Centers for Medicare & Medicaid Services

Questions and Answers from Open Door Forum: Hospital

July 20, 2021

1. I have a question about the RO model, specifically the estimates of Medicare program savings and the difference between the savings that were issued as part of the final rule from last September versus this most recent proposed rule. The final rule and last - that was issued last September estimated $230 million in savings, in this most recent proposal is estimating 160. And it's not clear to me what that $70 million difference is. It could be a variety of things. But I just wanted to see if you could shed a little light on that.
    a. The initial estimate, yes, so 260, and then when we proposed to start in July of 2021, it went to, I think it was 210. And now it has gone down to 160. And part of this is based - most of the changes in the savings is the result of lowering the discount and just changes from the baseline period and the removal of brachytherapy and liver cancer. That's all related. Those proposals that we have, if those proposals, you know, are not finalized, that savings estimate will change.
        i. Does that not include the estimated impact of the 2022 Medicare Physician Fee Schedule cuts that are proposed? They would flow through the transactor.
            1. I believe it does not because we base that estimate on things that are finalized.
2. I'd like to report that there is mass confusion out in the field with regard to these new requirements. The MACs are doing an uneven job in terms of both education and even answering correctly questions that our members have when they're trying to figure out how to navigate the system. There's a lot of confusion over whether the physician/surgeon is able to submit the prior auth and how that's got to be coordinated with the hospital, and so forth and so on. We're very disappointed in how this whole thing has rolled out and the lack of education really to the clinicians who have to now comply with these requirements. And it's been very disruptive for this month of July. My question is going to now be related to if you're going to start waiving prior auth requirements because of the 90% compliance or what have you. How is that information going to be disseminated to, you know, I guess not just the hospitals, but the surgeons who are working at those hospitals?
    a. I would suggest going on the CMS web site that we have listed in the agenda. We have our current Operational Guide and our FAQs. And if there's a specific MAC that's giving, you know, that's giving you the runaround or causing confusion, I would suggest that, if possible, if you could email the email address that I provided. And we will get right back to you and try to figure out a way to assist.
        i. And then what about with regard to the communication back to, you know, the doctors who are the ones who are interacting with the patients, not the hospital, when it comes to their scheduling, their services, and all of that,

and whether or not they're going to - how do they know whether or not they're going to ultimately be needing to get prior auth down the road? They meet that threshold.

1. I'm assuming your question or I'm just assuming that the answer would be - it will be - it's based on certain codes. So it's not everything. It's only certain codes that we're looking at. And for the implanted neurostimulators, it would be the code 6366, code 63650. So if they're using that code, that is what it will be requiring prior authorization.