Centers for Medicare and Medicaid Services
Hospital and Hospital Quality
Open Door Forum
Moderator: Jill Darling
Tuesday, January 16, 2018
2:00 p.m. ET

Operator: Good afternoon. My name is (Kim), I'll be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Hospital and Hospital Quality 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 1 on your telephone keypad. If you would like to withdraw your question, press the pound key. Thank you.

Jill Darling, you may begin your conference.

Jill Darling: Thanks, (Kim). Good morning and good afternoon everyone. I'm Jill Darling in the CMS Office of Communications. And welcome to the first Hospital Open Door Forum of 2018. Before we get into today's agenda, I do have my very quick announcement.

This Open Door Forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in but please refrain from asking question during the Q&A portion of the call. If you do have any inquiries, please contact us at press@cms.hhs.gov. And now, I'll hand the call over to our chair, Tiffany Swygert.

Tiffany Swygert: Thanks, Jill. Hi, everyone. This is Tiffany Swygert. I am the Director of the Division of Outpatient Care on the Medicare side of CMS. And I wanted to wish everyone a very happy new year and thank you all for calling into this open-door forum today.

I do have a couple of quick announcements before we jump into our agenda. The first one is an invitation to join another meeting that you should have received an invitation to through the open-door forum listserv. That was last Thursday. An invitation to the American Hospital Association Townhall Webcast which is scheduled for tomorrow Wednesday, January 17 at 4 PM Eastern Time.

AHA President and CEO Rick Pollack will be joined by CMS administrator Seema Verma to discuss current regulatory landscape. Together, they will discuss areas of priority and challenges for hospital and health system as well as for CMS. And they will preview new efforts to reduce regulatory burden that will be rolled out this year. So it sounds – it promises to be a very exciting webcast and please check your email or reach out to partnership@cms.hhs.gov. If you did not receive the message they can resend you the information so you can login to that.

The other announcement is related to a new resource that we have available for any questions related to midnight reviews and the QIO reviews of shortstay, hospital stay. That resource is shortstayreview, S-H-O-R-T-S-T-A-Y, review, all one word, @cms.hhs.gov. We typically receive a fair number of questions to the hospital open-door forum inbox related to short-stay reviews and questions for the QIO's that we have established as resource there for you so you can more easily get in touch with the folks who can address those questions. We'll repeat that later on if there are any questions and also that email address will also be added to the short-stay review website that's part of the CMS webpage.

So, with that, I will turn it over to Jill to start the agenda.

Jill Darling: All right. Thank you, Tiffany. First of we have (Tehila Lipschutz) who has a quick announcement about the 2019 wage index timeline.

(Tehila Lipschutz): Hi, this is (Tehila Lipschutz). We want to review certain changes that we made to the FY 2019 Wage Index Development Timetable. In late December, hospital should've received a letter automatically from their MACs notifying

them of the few changes to the fiscal year 2019 timeline, mainly the revised date for posting of the January PUF and the new appeal deadline.

The fiscal year 2019 Wage Index Development Timetable originally stated that January 30, 2018 would be the day of the release of the revised fiscal year 2019 wage index and occupational mix file as PUFs, public use files on the CMS website. However, as a result of hurricanes, CMS granted an extension for hospitals in certain affected areas to request revision to and to provide documentation for the wage and occupational mix data.

Now, this extension delayed the completion of fiscal year 2019 (desk reviews) for many hospitals in the affected area. Therefore, we may delay the posting of the two PUFs to anytime between January 30, 2018 and February 2, 2018. And the original date was January 30th. And now, we're making that a little broader until possibly February 2nd, just a few days later.

You can see the revised fiscal year 2019 Wage Index Development Timetable reflects this date change on the web. Now, in the FY 2018 final rule, we also stated that effective with the fiscal year 2019 wage index, CMS will institute the additional appeals process. For hospitals to appeal data corrections made by CMS after the closing of January PUF, to allow for input from hospitals concerning corrections that were made by CMS after the posting of January PUF that do not arise from the hospital's request for a (wage index) correct revision, hospitals could use the soonest approaching appeal deadline to dispute any adjustments made by CMS.

Specifically, if you refer to the revised fiscal year 19 Wage Index Development Timetable, you'll see that under the date of April 5, 2018, it indicates that April 5, 2018 is the deadline for hospitals disputes data correction made by CMS of which the hospital is notified after January 30th – after January 30th PUF, which as I mentioned before would now possibly be the February 2nd public use file, and prior to March 22, 2018, that do not arise from a hospital's request for a revision, so this is to dispute correction made by CMS not coming from the hospital.

Similarly, for any adjustments made by CMS between the April appeals deadline, which is March 23, 2018 and before the May appeals deadline which is May 16, 2018 this year, hospitals will have until the May appeals deadline, which is May 30, 2018 to dispute any adjustments.

In cases where the hospital disagrees with the CMS adjustments of which they were notified before May 17, 2018 or later, the hospital could appeal to the PRRB with no need for further review by CMS before such appeal. So it will be past the last deadline, the last internal appeals deadline.

The revised fiscal year 2019 Wage Index Development Timetable has this additional appeals deadline under the date of May 30, 2018. And hospitals can find the fiscal year 2019 Wage Index Development Timetable as well as other fiscal year 2019 wage index information on the web, I would suggest Googling FY 2019 wage index homepage. And that should bring you to all that information on the revised fiscal year 2019 Hospital Wage Index Development Timetable. Thank you very much.

Jill Darling: Thank you, (Tehila). Up next, we have (Bill Lehrman) who will talk about the new communication about pain question on the (HCAHP) survey that began this month, January 2018.

(Bill Lehrman): Thank you, Jill. I'd just like to say a few words about the new pain items on the (HCAHPS) survey. In August of last year, CMS announced that it would replaced the original pain items on (HCAHPS) survey with three new items to change the focus to how well the hospital communicated about pain with the patient during the hospital stay, these items 12, 13 and 14 on the (HCAHPS) survey.

These new questions are required on all surveys given to patients discharged from January 1, 2018 and forward. So the old – the original pain items apply to patient discharged until the end of 2017 and the new items pertain to those discharge beginning January 1, 2018 and forward.

The new items will comprise a measure called communication about pain and it will be calculated the same way that we calculate all the other (HCAHPS)

composite items on the survey. The new items will be publicly reported on Hospital Compare for the first time in October of 2020. So, what's going to happen is, we will collect the first year's worth of data that is calendar year 2018, but we won't report that publicly. However, we will report those scores to the individual hospitals who participate (on their Hospital Compare Preview Reports).

In October 2020, we will publicly report the scores of all hospitals and hospital compare for the first time. So, for the first year, we will – first two years really, we'll report the scores of hospitals only to the hospitals. And then, beginning October, 2020 on Hospital Compare, we'll publicly report the new Communication about Pain composite measure.

Also, I should note that for hospitals that participate in the Hospital Value-Based Purchasing program for HVBP, the Pain Management dimension has been removed beginning with this year, fiscal year 2018. So, there's no longer any Pain Management dimension in HVBP formula. To find out more information about the new pain items in the survey, please visit our podcast on HCAHPS online website. And the address for the podcast or website is on the agenda for this call. And I'll be happy to take up questions about this topic later, if you have any.

Jill Darling: All right. Thank you, (Bill). Up next, we have Ronke Fabayo, who has an announcement about the low-volume settlement opportunity.

Ronke Fabayo: Hi. Thank you, Jill. Good afternoon, my name is Ronke Fabayo and I am the Deputy Director for the Division of Medicare Debt Resolution in the Office of Financial Management. As part of the department's broader efforts to improve the appeals process, beginning February 5, 2018, CMS will make available an administrative settlement options for providers and suppliers or appellants with appeals pending at the Office of Medicare Hearings and appeals and the Medicare Appeals Council at the departmental appeals board.

The low-volume appeal settlement option or LVA will be limited to appellants with the low-volume of appeals pending at OMHA and the Council. Specifically, appellants with fewer than 500 Medicare part A or part B claim

appeal pending at OMHA in the council combined as of November 3, 2017 with the total billed amount of $9,000 or less per appeal could potentially be eligible, if certain other conditions are met. CMS will settle eligible appeals at 62 percent of the net approved amount.

CMS hosted a Medicare Learning Network provider call on January 9th to discuss the process in detail. The transcript for this call as well as the YouTube link to the full presentation will be available within the next two weeks on our LVA website. That website addresses is go.cms.gov/, capital LVA. Again, it's G-O.C-M-S.G-O-V/, capital L, capital V and capital A. Until then, there is a wealth of information regarding the settlement option on the LVA website including the settlement process document and frequently asked questions.

Please note, the CMS will host additional Medicare Learning Network call on February 13th and March 13th after the settlement process begins. We encourage those who are interested to visit our LVA website for information on this new opportunity and to attend our future Medicare Learning Network call. As a reminder, that website address again is go.cms.gov/lva. If you have any questions related to this process, please contact us at medicaresettlementfaqs, again all one word, medicaresettlementfaqs@cms.hhs.gov. Thank you, Jill.

Jill Darling: Thank you, Ronke. And last we have, (Agnelli Sybel) who will talk about the new payment model, bundled payments for care improvement advance.

(Agnelli Sybel)): Thank you, Jill. I want to share with you some details about a new voluntary payment model that CMS announced last week. CMS Innovation Center developed the bundled payment for care improvement advance model to build on their earlier successes of bundled payment models and it's an important step in the move away from fee-for-service and towards paying for value. The model will align incentives for reducing cost with those for improving coordination and quality of care to Medicare beneficiaries.

So, what is the bundled payment? The bundle – the BPCI Advanced model operates under a total cost of care concept. That means that the total Medicare

fee for services spending in all items and services furnished to a beneficiary are included in the clinical episode unless specifically excluded. Then those expenditures are compared against the target price previously calculated by CMS. If things go well, participants may receive additional payment from CMS. And if not, participants will owe money to CMS.

So, here's some details about the model. Like I said, it's a voluntary bundled payment model. It has a single retrospective payment and a single (risk) track within 90-day episode period. There are 32 clinical episodes, 29 are inpatient clinical episode and 3 are outpatient clinical episodes. That is something new for this model. Those three episodes are one procedure, eliminate the coma after percutaneous cardiac defibrillator, and back and neck except spinal fusion.

For those of you familiar with the BPCI, the initiative that has been in place since 2013, the number of episode have been reduced from 48 to 32, but we have a new one, which is disorder of the liver, excluding malignancy, cirrhosis, and alcoholic hepatitis.

Something that is also new for the BPCI Advanced is that preliminary target prices will be provided to participants before the start of the performance period. Also, this model qualifies as an advanced alternative payment model because it meets the three criteria. First, the payment is tied to quality measures. The model has seven quality measures, two that are general and apply to all clinical episodes and five that are episodes specific. Number two, participants will be financially at risk for up to 20 percent of the final target price. And third, participants will be required to attest to their use or certify electronic health record technology prior to participating in the model.

So, who can participate? There's two types of participants, convener participants and non-convener participants. A convener brings a group of organizations that share risk and initiate episodes. They can be Medicare enrolled providers or non-Medicare enrolled providers. A non-convener participant must be a Medicare enrolled provider that itself is an episode initiator.

So, who can be an episode initiator? For this model, episode initiators are limited to acute-care hospitals and physician group practices.

There is a small subset of acute-care hospitals that are not eligible to participate in BPCI Advanced. They are critical access hospitals, prospective payment system, exempt cancer hospitals, inpatient psychiatric facilities, hospitals in Maryland, hospitals in the rural community hospital demonstration and hospitals in Pennsylvania rural health model.

So, if you're interested in applying, the Request for Applications was published last week along with the application template and they can be found at the CMS Innovation website. Instead of giving you a very long website address, Google CMS Innovation Center and search for BPCI Advanced. The deadline for applications is March 12, 2018. And applications are only accepted via our web-based portal.

The next opportunity for applications would be the year 2020. On the website, you will find a variety of resources like fact sheets, frequently asked questions, episode definition and later in the week, we will have two webcast that provide model overview and how to apply. We will also hold an open forum for questions and answers on January 30th from 12 to 1 P.M. Eastern Standard Time. So, if you have some questions, you can email the BPCI Advanced team at BPCIadvanced@cms.hhs.gov. That's all I have.

Jill Darling: Thank you, (Agnelli). And thank you to all of our speakers. (Kim), we'll go in to our Q and A please.

Jill Darling: All right. Well, thank you everyone for joining us today. Please note that the next Hospital Open Door Forum is scheduled for February 27th. I know it's currently not on the agenda but as you know, it's always subject to change. So, just please note February 27. And we thank you for your time today. Have a wonderful day.

Operator: Thank you for participating in today's Hospital and Hospital Quality Open-Door Forum conference call. This call will be available for replay beginning today at 5 P.M. through midnight on January 18th. The conference ID

number for the replay is 31068802. The number to dial for the replay is 855-859-2056.

This concludes today's conference call, and you may now disconnect.

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