Questions and Answers from Hospital Open Door Forum- July 24, 2019

1. Are there any plans to ask KEPRO or make them reimburse hospitals for all of the free care that they had to give throughout that time to patients while they're waiting for the appeals?
   a. At this time, we are still investigating the best way to approach reimbursement moving forward. We are looking to provide updates to that in the future.

2. Is there any update on what's happening with the short stay review audits, and if there is a new contractor, will it be KEPRO and Livanta, will they have the same look back period. Will they be looking at total knee replacement as KEPRO and Livanta were?

a. For short stay review, we are currently undergoing the procurement process for that. Once awards have been made, we're anticipating sometime next month (August, 2019), that work will resume. So at this moment because it's still under procurement, there's not much detail I can provide at this time.

3. My question relates to the iQIES system. I'm designated as the provider security official (PSO) at my hospital and I'm also the assessment coordinator. As the PSO, will I also have submission capabilities (dual role)?

a. We are actually working on that at the moment because we prefer that individuals have the ability to have the dual role, but currently the roles are split. We will be sending out communication shortly one way versus another if you do have to have a second security official in order to submit assessments. We would still like you to have a second security official if possible in the event you're unavailable.

The PSO is just responsible for the approval and denial of requests for your organization; we realize that it would be beneficial for one person to have both of those roles – PSO and assessment submitter.

4. Follow up to Question 3- We do have 2 designated PSO's, but I just wanted to know if the PSO's will be able to submit assessments. There are so many different roles and descriptors and under the PSO role, it doesn't say anything about whether a PSO can submit assessments.

a. We will provide that clarification in a communication that will soon be released. We're working to try to have that dual role in place by October (of 2019) and as long as your organization is getting all the information that we've been sending out, you will receive that communication that will describe the roles and if that one person can perform both roles. The information will also be posted on QTSO.cms.gov.

5. I was just wondering if you have an approximate date of when the OPPS proposed rule will be available.

a. We do not have information available about the release of the OPPS rule, but we do expect that it will be in the near future.

6. Since the payment model will be half up front and half at the end, I assume the providers will be allowed to bill the patient for their 20% once they get there 50% reimbursement, is that correct?

a. That is correct. And we have a whole description in the rule about how you do that: there are options if the 20% is one chunk and is a little hefty for beneficiary.

7. There will not be a limit on it as there is with the Part A copay, part A deductible, you know, matching number.

a. The hospital outpatient limit will still be in existence.

8. Proton beam therapy is included as a modality of radiation. So proton beam therapy is reimbursed at a higher rate and tends to be subjectively over used, possibly because of the additional reimbursement. Will CMS be monitoring to ensure that physicians are choosing the modality that's best for the patient and not best for the financial aspects of the provider?

a. And that's the purpose of the bundle payment in making a modality agnostic --we're encouraging the use of the best treatment through this payment methodology, but we will be monitoring for changes in treatment patterns. What I didn't mention, but is mentioned in the rule, is between the two claims that where you get your 50% of the payment and be getting the 50%. And we will be asking provider systems at no pay claims with line item, RT services on there so that we can see just how much therapy is being given or not given during the model.

9. CMS is proposing to include in the bundle payment Brachy therapy sources, but it's not clear if the cost of the episodes or the cost of the actual sources are included in the proposed national base rates. Where those cost included in the national base rates.

a. Yes they were.

10. How exactly will it work for combination therapy for example where a patient with advanced prostate cancer goes through a course of external beam radiation therapy and then requires a Brachy therapy boost that would include you know more than one treatment planning session and you know obviously two different modalities of treatment delivery.

a. I would suggest that you submit that question through the comment period because I'm just not prepared to answer it right now on the phone.

11. Typically when we have technical questions you know we base our comments to the agency when we obtain information from the agency staff on technical issues like that. And I did submit

some questions and I was told you have to submit them to the Federal Register, but it's kind of difficult to write a written comment letter when we don't know exactly how that's going to work with the payment model. I mean if you don't explain to us how it works, then we don't know how to comment on that.

a. Now that I know who you are, it's clicked. I know you reached out to Astro is to work through them because they will be having an onsite meeting with us in the very near future to talk about some of the more technical things.

12. We are seeing more and more that Medicare Advantage plans are insisting that their beneficiaries remain as observation patients for days on end. Some plans are insisting up to 72-hours before they will allow inpatient admission. The problem I have with that is that these patients are Medicare beneficiaries. If they were following the Two-midnight rule, they would be given the important message from Medicare admitted and given appeal rights for their discharge. By keeping them in observation, they are not afforded the opportunity to receive an immediate appeal if there is discharge. And that seems to be a patient rights issue that CMS needs to take note of and act upon. I'm wondering if that's something that's come up on the CMS radar at all.

a. We don't have any one from the Medicare Advantage team on this call right now to answer that question. But I do have a question for you and that is to the extent that a Medicare beneficiary is receiving observation services, I think you said 72-two hours or greater. Are those beneficiaries receiving the MOON notice to your knowledge – being notified they are in outpatient, not an inpatient?