Centers for Medicare & Medicaid Services
Rural Health Open Door Forum.
Moderator: Jill Darling
Thursday, March 7, 2019
2:54 p.m. ET

Operator: Good afternoon. My name is (Regina) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services Rural Health 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: Great. Thank you, (Regina). Good morning and good afternoon everyone and welcome to today's Rural Health Open Door Forum. I'm Jill Darling in the CMS Office of Communications.

Before we get into to today's agenda, I have one brief announcement. This Open Door Forum is open to everyone but if you are member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you have any inquiries, please contact CMS at press@cms.hhs.gov.

And I will hand the call up to our chair, Carol Blackford.

Carol Blackford: Thank you, Jill. Good afternoon and good morning everyone. Thank you for joining our call today. I'd like to welcome you on behalf of myself and John Hammarlund, my other co-chair for this Rural Health Open Door Forum. And actually I'm going to keep my opening remark short today. I'm battling a little

bit of a cold and I'm sure everyone online doesn't want to necessarily hear me cough and sneeze, so I'll keep my remark short.

We have a really great agenda today that I'm excited about. And the items on the agenda or really are an (outgrowth) of all of your suggestions and feedback that you have provided around the information that you think would be useful and a productive way to use the time for this call. So, thank you for those suggestions.

At the end of the call, I will remind everyone of the e-mailboxes that you can use to continue to provide to feedback and your thoughts. So, for those of you who stay tuned for the entire call that will be one of your rewards, right? You will get that information again and hopefully you will continue to provide your feedback on agenda items.

So with that, let's go ahead and dive right in.

Jill Darling: Thanks, Carol. First off, we have Joe Clift who will go over the Hospital 5-Star Rating System.

Joe Clift: Hi. Can you hear me OK?

Jill Darling: Yes, go ahead.

Joe Clift: Great. Thank you very much and thank you for having me today. What I wanted to talk a little bit about today is Overall Hospital Quality Star Ratings and the information that CMS has put out for public comment. And then, you know, answer any questions anybody has time permitting.

So, before I dive in to the item for public comment, I just want to give us a status of where we are right now. So, the Star Ratings and the Hospital Compare datasets were updated on the Hospital Compare website, last week on February 28. That update to the star ratings, it's the most recent update we have had. As many of you know, with CMS did not refresh the star ratings in July of 2018. The prior refresh was December of 2017.

And in July of 2018, we had some hospitals reach out and we're concerned about what they saw was drastic changes in their star ratings. A lot of hospitals had moved up or down, two or three stars and were concerned about the methodology.

And CMS spends a good a part of remainder of 2018, talking with hospitals, reaching out through listening sessions, having stakeholder meetings with various organizations to understand what their concerns were.

And a few changes the CMS made for the star ratings methodology for February that I just want to touch one now. One change was a model input change where if a measure had a specifically significant negative loading in the model, we would remove that measure from the star ratings calculation for all hospitals. That is a – was just a model input change and there was no measure that had a statistically significant negative loading.

The other change we made for February was bringing in additional data to the Healthcare-Associated Infection measures and the safety of care group. Previously, the denominator for those measures was predicted infections. And for many hospitals that's a very small denominator, generally, around one, two, or three, or less than one.

And the latent variable model that is used for the star ratings – measures that have large denominators like the PSI-90 which is in the millions, gives more weight to measures within that group, and hence, has a higher loading. So, what we did was to bring in additional data elements to the model to increase the loading for those measures.

And those additional denominator elements are the number of the patient days on the device, number of procedures, et cetera, that already accompany the CDC measures. So, we still use the risk-adjusted standardized infection ratio, the SIR, to determine the hospital score. But we've brought in additional data elements to help bolster the loading for those measures by increasing the denominator.

So, those were the two methodology changes that hospitals saw in their preview report in December that predated the Hospital Compare refresh on last week, on the 28th of February.

In addition on February 28, CMS released for public comment. Some changes we're considering to the star ratings and that's what I want to spend a little bit of time going over.

And these changes that we're considering are a progression of the feedback that CMS has received from variety of stockholders, both on the provider side, and the patient, and consumer side. And in that document for public comment, we're seeking comment on two kind of buckets of changes.

The first bucket is changes that CMS can make relatively quickly, probably by the next refresh of the star ratings. And then the other changes are – things more long-term thinking where we need to do more analysis and have more thinking about those changes, but we wanted to put them out there to see what public comment was on those items.

So, I'll start by briefly going through the areas that was – can immediately address some stakeholder concerns that we're seeking comment on. And the first deals with measure grouping. And as many of you are aware, as a part of the Meaningful Measures initiative, CMS has a lot of measures that are being removed from programs, swapped between programs and also adding measures to programs.

So, what we're seeking comment on is there a way – is the current way we group the measures still the best way to do so? Are there public comments, feedback that our stakeholders have on how CMS should consider measure groupings in this new environment of measure changes? And we've put some ideas out there in the section for public comments. So, what we really want to see what the feedback is on this particular topic of measured groupings.

The second area we're seeking comment on is in dealing with incorporating measure precision into the latent variable model. And really what this is getting at is, are there ways that we can adjust the model so that the one

measure does not dominate all other measures within that group. And a really good example of this is the PSI-90 measure dominates the safety of care group, again because of each large denominator. And are there ways that we can incorporate changes into the model to help address that, so that the loadings between measures are a little more even. So, we're seeking comment on some ways that we can do that.

Another area we're seeking comment on is also dealing with the model but its ways to deal with period-to-period shifts. And this kind of gets out what happened between what hospital saw when the got there July 2018 preview report and they saw, maybe their star rating had dropped two or three stars, or for some hospitals, their star rating were actually went up two or three stars and they really want to make sure why.

So, what we're looking at is there ways that we can address those stakeholder concerns about what they perceive as large shifts in their star ratings from period to period. And this is particularly tricky because the highly comparative nature of the star ratings, period to period shifts are expected as measures are added to programs as hospital performance improves or, you know, worsens when compared to other hospitals.

So shifts are expected in the star ratings, but what hospitals have expressed as concern about is what they see is large swings in star ratings from period to period. So what we're looking at is that there are model inputs we can address to help deal with some of their shifts.

And the last item that we're looking at which I might be more relevant to this particular group is dealing with peer grouping. And what we have heard from a lot of hospitals is that a lot of smaller rural hospitals don't submit many of the same and number of measures that large hospitals submit. And to have all hospitals rated against each other, it's not appropriate.

So what CMS is seeking comment on this, are there ways that we can peer group hospitals so that there are more like to like comparisons. And some of the variables that we have put in the document for public comment that we're looking at are variables such as the number of measures the hospital submits.

And this is kind of getting at that a smaller hospital will submit fewer measures and the larger hospital will submit more measures. So is there a way that we can group hospitals together so that their hospitals star rating is based on hospitals that look more similar to them.

And this is something that, again, that we heard from a lot of hospitals during the listening sessions that we had last summer and also during the variety of stakeholder meetings that we had. Some of the longer term potential changes that we're looking at, and again, this require a little bit more thought, a little bit more analysis.

And one is looking at an explicit approach to calculating the star ratings. So, that could be coming up with a different statistical model to determine a hospital's score on the star rating looking at fixed weights for measures within a group. So, for example, instead of having a statistical model determine the loading of a measure within a group, we could assign a fixed weight for measures within a group.

Another thing that we're looking at is possibly alternative clustering. So right now what we use is a statistical approach called k-means clustering. And basically that clusters at hospitals based on their scores together into five categories. There's five categories being the one, two, three, four, or five star rating. So what we're looking at is there are other ways that we can assign the star rating that doesn't involve this statistical clustering approach.

And one item in the document that you'll see is we could setup predetermined cutoff points. So, for example, if you were – if you could plot all of the hospitals scores on the number line and set predetermined cutoff points for each star rating, would that be an approach – an alternative approach to finding a star rating for a hospital?

Another thing we're looking at is incorporation of improvement. We have heard from some hospitals that they think that if their star rating improves from a previous time period, that they should get credit for that. And there is a similar approach within the dialysis facility star ratings that uses an improvement. So what we're looking at is, is there a way that we can account

for an improvement in a star ratings on a hospital? So we have some ideas around that that we're seeking public comment on.

And finally the last thing – the long-term sort of thing we're looking at is the possibility of creating a user customized star rating. So what that means is that a patient or a consumer can go on Hospital Compare and select measures that are important to them for, you know, maybe something that they're looking at.

So, for example, if that patient is looking at having a joint replacement, they might type in joint replacement and some measures come up related to that, maybe some patient safety, surgical measures, the hip and knee complication measure. And a star rating could be generated from that user defined input.

So, again, that something that is going to certainly require a lot more thinking around but these areas that I just talked about CMS is interesting in getting some early stakeholder feedback on these items to help sort of drive our next thinking for future enhancements to the star ratings methodology. So the star ratings public comment period it open on the 28th and we are looking for comments to be received by March 29th.

After that time period, our support contractor is going to go through all of the comments received and kind of summarize the feedback from the various stakeholders, from the provider community, the hospitals, the associations, the patients' consumers. And then CMS is going to make some decisions around the next updates to the star ratings methodology.

Related to that is that you're also seeing a public comment is for – if CMS is considering moving to an annual star ratings. So currently, we refresh twice a year in July and January and then we were delayed from January. But we're looking at possibly moving from a twice a year refresh a star ratings to a once a year refresh. So we're also seeking public comment on that. And the idea is that based on the public comment that we received, we're helping form the next update to the star ratings methodology.

So that's what I wanted to go over this morning with – this afternoon with the group. And I can take any questions now or however you want to handle that.

Jill Darling: Great. Thanks, Joe. We'll be taking questions at the end of all presentations today.

Joe Clift: OK.

Jill Darling: And thank you. And up next, we have Ashby Wolfe who will go over the Opioid Prescribing Mapping Tool.

Ashby Wolfe: Thanks so much and hello everyone. My name is Dr. Ashby Wolfe. I'm one of the regional chief medical officer here at CMS based out in our western regions of 8, 9, and 10, so Denver, San Francisco and Seattle.

But the information I'm going to speak to is applicable across the entire country. And as many of you may be aware, CMS has been highly focused on the opioid epidemic for several years. You may recall that in June of 2018, so last year, we published the CMS Opioid Roadmap really to illustrate how our agency is working on the opioid epidemic, and specifically looking at ways that we can leverage data and the analysis of that data to best understand trends in opioid prescribing, opioid use and to better target our prevention and treatment effort.

Some examples of that work have included leveraging our over utilization monitoring system, our substance use disorder analytics tool for the Medicaid population, and of course our opioid prescribing mapping tools, of which there are two. There is the Opioid Part D Mapping Tool and the Medicaid State Opioid Prescribing Mapping Tool.

And on the agenda today, you had a link to the Medicare Part D Opioid Prescribing Mapping Tool website from which you can also find the Medicaid state tool as well.

So I wanted to take a few minutes just to describe this tool partly because the tools were just refreshed in February of this year, and now contain more information particularly that can be relevant to rural community.

So in brief, if you do take a look at this tool by following the link on your agenda, you'll see that it's actually both tools are interactive tools that show geographic comparisons. And the Part D tool in particular shows comparisons of the state, county and ZIP code levels.

What we're looking at with the Medicare Part D Opioid Prescribing Mapping Tool is the identified Medicare Part D opioid prescription claims. Either prescriptions that were written and then submitted to the field across the United States. And the mapping tool presents the Part D opioid prescribing rates as well as changes in the rates over time.

So as a user, you can actually see both the number and percentage of claims at the local level depending on what level you're looking at. And we hope this information will actually help folks better understand how the opioid epidemic is impacting communities across the country. The data as I mentioned can be used in an interactive way and displays multiple different versions of the data.

But in the Part D Opioid Prescribing Mapping Tool, this data, again, reflects Part D prescription claims prescribed by health care providers. The mapping tool does not contain any beneficiary information nor does the information presented in the tool indicate quality or appropriateness of care at all. It's really just an information tool to look at trends in terms of prescribing.

And as I mentioned, the tool was refreshed just last month and really is part of CMS's effort to provide a level of transparency about prescribing patterns, really to inform community awareness. CMS is also working with multiple other agencies including the Centers for Disease Control to develop additional support tools for clinicians in order to help them make informed prescribing decisions.

Now, with respect to the information in the tool, you can drill down, as I mentioned earlier in a variety of ways, on the Part D tool, you can look at the

prescribing rates and percentages of the state, county and ZIP code levels and you can select specific geographic areas as well as additional information that can be displayed.

You can also look at prescribing rates of opioid in general. You can look at the rates broken down by rural or urban community and you can do cross comparisons. You can look at the change in opioid prescribing rates as well as what we call hot spots and outliers. Areas of the country where there are particularly high clusters of opioid prescribing going on.

In the Medicaid State Opioid Prescribing Mapping Tool, the information is just about the same. Only the data that's reflected is for Medicaid prescription drugs prescribed by clinicians. And because Medicaid is a state federal partnership, you'll see that the data does look a little bit different than the Part D tool.

But again, the Medicaid tool does not contain any beneficiary information nor does it reflect the quality or appropriateness of care. Again, the Medicaid tool just like the Part D tool is really meant to provide a level of transparency of information about prescribing rates across the country.

So I hope if you aren't familiar with this tool that you will take a look, as I mentioned, the link on the agenda will take you first to the Medicare Part D Prescribing Mapping Tool and from that web page you will be able to find the Medicaid State Opioid Prescribing Mapping Tool as well.

Certainly happy to take any questions. But with that, I'll hand it back to our chair.

Jill Darling: All right, thank you, Ashby. Up next, we have JoAnna Baldwin, who will talk about Appropriate Use Criteria Program and CAHs and this is from in response from inquiries from you all.

JoAnna Baldwin: Hi everybody. So yes, this is JoAnna Baldwin, I work with the Appropriate Use Criteria Program under Medicare. And yes, we're here today because, you know, we want to thank the regional offices also increase for coming into

them, they've been sending them to us. So we've realized that this is a question about how Critical Access Hospitals relates the Appropriate Use Criteria Program. It's a question that's been coming in quite a bit. So we're here today, you know, to try to answer the question for a lot of people at one time.

So before I can get into the details of how CAHs interact with the program. There maybe a number of you on the phone that aren't familiar with the Appropriate Use Criteria Program. So I'm going to give kind of a short background on that.

So, we call it the AUC Program, Appropriate Use Criteria, it is for Medicare fee-for-service and it is for non-inpatient imaging services.

So, in general – so this came about through the PAMA legislation in 2014. And we have been slowly and steadily building up and beginning this program year by year through the Physician Fee Schedule, standing up different parts of the policy. And at the end of the day, what this is, is that a practitioner that orders the test for Advanced Diagnostic Imaging Services, that practitioner must consult Appropriate Use Criteria.

Now that consultation with AUC must occur through a qualified clinical decision support mechanism and CMS qualifies them. We have a list on our website.

And then that consultation information has to be reported on the claim that gets submitted by the facility and practitioner that furnished the advanced imaging service. So I say it that way, because it is the responsibility of the ordering practitioner to consult AUC, but CMS received that information through the claim that get generally in this the case submitted by the radiologist and the imaging center. So the information kind of has to come full circle.

So the AUC Program is required whenever that advanced diagnostic imaging service is furnished in what the statute calls an applicable setting. An applicable setting includes the physician office, hospital outpatient

department, ambulatory surgical center, or an independent diagnostic testing facility.

A critical access hospital is not an applicable setting for this program. Therefore, advanced diagnostic imaging that is furnished in a CAH is not subject to AUC consultation. And therefore, claims for those services are not subject to reporting AUC consultation information.

So advanced imaging that is furnished in applicable setting is subject to the AUC Program. So, if a patient received imaging in a setting that is not a CAH, then the AUC Program requirements may very well apply. So if a practitioner that is located within a Critical Access Hospital orders imaging for a patient, that patient goes to an imaging center somewhere else that is consider then an outpatient hospital or an ASC, then we would expect that claim for the imaging services to contain appropriate use criteria consultation information and it is again on that ordering practitioner to do the AUC consultation.

Like any good program, there are exceptions to it. And for the ordering practitioners, we did stand up just this year the significant hardship exception. Now, again, significant hardship applies to the ordering practitioner. So, examples of those, we have three categories and they are insufficient internet access, EHR or a vendor issues, and extreme and uncontrollable circumstances.

There is not an application for those hardships, it is self-attestation. So, if an ordering professional is experiencing the hardship, we are in the process of setting that HCPCS modifiers and related code so that that information can ultimately be reported on that furnishing practitioner claim.

So, I think, you know, I think the big message that I want to get across is that Critical Access Hospital is not an applicable setting for the AUC programs. Imaging that occurs within a CAH is not subject to reporting appropriate use criteria consultation information.

With that, I know there are probably still a lot of outstanding questions. But for the most part, I think that, you know, that should hit the biggest criteria that a CAH is not an applicable setting.

So with that, we shall move on to what's next.

Jill Darling: All right, thank you, JoAnna. Next we have Mike Keane, who will go over the DMEPOS Competitive Bidding Program temporary GAP period.

Michael Keane: Thanks Jill. Hi, all. This is Mike Keane working at the DME Competitive Bidding area along with Joel Kaiser who is with me today, who will also aid in this discussion.

Just to give some quick background, I don't know if the folks on the call know exactly what the DMEPOS Competitive Bidding Program is. What it is? It's a program whereby CMS awards contract to DMEPOS suppliers. And DMEPOS is Durable Medical Equipment, Prosthetics, Orthotics, and Supplies or DMEPOS. We award contracts to the DMEPOS supplier assessment bids to become contract suppliers, to provide certain items of durable medical equipment.

Some examples of the items that we've included in the program so far are enteral nutrients, hospital beds, nebulizers, oxygen, waters, and wheelchairs. So far to date, we've implemented in about 130 competitive bidding areas throughout the country. And the contracts were in place up until December 31st of 2018. Those contracts are now all expired and all of 130 areas in the country and they're on or no current competitive bidding programs in place, that is due to some changes that the administration decided to make to the program. We went through comment and rulemaking and finalize new regulations that went into effect January 1st of this year.

So, the changes are now going to be implemented very soon. CMS will be announcing in the near future the next steps of the program, where we'll be implementing new contracts and implementing these changes. So, as a result of that, they – we are reverting back to some of the fee-for-service rules in

these competitive bidding areas, and Joel Kaiser will be discussing those implications now as well as some additional information. So thank you.

Joel Kaiser: Thanks Mike. Hi, this is Joel Kaiser. And as far as impact on rural areas, competitive bidding in 130 areas that Mike mentioned are 130 fairly large metropolitan statistical areas. So, primarily, the program has been implemented in urban areas. There are some parts – since some of these metropolitan statistical areas are large geographically. There are some parts of the areas that are a little bit more remote, a little bit more rural than other areas, but you could have some rural areas surrounding the competitive bidding areas.

But the competitive bidding areas for the most part are not rural areas. But in any event, some of the changes that may affect beneficiaries during this – what's expected to be a two-year gap in the competitive bidding program, is that under competitive bidding, in these areas, contract suppliers are mandated to furnish items to the beneficiaries. They can't turn any beneficiary away anywhere in the area.

Now with the program paused for the moment, we don't have contract suppliers in these areas any longer so any enrolled supplier can furnish the items. Unlike competitive bidding, they don't have to furnish the items so if there's a beneficiary in a more remote part of a competitive bidding area, this part may not, you know, choose to take that patient on. So, they may have less choices of suppliers than they did under competitive bidding.

The other big change is that under competitive bidding the contract expires must accept the Medicare payment amount, as payment in full. So the beneficiary's liability is limited to 20 percent of the payment amount under competitive bidding.

Now, that the program is in a gap period, items that are furnished to beneficiaries in these areas that are former competitive bidding areas will be paid based on fee schedule amounts that are equal to the payment amounts we were paying under the competitive bidding area in 2018, updated by an inflation update factor. But the supplier does not have to accept that payment

as payment in full. They can choose not to accept the assignment of the claim and can charge the patient more.

Now, based on the history of suppliers and their assignment pattern in noncompetitive bidding areas where we pay for items based on competitive bidding rates, in those areas, historically, suppliers have not had to accept the assignment either but yet, it's 99.7 percent of the time they have.

So we're not expecting a large amount of unassigned claims during this gap period which is good, but we will be monitoring that to make sure that, number one, people are getting access to items and services; and number two, that we'll be tracking assignment to see if there is any impact on beneficiary cost sharing during this gap.

And the other thing we'll be doing during the gap is monitoring health outcomes to make sure there's no significant – it change, negative change in health outcomes during the gap period. Now that, you know, we don't have contract suppliers that are there to meet the needs of every beneficiary and every bidding area.

And I think that's all we wanted to cover regarding that update. Thank you.

Jill Darling: Great, thank you, Mike, and thank you, Joel, and thank you to the rest of our speakers today. (Regina), will you please open the lines for Q&A please.

Operator: As a reminder, 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.

And once again for any questions please press star one on your telephone keypad.

Your first question comes from the line of (Sheila Gopel).

(Sheila Gopel): Hi, thanks for taking our call. In September of 2018 there was a proposed rule for the regulatory provision to promote program efficiency, transparency and burden reduction. The comments were to be on November 19th. I was wondering if anyone in the room knows when the final rule will be out on that rule.

Carol Blackford: Hi, (Sheila). This is Carol Blackford. Do you have more information on the specific rule we published a couple of rules that could have a similar title? If maybe you could give me the title and the date, and e-mail that to RuralHealthODF@cms.hhs.gov, I can get you a response regarding when there would be a final rule published.

(Sheila Gopel): I can sure do that. Can you repeat the e-mail address RuralHealth@ …

Carol Blackford: Sure, it's RuralHealthODF, so for Rural Health Open Door Forum, and at cms.hhs.gov.

(Sheila Gopel): Thank you very much.

Carol Blackford: You're welcome.

Operator: Your next question comes from the line of (Diana Albust).

(Diana Albust): Hi. Thank you for taking the question. I have an AUC question. If the provider ordering imaging is on a Critical Access Hospital, the imaging occurs in the critical access hospital, but the person reading the image is located offsite, does that require an AUC?

JoAnna Baldwin: It does not. And the reason is because the – because of the setting where the imaging is furnished. Since the imaging service was furnished in a Critical Access Hospital, then that is all that needs to occur.

In situations where the radiologist for example will submit a separate claim for the professional component of that service, the place of service that they put on their claim is the place of the patient at the time that they were furnished the imaging service. So it's not based on the location of the radiologist that is reading the claim.

And we're on – we're in the process of making sure that as the program begins which this program has not started yet, it's only in a voluntary phase. We're working to make sure that we can identify all those variations of claim types that come in for services that are furnished within a CAH.

(Diana Albust): Thank you.

Operator: And we have no further questions at this time.

Jill Darling: All right. Well, thank you, everyone, for your participation today. If you do have a question that you were not able to ask on the call, please feel free to send us questions into our Open Door Forum mailbox, the address is RuralHealthODF@cms.hhs.gov. And you can use that e-mail box to send us suggestions for future Open Door Forum call agendas, so we look forward to receiving your questions, your agenda items and thank you again for participating today.

Operator: Thank you for participating in today's Rural Health Open Door Forum Conference Call. This call will be available for replay beginning at 5:00 p.m. Eastern Time today through 11:59 p.m. Eastern Time on March 11. The conference ID number for the replay is 3095008. The number to dial for the replay is 855-859-2056.

Thank you for joining and you may now disconnect.

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