

CENTERS FOR MEDICARE & MEDICAID SERVICES

The next CMS Hospital/Quality Initiative
Open Door Forum scheduled for:

Moderator: Jill Darling
January 11, 2017
2:00 p.m. ET

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

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, simply press "star" then the number "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: Thank you, (Kim). Good morning and good afternoon, everyone. Welcome to the first Hospital Open Door Forum of 2017.

Before we get into the agenda, just 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 CMS at press@cms.hhs.gov.

And I'll hand the call off to our chair, Tiffany Swygert.

Tiffany Swygert: Hi, everyone, and Happy New Year. I hope that everyone's 2017 is off to a great start.

Again, it's Tiffany Swygert, the acting director of the hospital – sorry, of the Division of Outpatient Care in the Hospital and Ambulatory Policy Group. I did want to apologize for the delay in starting this call; we understand that a number of callers are still dialing in. So, again, we appreciate your patience in waiting for us to begin this call; we do have a number of items to cover today.

And I also wanted to announce that there was a correction notice posted for the hospital outpatient prospective payment system on December 30. I believe that most folks have seen that already as it was published in the federal register but just wanted to make sure that everyone was aware that there was a correction notice posted. Additionally, there were some items posted relating to implementation of the 21st Century Cures Act on the CMS Web Site.

We'll be talking about some of those today so hopefully everyone has the agenda which includes the web links for the agenda items as applicable. With that, we will get started with our first agenda item -- David Rice will talk about section 16001 and 16002 of the 21st Century Cures Act.

David Rice: Hi, everyone. I'm David Rice, the Acting Deputy Director of the Division of Outpatient Care.

And I'll be providing a quick overview of the note we posted to the CMS Web Site regarding implementation of section 16001 and 16002 of the 21st Century Cures Act. As Tiffany mentioned, the link to that note is included on the agenda for this forum so if you haven't had a chance to look at that yet, I suggest you check that out when you have a chance.

The 21st Century Cures Act was enacted into law on December 13, 2016 and section 16001 and 16002 provided additional criteria by which off-campus departments of a provider could be accepted from the payment provisions enacted by section 603 of the Bipartisan Budget Act of 2015. Section 16001 provides an exception for off-campus provider-based departments that were in mid-build when the Bipartisan Budget Act was enacted.

For 2017 payment purposes, if the secretary receives from the provider prior to November 2, 2015 – receives from the provider prior to December 2 2015,

a provider-based attestation, such department will be deemed to be excepted from the payment provision of section 603. Accordingly, such departments will be paid (as) covered outpatient services under the hospital outpatient prospective payment system, the OPPOS, and should not use modifier PN which would trigger payment under the Medicare physician fee schedule.

Such departments shall continue to report the (PO) modifier as appropriate. For calendar year 2017, all other applicable off-campus departments of a provider that did not meet the attestation requirement to be deemed excepted for 2017 shall use modifier PN which includes those that anticipate meeting the exception requirements for 2018 and subsequent years.

For 2018 payment purposes, there is an additional mid-build exception and off-campus department of a provider that meets the following three requirements will be accepted from section 603 for items and services furnished on or after January 1, 2017 (should have said 2018). The first is if CMS has received a provider based attestation for the department not later than February 13, 2017. The second, the provider includes the department as part of the provider on its enrollment form in accordance with the enrollment process under section 1866(J).

And the third is that the main provider had a binding written agreement with an outside, unrelated party for the actual construction of the department as of November 2, 2015 and the secretary receives not later than February 13, 2017 a written certification signed by the chief executive officer or chief operating officer of the main provider that the department met such a requirement. Hospitals seeking this mid-build exception that's effective for 2018 should submit confirmation that they meet the provider-based attestation and the enrollment requirement as well as a written certification that they had a binding written agreement for actual construction of the department prior to the Bipartisan Budget Act to their Medicare Administrative Contractor by the February 13, 2017 deadline.

Section 16002 of the 21st Century Cures Act provides an exception for off-campus, outpatient departments of the 11 cancer hospitals that are paid under 1886 (d)(1)(B)(v) of the Social Security Act. If the department was provided

– was provider based to these hospitals after November 1, 2015 and before December 13, 2016 and the Secretary receives an attestation that they are provider based no later than February 13, 2017.

Alternatively, in the case of an off-campus department that is provider-based to these cancer hospitals, after December 13, 2016, the department will be excepted from the payment provisions of section 603 if the secretary receives from the provider an attestation that they are provider based no later than 60 days after the date that the requirement is first met by such department.

Off-campus departments and providers that meet these additional criteria for an exception should not use modifier PN on their hospital outpatient claims. So, that's a brief overview of sections 16001 and 16002 21st Century Cures Act. And at this point, I will pass it over to Janet.

Janet Miller: Thank you. I'm Janet Miller, I work in the Medicare enrollment and appeals group and have been working on the MOON notice and associated guidance and I just want to recap a little bit and then sort of say what the next steps are going to be in terms of what you're going to see related to the MOON. Last month, CMS released a Medicare outpatient observation notice for MOON along with its form instructions.

These can be found on our BNI web page which was sent out with the ODF agenda. Hospitals and critical access hospitals must begin using the MOON no later than March 8, 2017 and this indicates the 90 day implementation period that we gave to hospitals consistent with what we do with new notices in terms of the time that they have to begin delivering new notices.

The manual instructions regarding implementation of the MOON will be available on the same BNI webpage in the coming weeks. We expect that before too long, I just can't – I don't have a specific date at this time but I can tell you we're talking weeks and not months. The manual instructions will provide more specific detail on notice delivery and manual – I'm sorry (misspoke). Medicare Advantage plans will receive additional information related to MOON implementation via a health plan management system or HPMS memo.

But we're also establishing is a resource mailbox specific to the MOON and this will be available and we will put out that information when the manual instructions are released. Finally, we're going to send out an announcement to the hospital ODF listserv once the manual instructions and resource mailbox are available. So we'll have the link which will again just be on our BNI site but we will reiterate that as well as provide the resource mailbox address where questions can be e-mailed.

Lastly, I will not be remaining on this call. So, we hope you will please check our webpage for the information that we have available at this time related to the MOON. Thank you.

Jill Darling: Thank you, Janet. And thank you, David. Up next, we have Brian Elza who will go – who will go over the new fee-per-service recovery audit contractor contract.

Brian Elza: Yes, thanks everyone. So, I'd like to give an update on the RAC program and let everyone know that the main page for the Medicare fee-for-service recovery audit program Web Site can be found at go.cms.gov/rac -- R-A-C. And on that Web Site – on that page, that main page there, you will see at about the middle of the page, the announcement that CMS did award new fee-for-service RAC contracts on October the 31st of 2016. And it lists the five regions.

And we've changed our nomenclature a little bit here. So, instead of having regions with letters, we now have regions that have numbers. And the first four – numbers one through four are sort of AB RAC regions. Although the arrangement of the regions are a little bit different, and I'll get into that in a moment. The fifth one is actually a national contract that is specific to DME, Home Health, and Hospice claim reviews.

And so if you are looking at that main page also, you'll see an area down toward the bottom of the page that has downloads. And in that section, there are downloadable PDF files. And the first couple are actually related to our recent posting of our report to Congress.

But after that, there is a contact sheet – a RAC contact sheet. And this is very helpful for providers. It lists the region, the name of the RAC, the states that are in that new region. And then also it provides the Web Site and e-mail and phone number contact for each RAC. Then also on that same page in that downloadable area is a map which actually breaks out the different regions showing which MAC jurisdictions fall within them. And then it also shows the national contractor.

And then a little bit below that, you'll also that the RAC statements (of work) are posted. Regions four – the four – regions one through four rather basically have the same statement of work. So, we've just posted one copy rather than four copies that say the same thing. And then Region Five, as I mentioned before, is different because it's specific to DME, Home Health, and Hospice reviews only.

I'd also like to mention that we have a recent updates page on that Web Site, which is where we post all of our sort of up-to-date, latest new. And there's also a provider resources page where we currently have the ADR limits posted. There are documents in the downloadable section there that show the ADR limits. And we will soon be posting in the next week or so also a list of approved review topics for the RACs, which is something that we haven't had on our Web Site before. The RACs will continue to post things on their Web Sites, but we're going to have a consolidated list that we will post and update every month so that people can sort of go to one place and see all the different approved reviews.

And so that's basically the update.

Jill Darling: Thank you, Brian.

Brian Elza: You're welcome.

Jill Darling: Up next, we have Nora Fleming who will go over the episode payment model final rules.

Nora Fleming: Hi, this is Nora Fleming from the CMS Innovation Center. I'm the director for the Division of Specialty Payment Models. And I just want to take a few a

minutes on today's call to bring to everyone's attention that on December 20, we displayed in the federal register the final rule on advancing care coordination episode payment models. This rule puts in place three new bundled payments. We have an AMI model, a CABG model, and a surgical hip and femur procedure model.

We also –in this rule, are putting forth a cardiac rehab incentive payment model. And we are making changes to the Comprehensive Care for Joint Replacement Model to better align it with EPM and also to provide an opportunity to make CJR an advanced APM track. So, the three bundled payments – AMI, CABG, and the surgical hip and knee – are all going to be advanced APMs starting in 2019 because that's when downside risk will initiate for those models. The CJR model advanced APM track option begins as of February 18, 2017 when this rule becomes effective.

These models are hospital-driven models. They're based on DRG assignment. They start with admission to the hospital in a number of DRGs for AMI, CABG, and SHFFT. They will conclude 90 days after discharge from the hospital from that initial stay. Hospitals again are accountable for quality and cost for the entire 90-day post-acute episode in addition the initial hospitalization.

There are provisions in the rule for hospitals to set up financial arrangements with physicians and other collaborating post-acute care providers to help incentivize cooperation across the units of care. And they are being run in 98 MSAs, the AMI and CABG models. And the CJR model is running in 67 MSAs. And the surgical hip femur procedure model is also running in the same 67 MSAs.

On the EPM Web Site which I believe was in the agenda for this call and can be accessed at innovation.cms.gov/initiatives/epm– or if you Google "CMMI EPM", it will take you right to that page. We have the list of MSAs where the models are running. We also have a list of providers and addresses for providers that we think will be in the model. There is an EPM rule email box, EPMrule@CMS.HHS.gov. We are asking providers who are in the model to

contact us and let us know the point of contact – e-mail point of contact and name- so that we can reach out and get you materials about the models.

If there are any issues with the addresses that we have on the Web Site- CMS used our provider of services file to generate the addresses and admittedly, we are not always the most up to date on those things. So, if there are any issues or if you do not believe you should be in the model, please let us know through that e-mail address. And if you have questions about the model, we're certainly happy to respond to those questions via e-mail. So, EPMrule@CMS.HHS.gov.

Jill Darling: Thank you, Nora. Next, we have Michael Treitel who will go over the fiscal year 2018 inpatient prospective payment system wage index.

Michael Trietal: Thank you. So, I want to just talk about the wage index development timetable for the upcoming fiscal year for 2018. There are two upcoming important deadlines concerning the annual wage index cycle. The first deadline is the upcoming on January 30, 2017. It's not a deadline, but CMS will actually be posting the public use file which contains the most up-to-date wage index and occupational mix data.

These files will – the data on these files will have been (best) reviewed and verified by the MACs. And we encourage all hospitals to review that file to make sure that the data in those files are correct. After January 30, hospitals have until February 17, 2017 to submit requests to the MACs to correct errors in the public use file, for CMS or the MACs must handle the data, or to make revisions of the desk review adjustments to their wage index data is included in the January (puff will) provide documentation if there's anything that's still outstanding. No new requests for wage index and occupational mix data revisions will be accepted by the MAC at this point as it's too late in the process for a new request.

But again, to ensure the accuracy of the data for the upcoming fiscal year, we encourage all hospitals to double check that public view file January 30th and to follow up with the MAC is there's any errors by February 17. Thank you.

Jill Darling: Thanks, Michael. And last we have Amanda Barnes who will go over the (proof of care) provider participation request for the pilot testing transfer of health information.

Amanda Barnes: Thank you, Jill. CMS contracted with RTI and (Abt) to develop and implement two transfer health information and care preferences quality measures. The transfer of health measures meet requirements under the Improving Medicare Post-acute Care Transformation Act, as known as the IMPACT of 2014.

Data for these cross setting measures will be collected in the following post-acute care settings; inpatient rehabilitation facilities, long-term care hospitals, skilled nursing facilities as well home health health agencies. As a part of measure development process, RTI in collaboration with (Abt) is pilot testing the transfer of health measures to investigate data collection methods and times to complete the items, the feasibility of implementing the transfer of health quality measures and measure properties.

We refer you to the transfer of health pilot January 2017 zip file on the IMPACT downloads and video webpage. And we've included that in this ODF announcement for today. To participate in the pilot test, the interest forms need to be submitted by Tuesday, January 17, 2017. Thank you.

Jill Darling: Thank you, Amanda, and thanks to all of our speakers today.

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