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

Coordinator: Welcome, everyone, and thank you for standing by. At this time, I'd like to inform all participants that your lines will be in a listen-only mode until the question-and-answer session of today's conference call. If you would like to ask a question on the phone line, please press star 1 on your phone. You may record your name when prompted. Today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the meeting over to our first speaker, Ms. Jill Darling. Thank you. You may begin.

Jill Darling: Great. Thank you, (Bridget). Good morning and good afternoon, everyone. Welcome to the Hospital Open Door Forum. We greatly appreciate you joining us today. Starting a little later than normal. We do have a lot of speakers today to go over the OPPS Proposed Rule and the IPPS final rule. So, we always appreciate 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 in 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 will hand the call off to our chair, (Tiffany Swygert).

(Tiffany Swygert): Thank you, Jill. And hi, everyone. It's been a while since we've had one of these open door forums so I'm very happy that we're able to have it today to cover some highlights of some really important rules, one being the outpatient

proposed rule and the other being the inpatient hospital and long-term care hospital final rule.

As Jill mentioned, we do have a lot to cover today so I won't be long but I will say that it's been nice to hear a lot of you participating on the pandemic-related calls for the Covid-19 Office Hours and other calls that we've had. While we've attended to those issues, we've obviously had to also keep the non-pandemic work - related work going on as well.

So, we're happy to be able to have this hospital open door forum today and happy to hear any of your questions at the end, time permitting.

So, without further ado I will turn it over to David (Rice) to begin the conversation of the hospital outpatient perspective payment system proposed rule.

David (Rice): Thanks, (Tiffany). The calendar year 2021 OPPS ASP proposed rule with common period, displayed on August 4th, 2020. This proposed rule contains a number of policies that would give Medicare beneficiaries more choices in where they seek care and lower their out-of-pocket costs for services.

Today we are briefly highlighting proposed policies but remind the public to please review the complete proposed rule and provide comments on the proposed rule. The deadline for submitting comments is October 5th, 2020.

Additionally, to do some little setting, since we are within the public comment period, we cannot share any non-public information that is not already included in the proposed rule whether that be on the proposed rule process or anything for the final rule.

To move to the first issue for the calendar 2021 OPPS rate update, in accordance with statute, CMS is proposing to update the OPPS payment rates by 2.6%. This update is based on the proposed hospital market basket increase of 3% minus a .4 percentage point adjustment for multi-factor productivity.

Now I'll turn it over to Gil (Ngan) to discuss the 340.B payment policy.

(Gil Ngan): Thanks, Dave. CY 2021 OPPS payment methodology for 340B purchase drugs. Section 340B of the Public Health Service Act, 340B, allows participating hospitals and other providers to purchase certain covered outpatient drugs from manufacturers at discounted prices.

In the CY 2018 OPPS/ASC final rule. CMS re-examined the appropriateness of the payment methodology for drugs acquired through the 340B program given that 340B hospitals acquire these drugs at steep discounts.

Beginning January 1st, 2018, Medicare adopted a policy to an adjusted amount of ASP minus 22.5% for certain separately payable drugs or biologicals applied through the 340B program.

This policy has been subject to ongoing litigation and CMS's policy was recently upheld by the D.C. Circuit Court on July 31st, 2020.

In this rule, we are proposing to adopt a proposed rate of ASP minus 34.7%, plus a 6% of ASP add-on amount for overhead and handling costs for a net rate of ASP minus 28.7% for separately payable drugs or biologicals that are acquired through the 340B program.

This proposed rate is based on the results of the 340B hospital survey of drug acquisition costs administered by CMS earlier this year. We also solicit comment on –an alternative proposal of continuing the current Medicare payment policy of paying ASP minus 22.5% for 340B acquired drugs for CY 2021 and subsequent years, given the D.C. Circuit Court decision.

Additionally, we are proposing that the rural sole community hospitals, children's hospitals and PPS exempt cancer hospitals be excepted from either of the proposed 340B payment policies. I'll be followed by Elise Barringer.

(Elise Barringer): Good afternoon. I'll be discussing the method to control for unnecessary increases and utilization of outpatient services. As finalized in the calendar year 2020 OPPS rule, CMS completed the two-year phase in a method to reduce unnecessary utilization in outpatient services by addressing payments for clinic visits furnished in off-campus hospital outpatient settings.

Clinic visits are the most common service built under the OPPS. Currently Medicare and its beneficiaries often pay more for the same type of clinic visit in the hospital outpatient setting than in a physician office setting. This change will result in lower copayments for beneficiaries and estimated savings for the Medicare program of $810 million for 2020.

For example, for a clinic visit (unintelligible) an expected off-campus provider-based apartment, average beneficiary cost sharing was $16 in calendar year 2019 but would have been $23 absent this policy. With the completion of the two-year phase-in, that cost sharing reduced to $9 saving beneficiaries an average of $14 each time they visit an off-campus department for a clinic visit in calendar year 2020.

This policy has been under litigation and on July 17th, 2020, the United States Court of Appeals for the District of Columbia Circuit Court ruled in favor of CMS holding that our regulation was a reasonable interpretation of the statutory authority to adopt a method to control for unnecessary increases in the volumes of development service.

And now I will turn it over to (Lela Strong-Holloway) to discuss the inpatient only list.

(Lela Strong-Holloway): Good afternoon, everyone. I'll be discussing the proposed changes to the inpatient-only list. In the calendar year 2021, LPPS, ACS proposed rule, we are proposing to eliminate the inpatient-only list, which is a list of services that are typically provided in an inpatient setting and are therefore not paid under the OPPS.

We proposed to do this elimination over a three-year transitional period with the list completely phased out by calendar year 2024. We're proposing to begin with their removal of nearly 300 musculoskeletal-related services which would make these procedures eligible to be paid by Medicare in the hospital outpatient setting when care is appropriate in addition to the existing flexibility for payment in the hospital inpatient setting when inpatient care is appropriate as determined by the physician.

We are also soliciting comments on several issues - several related issues including whether three years is an appropriate timeframe for transitioning to eliminate the inpatient-only list, whether there are other services that are candidates for removal from the inpatient-only list for calendar year 2021, and how we should sequence the removal of additional clinical families and/or specific services from the inpatient-only list in future rulemaking.

In this year, in this rule we're also proposing to continue the two-year exemption from certain medical review activities relating to patient status for procedures removed from the inpatient-only list that was finalized in the calendar year 2020, OPPS, ASD final rule with comment period.

Under this policy, procedures that have been removed from the inpatient only list are not eligible for referrals to recovery audit contractors for noncompliance with the two midnight rule within the first two calendar years of their removal from the inpatient-only list.

These procedures are not considered by the beneficiary as family centered care quality-improvement organizations or QIO's in determining whether a provider exhibits persistent non-compliance with the two midnight rule for purposes of referral to (unintelligible) nor are these procedures reviewed by (unintelligible) for patient status.

During the two-year period, QIO's will have the opportunity to review these claims in order to provide education for practitioners and providers regarding compliance with the two midnight rule but claims identified as non-compliant are not denied with respect to the site of service under Medicare Part A.

Again, this information will be gathered by the QIO's when reviewing procedures if they are newly removed from the inpatient-only list but it will be used for educational purposes only and does not result in a claim denial during the two-year exemption period.

We are also soliciting comments on whether the two-year period is appropriate or whether a longer or shorter exemption period would be more appropriate.

And now I'm going to transition over to my colleague, Josh (McFeeters) who will discuss outpatient therapeutic services.

(Josh McFeeters): Thank you, (Lela). I will be discussing outpatient therapeutic services and the physician supervision level requirements for some of those services.

For calendar year 2021, CMS is proposing to establish general supervision as the minimum required supervision level for all non-surgical extended duration therapeutic services, otherwise known as NSEDTS for the entire service including the initiation of the service.

General supervision means that the procedure is furnished under the physician's overall direction and control but that the physician's presence is not required during the performance of the procedure.

CMS is also proposing to change our regulations for pulmonary rehabilitation, cardiac rehabilitation and intensive cardiac rehabilitation services to specify that direct supervision for these services includes the virtual presence of a physician through audio or video real-time communication technology subject to the clinical judgment of the supervising physician.

We clarify in the proposal that the virtual presence required for direct supervision would not be limited to mere availability but rather real-time presence via interactive audio and video technology throughout the performance of the procedure.

Now I will turn over the discussion to my colleague, (Allison Bramlett) and she will discuss device pass through policy.

(Allison Bramlett): Thank you, Josh. I'll review the device pass through policy. As you may already know, under OPPS, a device is typically packaged into the payment for the associated surgical procedure. However, Medicare statute provides a temporary additional payment for devices that are approved by Medicare for device pass through status for a period of up to three years.

The intent of transitional device pass through payment is to facilitate access for beneficiaries to new and innovative devices before the Medicare payment rate, for the procedures updated to reflect claims data that includes the cost for such devices.

We received five device pass through applications for 2021 proposed rule. Information on each of these applications is included in the proposed rule. Three of the five devices have breakthrough device designation. They are artificial iris, exalt and (unintelligible) system. And two of the five - artificial iris and exalt, have preliminary pass through approval through the quarterly review process.

We do not propose to approve or deny any of the applications in the 2021 proposed rule. We solicit comment from the public before making a final determination on each of the applications in the 2021 final rule.

And I'll turn the call over to (Scott Talaga) to discuss the ASC rate updates.

(Scott Talaga): Thank you, (Allison). In previous years CMS has updated the annual payment rates for ambulatory surgical centers or ASCs by the percentage increased in the consumer price index for all urban consumers, also known as CPIU.

In the calendar year 2019, OPPS ASC's final rule comment period, we finalized our proposal to apply the optimal market basket update to the issue

payment system rates for an interim period of five years, calendar year 2019 through calendar year 2023.

CMS is not proposing any changes to its policy to use the optimal market basket update for AC payment rates for calendar year 2021 through 2023.

Meeting the hospital market basket, CMS proposed to update ASC rates for calendar year 2021 by 2.6% for ASC's meeting relevant quality (unintelligible) new requirement. This change is based on a projected hospital market basket increase of 3.0% minus a 0.4% percentage point adjustment for multi-factored productivity.

I will now turn it over to (Mitali Dayal) who will discuss proposed changes to the ACS list of covered surgical procedures.

(Mitali Dayal): Thanks, Scott. The ASC covered procedures list or CPL is a list of covered surgical procedures that are payable by Medicare when furnished in an ambulatory surgical center. For calendar year 2021, CMS is proposing to expand the number of procedures that Medicare would pay for when performed in an ASC which would give patients more choices in where they received care and ensure that CMS does not favor one type of setting over another.

For calendar year 2021, we proposed to add 11 procedures to the ASCPL including total hip arthroplasty. Since 2018, CMS has added 28 procedures to the CPL.

Additionally, we are proposing two alternatives that would further expand our goals of increasing access to care at a lower cost.

Under the first alternative, CMS would establish a process where the public could nominate additional services that could be performed in ASC's based on certain suggested quality and safety parameters.

Under the other proposed alternative we would revise the criteria used to determine the procedures that Medicare would pay for in ASC potentially adding approximately 270 procedures that are already payable when performed in the hospital outpatient setting to the ASC CPL).

Now, I'll hand it off to Josh (McFeeters) to discuss the wage index.

Josh (McFeeters): Actually, (Mitali), we're going to go ahead and discuss the skin substitutes instead. Skin substitute products are packaged into their associated surgical procedures as part of a broader policy to package all drugs and biologicals that function as supplies when used in a surgical procedure.

Under current policy, skin substitute products are either placed into a high-cost group or a low-cost group if they exceed the mean unit cost or per-day cost of these products. CMS is proposing to continue our policy established in calendar year 2018 to assign skin substitute to either the low-cost or high-cost group.

In addition, CMS is proposing to allow synthetic graft skin substitute products to be billed with CPT codes, 15271 through 15278 or HCPCS codes, C5271 through C5278 in the same manner as biological graft skin substitute products when those services are provided in the outpatient setting and receive payments through the OPPS.

I will turn over the discussion to my colleague, (Elise Barringer).

(Elise Barringer): Thanks, Josh. And I'll be discussing the advisory panel on hospital payment. On August 31st, CMS hosted the 2020 Advisory Panel on Hospital Payment Meeting. Recommendations from the panel are available on the CMS website. CMS is seeking nominations to fill vacancies on the (unintelligible) panel. To qualify, applicants must be fulltime employees of an OPPS hospital or health system participating in the OPPS and have a minimum of five years of requisite experience as an expert.

If you or someone you know may be interested, please refer to the CMS hot panel webpage for more information. Nominations are accepted on a rolling basis.

Now, I'll toss it to Justin (Carlisle) to discuss prior authorization.

Justin (Carlisle): Thanks, (Elise). I just wanted to take this opportunity to remind people that back on July 1st, 2020 CMS began acquiring prior authorization of certain hospital outpatient department services from the Category (unintelligible) botulinum and toxin injections, (unintelligible), rhinoplasty, and vein ablation for procedures provided on or after July 1, 2020.

Now that this process has been implemented for a few months, I wanted to remind providers of a few important things. Please note that botulinum and toxin injection codes only require prior authorization when paired with a service codes 64612 or 64615. They otherwise do not require prior authorization on their own.

Prior authorization requests can be submitted by either the Part A, Hospital Outpatient Department or the Part B provider's office on behalf of the hospital outpatient department. Note that Part B providers will not be able to use the

Medicare administrative contractor portals and will need to use mail or fax to submit the requests.

When submitting prior authorization requests on behalf of the hospital outpatient department, Part B providers must provide the hospital and provider information such as the hospital's NPI number. Please refer to the operational guide or reach out to your MAC, Medicare Administrative Contractor for a complete list of required information.

Additionally, while CMS only requires prior authorization for hospital outpatient department services, we will be reviewing related claims and services, and payments for those services will be impacted if the primary service is not prior authorized and approved. For a full list of codes that require prior authorization, frequently asked questions and additional resources, please visit go.cms.gov/opde_pa for more information.

Additionally, in the calendar year 2021, OPPS/ASC proposed rule, we are proposing the addition of two new service categories to the hospital outpatient department prior authorization process that have exhibited increases in volume. The two new service categories are cervical fusion with disc removal and implanted spinal neurostimulators.

If finalized, prior authorization for these hospital outpatient department services would be required as a condition of payment beginning for dates of service on or after July 1st, 2021. We did not propose any changes to either the program or process requirements that were finalized in last year's rule.

Thank you for your time. I would now like to pass it to (Michelle Schreiber).

(Michelle Schreiber): Thank you. I will be covering the various hospital and ambulatory surgery quality reporting programs. So, we proposed in the hospital acquired condition reduction program - that's infections and complications - we did not make any measure-related changes and only refined validation procedures per health care acquired infection.

For the hospital readmissions reduction program, we also did not make any measure-related proposals changes but will be adopting a policy to automatically adopt applicable periods starting with fiscal year 2023. So, this is period determination.

For hospitals value-based purchasing programs, every year we're required by statute to update performance standards to certain measures and so we made those updates that will be effective fiscal year 2023.

For the hospital inpatient quality reporting program, again we did not propose to add or remove any measures, but we are proposing three administrative proposals.

The first one is around electronic clinical quality measures. Hospitals have been reporting a choice of electronic clinical quality measures for several years and currently they're reporting one quarter of data and it is not publicly reported.

So, we proposing that over time there will be a transition from the current one quarter reporting to four quarters of reporting. This will happen over the next three years in increments as well as to start public display of electronic clinical quality measures that will begin in the fall of 2022.

We believe that this will increase the visibility of electronic clinical quality measures. We are also proposing to streamline the validation process requiring the use of electronic files submissions.

For the cancer exempt hospitals -- the PPS exempt cancer hospitals -- we did not make any proposals changes to add or remove measures but we will be refining two measures. Catheter associated urinary tract infections and healthcare acquired bloodstream infection to modify them and update the risk adjustment that is currently recommended by the Centers for Disease Control and Prevention. We'll begin publicly reporting those refined versions in 2022.

For the hospital outpatient quality reporting program, we codified some previously finalized administrative procedures including the definition of what non-workdays are so that we can have clear program deadlines but we did not propose ot remove or add any measures.

And for the ambulatory surgery center program, we also revised and codified some administrative procedures around non-workday as definition and did not propose or remove any additional measures.

Thank you and I will pass to (Joe Clift) for the hospital star program.

(Joe Clift): Hi. Thank you, Michelle. I'll be really quick about this. So, this is the first time that hospital star ratings has gone through rulemaking so the proposal in the outpatient rule is quite detailed.

Within that methodology, we are proposing to keep some things the same as our current methodology, which is to calculate the star ratings annually to use measure data publicly reported and to use k-means clustering to assign hospitals to a star rating.

We are making proposals to update the methodology and we seek comment on regrouping measures as a result of CMS's measure - meaningful measures initiative by combining the three processed measures groups into one, a proposal to remove the latent variable model and use simple average of measured group scores to calculate, to stratify the readmission group using proportion of dual eligible patients to align with hospital readmission reduction program, proposal to change the reporting threshold to require that a hospital must have safety or mortality data to get a star rating and a proposal to peer group hospitals by the number measured groups that they have data.

Non-methodology proposals we're also making is we are proposing to formally add critical access hospitals into the star ratings and we have a proposal to add Veterans Health Administration hospitals to the star ratings in the future.

Thank you. And I will pass it to (Michelle Hudson).

(Michele Hudson): Thank you. Now, we'll switch topics and move over to the IPPS and LTCH PPS Final Rule which was issued earlier this month on September 2nd. In this Final Rule, CMS increased the operating IPPS payments by approximately 2.9% based on the market basket update of 2.4%, a zero percent adjustment for productivity and a .5 percentage point adjustment required by legislation for prior documentation and coding adjustment.

This increase will apply to hospitals that successfully participate in the hospital quality reporting and meaningful electronic health user program. Hospitals that don't successfully participate in these programs are subject to other reductions as required by the law.

Overall, we estimate that total Medicare spending under the IPPS and FY 2021 will increase by about $3.5 billion or 2.7%.

Similar to the IPPS rate update, the long-term care hospital federal rate will be updated by 2.3% in FY 2021 based on an increase in the (unintelligible) market basket and the same zero percent productivity adjustment that's applied under the IPPS. This is the update to the federal rate that applies to long-term care hospital cases that meet the statutory patient criteria.

For those long-term care hospital cases that don't meet those patients' statutory criteria, they will be completing the statutory transition to the relatively lower site mutual payment rates under the dual rate system.

Overall, for FY 2021 we expect that long-term care hospital PPS payments will decrease by approximately 1.1% or $40 million which reflects that continued statutory implementation of the revised LTCH PPS.

In the proposed rule, we established several DRG changes. One I'd like to highlight for you is that we created a new DRG for cases involving chimeric antigen receptor T cell therapies or CAR T therapy. It's MSD DRG number 018. And in developing the payment policies for CAR T cell therapies for '21, we considered the distinction between cases where the hospital incurred the cost of the CAR T-cell therapy products and where it did not.

For example, like clinical trial cases or in expanded access use situations.

We took this distinction into consideration when we set the relative weight for new DRG 18 and we also established a corresponding payment adjustment for CAR T-cell cases where the therapy was provided without a cost.

In this final rule, we also had some updates for new technology add-on payments. For FY 2021, CMS approved 13 technologies that applied for these payments for 2021. Six of these technologies were under the traditional pathway. Two of the technologies were under the alternative pathway for devices under the Breakthrough Device Program. And five technologies were under the alternative pathway for qualified infectious disease products that receive that designation from the FDA.

CMS also provided a conditional approval for one QIDP product that otherwise meets the alternative pathway criteria but has not yet been FDA approved.

We're also continuing new technology add-on payments for 10 of the 18 technologies that are currently receiving those payments. The remaining eight technologies will no longer be within the (newness) period for FY 2021 and that includes the new tech add-on payment for the existing CAR T-cell therapy products.

So, in total, there'll be 24 products eligible to receive inpatient new tech add-on payments in FY 2021 and we estimate that Medicare spending on this inpatient new tech payments will be approximately $874 million.

In light of the ongoing concerns related to anti-microbial resistance, we also made some additional changes to the new tech policy related to antimicrobial products.

First, we expanded the application of the alternative pathway that currently applies to QIDP products to also apply to products approved under the FDA's limited population pathway for antibacterial and antifungal drugs or the LPAD pathway. This is a pathway that encourages the development of safe and

effective drug products that adjust unmet needs of patients with serious bacterial or fungal infections.

And just like the case where breakthrough devices and QIDP's, in LPAD products applies for a new technology add-on payment, they will not need to demonstrate that they're not substantially similar to an existing product and will not need to demonstrate that they meet the substantial clinical improvement criteria. They will need to meet the cost criteria.

The other change that we made in relation to antimicrobial products is we adopted a policy that will allow for those products to receive the add-on payment sooner by adopting a conditional approval policy for those antimicrobial products that otherwise meet the new technology alternative pathway criteria but haven't yet received FDA approval in time for the consideration in the final rule.

So, under this policy, those antimicrobials that otherwise meet the payment criteria can begin to receive a new technology add-on payment effective with the discharges after the quarter after they receive FDA marketing authorization rather than having to wait until the next fiscal year.

And I'll turn it over to Don (Thompson) for a summary of the changes for Medicare uncompensated care payments.

Don (Thompson): Thanks, Michele. I'm going to go quickly given the clock. I'm going to show you some time at the end for questions. In the final rule, CMS will distribute roughly $23 billion in Medicare uncompensated care payments for fiscal 2021. For the vast majority of hospitals, CMS will use the data on uncompensated care costs from worksheet S10 of the hospital's fiscal 2017 cost reports to distribute those funds.

We also finalized a policy where for all subsequent years we will also be using audit worksheet S10 data on uncompensated care costs for the most recent available year. For additional details, there's a factsheet on our Web site as well as see the rule itself.

I'm going to turn it over to (Renate Dombrowski) to talk about GME education updates.

(Renate Dombrowski): Thanks. I'll be providing an update on the policy change related to residents affected by a program on teaching hospital closure. Under the closed program and closed hospital rules, hospitals training residents displaced due to a hospital or program closure can receive temporary and Medicare GME funding for these residents until they graduate.

The change included in the final rule relates to which residents are considered displaced residents for Medicare payment purposes.

Prior to the change made in the final rule, displaced residents were considered residents who were, one, physically training in a hospital on the day prior to or day of program or hospital closure or two, residents who would have been at the closing hospital or program on the day prior to or day of closure but were on approved leave.

In the proposed rule, we've proposed to make the following changes to the Medicare policy regarding displaced residents.

First, instead of linking temporary Medicare funding to the day prior to or day of closure, we proposed to link the temporary funding to the day that the closure was publicly announced.

Secondly, related to this change, we propose to allow temporary funding to be transferred for residents who are not physically at the closing program or hospital but who intend to train at the hospital or program in the future.

Both of these concepts were finalized in the final rule such that under our revised policy a displaced resident includes a resident who one, made the program after the hospital or program closure is publicly announced but before the actual hospital or program closure, two, is assigned to and training at planned locations at another hospital and will be unable to return to his or her rotation at the closing hospital or program.

Three, is accepted into a GME program at the closing hospital or program but has not yet started training at the closing hospital or program. Four, is physically training in the hospital on the day prior to or day of program or hospital program closure. And lastly, a resident who is on approved leave at the time of the announcement of closure or actual closure and therefore cannot return to his or her rotation at the closing hospital or program.

I'm now going to turn it over to (Emily Forrest). Thanks.

(Emily Forrest): Thanks. I'm going to be talking about the market-based data collection and the MS-DRG relative weight methodology. In the fiscal year 2021 IPPS final rule we finalized the collection of market-based rate information on the Medicare cost report, specifically for cost reporting period ending on or after January 1, 2021.

More specifically, we are finalizing to collect - some hospitals are (unintelligible) specific new share charges that they have negotiated with Medicare managed organizations or MAOs by MS-DRG. Originally, as folks

recall in the proposed rule we proposed to collect two (unintelligible) of median pairs for the (unintelligible) new share of charges, the first of which was - were charges that hospitals negotiate with MAOs and the second was charges the hospital negotiates with all third party payers which included MAOs.

So, after reviewing the comments that we received on a proposed rule, we finalized a modification to the proposed policy and finalized the requirement of the collection of only the market-based data that hospitals have negotiated with MAOs.

We also are adopting a new market-based MS-DRG relative weight methodology which will use the median care specific negotiated charge data and how we set the MS-DRG relative weights.

As folks are aware, MS-DRG relative weights are used in the methodology because they (unintelligible) hospital payments. This market-based methodology will be used for a relative weight, a (unintelligible) of the relative weight beginning in fiscal year 2024 and is the same market-based methodology - market-based MS-DRG relative weight methodology we described in the proposed rule and (unintelligible) that we may file it in the final rule.

So, with that I will turn it over to Jill for questions.

Jill Darling: Great. Thank you, Emily, and to thank you to all of our speakers for today. Fran, will you please open the lines for questions?

Coordinator: I'd be happy to and thank you so much. If you would like to ask a question, please press star one. If you muted your phone, please unmute your phone

and record your name clearly when prompted. Your name is needed to introduce your question. So, again, star, then one and please record your name. One moment, please.

Again, star then one. Our first question now from (Donald Hirsch). Mr. (Hirsch), your line is open.

(Donald Hirsch): Hi. It's Ronald, you guys know that. So, my question is about the ASC list method two. When I'm looking through that list, it includes things like gunshot wound to the chest, tracheostomy, thrombolytic therapy to the brain, and those just don't seem like things that meet any kind of criteria at all to be in ASC. So, can you explain method two criteria that you would use to come up with that list?

(Tiffany): Hi, Dr. (Hirsch). This is (Tiffany). I don't know if Dave or (Mitali) want to add anything but I'll just say it is a proposed rule so it's open to comment and we're not - obviously not able to comment on or provide information with further detail that wasn't included in the proposed rule, but I think that's the type of feedback that would be helpful to the extent that those or any other procedures in your view or for anyone who's commenting, may not be appropriate or maybe would be appropriate but weren't proposed under one of the alternatives. I think that's the sort of thing that we'd love to see in the comments.

Dave or (Mitali), did you want to add anything additional?

Dave: Just so you know, I think you covered it. Thank you.

(Ronald Hirsch): Okay. Thank you, (Tiffany).

(Tiffany): Thank you.

Coordinator: Our next question is from Kim (Drobineck). Ma'am, your line is open now.

(Kim Drobineck): Thank you. I had a question - or actually, I'd like just to make a request in regards to the prior authorization program. We've had a lot of patient concerns over the process and just delays and specifically with the Botox and we realized that there's the two procedures that have to be billed. But we looked on the Medicare.gov and patients have called and it doesn't seem that the folks at the Medicare.gov line are aware of the prior authorization plan. And I didn't know if there was something that CMS could put out just so that patients or beneficiaries are aware of the whole prior authorization plan or program.

(Amy): Hi, thank you. This is (Amy) from (unintelligible), definitely (unintelligible) beneficiary contact process and make sure that they have this information. Thank you.

(Kim Drobineck): Great, thanks.

Coordinator: Our next request is from Lisa (Cajano). Ma'am, your line is open now.

Lisa (Cajono): Hi, I just had a quick question on where I can find the documentation from today's meeting.

Woman: Jill, would you like to take that one?

Jim Darling: Do you mean the agenda that was sent out?

Lisa (Cajono): Not just the agenda but you mentioned a lot of different codes and I'm just wanting to make sure I wrote them all down right and just all of the data specifically.

Jill Darling: So, we will be getting a transcript and an audio recording. So it'll take about three weeks or so. We post that. We have a podcast and transcript webpage available. If you google CMS podcast and transcripts, it'll pop up there, so you just check it periodically for the transcript and it'll provide everything spoken today.

Lisa (Cajono): Okay…

Woman: Right.

Lisa (Cajono): …so it won't be on the CMS website anywhere - all of these new rules?

Tiffany Swygert: Just a quick reminder. Everything that was said today was in a public rule, so either in the OPPS rule or the IPPS rule, so all of that information is already publicly available. There's no new information that was provided on today's call but if you're interested in listening to the podcast, you can Google that and also the transcript if you're interested.

Lisa (Cajono): Okay. I was just trying to find the OPPS rule.

Tiffany Swygert: That is posted online in a couple of different spots. If you want to send us an email, we can send you the link if you're not able to find it. Jill, do you want to read off the resource mailbox email?

Jill Darling: So, the email is hospital_odf@cms.hhs.gov and that email is listed on the agenda.

Lisa (Cajono): Thank you.

Coordinator: Thank you. If you would like to ask a question, please press star one. My last question at this time is from Alvin Gore. Sir, your line is open.

(Alvin Gore): Thank you - very nice presentation. Just a quick question in regards to moving procedure to the AAC settings. In order to limit beneficiaries' out of pocket expenses, have you considered capping beneficiaries liability when procedures have moved from the hospital outpatient department into the AAC? Because the outpatient department expenditures would be limited by inpatient deductible but there is no such limit in the AAC setting.

Man: Yes, thank you for your comment. I think it's just worth noting, statutorily the outpatient co-payments are limited at the inpatient deductible and that is not in statute for ASC's.

(Alvin Gore): Because it will be a big dis-incentive?

Man: Yes.

(Alvin Gore): Especially…

Man: Yes.

(Alvin Gore): …in procedures like (unintelligible).

Man: Yes, and again, a statutory provision but thank you for the comment and feel free to comment on the proposed rule for the final rule and raising that issue.

(Alvin Gore): Thank you.

Coordinator: Our next question now from (Gail Grant). Miss (Grant), your line is open.

(Gail Grant): Great, thank you. I just have a point of clarification about the ECQM public reporting. Did you say for the IQR program that public reporting of ECQM data would begin in the fall of 2020 - this year?

(Julie Venanzy): Hi, this is (Julie Venanzy). So, for the hospital IQR program, we will first begin publicly displaying ECQM data using the calendar year, the 2021 data, and that will be first displayed in the fall 2022.

(Gail Grant): Okay, great. Thanks for that clarification.

(Julie Vananzy): Thank you.

Coordinator: If you have a question, please press star one. My next is again from (Ronald Hirsch). Mr. (Hirsch), your line is open.

(Ronald Hirsch): Hi, again. So, I have a question for the gentleman who is talking about cardiac and pulmonary rehabilitation with supervision. So, my question is you're allowing remote supervision by a physician and you said it's not just the mere availability. So, does that mean the physician must be sitting in front of their computer with their face visible on the screen at the rehab center during the whole time that patients are receiving treatment? Or can the physician be in their office seeing patients, doing paperwork and then if they scream for him, he can - he or she can run over to the computer and address the issue?

(David Rice): So, I don't think - and I'll see if (Tiffany) has anything to add to this, but I don't think we can provide any more detail beyond what was in the proposed

rule. But to the degree to which you think there's ambiguity on what that means in the proposed rule, please do provide a comment and then we will address that in the final rule. (Josh), I don't know if you have anything to add.

(Josh McFeeters): No, Dave, I agree with what you said.

(Ronald Hirsch): Okay. Thank you again. The comment on the way.

Coordinator: Thank you very much. At this time, I have no further questions in queue.

Woman: Great, thank you. And Jill Darling, did you want to go ahead and close it out for today?

Jill Darling: Well, thanks, everyone, for joining us today. The email is available for you to send questions and feedback. Again, that email is hospital_odf@cms.hhs.gov. And we look forward to talking with you on our next open-door forum. Thanks, everyone. Have a great day.

Woman: Thanks, Jill. And one last item. If you do have an official public comment for the rules, please use regulations.gov. For that, the comment period closes for the OPPS rule on October 5. Thank you.

Coordinator: Today's conference is now concluded. Again, thank you for your participation. Please go ahead and disconnect. Thank you very much.

End