Centers for Medicare & Medicaid Services
Hospital Quality Open Door Forum
Moderator: Darling, Jill
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02:00 PM ET

Operator: Good afternoon. My name is Amy and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Hospital Quality Open Door Forum. All lines have been placed on mute to prevent any background noise.

After the speaker's 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, please press the pound key.

I would now like to turn the call over to Jill Darling, you may begin.

Jill Darling: Thank you Amy. Good morning and good afternoon everyone, and welcome to today's Hospital Open Door Forum. As always, we appreciate your patience. As always, we try to get as many folks in as we can. So before we get into today's agenda, one brief announcement from me. This open door form is open to everyone, but if you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call.

If you have any enquiries, please contact CMS at press@cms.hhs.gov. And now I will turn the call over to our chair, Tiffany Swygert.

Tiffany Swygert: Thanks Jill. Hi everyone, this is Tiffany Swygert, I am the Acting Deputy Director of the Provider Billing Group. And I'm happy to welcome you to today’s hospital open door forum. We do have a number of items to cover today and we're glad for your participation and any questions that you may have at the end, we'll be in touch with the next hospital open door forum, which we'll talk about some of the payment rules that I know that lots of you are accustomed to hearing about on this call.

So without further ado, I will turn it back over to Jill.

Jill Darling: Thank you. First on the agenda, we have Marcie O'Reilly's, who will give an overview of the proposed radiation oncology model.

Marcie O'Reilly: Thank you Jill. Hi, I'm going to provide as Jill said an overview of the radiation oncology model that CMS and the Center for Medicare and Medicaid innovation has proposed to begin in 2020. The radiation oncology model is included in the Medicare program, specialty care models to improve quality care and reduce expenditures, notice of proposed rulemaking that published last week.

The proposed rule number is CMS-5527-P, it can be downloaded from the Federal Register and public comments can be submitted through September 16th. The aim of this model would be to test whether perspective site neutral episode based payments to physician groups, hospital outpatient departments, and freestanding radiation therapy centers for episodes of care would reduce Medicare expanders while preserving or enhancing the quality of care for our beneficiaries.

We believe that this patient centric and provider focused model will improved the quality cancer care patients receive and improve patient experience by rewarding high quality patient centered care that results in better outcomes through our perspective episodes of payment methodology.

If finalized the radiation oncology model would in addition to improving the quality of care for cancer patients receiving radiotherapy treatment, it would reduce provider burdened by moving towards a simplified and predictable payment system. The 5-year model is currently projected begin either January 1, 2020 or April 1, 2020, and end December 31st, 2024.

So let me provide a little background as to why we have proposed this radiation oncology model. Since 2014, CMS has been exploring potential ways to test an episode based payment model for RT services. In December of 2015, Congress enacted the patient access of Medicare Protection Act which required the secretary of HHS to submit a report to Congress on the development of an episodic alternative payment model for RT services.

The report which is available on the innovation center website was provided to Congress in November of 2017. The report identified three key reasons, why radiation therapy is ready for payment and service delivery forum.

One, the lack of site neutrality for payments. Two, the incentives that encourage volume services over the value of services. And three, coding and payment challenges that we've been experiencing. As per site neutrality, RT services furnished in a free setting radiation therapy center are paid under the physician fee schedule at the non-facility rate including payment for the professional and technical components of services.

For RT services furnished in an outpatient department of hospital, the facility services are paid under the hospital outpatient prospective payment system, and the professional services under the physician fee schedule. These payment systems determine payment rates for the same services in different ways, which creates site of service payment differentials.

This difference in payment rate may incentivize Medicare providers and suppliers to deliver RT services in one setting over another even though the actual treatment and care to receive by Medicare beneficiaries for given modality is the same in both settings. As for aligning payments to quality and value rather than volume; under both OPPS and the physician fee schedule, entities and physicians that furnish RT services are typically paid incrementally.

The more services they provide, the more claims they can submit to Medicare for payment. These incentives are not always aligned with what is clinically appropriate for the beneficiary. For example, for some cancers type stages and beneficiary characteristics, a shorter course of radiation therapy treatment with more radiation per fraction may be clinically appropriate.

The model design encourages that adherence to nationally recognized evidence based clinical guidelines. As for the coding and payment challenges, CMS examines an RT services and their corresponding paper service code as part of the CMS miss valued code initiative based on our high volume and increasing use of new technologies.

CMS determine if there are difficulties in coding and setting payments rates appropriately for RT services. These difficulties that led to changes to the valuations of the services under the physician fee schedule, and coding complexity across both payment systems.

The patient access and Medicare protection act also froze payment rates for certain RT delivery and related imaging services in 2017 and 2018, and excluded those same services from being considered on their miss valued codes initiatives for that same period.

The Bipartisan Budget Act of 2018, extended these policies to 2019, that's why the model was proposed to start in 2020. I will now walk through key aspects of the model design. The proposed radiation oncology model would take significant steps towards making prospective cancer specific, episode based payments in a site neutral manner that would cover radiotherapy services furnished in a 90-day period for 17 cancer types.

The model is modality agnostic, meaning most types of radiotherapy are included in the bundled payment amount. We proposed to include external beam therapy including three-dimensional conformal radiotherapy, intensity modulated radiotherapy, stereotactic radiosurgery, stereotactic body radiotherapy, and proton beam therapy.

Also intraoperative radiotherapy, image-guided radiation therapy, and Brachytherapy are included. The model would require participation from RT providers and suppliers that furnished RT services and within randomly selected core based statistical areas or CBSA. CBSAs selected for the model, would contain a probably 40% of all eligible Medicare fee for service radiotherapy episodes nationally.

Exclusions to required participation includes providers and suppliers, furnishing RT services only in Maryland Vermont and the US territories as well as hospitals participating in or eligible to participate in the innovation centers Pennsylvania Rural Health model. Additionally, ambulatory, surgery centers, critical access hospitals, and PPS exempt cancer hospitals are excluded from participation in the radiation oncology model.

Beneficiaries would still be able to receive care from any provider supplier of their choice. Model participants treating beneficiaries with one of the included cancer types would receive perspective episode based payments for the RT services furnished during that 90-day episode of care instead of regular Medicare fee for service payments.

It is important to note that this is not a total cost of care model that it's only radiation therapy that's included in the bundle payment. Model episodes would be split into a professional component or PC payment which is meant to represent payment for the included RT service that may only be furnished by a physician and the technical claim component or TC payment which is meant to represent payment for the included RT services that are not furnished by a physician including the provision of equipment supplies, personnel, and costs related to RT services.

This physician reflects the fact that RT professional and technical services are sometimes furnished by separate providers and suppliers. Participants specific payment amounts would be determined based on proposed national base rate, trended forward each year, and adjustment for each participant case mix, historical experience, and geographic location.

The national base rates were constructed using episodes initiated between 2015 and 2017 during which the majority of the technical services were provided at a hospital outpatient department. CMS would further adjust payment amounts by applying a discount factor. The discount factor or the set percentage by which CMS reduces an episode payment amount would reserve savings for Medicare and reduce beneficiary cost sharing.

The discount factor for the professional component would be 4%, and the discount factor for the technical component would be 5%. The payment amount would also be prospectively adjusted for withholds for incomplete episodes, quality, and patient experience.

Model participants would have the ability to earn back a portion of the quality and patient experience withhold based on clinical data reporting, quality measure reporting and performance, and the results of the beneficiary reported consumer assessment of health care provider systems or CAHPS, cancer radiation therapy survey.

During the model, CAHPS survey will be administered to beneficiaries by an independent contractor and no cost to the model participants. The standard sequestration and geographic adjustment requirements would remain in effect.

Beneficiaries would still be responsible for the same cost sharing requirement as under the traditional payment system, typically 20% of the Medicare approved amount for services. But because CMS will be applying a discount to each of these components beneficially sharing, maybe on average lower relative to what would typically be paid under the traditional Medicare fee for service payments.

34 radiation oncology model-specific HCPCS code have been developed for the model. One for the PC of each included cancer type, and one for the TCO each included cancer type. One of these codes along with one of two modifiers which would indicate the start of an episode or the end of episode would be required on each claim.

50% of the bundle payment would be paid upon submission of the start of episode claim and the other 50% upon completion of the episode and submission of the end of the episode claim. And I wanted to point out some components of the model that are specific to the hospital outpatient department. The 34 RO model specific HCPCS codes would be mapped to RO model specific APC's for the payment purposes under the OPPS.

Next under the RO model, we proposed the wave application of a hospital outpatient quality reporting program payment adjustment. This waiver would only apply to APC's that include only the new HCPCS codes that are created for the RO model rather than all APC's that package radiation therapy HCPCS code.

And would only apply when a hospital doesn't meet requirements under the hospital OQR program, and would otherwise be subject to the 2.0% reduction. Only technical participants using the RO model specific HCPCS codes would be paid under the model. So APC’s not included in the model and those not using the RO model specific codes, will continue to be paid under the OPPS and subject to the 2% point reduction under the hospital outpatient quality program.

We believe this is necessary in order to equally evaluate participating HOPC and free setting radiation oncology centers on both health and quality. Under the model, we proposed to waive application of the PFS relativity adjuster which applies to the payments under the PFS for non-extended items and services identified by section 603 of the Bipartisan Act of 2015 for all RO model specific payments to applicable OPD's.

If a non-exempted off-campus PBD were to participate in RO model, it would be required to submit RO model claims consistent with our professional and technical billing proposals. In addition, we would not apply to PFS relatively adjuster to the RO model payment and instead pay them in the same manner as other RO model participants because of the RO models pricing methodology design tests site-neutral national base rates, and adding the PFS relatively adjuster to the RO model payment for participants that are non-exempted would disrupt this approach and introduce a payment differential. We believe this waiver is necessary to allow for consistent model evaluation and ensure site neutrality which is a key feature of the RO model.

We would continue to apply the limit on beneficiary liability for co-payment for a procedure for nursing hospital outpatient department to the international base rates that concerned the technical component. That's an overview.

A quick overview of a very the long NPRM. I just wanted to remind you that CMS based the design of the radiation oncology model on considerable stakeholder input received before during and immediately after a public listening session held in May 2017, in preparation of the report to Congress. CMS continues to engage in extensive outreach to radiotherapy professional societies and patient groups.

And we encourage you to review the proposed RO model and submit your comments on regulations.gov. Again the RO model is included in the Medicare program specialty care models to improve quality of care and reduce expenditures NPRM, the proposed rule CMS-557-P can be downloaded from the Federal Register and again the comment period ends September 16th. Thank you.

Jill Darling: Thanks Marcie. Next we have Katie Cartwright, who will talk about the appeal settlement initiative.

Katie Cartwright: Thank you Jill. Good afternoon everyone. I wanted to let callers know that CMS has initiated a new appeal settlement process. On June 17th 2019, CMS began accepting Expressions of Interest for a settlement option targeted towards certain Inpatient Rehabilitation Facility (IRF) appeals, pending at all levels of review. Specifically, IRF appellants that filed appeals at the MAC for re-determination no later than August 31st 2018, may be able to settle their eligible appeals as follows.

CMS will pay 69% of the net payable amount for all claims associated with pending IRF appeals that do not otherwise meet the following special criteria. One, specific to Intensity of Therapy appeals, CMS will pay 100% of the net payable amount for all IRF appeals in which the claim was denied based solely on a threshold of therapy time not being met where the claim did not undergo more comprehensive review for medical necessity of the intensive rehabilitation therapy program based on the individual facts of the case.

And two, CMS will pay 100% of the net payable amount for all IRF appeals in which the claim was denied solely because justification for group therapy was not documented in the medical record.

We encourage appellants who are interested in learning more about this settlement process to visit CMS' website at go.cms.gov/IRF. Here you will also find registration information for the Medicare Learning Network Provider Call CMS will be holding on August 13, 2019. Lastly, any questions regarding the appeals settlement process can be submitted to our dedicated email mailbox at MedicareAppealsSettlement@cms.hhs.gov.

And again all of this information is available on our website. Thank you.

Jill Darling: Thank you Katie. Next we have Jessica Wentworth, who will talk about the iQIES access for providers.

Jessica Wentworth: Good afternoon, thanks Jill. I have presented this topic in prior months, but wanted to provide a quick update. If you haven't been made aware CMS is developing an enhancement to the current assessment submission and processing and reporting systems referred to as ASAP and CASPER and collectively known as QIES.

The enhanced system is referred to as iQIES, which stands for the Internet Quality Improvement Evaluation System. It will be delivered in a phased approach by provider type. The process that providers follow for submitting patient assessments will not change, but the enhanced system is now Internet facing and it will allow providers to submit assessments and view associated reports in one place.

The first release rolled out in March to long-term care hospitals and the next provider to onboard iQIES will be inpatient rehab facilities and they will have the ability to submit their assessments to iQIES this coming October.

In order to prepare for this next release, we are requesting that IRF providers request security official access to iQIES as soon as possible. If an organization does not have a registered security official in iQIES, they will not be able to submit patient assessments in iQIES on October 1st.

We also advise that IRFs register a second security official now, if possible, as this will allow for a smoother transition prior to the October go live date. We have started sending out targeted communications regarding iQIES access and general info to IRF providers and will continue to do that for the next several weeks.

If your organization hasn't received this information or if you have any general iQIES questions, you can contact the iQIES broadcast mailbox at iQIES_broadcast@cms.hhs.gov. Thanks and that's my very quick update and I'll turn it back over to you Jill.

Jill Darling: All right, thank you Jessica. And last on today's agenda, we have Tiffany Jackson-Dickey, who has some updates on the BFCC-QIO transition.

Tiffany Jackson-Dickey: Thank Jill. Hello everyone, good afternoon. My name is Tiffany Jackson-Dickey. I am the CMS representative for the case review work of the beneficiary and family centered care quality improvement organization, also known as the BFCC-QIO. The case review work includes the BFCC-QIO handling of complaints and quality of care reviews, appeals of service terminations and hospital discharge notices and other types of case reviews for Medicare beneficiaries.

On June 8th, CMS entered into new BFCC-QIO contracts with both KEPRO and Livanta and through this process, the QIO program transitioned 24 states between these two contractors. I'm here today and will be participating in subsequent open door forms to provide a status update as it relates to the BFCC QIO transition of updates. The associated concerns and overall impact to the provider community.

We want to provide better communication throughout this process and we remain committed to working with you in addressing your concerns as quickly as possible. Recently we have begun to receive calls and inquiries from providers that the BFCC-QIO, KEPRO, is experiencing delays in responding to Appeals, thus affecting customer service in terms of wait and response times.

To date, CMS in conjunction with the BFF QIO KEPRO has taken a number of steps to mitigate the situation. One July 1st, 2019 CMS enhanced a case review system to help QIO's resolve issues with the transmittal of medical records which should positively impact the QIO's appeals case response time.

CMS representatives are communicating with KEPRO frequently to help the current issues with the level of customer service and appeals case review timeliness.
CMS has provided KEPRO temporary use of their online tracking system until CMS can replace it with similar functionality. All cases open as of July 14th, can now be tracked online for status updates.

This is also contributing to a lower call value for KEPRO. KEPRO is also implementing internal processes to improve its operational effectiveness and are hiring additional staff for the call center and nurses to perform appeals case reviews.

KEPRO website has been updated to reflect an updated fax number for communications as well as the provider bulletins. CMS will continue to provide status updates and future open door form over the next several months. But in the interim if there are any issues providers may send their enquiries via email to QIOconcerns@cms.hhs.gov. Thank you for your time and I will turn it back over to you Jill.

Jill Darling: Great, thank you Tiffany and thank you to all of our speakers today. Amy, will you please open the line for Q&A.

Operator: As a reminder ladies and gentlemen if you would like to ask a question, please press star than the number 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.

Your first question today comes from the line of Ronald Hirsch of R1, your line is open.

Ronald Hirsch: Hi, there and thank you. Hello everybody. First question is with the QIO changeover, you know it's clear that there was absolutely no change in volume and the KEPRO should have been able to estimate how many calls they were going to get? So it's very disappointing that hospital had to wait up to a week to get an appeal to determination.

Is 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?

Tiffany Jackson: Hi, this is Tiffany. Thank you for your question. 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.

Ronald Hirsch: Okay, thank you. Second follow up on that is there any update on what's happening with the short stay review audits, and is there 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?

Tiffany Jackson: Sure. Again this is Tiffany. For short stay review, we are currently undergoing the procurement process for that. Once awards have been made, we're anticipating sometime next month, 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.

Ronald Hirsch: Thank you very much.

Operator: Your next question comes from a line of Donna Baker of Emory Rehab Hospital. Your line is open.

Donna Baker: Hi, 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)?

Jessica Wentworth: 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.

Donna Baker: Okay. 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.

Jessica Wentworth: We will provide that clarification in a communication that will soon be released. Like I said, we're working to try to have that dual role in place by October 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.

Donna Baker: Okay, thank you.

Operator: And your next question comes from the line of Karen Miska of Trinity Health, your line is open.

Karen Miska: Thank you, good afternoon. I was just wondering if you have an approximate date of when the OPPS proposed rule will be available.

Tiffany Swygert: Hi, this is Tiffany Swygert. 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.

Karen Miska: Thank you.

Operator: And again if you would like to ask a question, please press star than the number one on your telephone keypad.

Your next question comes from the line of Ronald Hirsch of R1, your line is open.

Ronald Hirsch: Wow, I get two shots. So now we are going to about radiation oncology, and I have couple of questions. First of all, 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?

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

Ronald Hirsch: Okay, there will not be a limit on it as there is with the part A copay, part A deductible you know matching number.

Marcie O'Reilly: The hospital outpatient limit will still be in existence.

Ronald Hirsch: All right. My second question is it sounded like proton beam therapy is included as a modality of radiation.

Marcie O'Reilly: That's correct.

Ronald Hirsch: Okay. 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?

Marcie O'Reilly: And that's the purpose of the bundle payment and making it modality agnostic is so that 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 where you get your first 50% of the payment and getting the second 50%, we will be asking providers to submit 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.

Operator: And your next question comes from a line of Wendy Smith of Health Policy Solutions. Your line is open.

Wendy Smith: Hi, thank you. And I have two questions regarding the radiation oncology model. CMS is proposing to include in the bundle payment brachytherapy 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.

Marcie O'Reilly: Yes, they were.

Wendy Smith: They were, okay. And then my second question is 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 brachytherapy boost that would include you know more than one treatment planning session and you know obviously two different modalities of treatment delivery.

Marcie O'Reilly: 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.

Wendy Smith: Yeah, well that's a little troublesome because 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.

Marcie O'Reilly: Okay. Well what I would also -- and 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.

Wendy Smith: Okay, yeah, but yeah, but others -- I mean that's an astro meeting. These are questions that you know aren't necessarily related to astro, okay. Thank you.

Operator: And again that is star than one in order to ask a question. Your next question comes from a line of Ronald Hirsch of R1, your line is open.

Ronald Hirsch: Hi, I have a totally unrelated issue. And that is that 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 and 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.

Tiffany Swygert: Hi, this is Tiffany Swygert. 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 – be notified they are in outpatient, not an inpatient.

Ronald Hirsch: Yeah. And by the way MOON, and hence I notice so you really just call it the MOON. But I'll let you off.

Tiffany Swygert: Okay. So they are being notified that they're an outpatient, but your concern is that the plans are not following the Two-midnight rule guidance.

Ronald Hirsch: Well, more of it by not following it. They're depriving a patient who's spending three days in the hospital and had a serious illness of being able to appeal their discharge.

Tiffany Swygert: No, I think I understand, but I don't like to paraphrase people's words when I'm the messenger. So if you don't mind sending your question via email, will make sure that it gets to the right folks here within CMS.

Ronald Hirsch: Thank you very much.

Tiffany Swygert: Thank you.

Operator: And there are no further questions in queue at this time. I will now turn the call back over to Ms. Darling.

Jill Darling: All right, well. Thank you Amy, thank you all of our speakers and thanks to everyone on the line who ask questions. You will get some time back today. So as always, we appreciate you calling in and have a wonderful day.

Operator: Thank you for participating in today's hospital quality open door forum conference call. This call will be available for replay beginning today at 5 PM eastern until July 26th at midnight. The conference ID number for the replay is 2818049. The number to dial for the replay is 855-859-2056.

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