpatient psychiatric beds, CMS finalized changes to the regulations to allow greater flexibility for hospitals to open and bill Medicare for new excluded inpatient psychiatric distinct part units. Beginning in fiscal year 2024, CMS is amending the regulation at 42 CFR Section 412.25(c) to allow hospitals to open a new excluded IPF unit at any time during the cost reporting period rather than only at the start of a hospital's cost reporting period.

This change will allow a hospital's excluded IPF unit to start being paid under the IPF PPS as long as the hospital provides at least 30 days' notice to the CMS regional office and Medicare administrative contractor. CMS believes this change will alleviate unnecessary burden and administrative complexity placed on hospitals when opening a new excluded psychiatric unit, helping to expand access to behavioral health care in line with CMS's behavioral health care strategy. I will now turn it over to Amy Miller, who will discuss the IPF PPS data collection and revisions required by the Consolidated Appropriations Act of 2023.

Amy Miller: Thanks, David. New provisions in the CAA 2023 require CMS to revise payments under the IPF PPS for rate year 2025, which under the IPF PPS is fiscal year 2025, as the Secretary has shown is appropriate. Accordingly, CMS included a Request for Information in a proposed rule that would be used to inform future payment revisions. In the proposed rule, CMS addressed the specific types of data and information that the CAA 2023 suggests CMS may collect and solicit as comments on additional data and information that could be collected to inform future payment revisions. Commenters offered various suggestions of payment characteristics and factors we could consider for analysis. CMS will be taking these comments into consideration for future rulemaking.

I will now turn it over to Bill Lehrman to discuss HCAHPS.

William Lehrman: Thank you, Amy. Now, for something a little bit different. CMS and its HCAHPS project team recently posted a new podcast on HCAHPS online website entitled "Updates to HCAHPS Survey Mode Adjustments Effective January 2023." You can see this podcast on our HCAHPS online website, which is hcahpsonline.org. Based on findings from the 2021 HCAHPS mode experiment, we are updating the HCAHPS survey mode adjustments with a mail-only mode, a telephone-only mode, and mixed mode. And these new survey mode

adjustments will begin with patients discharged in Quarter 1 2023 and forward.

Quarter 1 2023 results will be rolled into publicly reported HCAHPS scores on Care Compare beginning in October of 2024, so they won't actually be rolled into scores for a while. As always, both the current and the new survey mode adjustments can be found on our HCAHPS online website under the Mode and Patient-Mix Adjustment button.

Secondly, I'd like to note that the FY 2024 IPPS rule, which was published in the Federal Register on August 28, finalizes some important changes to the HCAHPS survey administration that will begin in January 2025. We will be providing more information in a later review of that rule. And we'll also provide more information about those changes on HCAHPS online.

And with that, I will turn it over to Beth Karpiak.

Beth Karpiak: Thank you. Hello. I am here today to speak about a guidance letter that the National Standards Group, or NSG, within the CMS Office of Burden Reduction and Health Informatics, issued at the end of July related to National Provider Identifier, or NPI, enumeration for organization health care providers. So, the letter speaks to organizations rather than individual providers.

For some brief background, NSG, on behalf of the Secretary of HHS, administers HIPAA administration simplification provisions relating to adopting standards for administrative electronic health care transaction. As such, NSG adopts and enforces compliance with standards that dictate the data content and format that all HIPAA-covered entities must follow when conducting particular electronic administrative health care transactions, such as claims and remittance advice transactions.

In addition to adopting those data content and format standards, NSG has also adopted the NPI as the unique health identifier for health care providers. So anytime a provider is referenced in an electronic transaction for which the secretary has adopted a standard, the provider must be identified using their NPI. The regulations requiring use of NPI mandate that all health care providers that transmit health information in electronic form in connection with a transaction for which the secretary has adopted under HIPAA must obtain an NPI. Further, a covered organization health care provider must obtain an NPI for any subpart that meets the definition of a covered health care provider.

We provide in the guidance letter that subparts include components of an organization provider that are separately certified, licensed, or identified by a federal or state regulatory body as a different provider type, regardless of whether the components share the same physical location as the main organization or with another subpart. Subparts also include separate physical locations of the same provider type with a known organization that may not be separately licensed or certified.

The guidance letter clarifies that an additional regulation be promulgated at 45 CFR 162.412(b), that states a health plan may not require a health care provider that has been assigned an NPI to obtain an additional NPI. In relation to this prohibition, covered entities have asked NSG: do HIPAA rules prohibit a health plan, like a state Medicaid agency, for example, requiring that a subpart of an organization provider obtain a unique NPI—unique meaning an NPI that's not shared with the subpart's main organization provider or another subpart within the organization—so, can a health plan require a subpart of an organization obtain a unique NPI as a condition of enrollment with that plan?

We conclude that no, HIPAA does not prohibit a health plan from requiring that a subpart of an organization provider obtain a unique NPI as a condition of enrollment with the plan. Should a subpart already have its own unique NPI, that prohibition at 45 CFR 162.412(b) prohibits the plan from requiring that subpart obtain an additional NPI, but it does not prohibit a health plan from requiring that a subpart that does not have a unique NPI obtain a unique NPI as a condition of enrollment with the plan. The guidance letter concludes with several examples of health plan requirements that are not prohibited under HIPAA. I'll go through just a few of them.

So, we say HIPAA would not prohibit requiring a hospital that operates as a unit within a hospital, an inpatient rehab facility, to enroll the inpatient rehab facility separate from the hospital with a unique NPI. A second example we provide is requiring a clinic that has multiple locations throughout a metropolitan area to obtain unique NPIs for each clinic location.

And I'll conclude by noting that should you have any questions about the information in the guidance letter, please send them to the email address noted at the end of the letter, which is administrativesimplification@cms.hhs.gov.

And with that, I'll turn it over now to Yuliya Cook.

Yuliya Cook: Thank you, Beth. We would like to remind hospital OPD providers that prior authorization for facet joint interventions is required beginning July 1st. Providers can start submitting prior authorization requests for facet joint interventions on June 15, 2023, for dates of service on or after July 1, 2023. The facet joint interventions category was added to the prior authorization process as part of the calendar year 2023 Outpatient Prospective Payment System Rule. It includes 10 CBT codes: six codes are for facet joint injection services and four for facet joint nerve destruction services. OPD providers that are currently exempt from submitting prior authorization requests will stay exempt for all eight service categories, including facet joint interventions. Please visit our OPD prior authorization website for more information on the OPD prior authorization process. And you can always reach us by emailing the OPD mailbox. The address is opdpa@cms.hhs.gov. And, again, the email OPD mailbox is opdpa@cms.hhs.gov. Thank you.

And I will turn it over to Joe Brooks.

Joseph Brooks: Thank you, Yuliya. And thank you to all of our speakers today. We'll now begin the Q&A portion of this Open Door Forum. As I mentioned earlier, please use the raised hand feature at the bottom of your screen to indicate you have a question. When the moderator says your name, please unmute yourself on your end to ask your question and one follow-up question as necessary.

Karen, will you please start the Q&A portion of today's open forum?

Moderator: Yes. Let me find the first person. There we go. Stephanie Van Zandt, you may unmute yourself and ask your question.

Stephanie Van Zandt: Hi, this is Dr. Stephanie Van Zandt. I'm calling from Clearwater, Florida. I'm the Medical Director at BayCare Health Systems. I have two questions. The first is considering Livanta's recent publication, the CMS—who is a CMS contractor that reviews short hospital stays under Medicare's Two-Midnight Rule—in their recent publication they opened up the door to the greater use case-by-case exception, and it seems that they have a more generous view of inpatient admission than in its previous audits, including that for urgency appendectomies and emergency gallbladder removals, according to their 2023 July publication, and that prompts the following question. Livanta says that every emergent appendectomy is appropriate for inpatient regardless of the patient's comorbidities. Does CMS agree with this, and does it also apply to the MA plans as a part of the 2024 rule?

Joseph Brooks: Hi, this is Joe Brooks. I'm not sure that we have anybody on with our agenda today that covers that topic. But we can get your question to the right folks if you'd be willing to email your specific question to our inbox, hospital_odf@cms.hhs.gov.

Stephanie Van Zandt: I sent it in already. Thanks. Another question. CMS has already incorporated the Two-Midnight Rule, applicable to MA plans under 42 CFR 422.101(b)(2). Since that is current, shouldn't the MA plans have to abide by the Two-Midnight Rule and all provisions as described currently? And how can they ignore an active federal regulation?

Joseph Brooks: Thank you for that question as well. So, I think both questions relate to a similar topic, the Two-Midnight Rule, and short stays in a Livanta memo. If we could have both of those questions—unless you may have already submitted the second one as well. If you have, then we will circle back to the inbox and make sure those are being connected with the correct people to provide you with the response.

Stephanie Van Zandt: Great. Thank you, sir.

Joseph Brooks: Thank you. Okay. Karen, do we see any further questions at this time?

Moderator: Niraj Patel, you may unmute yourself and ask your question.

Atish Patel: Actually, Niraj Patel is myself. My name is Atish Patel. I'm a Medical Director at the Atrium Medical Center in Houston, Texas. The question is, with the IPPS payments of standard and neutral, a patient who comes to us with wounds [inaudible] is not considered standard, there's no way somebody can finish the treatment in eight days or seven days. As for the PPS payment, we are looking at maximum of eight to 10 days. You can't even have done the treatment plans and everything else for stage 3, stage 4 wounds, which we are seeing more in this hospital, to take care of it. I think that CMS needs to consider those rules, not only when [inaudible] but also the people with the stage 3, stage 4 wounds can be considered at a higher level, that they can get more days up here, for up to 25–30 days to get these things—to take care of it instead of the seven to eight days. We are now rotating on these patients; we're not helping the patients. Thank you.

Donald Thompson: This is Don Thompson. I'm not entirely sure what the question part of that was, but if there was a—it seems like an observation, but if there was a question portion of that, —if—I wasn't sure.

Atish Patel: Yeah, there's a question. Can you unmute? There's a question to you. Because the IPPS payment plan for—on a standard and the [inaudible] is too different. So, what we are asking you is you have considered only standards for those people who are in ICU, who have been on a vent, and those ones—why—the question comes about, why is the standard [inaudible] on those business only not also on the wound perspective also?

Donald Thompson: So, the—I think you're referring to the—the LTCH PPS?

Atish Patel: Yes.

Donald Thompson: Okay. So, the criteria for what constitutes a standard rate payment is statutory. So that's the primary reason. It's in the law so when the law was set up about what constitutes a standard rate case, that's—those are the criteria that we apply. If you wanted to sort of lay out the particular case and send that to the Open Door Forum mailbox, I'd be happy to sort of explain how the criteria get applied, but the short answer to your question, if I followed it correctly, is that those are the statutory criteria.

Atish Patel: I get you loud and clear. And that is what the hospital does there because there's no changes to it so, you know, it's one way in and one way out within seven to eight days. Does that help the patient—I mean to say, is this written on the wall, can't be changed? How do we make these things? Because all the medical directors and everybody else who are the caretakers of the patients, this is not what we think is right for the patient.

Donald Thompson: So, in terms of CMS, we don't have the ability to change the law unilaterally. You know, we can implement the law, were it to change, and we would do so, but we don't have the ability to change the law.

Atish Patel: I see. But this is my concern. Maybe we can bring up to the—in another forum or somewhere where we can put it down to the CMS. I understand what you are trying to say. You are just—you are educating us about the law, but you can't do anything about it.

Donald Thompson: Thank you for the question.

Atish Patel: Thank you.

Joseph Brooks: Okay. Karen, and the next question?

Moderator: I am not seeing any hands raised at the moment, but I encourage you to raise your hands and ask questions. We will call on you.

Joseph Brooks: Okay. Thank you, Karen. And as we've mentioned before, after this Open Door Forum is complete, you are more than welcome to email us at the email address provided, which, again, is hospital_odf@cms.hhs.gov if you have further questions.

Moderator: And we have a hand raised by Susan Roddy. You are able to unmute and ask your question.

Susan Roddy: This is Susan Roddy. I am a Quality Coordinator at Tidelands Health. This may be a very easy question—I'm hoping. The Hospital Value-Based Purchasing for severe sepsis and sepsis shock—I have the specifications for the current sepsis program. The Hospital-Based Value Purchasing specifications sheet, has that been released? I did get the information on the percentage of patients who received the severe sepsis protocol within the three hours, but will that actually—will this particular measure have a spec sheet that we can pull from CMS?

Julia Venanzi: Hi there. This is Julia. Short answer is yes. If you want to send in your question in writing, I can send you a direct link, but the Hospital Value-Based Purchasing Program version of the measure is the same as the hospital IQR version, which is what I'm guessing you have pulled. So, the specifications are the same across both. But if you want to send a written question, I'm happy to send you a direct link.

Susan Roddy: Perfect. One more thing. With the PC-01 removal measure, that will be January 1, 2024. When—I'm asking this because this is my first year in quality and this is—I'm kind of—I'm not fully understanding how this works. When a measure gets retired, if it gets retired January 1, 2024, will that—the quarter that is due—like, the October quarter—will that be the last data that we submit, or will it be whatever quarter is due January 1 or December 31? Does that make sense? I'm still—I'm still trying to figure this out. [Laughter]

Julia Venanzi: No problem at all. And I think too when you were—there's a bunch of resources I can send that we have for new quality stuff, but to answer your specific question, when we remove something, we remove it starting with the reporting period. So, when we say we are

finalizing PC-01 for removal beginning with the Calendar Year 2024 reporting period, that would mean the last data that we required to be collected would be that quarter for 2023. That data does get reported in—

Susan Roddy: Perfect.

Julia Venanzi: —in 2024.

Susan Roddy: I understand.

Julia Venanzi: And we're running on a three-month behind actual data. But, yeah.

Susan Roddy: Okay. So, Quarter 4 2023 data will be the final—

Julia Venanzi: —submission.

Susan Roddy: —submission. Thank you so much. I appreciate it.

Julia Venanzi: You're welcome.

Joseph Brooks: Karen, do we have any more questions in the queue?

Moderator: No additional questions.

Joseph Brooks: Okay. We'll give it about a minute or so to see if anyone else raises their hand. I will pause there for about maybe 30 to 40 more seconds and see if we have any further questions. Okay. Karen, how are we looking? Any further questions or are we still not seeing any?

Moderator: No further questions.

Joseph Brooks: Okay. Okay. Well, then at this time I would like to say thank you to everyone once again for the presentations and thank you, everyone, for joining us today for the Open Door Forum. Once again, please don't hesitate to reach out and email us at hospital_odf@cms.hhs.gov. We don't always have the ability right away to answer questions, especially because of the coordination that's required sometimes to make sure we have the most accurate response to be able to provide to you. So please email us and we'll work on getting a response to your questions. This will conclude today's call. Have a wonderful day, everyone. Thank you.