Centers for Medicare & Medicaid Services
Hospital/Quality Initiative Open Door Forum
Moderator: Jill Darling
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2:00 pm ET

Coordinator: Welcome and thank you for standing by. For the duration of today's conference all parties will be in listen-only mode until the question-and-answer session of the conference. At that time you may press star 1 on your phone to ask a question. I would like to inform all parties that today's conference is being recorded. If you have any objections you may disconnect at this time. I would now like to turn the conference over to Ms. Jill Darling. Thank you. You may begin.

Jill Darling: Great. Thank you (Tara). Good morning and good afternoon everyone and welcome to today's Hospital/Quality Initiative Open Door Forum. We greatly appreciate your patience. I know we started later than we normally do but a lot of folks for the (IPPS) were on a previous call so we were waiting for all of our speakers for today's call to join us. So again thank you for your patience.

Before we get into the agenda I have one brief announcement. This open door forum is open to everyone. But if you are a member of the press you may listen but please refrain from asking questions during the Q&A portion of the call. If you do have any inquiries please contact CMS at press@cms.hhs.gov. And I'd like to hand the call over to our Acting Chair Emily Forrest.

Emily Forrest: Thanks Jill. Hi everyone and thank you for joining us today. For those you who don't know me, my name is Emily Forrest and I am the new Acting Chair of the Hospital Open Door Forum. I also work in the Hospital Ambulatory and Policy Group in the front office along with the Division of Acute Care.

I also want to take a moment to thank Tiffany Swygert for her leadership as the previous care of the hospital open door forum. We have a pretty packed agenda today. We'll be covering three important Medicare payment rules for Fiscal Year 2022, the inpatient rehab facility proposed rule (IRF PPS), inpatient psych (IPF PPS) proposed rule and the IPPS and LTCH proposed rule along, with two other issues.

I also wanted to thank those of you who have participated in our previous weekly COVID office hour calls. We have actually transitioned those calls and will now be taking COVID related questions at the first few open door forums, including this one.

Also I want to apologize for the barking puppy in the background. Nature of teleworking, but anyway as I mentioned we have a packed agenda. We will try to also reserve some time at the end to take some questions on the issues presented today along with any hospital related COVID questions. So without further ado I will turn it over to (Kim) for the (IRF PPS) update.

(Kim): Thanks Emily. On April 7, 2021, the Centers for Medicare and Medicaid Services issued a proposed rule that would update Medicare payment policies and rates for facilities under the Inpatient Rehabilitation Facility Perspective Payment System and the - our Quality Reporting Program for Fiscal Year 2022.

The rule proposes the following updates to IPF PPS payment updates for the Fiscal Year 2022. CMS proposes to update the IPF PPS payment rates by 2.2% based on the proposed first specific market basket using the 2016 based year estimate of 2.4%, less a 0.2 percentage point productivity adjustment.

CMS is proposing that as more recent data becomes available for example, a more recent estimate of the market basket or multi-factor productivity adjustment, we would use the more recent estimates to determine the Fiscal Year 2022 market basket update and multi-factor credit to the adjustment in the final rule.

In addition the proposed rule contains an adjustment to the outlier threshold for Fiscal Year 2022 of $9,192 to maintain outlier payments at 3% of total payments. This proposed adjustment would result in a 0.3 percentage point decrease in outlier payments. We estimate that the overall increased (unintelligible) payments for Fiscal Year 2022 would be 1.8% or $160 million relative to payment in Fiscal Year 2021.

That concludes my update and I'll turn it over to my colleague (Ariel). Thank you.

(Ariel): Thank you (Kim). I will be presenting the quality reporting program proposal for the Fiscal Year '22 rule. So CMS is proposing to adopt the COVID-19 vaccine coverage among healthcare personnel measures to track COVID-19 vaccinations (unintelligible). CMS is proposing to update the denominator of the transfer of health information to the patient post-acute care quality measure for patients discharged home under the care of an organized home health service organization or hospice.

CMS is proposing to update our public reporting of quality measures using fewer than standard number of quarters due to the exceptions granted for (unintelligible) for Q1 and Q2 of 2020 due to the COVID-19 public health emergency.

Finally we are requesting comments on two topics. The first is the use of the fast healthcare interoperability resource or FHIR in support of digital quality measure in the post-acute quality reporting program. And the second is closing the health equity gap. That is it for the quality reporting program. I will hand it back over to Jill. Thank you.

Jill Darling: Thank you (Kim) and (Ariel). Next we have Nicholas Brock and Lauren Lowenstein who will go over the IPF PPS proposal.

Nicolas Brock: Thanks Jill, good afternoon. My name is Nicolas Brock and I'm going to walk through the proposed payment policy updates for the Fiscal Year 2022 Inpatient Psychiatric Facility Perspective Payment System and quality reporting proposed rule.

These updates will begin on October 1, 2021. The proposed rule displayed on April 7th with a 60 day comment period ending June 7th. The Inpatient Psychiatric Facilities Perspective Payment System or IPF PPS pays a per diem rate for furnishing inpatient hospital psychiatric services to patients of inpatient psychiatric facilities or IPFs.

IPFs includes Medicare participating psychiatric hospitals and certified psychiatric units in acute care hospitals and critical access hospitals. There are approximately 1600 IPFs consisting of about 35% freestanding and about 65% units.

For Fiscal Year 2022 we're proposing annual updates, an update to our teaching policy and IPF quality reporting updates which Lauren will discuss in more detail later. The proposed annual updates include updating the IPF PPS payment rates for FY' 22 by 2.1% which is based on an IPF market

basket update of 2.3%, less a statutory required 0.2% adjustment for multifactor productivity.

Also updating the IPF wage index value to reflect the hospital inpatient wage index without reclassifications, updating the outlier threshold amount to maintain estimated outlier payments, at 2% of total estimated payments, decreasing the labor related share from 77.3% to 77.1% and updating the cost of living adjustment factors for IPFs in Alaska and Hawaii.

We estimate that the total impact of these changes will be a net increase of approximately $90 million in payments to IPFs which is about a 2.3% increase. The estimated impact is a 2.3% increase for urban IPFs and 2.4% for rural IPFs. Lastly we're proposing for Fiscal Year 2022 and for subsequent years to adopt conforming changes to the IPF teaching policy with respect to IPF hospital closures and displaced residents to align our IPF teaching policy with changes that were finalized for inpatient acute care hospitals for Fiscal Year 2021.

These changes include clarifying which residents are considered displaced when an IPF hospital closes and the timeline when residents become displaced; clarifying how to count FTEs of displaced residents and who's responsible for assigning the number for FTEs for residents; and limiting the amount of personally identifiable information that's required for submission letters to Medicare administrative contractors when requesting a temporary increase to an IPFs resident cap. Now I'll turn it over to Lauren to talk about the proposed IPF quality reporting updates for FY 2022.

Lauren Lowenstein: Thank you Nick. My name is Lauren Lowenstein and I'm the Program Lead for the Inpatient Psychiatric Facility Quality Reporting Program. This is a (unintelligible) reporting program and IPS that do not complete all program

requirements receive a 2.0 percentage point reduction to their annual payment update. Each year approximately 97% of participating IPS meet all of the program requirements and receive their full payment update.

There are currently 14 measures in the IPS QR program and in the Fiscal Year 2022 IPFPSS proposed rule we proposed to remove three chart extracted measures. Those are 1, the alcohol use brief intervention provided or offered measure, the tobacco use treatment provided or offered measure and lastly the timely transmission of transition record measure.

We also proposed removing the claims based measure follow up after hospitalization for mental illness because we are proposing to replace it with a measured called follow up after psychiatric hospitalization. This new measure expands the original measure which only evaluated follow up rates for patients with mental illness to now evaluating patients with both mental illness and substance use disorders.

We are also proposing to add one new measure, the COVID-19 healthcare personnel vaccination measure which will assess the percentage of healthcare personnel employed at the facility that received the vaccination for COVID-19. Finally we proposed to move away from aggregate level data reporting and to begin patient level data reporting.

We also included in this year's rule a request for comment on several topics including a request for information on ways to better attain health equity for the IPS patient population. That is all for the IPS QR program updates. I will turn things back over to Jill.

Jill Darling: Thank you Lauren, and next we will dive into the Fiscal Year 2022 IPPS LTC proposed rule and we will start off with Don Thompson.

Operator: Don please check your mute button.

Don Thompson: Thanks. So yesterday the inpatient perspective payment system and long term care perspective payment system proposed rule went on display. We're going to talk about a number of different topics that were contained in the rule but I'm going to start off with the payment rate update.

So for IPS hospitals that successfully participate in the inpatient quality reporting program and our meaningful health record users, we are anticipating the update will be 2.8% in the payment rates - the operating payment rates. This reflects the projected hospital market estimate at 2.5% reduced by a 0.2 percentage point productivity adjustment and then increased by half a percentage point required in legislation.

Individual hospitals may have additional adjustments to that update for access readmission on to the hospital readmission production program, if you're in the lowest performing quartile on to the hospital required conditions program and then there's also adjustments under the hospital value-based purchasing program.

Before taking into account changes in spending for Medicare just (unintelligible) chair hospital payments and on concentrated care payments the proposal creates the operating rates, increase in capital payments, increases in payment stream medical technology, increases in payments through the implementation of the imputed floor. We'll talk about it a little later and other proposed changes will increase hospital payments in Fiscal Year 2022 by about 3.4 billion or 2.8%.

CMS is projecting that Medicare (unintelligible) payments and Medicare uncompensated care payments are going to decrease in Fiscal 2022 compared to Fiscal 2021 by approximately 0.9 billion. So the net of those is overall - we estimate that hospital payments will increase by about 2.5 billion.

Also in the proposed rule we talk about the data that we will be - that we are proposing to use for the Fiscal 2022 rate setting. As part of setting the rates for the coming fiscal year we usually use historical data as part of that process due to the influence of the COVID-19 public health emergency on the Fiscal Year 2020 data that we would normally use.

We are proposing to use data from Fiscal Year 2019 the full year prior to the first year that contained the public health emergency data. But we are also seeking comments about the use of the Fiscal 2020 data. With that I'm going to turn it over to (Jim Rosenberger) to talk about changes to the (unintelligible) rates under the LTC PPS.

(Jim Mildenberger): Thanks Don. I'm (Jim Mildenberger) and I'm going to be presenting payment updates for long term care hospitals.

So similar to the IPSS we primarily use data from Fiscal Year 2019 to determine the proposed LTEC rates for Fiscal Year 2022. As of the case for IPSS hospitals we found that LTEC utilization patterns were meaningfully impacted by the COVID-19 PAG in 2020 and believe that data from 2019 will be a better approximation of 2022 utilization.

We are proposing a 2.2% annual update to the LTEC PPS standard federal payment rate. This is based on our current estimate of the Fiscal Year 2022 LTEC market basket increase for inflation of 2.4%, adjusted downward by 0.2% adjustment for productivity.

We are estimating that overall LTEC PPS payments in Fiscal Year 2022 would increase by approximately 1.4% which is about $52 million. This estimated change reflects an estimated increase in payments to LTEC PPS standard federal payment rate cases with approximately $41 million and estimated increases in payments to LTEC site neutral payment rate cases of approximately $11 million.

So now I'll turn it over to (Tehila) who will discuss the implementation of the imputed rural floor legislation.

(Tehila Lipschutz): Thank you Jim. Hi, my name is (Tehila Lipschutz) and I'm going to talk about the imputed rural floor. In the FY 2022 NPRM, we implemented Section 9831 of the American Rescue Plan Act, which requires the permanent reinstatement of the imputed floor for all urban states. The imputed floor sets a minimum wage index amount for hospitals in all urban states. Section 9831 of the Act also defines all urban states, and exempts the resulting higher payments resulting from the imputed floor from budget neutrality under the IPSS.

So any payments made as a result of the imputed floor are not budget neutral. The original and alternative methodologies for calculating an imputed floor that were in effect in 2018 before CMS ended the imputed floor were reinstated permanently. For FY 2022 Section 9831 of the American Rescue Plan Act will apply to all urban states of New Jersey, Rhode Island, Delaware, Connecticut, the District of Columbia and Puerto Rico.

CMS estimates that this provision will increase FY 2022 Medicare payments to hospitals located in those states by approximately 0.2 billion. Thank you very much, I will turn it over to…

(Renate): Hi, this is (Renate). This is (Renate). I'm going to be discussing the graduate medical education policies included in the proposed rule.

There are three graduate medical education or GME provisions of the Consolidated Appropriations Act of 2021 which are being proposed for implementation in this rule. We are proposing an application process to implement Section 126 of this CAA which makes available an additional 1000 resident cap slots phased in at a rate of no more than 200 slots per year beginning in Fiscal Year 2023.

Section 126 requires that a hospital fit into at least 1 of the following 4 categories in order to receive slots: a hospital in a rural area or being treated as being located in a rural area, a hospital currently operating over its GME cap, a hospital in a state with a new medical school or additional location, and a hospital that serves an area designated as a health professional shortage area.

We are proposing to implement also Section 127 of the CAA which concerns rural training tracks or RTTs. These are programs where residents spend more than 50% of their time training in rural areas. We are proposing to implement several provisions included in Section 127 which promotes training in rural areas including allowing a rural hospital participating in a rural training track to receive an increase in its resident cap based on training occurring at the rural hospital.

And thirdly, we are proposing to implement Section 131 of the CAA which resets the per resident amounts or PRAs and caps of certain hospitals that may have inadvertently set (de-minimis) PRAs or caps as a result of accepting residents from other training programs. And now I'm going to turn it over to Emily Forrest.

Emily Forrest: Thanks. I'm going to talk about the market-based data collection proposed repeal policy. As you may recall, last year we finalized the requirement that hospitals report to CMS market-based data that a hospital negotiated with Medicare Advantage Organizations for each MS-DRG for cost reporting periods ending on/after January 1, 2021. We also finalized the use of that data within a new methodology for calculating the MS-DRG relative weights, effective for fiscal year 2024.

In this year's fiscal year 2022 rule, CMS is proposing to repeal that requirement that a hospital reports its market-based data. We also are proposing to repeal the market-based MS-DRG relative weight methodology effective for FY 2024, and to continue using the existing methodology for calculating the relative weights to set Medicare payment rates for inpatient stays for FY 2024 and subsequent fiscal years.

So, with that, I will turn it over to Michael Treitel for an overview of the new technology provisions of the rule.

Michael Treitel: Thanks Emily. So for this year for FY 2022 in connection with the proposal to use FY 2019 data for the 2020 as Don mentioned earlier, we're proposing a one year extension of new technology add on payments for the 14 technologies for which new technology on payments otherwise be discontinued beginning in FY 2022.

In addition for FY 2022 we did receive 16 applications over the alternative pathways which are discussed in the proposed rule. We also have (about) 22 new applications applying to add on payments for FY 2022 that's already discussed as well in the proposed rule.

In addition in response to the pandemic CMS established the new COVID-19 treatment add on payment for eligible discharges during the PHE and we anticipate inpatient cases of COVID-19 beyond the PHE at this point. So therefore it continues to mitigate the potential financial (disincentive) for hospitals or by them with these new COVID-19 treatments to minimize any potential payment disruption immediately following the (end of the) PHE. We proposed to extend that as that (unintelligible) that COVID-19 add on payment through the end of the fiscal year in the PHE ends.

We're also proposing to discontinue these add on payments for these charges on or after October 1, 2021 for products that would receive the add on payment for a new technology add on payment, the regular new technology add on payment beginning FY 2022.

This COVID-19 add on payment is not to be confused with the 20% additional payment that Congress authorized. This add on payment is (unintelligible) through CMS to other payments, other add on payments. And with that I will think I will turn it over to Grace Snyder who will discuss hospital quality updates.

Grace Snyder: Okay, thanks, Michael. This is - good afternoon. This is Grace Snyder and I'll be providing an update on the statutory quality reporting and payment program for acute care, long-term care, and PPS-exempt cancer hospitals addressed in this proposed rule.

For all three hospital types, we're proposing to adopt a COVID-19 Vaccination Coverage Among Healthcare Personnel measure, which will be reported using the CDC's National Healthcare Safety Network. The COVID vaccine measure has been similarly proposed for other quality programs as described by the speakers today.

For the three hospital pay for performance programs, namely, the Hospital Readmissions Reduction Program, the Hospital-Acquired Condition Reduction Program, and the Hospital Value-Based Purchasing Program, we're proposing a measure suppression policy due to the impact of the COVID-19 public health emergency on quality measure performance and value-based scoring, and our concerns about ensuring that these programs do not penalize or reward hospitals based on circumstances caused by the public health emergency that the measures were not designed to accommodate.

Specifically for the Fiscal Year 2022 Hospital Value-Based Purchasing Program, we're proposing to apply measure suppression for a relatively large number of measures used in the program that are focused on patient experience, Medicare spending for beneficiary, and healthcare-associated infections because based on our analyses we believe these measures have been significantly impacted by the COVID-19 public health emergency.

And with the measure suppression we're also concerned in the ability to make fair national comparisons across hospitals under the program. Therefore, we're also proposing to not calculate a Total Performance Score for any hospital and to instead award all hospitals a value-based payment amount that is equal to the 2% withhold amount. That means hospital value-based payments would be net neutral for the Fiscal Year 2022 program.

For the Fiscal Year 2023 program we're proposing to suppress 1 measure for pneumonia mortality that uses 2020 data as part of the look-back period because of a significantly large percentage of COVID-19 patients who also had pneumonia. However, for purposes of value-based scoring we believe we can score hospitals without any modifications to the Fiscal Year 2023 scoring methodology.

For the Hospital Readmissions and Hospital-Acquired Condition Reduction Programs, which use longer measure look-back periods, we believe even with some measure suppressions as we are proposing in the rule, we still have sufficient, valid, and reliable data to score hospitals.

On the Inpatient Quality Reporting Program, we're proposing several quality measures in addition to the COVID-19 vaccine measure. These measures include: a Maternal Morbidity structural measure that assess hospital participation in maternal health quality improvement initiatives; a Hospital-wide, All-Cause Mortality measure that uses data from both claims and hospitals' certified electronic health records; and 2 electronic patient safety measures that focus on hyperglycemia and hypoglycemia, i.e., too high or too low blood sugar levels, in the inpatient care setting.

We are also proposing to remove several measures from the Inpatient Quality Reporting Program due to the availability of a more broadly applicable measure and a measure that is more strongly associated with desired patient outcomes.

Finally, as with other quality programs for which we recently issued proposed rules, we're soliciting input from the public on closing the health equity gap through the improvement of data collection and measuring and reporting disparities in the quality of care.

We're also seeking feedback on modernizing the quality measurement enterprise by leveraging digital quality measures and the FHIR®, or Fast Healthcare Interoperability Resources, health IT standard. This concludes my updates. I'll turn it over to Elizabeth Holland to speak about the promoting interoperability proposals. Thank you.

Elizabeth Holland: Thank you Grace. So I'm going to talk about the Medicare Promoting Interoperability Program. Just as a reminder 2021 is the very last year of the Medicaid Promoting Interoperability Program. So all of our proposals this year will only apply to a Medicare program.

First we are proposing to add a health information exchange bi-directional exchange measure. We are also proposing to change the Public Health and Clinical Data Exchange objective to require four measures instead of two. We're also proposing to add a requirement that hospitals must review nine of the safety assurance factors for EHR resilience guides, also known as the SAFER guides.

We are proposing to keep the Query of Prescription Drug Monitoring Program or PDMP measure as an optional measure, and we are also proposing to increase the bonus points associated with it from 5 to 10 points. We are proposing to raise the performance threshold from 50 to 60 points, and just as a reminder hospitals must score at or above the performance threshold to avoid a negative payment adjustment. Or if they are eligible they may be able to apply for a hardship exception.

Hospitals, I will note, are limited to five years of hardship exceptions since we implemented this program in 2011. So now turning it over to Michael I think or to Tehila, sorry.

(Tehila): For the FY 2022 wage index timeline, as you know, the proposed rule posted yesterday. However, the most up-to-date data for hospitals' wage index data and occupational mixed data will be posted on the CMS webpage on April 30th. That's in two days, on Friday. We'll release that data, the final FY

2022 wage index and occupational mix data and public use files, on the CMS webpage.

Hospitals will then have approximately one month to verify their data and submit correction requests to both CMS and the MACs to correct any errors due to CMS or MAC mishandling of the final wage and occupational mix data. This is hospitals' last opportunity to request correction to errors in the final data, so please use the opportunity to review it.

Changes to the data will be limited to the situations involving errors by CMS or the MAC that a hospital could not have known about before review of the final April PUF. Data that were incorrect in the preliminary or January wage index data PUFs, but for which no data correction request was received by the February 16, 2021 deadline, will not be considered for correction at this stage. This is only for new errors that recently came up, and that is it for the reminders. And I believe that concludes the updates and I'll turn it back to Jill.

Jill Darling: Last we have (Shaheen) who will go over the BFCC-QIO which is the Beneficiary and Family Centers of Care and Quality Improvement Organization Claims Contract Review Award.

(Shaheen Halim): Yes, thank you Jill. So my name is (Shaheen) Halim. I represent the Beneficiary and Family Centers of Care Quality Improvement Organization Program.

Many of you may be familiar with our contractors Livanta and KeyPro who perform case review work for beneficiary complaints and appeals. We are pleased to announce that we have now awarded the BFCC-QIO claims review

contract which as you know has been pending awards since the summer of 2019.

We're pleased to announce that that award has been made and that claims review activities for inpatient short stay reviews and higher waited DRG claims will resume over the next few weeks. The contract was awarded to Livanta.

They will be performing these claims review function on a nationwide basis. You can expect Livanta to reach out to hospitals with a (unintelligible) to establish relationships with over the next few weeks. They will reach out to establish memorandums of agreement so that they can perform the claims review work.

I'm going to provide you now with contact information for Livanta in case you have questions or you wish to find additional information. So a good way to contact the claims review contractor, the beneficiary family care to IO claims review contractor, Livanta is through their email address for claims review.

It is claim review, C-L-A-I-M, R-E-V-I-E-W -- one word -- at Livanta, L-I-V-A-N-T-A, dot com. Additionally Livanta has posted - has preliminarily posted some frequently asked questions, a copy of the MOA template, information about medical record submission and the various review types, you know, the high rated DRG review type and short stay review on their Web site for claim review services. And their Web site, I'll leave that out to you now. It's LivantaQIO.com/en/claimreview/-- just one word -- index dot HTML.

And once again the BFCC-QIO program is pleased to announce this award and is looking forward to resume claims review activity. Please contact Livanta at the claim review at Livanta.com email address if you have questions. Thank you very much.

Jill Darling: Great, thank you Shaheen and thank you to all of our speakers today. (Tara) will you please open the lines for Q&A?

Coordinator: Thank you. We will now begin the question and answer session. If you would like to ask a question please press star 1 on your phone and record your name clearly. I do need your name in order to introduce your question.

If you choose to withdraw your question please press star 2. Again if you would like to ask a question please press star 1. It will take a few moments for questions to come through. Please stand by. Again if you would like to ask a question please press star 1 on your phone and record your name. One moment. The first question comes from Diane Holland, one moment.

Diane Holland: Question for Livanta, the URL.

Coordinator: Go ahead. Diane your line is just open. Could you please repeat your question please?

Diane Holland: I'm sorry. Would you be able to repeat that QIO information, the URL information for Livanta please?

(Shaheen Helene): Sure. Hi, this is (Shaheen Halim). So the Web site is livantaqio.com/en/claimreview/index.html.

Diane Holland: Perfect. Thank you.

(Shaheen Helene): Thank you.

Coordinator: The next question comes from (Lisa Litwiller). Your line is open.

(Lisa Litwiller): Hi. Yes, I was just following up. You said the Livanta would reach out to us about the MOAs. If we already have an established MOA with them will they utilize the content within the MOAs that they have?

Woman: Yes, that is correct. If they already have an established MOA with a hospital they would continue to operate under that MOA.

(Lisa Litwiller): Okay thank you.

Woman: Thank you.

Coordinator: As a reminder if you would like to ask a question please press star 1 on your phone and record your name. The next question comes from (Valerie). Your line is open.

(Valerie): Thank you. First of all I just want to thank CMS for all their considerations given the impact of the public health emergency on the hospital industry across various policies, very much appreciate it. I have a couple of questions.

One, I notice in some of the data files released with a proposed rule that the 2019 data and the 2020 data seems to look very similar. So it's so similar that it raises questions as to whether there's perhaps - maybe got copied by mistake or something in some of the data files. For example, the AOR, BOR files for case counts by DRG that charges by DRG. So that was one question.

The other question concerns the evolution to the digital quality measures in some of the data standardization, the fire, and APIs. One of the key questions that CMS released an earlier transmittal and I thought maybe there would be more in the proposed rule, is about getting actual data on key drugs used during an inpatient case by requesting hospitals to just report two electronic claims, the national drug code since it's all part of the HIPAA transactions. That would be an easy thing to do so I was wondering if they could address that.

Emily Forrest: Don, Michael, do either of you want to take the first part of the question regarding the 2019/2020 data?

Man: Yes, sure. (Unintelligible).

Man: Yes. I was just going to say we did update the AOR, BOR files around two hours ago. So you should see a corrected file up on the Web site and any other issues, just let us know.

(Valerie): Perfect. Thank you.

Coordinator: Again as a reminder…

Emily Forrest: And for the second part of your question, I believe it's either Grace or Elizabeth.

Grace Snyder: This is Grace. I'm sorry. Can you repeat that, the second question again please?

(Valerie): Yeah. Seems like it would be very much promoting CMS's desire to move to more digital quality measures and for other purposes actually reading and

having hospitals report the national drug codes for drug use on inpatient cases on the claims.

It's all set up. It happens automatically in outpatient claims. Oftentimes it's reported on inpatient claims. It's just not being read. So it's a HIPAA transaction standard (NDCs) including on inpatient claims. And so I just feel like it fits so much with so many of your objectives for digital quality measures and whatnot to get detail on the types of drugs used during inpatient cases since drugs have increased in their proportion of cost even with the market basket rebate you report in this rule. So is CMS planning to have hospitals report (NDCs) for inpatient drugs?

Grace Snyder: Okay. This is Grace. Thank you very much for the question. I don't - in the proposed rule we don't go into that level of detail. But I really encourage you to submit a comment formally to the comment process and we'll definitely take it into consideration. So thank you.

(Valerie): Thank you.

Coordinator: Again as a reminder this is a chance for you to ask a question or make a comment. Please press star 1 on your phone if you would like to do so.

(Pause)

Coordinator: We do have one more question coming in. One moment. The next question comes - one moment. Next question comes from (Bill). Your line is open.

(Bill): Yeah, hi. This is (Bill). Thanks for taking the call. I was off for a couple of minutes. I don't know if this was already asked but I'll ask it anyway. About accelerated payment relief for hospitals under some CARES funding that

came down the pipe and the repayment plans are now being operationalized let's just say with CMS and there's some advocacy going on about seeking a waiver of that. Can you comment on that at all?

Emily Forrest: Thanks Bill, this is Emily. I don't believe we have someone on the phone that can speak to that specific question. If I'm incorrect, any of the speakers, please feel free to jump in. If you wouldn't mind submitting that question to us via the hospital open door forum inbox we will gladly try to get you an answer as best we can.

(Bill): Thank you.

Emily Forrest: And the inbox is hospital_odf@cms.hhs.gov.

(Bill): Thank you.

Coordinator: There are no further questions at this time.

Jill Darling: Great. Thanks everyone. I will kick it back to Emily for closing remarks.

Emily Forrest: Thanks Jill and thanks everyone for the questions and your participation today. I just wanted to remind folks of the comment period deadlines for the three payment rules we discussed today, IRF PPS and inpatient psych PPS (IPF PPS) comment periods close on June 7 of this year, and the IPPS and LTCH proposed rule comment period closes on June 28.

So thank you again. If you have any further questions please feel free to email the hospital ODF email. Again it's hospital_odf@cms.hhs.gov. It's also listed in the agenda.

With that, that concludes today's call. I thank you again for joining and have a wonderful rest of your day.

Coordinator: That does concludes today's conference. Thank you for participation. You may disconnect at this time. Speakers please allow a moment of silence and stand by for your post conference.

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