Centers for Medicare & Medicaid Services
Hospital Quality Initiative
Open Door Forum
Moderator: Jill Darling
Tuesday, November 7, 2017
2:00 p.m. ET

Operator: Good day. My name is (Jack) and I'll be your conference operator today. At this time I would like to welcome everyone to the Centers for Medicare & Medicaid Services Hospital Quality Initiative Open Door Forum.

All lines have been placed on mute to prevent any background noise. After 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, press the pound key.

Thank you. Jill Darling, you may begin your conference.

Jill Darling: Thank you so much, (Jack). Good morning and good afternoon everyone and welcome to today's Hospital Open Door Forum. I'm Jill Darling in the CMS Office of Communication.

Before we get into today's agenda, as always, one brief announcement from me, 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 questions during the Q&A portion of the call.

If you have inquiries please contact us at press@cms.hhs.gov. And now I'll hand the call over to Chair, Tiffany Swygert.

Tiffany Swygert: Thanks, Jill. And hello everyone, we have a rather packed agenda and a number of you have submitted questions to the Hospital Open Door Forum mailbox. We will try to touch on as many of those questions as possible. In

our presentation, however, if we are not able to get to them, please feel free to follow up with us after of this call.

I do want to start with a quick update on the calendar year 2018 final rule for the Hospital Outpatient Prospective Payment System. That rule was issued on November 1st. It is the final rule with comment period. The items that are subject to comment are identified in the addenda; they're the new codes that are identified with a specific comment indicator to note that we're accepting comments on those new codes. Those comments on those issues will be accepted through December 31st, and instructions for submitting those comments are included in the final rule.

I'll give a very quick update on what the payment update is for hospitals who are paid under the (OPPS) for 2018 relative to 2017, and then I'll turn it over to Carol Blackford to talk about some of the very important issues that were included in this final rule.

So for 2018, the rate update is 1.35 percent. This change is based on the Hospital Market Basket of 2.7 percent which was decreased by a 0.6 percentage point adjustment for multifactor productivity as required by law, as well as 0.75 percentage point adjustment also required by law.

After considering all of the policy changes that were included in the final rule including the estimated spending for pass-through payments, we estimate an overall increase of 1.4 percent for providers paid under the OPPS in calendar year 2018 relative to 2017.

With that, I will turn it over to Carol Blackford, the Director of Hospital and Ambulatory Policy Group to discuss a few important issues in the rule. Carol?

Carol Blackford: Thank you. As Tiffany mentioned, the calendar year 2018 OPPS and ASC rule was released on November 1st. There are a lot of topics covered in that rule that our program experts will highlight in a bit. But there are a couple of topics that I want to highlight as well during the call today.

First, the administration's priorities are to support care delivery, promote flexibility and health care, lower beneficiary out of pocket drug cost, enhance the patient-doctor relationship, and reduce burden on providers particularly those in rural areas.

As you may know, CMS recently launched the "patients over paperwork initiative" which is a cross cutting collaborative process that evaluates in streamlines regulations with the goal to reduce unnecessary burden, increase efficiencies and approve the beneficiary of experience.

Through the patients over paperwork initiative, CMS along with our partners and stakeholders, we are committed to removing regulatory obstacles that get in the way of providers spending time with patient.

Among the efforts to reduce regulatory burden in the OPPS final rule include – CMS is reinstating the non-enforcement of direct supervision requirements for outpatient therapeutic services for critical excess hospitals, and small rural hospitals having 100 or fewer beds for calendar years 2018 and 2019.

CMS is also finalizing the removal of three ambulatory surgical center quality recording program quality measures for the calendar year 2019 payment determination and subsequent years.

Removal of these measures would alleviate maintenance cost and administrative burden to the ACS. Resulting in a burden reduction of 1,314 hours and saving about 48,000 in calendar year 2019.

CMS is also finalizing the removal of six hospital outpatient quality reporting program quality measures resulting in a burden reduction of about 460,000 hours and saving $16.7 millions in calendar year 2020 for hospitals.

Next, I want to highlight an important provision with respect to how Medicare will pay for certain drugs acquired under the 340B program, which is a drugs discount program administered by HRSA. Under this program, certain drugs maybe purchased by eligible hospitals and other entities as deeply discounted rates. Currently Medicare pays hospitals more then the average sales price for

drugs acquired under the 340B Drug Pricing Program, which is more than what hospitals pay to purchase those drugs.

And because the cost to patient is based on what Medicare pays hospitals to administer the drug, patients are paying a higher rate for the drugs as well. In order to lower drug prices from Medicare beneficiaries, CMS has finalizing paying for drugs purchased through the 340B program and provide some Medicare patients and hospital outpatients setting at the average sales price minus 22.5 percent rather the current payment of ASP for a six percent. Drugs not purchase under the 340B program would continue to received ASP plus six percent payment.

In addition, this payment changes does not apply to vaccines or drugs receiving pass-through payments. As you'll notice in the final rule, children's hospital, PPS exempt cancer hospitals and rural to all community hospitals will be accepted from this drug payment reductions for calendar year 2018. We have received a few questions about how to identify a rural to all community hospital. So I wanted to touch on that a little bit quickly here.

In a nutshell, rural sole community hospitals received a 7.1 percent add on adjustment under the OPPS. These providers meet the definition of an SCH under the regulations at 412.92 or an H which as essential access community hospital, which is consider to be an SCH under the statute. And are located in the rural area, as defined under section 412.64B of the regulations or are treated is being located in a rural area under section 412.10 of the regulations.

In addition, critical access hospitals are not affected by these policies since they are not paid under the OPPS. The redistribution of estimated savings from adopting this report to 340B drug payment policy is being relocated across all non-drug services that are paid under OPPS. And we estimate that the reduction in drug payments due to this policy including beneficiary (from) payments will be approximately $1.6 billion in 2018. Medicare beneficiaries would share in the discount hospitals receive under the 340B discount program, saving an estimated $320 million on drug cost annually.

In addition, after considering the administrative and financial challenge associated with providers reporting the modifier as described in the propose rule. And in order to reduce regulatory burdens, we are reversing our physicians on how to modifier will be used by providers to effectuate the payment adjustment for the 340B purchase drugs.

Specifically, begin in January 1st, 2018, providers who are not exempted from the 340B payment adjustment will report modifier JG which is for drug or biological acquired with the 340B drug pricing program discount. They would use that modifier JG to identify if a drug was acquired under the 340B programs.

This requirement is aligned with the modifier requirement already mandated at several stage under their Medicaid program. Drugs that were not acquired under the 340B program should not be reported with the modifier JG For separately payable drugs, status indicator K, application of modifier JG will trigger the ASP minus 22.5 percent rate for the drugs.

In addition, providers that are accepted from the 340B drug payment policy for calendar year 2018, which include the rural SCHs, children's hospitals and PPS exempt cancer hospitals should not report modifier JG but should instead report the information on modifier TB for drug or biological acquired with 340B drug pricing program discounts, reported for information purposes. So you would report that modifier TB for a 340B acquired drugs.

The information on modifier TB will facilitate the collection of tracking the 340B claims data for OPPS providers that are accepted from the payment adjustment in calendar year 2018.

However, use of modifier TB will now trigger a payment adjustment and these providers will continue to receive ASP plus six percent for separately payable drugs. As stated in the final rule, we expect to issue additional sub-regulatory guidance about the use of these modifiers including additional details about when use of informational modifier is appropriate.

Accordingly, we would not be answering detailed questions about the modifiers on this call today. But please, look for the additional sub-regulatory guidance to come. That will be posted up on the web.

So, at this point I will turn it over to Josh McFeeters.

Josh McFeeters: Thank you very much, Carol. I would like to go over now two topics from the final rule, the physician supervision enforcement instruction for critical access hospitals and small rural hospitals and skin substitute payments.

First of all, physician supervision enforcement instruction, direct supervision is required for hospital outpatient therapeutic services covered and paid or by Medicare they're furnished in hospitals as well as in provider based departments and hospitals.

In the final rule, we finalized our proposal to reinstate the enforcement instruction for outpatient therapeutic services first in critical access hospitals and small rural hospitals having100 or fewer beds for calendar years 2018 and 2019, to give these critical access hospitals and some small rural hospitals more time to comply with the supervision requirements for outpatient therapeutic services. We give all parties additional time to submit specific services to be evaluated by the (hot) panel for recommended change in supervision level.

The enforcement instruction gives these hospitals more time to comply with the direction supervision requirements and identify additional services that could be reviewed by the advisory panel, the (hot) panel to considered change in the supervision level. A question that many stakeholders have is what will happen with enforcement for calendar year 2017.

While we do not have in place an enforcement instruction to our contractors for calendar 2017, directing them not to enforce direct supervision requirements for outpatient therapeutic services furnished in CAHS and small rural hospitals. We anticipate that limited audit and enforcement resources would be directed towards other higher priority matters during the year.

For skin substitutes. Skin substitutes are packaged into their associated surgical procedures in the part of a broader policy to package all drugs and biologicals that function as supplies when using a surgical procedure. Under current policy, skin substitute products are either replaced into a high cost group or a low cost group in order to ensure adequate resource homogeneity among APC assignments for the skin substitute application procedures.

This involves comparison above the mean unit cost or the ones known to MUC and the; per day cost or PDC of these products.

Some stakeholders have raise concerns about the significant fluctuation in both the MUC threshold and the PDC threshold from year to year. The fluctuation in these thresholds may result in the reassignment of several skin substitutes from a high cost group to the low cost groups which are on a current payment rates, same results in a significant payment difference with the same procedure.

In order to allow additional time to evaluate concerns in suggestions, some stakeholders about the volatility of the MUC and PDC threshold for 2018, we finalized a proposal that a skin substitute that was assigned with a high cost group. For calendar year 2017 would also be assigned to the high cost group for calendar 2018 even if does not exceed the 2018 MUC or PDC thresholds.

In addition, for consideration for calendar year 2019 and subsequent years, we request that public comments on the methodology that they're use to calculate prizing threshold as well as the payment grouping that recognize a low cost group and a high cost group.

We say that we're – we were especially interested in suggestions that are based on an analysis of Medicare claims data from hospital outpatient departments that might better promote improved payment stability for skin substitute product under the OPPS. We receive many comments in response to our request for public comments and we'll take them into consideration for calendar year 2019 and subsequent years.

So thank you for your time and I'm going to turn over the discussion to (Lela Strong).

(Lela Strong): Thanks, Josh. I'll be discussing the packaging of level one and level two drug administration and services for calendar year 2018. The OPPS packages payment of all integral ancillary supportive, dependent or adjusted services into payment for primary services. In calendar year 2014, CMS proposed but did not finalize to package all add on procedures including drug administration and on services.

In calendar year 2015, CMS conditionally packaged payment for ancillary services. When those ancillary services are assigned to an ambulatory payment classification group or APC, with the geometric main cost of $100 or less but excluded drug administration services

For calendar year 2018, they continue CMS' work on bundles to payment under the OPPS and encourage hospital efficiencies. CMS finalized its proposal without modifications to a conditionally package payment for low cost, drug administration services assigned to APC-5691 which is level one drug administration and APC 5692 which is level two drug administration.

Because preventive services are excluded from our packaging policies, we are continuing to pay separately from Medicare part B, vaccine administration services. In additions, at this time we are not packaging any drug administration services that are assigned to APC-5693 which is level 3 drug administration or APC-5694 which is level 4 drug administration.

The status indicators for drug administrated service -- drug administration services in APC-5691 and 5692 for calendar year 2018 are listed in addendum B of the final rule with common periods. But now, I also be discussing changes to the inpatient-only list for calendar year 2018. The Medicare inpatient-only list includes procedures that are typically only provided in the inpatient setting, and therefore, are not paid under the OPPS.

Every year, CMS uses established criteria to review the inpatient-only list and determine whether or not there are any procedures that should be removed

from the list. For calendar year 2018, CMS is removing Total Knee Arthroplasty also known as TKA, from the inpatient-only list as well as five other procedures.

As a reminder, the removal of the procedure from the inpatient-only list does not require the procedure to be performed only on an inpatient -- I'm sorry, only on its outpatient basis. Removal of a procedure from the inpatient-only list allows for a payment of the procedure and either the inpatient settings or the outpatient settings.

In addition, CMS is precluding the recovery audit contractors from conducting patient status or site of service review of outpatient Total Knee Arthroplasty procedures for a period of two years.

There are several commenters including some orthopedic specialty societies that noted that the physician should be the final arbiter of the type of service for the Medicare beneficiary but requested that CMS to establish patient selection criteria for outpatient TKA procedures.

We know that while we expect providers to perform outpatient TKA on Medicare beneficiaries to use comprehensive patient selection criteria to identify appropriate candidates whereas the procedure. We believe that for the providers and medical specialty societies who perform outpatient TKA and possessed specialized clinical knowledge and experience are the most suited to create these guidelines. As such CMS does not expect to create or endorse specific guidelines or content for the establishment of provider's patient selection protocols for outpatient TKA.

Lastly, CMS is also adding one procedure to the inpatient-only list in response to public comment. So lastly, I'll give a brief review of the comprehensive ACC policies for calendar year 2018. For calendar year of 2018, there will be a total of 62 comprehensive ACCs. We did not supposed to create any new comprehensive ACCs or make any extensive changes to the already established methodology used for (CAPC).

For calendar year of 2018, the comprehensive ACC for stereotactic Radiosurgery or SRS, we are continuing to make separate payments for the 10 planning and preparation services that are adjunctive to the delivery of the SRS treatment when using either the Cobalt-60 based or Linac-based technology when furnished to a beneficiary within 30 days of the SRS treatment.

In addition, the data collection period for SRS claims with modifier CP, is set to conclude on December 31, 2017. Accordingly, for calendar year 2018, we are deleting this modifier, modifier CP and discontinuing its require use.

So now, I will turn it over to (Craig Dobyski).

(Craig Dobyski): Thank you, (Lela), I would be providing a brief summary of CMS's revised laboratory date of service policy. In the calendar year 2018 OPPS final rule, CMS addressed comments regarding the laboratory date of service policy and its impact on billing for molecular pathology tests and certain advance diagnostic laboratory tests (or ADLTs) which are ordered less than 14 days following a hospital outpatient discharge.

After considering the public comments received on this topic, we added an additional exception to the current laboratory date of service regulations effective January 1st, 2018. This new exception to the laboratory date of service policy specifies that in the case of a molecular pathology test or test designated by the CMS as an ADLT under criterion A, the date of service must be the date the test was performed only if the test was performed following a hospital outpatient's discharge from a hospital outpatient department; the specimen was collected from a hospital outpatient during a hospital outpatient encounter;

it was medically appropriate to have collected the sample from the hospital outpatient during the hospital outpatient encounter; the results of the test do not guide treatment provided during the hospital outpatient encounter; and the test was reasonable and medically necessary for the treatment of an illness.

This new exception to the laboratory date of service policy will enable laboratories performing criterion A, ADLTs and molecular pathology tests excluded from the OPPS packaging policy to bill Medicare directly for those test, instead of requiring them to seek payment from the hospital outpatient department. At this point, I'll turn it over to Anita Bhatia. Thank you.

Anita Bhatia: Thank you, (Craig). Good afternoon. I will be discussing the Hospital Outpatient Quality Reporting or OQR program. For the Hospital OQR program, hospitals not meeting program requirements receive a two percent reduction in their annual payment update. This year, our finalized proposal balanced the value of collecting and reporting quality data with provider burden; we are also refining some program processes and procedures.

In terms of measures, we are removing six measures. The burden reduction associated with this was discussed at the beginning of this forum. We had proposed a staggered approach to this removal, but in response to public comment requesting earlier removal, we finalized the removal of all of these measures beginning with the calendar year 2020 payment determination which is upcoming data collection which is, again, roughly at the beginning of calendar year 2018.

We are delaying, not removing, the mandatory implementation of the Consumer Assessment of Healthcare Providers and Systems and Ambulatory Surgical Center survey or OAS CAHPS. That wasn't quite right. I have a strange listing of the name here. Under the Hospital OQR program beginning with the calendar year 2018 payment – 2018 data collection, so just to reiterate that, this is the OAS CAHPS survey and under the Hospital OQR program that implementation is being delayed and not removed.

We will begin to publicly report OP-18c, the median time from emergency department arrival to emergency department departure or discharge for emergency department patients. This is a – this is for the strata which consists of psychiatric mental health patients. And we will be making this data available in the online downloadable files.

We refined some processes and procedures including targeting for performance for validation selection, formalizing the educational review process aligning when a hospital is to begin data submission, and aligning the naming of the extraordinary circumstance exception or ECE policy. So at this time I will return the call to the forum lead.

Jill Darling: Thank you, Anita, and to all of the speakers who went over the OPPS final rule. Next we have Don Thompson who has announcement about the extension to the January 2nd, 2018 of the deadline for resubmission of the 2014 and 2015 worksheet S-10 data.

Don Thompson: Thanks, CMS granted an extension from October 31st, 2017 until January 2nd, 2018 for all inpatient prospective payment system, hospitals to resubmit certain worksheet S-10 data. For the revision to be considered amended fiscal 2014 and 2015 cost reports due to revise or initial submissions of worksheet S-10 must be received by the Medicare administrative contractors on or before January 2nd, 2018.

We do want to note that although the deadline has been extended to January 2nd, 2018 only revisions submitted to the MACs on or before December 1st are expected to be uploaded to HCRIS by December 31st which is the data historically that has been used to determine S-10 data to be included in the IPPS proposed rule for the coming fiscal year.

Revisions after December 1st, but before the deadline of January 2nd are expected to be uploaded to HCRIS no later than January 31st. Well, before the date which has historically been used to determine S-10 data included in the IPPS final rule. Further questions regarding to extension can be directed to your MAC.

Jill Darling: Thank you, Don. And last, we have Kelly Shannon who will go over some clarifications and changes to worksheet S-10.

Kelly Shannon: Thank you, Jill. I'm going to review some major updates to the worksheet S-10 in the corresponding instructions and section 4012 of chapter 40. The provider reimbursement manual two which is CMS pub 15-2, the first thing

that we did was revive the electronic health record payment instruction to applied to Puerto Rico subsection B hospital for cost reporting period beginning on or after October 1st of 2016.

The next few items I'm going to discuss are clarifications that apply to cost reporting periods beginning on or after October 1st of 2013.

For line 20 of the S-10 worksheet which is charity care charges and uninsured discounts, we clarify the definition of charity care to include discounts for uninsured patients who meet the hospitals charity care or financial assistance policy. These items are reported on line 20 column one. The hospital must have a written policy for a charity care to include this uninsured discounts and the policy to be able to include these items online 20 column one.

For column two, the charges for uninsured patients that are in Medicaid or other indigent programs for nine covered days beyond a length of stay limit are reported on line 20, column two, only if such inclusion is specified in the hospitals charity care policy or the financial assistance policy. These charges must also be separately identified on line 25 and are subject to the cost for charge ratio.

All other amounts on line 20, column two which are the unpaid deductible co-insurance, amount is attributed to charity care are not subject to the cost to charge ratio.

For line 21 which is the cost of charity care and the cost of uninsured discounts, we modified the calculation for line 21 column two, such that the portion of the charges from line 20 column two that are attributable to charges for nine covered days for beyond the length of stay limit for uninsured patients and Medicaid or other indigent care programs are subject to the cost for charge ratio.

For line 23 which is the cost of charity care by subtracting line 21 from line 22, the payments we just wanted to specify that columns one and two are independent of each other. If payments are received or expected to be received exceed the cost, you are to enter zero on this line. And the cost

where – cost reports software will enter zero on columns one and two when the line 22 are greater than the cost.

We don't really expect to see many payments for cost reporting periods beginning on or after October 1st of 2016, however if there are payments received they should be recorded on line 22.

For line 26 which is the total bad debt for the entire hospital facility, this is for Medicare and non-Medicare bad debt. We wanted to stress that this line is net of bad debt recoveries.

For line 2701 – excuse me, which is a new line that we created to record the Medicare allowable bad debt for the entire hospital facilities and this was necessary so that we could compute the non-Medicare bad debts separately from the non-reimburse Medicare bad debts. The data on this line 27-01 is pulled from other worksheets as you can see in the instructions.

For line 28 which is the non-Medicare bad debts that's arrived debt the calculating it's calculated – I'm sorry – by subtracting line 2701 which is Medicare allowable bad debt from line 26 which is the total facility bad debt. Line 28 is subject to the cost of charge ratio.

For line 29, which is the cost to non-Medicare and non-reimbursable Medicare bad debts, we modify the calculation so that it only applies the cost for charge ratio to the non-Medicare bad debt and add to it the non-reimbursable Medicare bad debt which is the deductible on coinsurance that is not subject to the cost to charge ratio.

Just other items we wanted to stress were that there should be no negative values recorded for lines 20 through 31. The cost report software we'll replace all negative values with the zero. Regarding the cost reports software added, if your cost report flags and edit where you will not be able to take advantage of these calculations. We strongly suggest that all providers review your data to ensure that you're edits were not flagged.

If the edits do flag your data we will not be able to re-HCRIS or reenter your items in HCRIS so that the total amount on line 20 will likely be subject to

cost to charge ratios. And your Medicare bad debt would not be subject to cost to charge ratios. So we strongly request that providers review your data to make sure that these software edits will not flag your data.

Some of the major edits we wanted to go over just a few were be line 20 for column three which must be less than worksheet C like cat, line 200 column eight which is the subtotal of the provider charges. The second added is line 28 column two must be greater than or equal to line 25. And the third edit that we wanted to review is line 26 must be greater then or equal to line 2701. And that is all that I have for my portion.

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