Centers for Medicare & Medicaid Services
Open Door Forum: Hospital Quality Initiative
July 20, 2020
3:00 pm ET

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

Jill Darling: Thank you, (Katrina). Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications. And welcome to today's Hospital Quality Initiative Open Door Forum. We appreciate you waiting. I know we're starting a little later. We were making sure we have all the folks on the line because of our packed agenda.

So, again, we appreciate your patience. And one brief announcement from me. 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 have any inquiries, please contact CMS at press@cms.hhs.gov.

And now I will hand the call over to our chair Emily Forrest.

Emily Forrest: Thanks, Jill. Hi everyone, and thank you for joining us today. As Jill mentioned, we have a pretty packed agenda. We'll be providing an overview of the proposals and the recently released CY '22 OPPS ASC/PPS proposed

rule. We'll also be providing a couple of payment software and prior authorization updates as well.

I just want to ask that every speaker, I'll just ask that you state which topic your briefing on prior to going into your remarks. That way, folks on the phone can follow along since there's a lot of different topics we'll be discussing under each of the bullets that were listed in the public agenda.

I want to also thank everyone for participating in our previous weekly COVID Office Hour calls. Over the last couple months, we've been transitioning from those weekly calls to now taking any COVID-related questions in the first few open door forums, including this one. So if you have COVID-related questions, please feel free to ask those during the Q&A portion at the end of today's presentation.

So, as I mentioned, we have a packed agenda. But we will try to take some questions at the end of today's call.

But without further ado, I will turn it over to (Susan) to start us off our agenda with an overview of the CY '22 OPPS ASC proposed rule.

(Susan): Thanks, Emily. So the Calendar Year 2022 OPPS/ASC proposed rule with comment period just went on display yesterday, July 19, 2021. Today, we are briefly highlighting proposed policies but remind commenters that any public comment should be based on the full information that was included in the proposed rule. The deadline for submitting comments on the proposed rule is September 17, 2021. Additionally, since we are within the public comment period and the final rule has not yet been published, we won't be sharing information that's not already included in the proposed rule.

So I'm going to go ahead and turn it over to Erick to start on our topic areas. Thank you.

Erick Chuang: Hi. This is Erick. I'll be talking about the 2022 OPPS update and proposal to use 2019 claims data and rate setting. In accordance with Medicare law, CMS is proposing to update OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.3%. This update is based on the projected hospital market basket increase of 2.5% reduced by 0.2 percentage points for the productivity adjustments.

To start the Calendar Year 2022 OPPS and ASC payment rates, normally we would use Calendar Year 2020 claims and cost support data. However, because the Calendar Year 2020 data includes the COVID-19 Public Health Emergency, which significantly affected outpatient service utilization, we've determined that Calendar Year 2019 data would better approximate expected Calendar Year 2022 outpatient service utilization. As a result, we are proposing to use Calendar Year 2019 data with that Calendar Year 2020 OPPS and ASC payment rates. This use of 2019 data narrows the use of Fiscal Year 2019 data by the IPPS for their Fiscal Year 2022 proposed payment rates.

And I'll be turning it over to (Gil) for the 340B drug payment methodology.

(Gil): Thanks, Eric. The 340B Program is a HRSA administered program that allows covered entities to purchase covered outpatient drugs at a state discount. Due to pending litigation, we are proposing to maintain the status quo for CY 2022 and pay ASC minus 22.5% for 340B acquired drugs and potentially revisit this policy for CY 2023 when the litigation is complete.

I'll be followed by (Cory) on the nonopioid products in Section 6082 of the SUPPORT Act.

(Cory): Okay. Thanks, (Gil). Hi, everyone. This is (Cory). So as (Gil) mentioned, I will now cover our nonopioid pain management payment policy proposal authorized by Section 6082 of the SUPPORT Act.

The Section 6082 of the Support for Patients and Communities Act mandates that the Secretary review and revise the OPPS and ASC payment systems to avoid financial incentives to use opioids instead of nonopioid alternatives.

In this proposed rule, CMS proposes that beginning on or after January 1st, 2022 a nonopioid pain management drug or biological that functions as a surgical supply in the ASC setting would be eligible for separate payments when those products are FDA approved, FDA indicated for pain management, or as an analgesic and with a per-day cost above the OPPS drug packaging threshold.

Accordingly, CMS is proposing to continue separate payments in Calendar Year 2022 for the two products currently receiving separate payment under this policy for Calendar Year 2021 as these products meet these newly proposed criteria.

In addition, CMS is soliciting comment on additional criteria and policy modifications including an application process for new products, requiring peer-reviewed literature demonstrating an opioid reduction, requiring proof of utilization decreases, expanding this policy and associated criteria to the hospital Outpatient Department setting, expanding the policy to include non-drug products, and finally, flexibility and FDA indication. We are also

soliciting comment on additional products that meet our proposed criteria for Calendar Year 2022.

This concludes our overview on our nonopioid pain management payment policy proposal. I believe next is the pass-through drugs and devices proposal with Lela.

Lela Strong: Thanks, (Cory). Hi. My name is Lela Strong. And I will be discussing Calendar Year 2022 policies related to device and drug pass-through payments.

Transitional pass-through payment for devices is an interim measure to allow for adequate payment of the new technology while we collect the necessary data to incorporate the cost for these items into the Procedure ASC payment.

According to statute and transitional pass-through payments for devices must be made for a period of at least two years, but not more than three years, beginning on the first day on which the pass-through payment was made for the device. We received eight applications for the Calendar Year 2022 OPPS ASC rule cycle. In this proposed rule, we provide an assessment of the application regarding the criteria for device pass-through followed by the 60-day public comment period.

And we'll make a final determination to approve or deny the application for pass-through payments in the final rule.

Additionally, as a result of the proposal to use Calendar Year 2019 claims data rather than Calendar Year 2020 claims data to inform Calendar Year 2022 rate setting, CMS is also proposing to use its Equitable Adjustment Authority under 1833(t)(2)(E) to provide up to four quarters of separate payments for 27

drugs and biologicals and 1 device category whose pass-through payment status will expire between December 31, 2021, and September 30, 2022. This will ensure that we have a full year of data from Calendar Year 2021 to use in Calendar Year 2023 rate setting.

So now I'll turn it over to (Au'Sha Washington).

(Au'Sha Washington): Thank you, Lela. Hi everyone. This is (Au'Sha Washington). And I will be covering the inpatient-only or IPO list. The IPO List has existed since the start of OPPS and is a list of services that Medicare will only pay for when provided in an inpatient setting because of the nature of the procedure, the underlying physical condition of the patient, or the need for at least 24 hours of post-operative recovery time, or monitoring before the patient can be safely discharged.

In the CY 2021 OPPS ASC final rule, we eliminated the IPO List with a three-year phase-out removing 298 services at the first phase of the elimination without a clinical review or evaluation using the long-standing criteria of the removed services.

After further consideration of stakeholder feedback, CMS evaluated the procedures removed from the IPO List for CY 2021 using the long-standing criteria. And we do not believe these procedures need to establish criteria for removal from the IPO List. Our review of each of the services removed from the list in the CY 2021 rulemaking using the established criteria did not find sufficient evidence that any of these services are safe to perform on the Medicare population in the outpatient setting.

CMS is increasing Medicare beneficiaries' safety by reversing these changes made for 2021. And in this rule, we propose the, also, elimination of the IPO

List. And after the clinical review of the services removed from the IPO List in CY 2021, we propose to add the 298 services back to the Inpatient-Only List beginning in CY 2022.

We are also proposing to codify the five long-standing criteria used to determine the placement of a service on the IPO List, and additionally, we are soliciting comment on whether CMS should maintain the longer-term objective of eliminating the Inpatient-Only List or if CMS should maintain the Inpatient-Only List and continue to systematically scale the list back so that inpatient-only designations are consistent with current standards of practice.

Thank you. Next, we'll have (Elise) who will discuss the Two-Midnight Rule.

(Elise Barringer): Thanks, (Au'Sha). This is (Elise Barringer). And I'll be discussing the Two-Midnight Rule medical review exemption. Effective January 2013 we finalized the Two-Midnight Rule, which directs how hospital claims are to be reviewed by Medicare review contractors to determine the appropriateness of Medicare Part A payment.

In the Calendar Year 2020 OPPS ASC final rule, we established a policy that services removed from the IPO List effective January 1, 2020, would be exempt from certain medical review activities under the Two-Midnight benchmark for a period of two years. In the Calendar 2021 final rule, we established that procedures removed from the IPO List beginning January 1, 2021, would be indefinitely exempted from Two-Midnight medical review activities.

As we were proposing to halt the elimination of the IPO List, this indefinite assumption seems no longer necessary. And in this proposed rule we are

proposing to revise the exemption to apply for a more limited period of two years.

And now I will hand it back to Erick Chuang to discuss the Calendar Year 2022 ASC payment update.

Erick Chuang: Thank you. In the Calendar Year 2019 OPPS ASC's final rule with comment period, we finalized our proposal to apply the hospital market basket update to ASC payment system rates for an interim period of five years or Calendar Years 2019 through 2023. Using the proposed hospital market basket CMS is updating the ASC rates for Calendar Year 2022 by 2.3%. The proposed update applies to ASCs meeting relevant quality reporting requirements. This change is based on the projected hospital market basket increase of 2.5% with a 0.2 percentage point productivity adjustment.

And I'll be turning it over to (Mitali) for the ASC Covered Procedures List.

(Mitali Dayal): Thanks, Erick. This is (Mitali Dayal). And I'll be discussing the ASC Covered Procedures List or CPL.

The CPL was developed under a statutory requirement that the Secretary specify surgical procedures that can be performed safely on an ambulatory basis in ASC. The statute also requires that the Secretary regularly review and update the ASC CPL.

In CY 2021, we removed several criteria used to add surgical procedures to the CPL. Removing these criteria meant that CMS would no longer make a medical judgment regarding the safety of a procedure in the ASC. Using the revised criteria, we added 267 codes to the CPL.

After further evaluation for CY 2022, we are proposing to revise the criteria back to the CY 2020 criteria and remove 258 services from the CPL that were added in 2021. We also proposed to allow stakeholders to nominate procedures they believe are safe in the ASC for our review during rulemaking beginning in CY 2023.

We are requesting comments on whether stakeholders believe that any of the 258 procedures meet the CY 2020 criteria that we are proposing to reinstate. We are also seeking comment on how CMS might prioritize our review of nominated procedures in the event that we receive an unexpectedly large volume of nominations for which we have insufficient resources to address and during rulemaking.

Now I'll pass it along to Emily Yoder to discuss the comment solicitation on temporary policies for the PHE.

Emily Yoder: Thank you so much, (Mitali). So this is Emily Yoder. And I'm going to cover a few of the comment solicitations in this year's OPPS rule that pertain to certain of the temporary policies implemented for the public health emergency for COVID-19.

In response to the COVID-19 pandemic, CMS undertook emergency rulemaking to implement a number of flexibilities to address the pandemic, such as preventing spread of the infection and supporting diagnosis of COVID-19. While many of these flexibilities will expire at the conclusion of the PHE, we are seeking comment on whether there are certain policies that should remain permanent. So these include payment for mental health services furnished by hospital staff to beneficiaries in their homes through the use of communication technology, revision of the supervision requirements for certain rehabilitation services to include the presence of the supervising

provider by two-way audio/video communications technology, and whether we should continue payment for specimen collection for COVID-19 tests after this COVID-19 pandemic ends.

And I will be handing it off to Kianna Banks to discuss the Rural Emergency Hospital RFI.

Kianna Banks: Thank you, Emily. There is a growing concern over closures of rural hospitals and critical access hospitals that is leading to a lack of services for people living in rural areas. One of these key services is access to emergency care.

Following these concerns, Congress enacted Section 125 of the Consolidated Appropriations Act of 2021, which establishes a new provider type called Rural Emergency Hospital. The Consolidated Appropriations Act defines Rural Emergency Hospitals as facilities that convert from either a critical access hospital or a rural hospital with less than 50 beds but do not provide acute care and patient services. Rural Emergency Hospitals are permitted to provide skilled nursing facility services furnished in a distant part unit. Furthermore, Rural Emergency Hospitals will be required to furnish Emergency Department services and observation care, and may provide other outpatient medical and health services as specified by the Secretary through rulemaking.

The Consolidated Appropriations Act provides that the statutory provisions governing Medicare payment for Rural Emergency Hospitals shall apply to items and services furnished on or after January 1, 2023.

We have published a Request for Information in this proposed rule to obtain feedback and comments from the public that we will use to inform our

policymaking as we develop health and safety standards, quality measures and reporting requirements, and payment policy for Rural Emergency Hospitals. Some of the targeted areas we are seeking input are the extent to which the existing health and safety standards for hospitals, critical access hospitals, and skilled nursing facilities should apply to Rural Emergency Hospitals. Additional health and safety standards that should apply to Rural Emergency Hospitals, quality measurement and reporting, payment policies, addressing health equity, and data sources, additional considerations, and unintended consequences that we should consider in the development of policies for Rural Emergency Hospitals.

We encourage you to provide your comments on the Request for Information for Rural Emergency Hospitals via the standard process of commenting on Notice of Proposal Making by visiting regulations.gov in the comment period for the rule of open.

Thank you. And now I'll turn it over to Terri Postma for the discussion of hospital price transparency.

Emily Forrest: Actually, this is Emily Forrest. We have a last-minute add before Terri goes into price transparency update. Going to pass it to (Andrea) for the health equity and the conditions of participation update.

(Andrea Curtis): Hi. Yes. This is (Andrea Curtis) with the Clinical Standards Group in CCSQ. CMS periodically conducts a comprehensive review of the current health and safety standards, the conditions of participation, COP, and conditions of coverage, CfC, with the goal of evaluating the efficacy of the current standards and identifying opportunities for regulatory improvements. The COPs and CfCs are the health and safety standards that providers and suppliers must meet in order to receive Medicare and Medicaid

payment. They apply to all individuals that receive care in a healthcare organization regardless of the payor type. They vary by provider, but generally cover issues such as care planning, governance, quality assessment and performance improvement, emergency preparedness, patient/resident client rights.

In accordance with President Biden's three Executive Orders addressing issues of health equity, we are now evaluating how we can address health equity and improve health disparities through the COPs and CfCs. We are committed to advancing equity for all including racial and ethnic minorities, members of the LGBTQ community, people with limited English proficiency, people with disabilities, rural populations, and people otherwise adversely affected by persistent poverty or inequality.

In order to achieve these goals, we are asking for any information, input, and ideas from the public on ways that we can address health equity within the COPs and CfCs. We are asking for data, research, studies, and any other information that can help inform any potential changes to the COPs and CfCs that we might make in the future. In particular, we are looking for input on how health equity can be improved during the care planning process and how providers can partner with community-based organizations to improve a person's care and outcomes after discharge.

Ways to hold a facility's governing body and leadership responsible and accountable for reducing disparities within their facility and advancing health equity policies and efforts.

How the COPs can ensure that health equity is embedded into a provider's strategic planning and quality improvement efforts. What types of staff

training and other efforts are necessary to ensure that people receive culturally competent care?

Ways to combat implicit and explicit bias in healthcare. How the COPs can be improved to ensure that providers are not discriminating against individuals and underserved populations particularly racial and ethnic minorities, those with disabilities, sexual and gender minorities, people with limited English proficiency, and rural populations.

Ways to reduce health disparities amongst rural populations and increase access to care in rural areas. How the COPs can ensure that providers offer fully accessible services for their patients in terms of physical, communication, and language access and any other data or additional information on ways to ensure that a provider is addressing and reducing health disparities within their facility.

We encourage you to submit information and your valued input to the following mailbox, he.outreach@cms.hhs.gov. Again, that's he.outreach@cms.hhs.gov. We will review the information that we receive and use it to inform potential future policymaking. he.outreach@cms.hhs.gov. Again, that's he.outreach@cms.hhs.gov. We will review the information that we receive and use it to inform potential future policymaking.

Now back to you Jill.

Terri Postma: Hi. This is Terri Postma. I'll be covering the hospital price transparency proposals in the OPPS. Just by way of background, the Hospital Price Transparency Final Rule was issued in November of 2019. It became effective on January 1st of this year.

The authority for the Hospital Price Transparency Rule comes from Section 2718(e) of the Public Health Service Act, which requires each hospital operating in the United States to make public their standard charges for items and services that they provide. The final rule requires hospitals to make public their standard charges in two ways: First, as a comprehensive machine-readable file with all standard charges for all items and services. And second, as a consumer-friendly display of some standard charges for some shoppable services.

This provision applies to all Medicare and non-Medicare enrolled institutions that meet the definition of hospital as finalized in the rule.

Under the final rule, CMS may take enforcement action to address hospital non-compliance including issuing a warning notice, requesting a corrective action plan, imposing civil monetary penalties of up to $300 per day, and publicizing the names of non-compliant hospitals on a CMS website. This Administration expects hospitals to comply with these legal requirements, and CMS is actively enforcing the Hospital Price Transparency Final Rule to ensure Americans know what a hospital charges for their items and services.

To align with the Secretary's ongoing support for public access to pricing information and enforcement, CMS is proposing several modifications designed to increase compliance and reduce hospital burden. And if finalized as proposed, these changes would begin January 1, 2022. They include the following:

First, we're proposing to increase the civil monetary penalty amount. We're proposing to set a minimum CMP of $300 per day that would apply to smaller

hospitals with a bed count of 30 or fewer, and then scaling up by $10 per bed per day to a maximum daily dollar amount of $5,500.

Second, we're proposing to do deem state forensic hospitals as having met requirements. We're proposing to deem state forensic hospitals as having met requirements so long as the facility provides treatment exclusively to individuals who are in the custody of penal authorities and the facility does not offer services to the general public.

Third, we're proposing to require that the machine-readable file be accessible to automated searches and direct downloads.

And then finally, in the OPPS proposed rule, we're offering some clarifications and seeking comment from the public on a number of issues for future rulemaking. First, we're clarifying the expected output of a hospital online price estimator tool if the hospital chooses to use such a tool in lieu of posting its standard charges for 300 shoppable services in a consumer-friendly format. Specifically, we clarified that an online price estimator tool must provide a cost estimate to an individual that takes into account the individual's insurance information and that the estimate reflect the amount the hospital anticipates will be paid by the individual for the shoppable service absent unusual or unforeseeable circumstances.

We're also seeking comment on a number of issues including methods to identify and highlight exemplar hospitals and for improving standardization of the machine-readable files.

Thanks for that. And I'll turn it over to Marcie O'Reilly to address the radiation oncology model.

Marcie O'Reilly: Thank you, Terri. In review, the radiation oncology or RO Model will test whether making site-neutral, modality agnostic, prospective, episodic-based payments to hospital outpatient departments and physician group practices including free-standing radiation therapy centers for 90-day episodes of radiotherapy will preserve or enhance the quality of care furnished to Medicare beneficiaries while reducing or maintaining Medicare spending.

The RO Model requires participation from radiation therapy providers and suppliers that furnish RT services within randomly selected core-based statistical areas or CBSAs.

In September of 2020, the Center for Medicare and Medicaid Innovation published a final rule that established the RO Model with a start date of January 1, 2021. As a result of the ongoing COVID-19 Public Health Emergency, CMS included an interim final rule with comment period in the Calendar Year 2021 OPPS and ASC Payment System final rule to delay the start of the RO Model until July 1 of 2021. Subsequently, the 2021 Consolidated Appropriations Act included a provision that prohibits implementation of the RO Model prior to January 1, 2022. Thus, CMS is making proposals to address necessary changes as a result of this legislatively mandated delay and additional proposed modifications to the model design.

We are proposing to begin the RO Model on January 1, 2022, with a five-year model performance period ending December 31 of 2026. We are proposing to change the baseline period from 2016 through 2018 to 2017 through 2019. We are proposing to lower the discounts on professional component payments to 3.5% and to 4.5% for the technical component payments. Additionally, we are proposing to remove brachytherapy from the list of included modalities under the RO Model so that it would continue to be paid fee-for-service.

And in light of the current public health emergency and several recent natural disasters, we are proposing to adopt an extreme and uncontrollable circumstances policy. This policy would provide flexibility to reduce administrative burden of model participation including reporting requirements and/or adjusting the payment methodology as necessary when such circumstances exist.

We are proposing to exclude hospital outpatient departments participating in the community transformation track of the new CHART Model from participation in the RO Model. For the CHART Model's ACO transformation track, we would follow the same policy for overlap between the RO Model and the Medicare Shared Savings Program ACOs.

And finally, we are proposing to modify our overlap policy such that only hospital outpatient departments that are participating in the Pennsylvania Rural Health Model would be excluded from the RO Model rather than all HOPDs that are eligible to participate in that model.

We are also removing liver cancer from the RO Model because the treatment of liver cancer is rapidly changing and thus does not satisfy the model's cancer inclusion criteria.

Finally, we have included clarifications to help address questions from stakeholders and future participants related to the interaction between RO Model and the Quality Payment Program. We are seeking comments on these proposals.

As for next step, I encourage all RT providers and RT suppliers that are furnishing, included RT services in the selected CBSAs as identified by ZIP

Code, to visit the RO Model web site at the URL included on today's agenda to review the participating zip code lists and to download and review many new or revised resources designed to assist RO participants.

I also want to note that there - to encourage you to register for upcoming webinars. Next week, July 27th at 1:30 pm Eastern, we will be hosting the RO Model 101 Refresher and Portal Overview webinar.

And on August 24th, we will be hosting the RO Model Coding, Billing, and Pricing webinar followed by Office Hours the next day. Registration links are on the RO Model web site.

And if you have further questions or would like to start your onboarding activities, I encourage you to contact our RO Model Help Desk to obtain your Model ID. And you can - the contact information for the Help Desk is also included on today's agenda.
Thank you for your time today. And I look forward to engaging with you further. I'll hand it over to (Shaili Patel).

(Shaili Patel): Hi. Good afternoon. This is (Shaili Patel). I will cover all the Quality Reporting Programs that are in this proposed rule. The OQR, Outpatient Quality Reporting, and the ASC QR, Ambulatory Surgical Center Quality Reporting Programs, are paid for reporting programs.

For both the OQR and ASC QR Programs, CMS is proposing to adopt COVID-19 vaccine coverage amongst healthcare personnel measures starting with Calendar Year 2022 reporting period, which would be reported through the CDC's NHSN, which is a web-based surveillance system.

Next for the OQR Program only is the proposal to adopt ST STEMI, ST Segment Elevation Myocardial Infarction, STEMI eCQM, which is an electronic Clinical Quality Measure starting with voluntary reporting for Calendar Year '22, then mandatory starting with Calendar Year 2023.

Third again for the OQR Program only is the proposal to adopt the breast screening recall rate. It's a claims-based measure starting with Calendar Year 2022 reporting period.

Moving onto measure removal, CMS is proposing to remove two charter abstracted measures from the OQR Program that would be replaced by the STEMI eCQM mentioned earlier.

For the OQR and the ASC QR Programs, CMS is proposing to require data collection for measures that are either currently voluntary or suspended. These measures include data collection of the cataract measures starting with Calendar Year '23 reporting period as well as resumption of data collection for the OAS CAHPS Survey measures starting with voluntary reporting for Calendar Year 2023, then mandatory starting with Calendar Year '24.

For the ASC QR Program only, CMS is proposing to resume data collection for four patient safety measures via a web-based tool starting with Calendar Year 2023 reporting period to monitor for rare events that affect patient morbidity and mortality.

Furthermore, CMS is seeking stakeholder's input on the future digital quality measurement to modernize quality measurement initiative. CMS is also seeking comment on health equity on ideas to revise the OQR and the ASC QR Programs to make reporting of health disparities based on social risk

factors and race and ethnicity more comprehensive and actionable for facilities, providers, and patients.

And lastly, for the Hospital Inpatient Quality Reporting and Promoting Interoperability Program, CMS is requesting comment on potential measure updates for the continued use of the previously finalized safe use of opioids concurrent prescribing eCQM measure.

This concludes the Quality Reporting Programs-related proposals. Back to you Jill.

Jill Darling: Thank you so much. Next, we have Will Gehne, who has an announcement on modernizing CMS payment software.

Will Gehne: Thanks, Jill. I work in the Provider (Working) Group. And I'm going to call everyone's attention to a new resource about our efforts to modernize Medicare claims processing software.

On your agenda is a link to a Fact Sheet summarizing our progress and describing upcoming releases of Java versions of various programs. Hospitals should note that we will convert the hospital inpatient claim software, that is the Medicare Code Editor or MCE, and the MS-DRG Grouper beginning with Version 39 coming up in - coming up October 1, 2021.

We released test versions of the Java software for MCE and MS-DRG Grouper based on Version 38.1 on the CMS web site back in April. Interested providers and their software vendors can still access those test versions now.

To allow you additional time for transition, we will make the mainframe versions of Version 39 available to the public this year, even though the Java

versions will be used by Medicare systems. Both versions produce the same results reflecting the Fiscal Year 2022 final rule.

Both the new JAVA versions for anyone ready to use them and the mainframe versions for folks who want to make use of this transitional year will be posted in August.

Next year, beginning with Version 40 in October 2022 we will post only the Java version of the programs on the CMS web site. So please be sure to take the necessary steps during Fiscal Year 2022 in order to be ready come next October.

Thanks. Jill.

Jill Darling: Thanks, Wil. And last, we have Sabrina Betts who has a prior authorization edition announcement.

Sabrina Betts: Hello. My name is Sabrina Betts. And I'm the Acting Deputy Director for the Division of Payment Methods and Strategy in the Provider Compliance Group. Today, I'll be providing updates in regards to a Hospital Outpatient Department Prior Authorization Program.

In July of last year, CMS established a Prior Authorization Program for Hospital Outpatient Department Services. These services are blepharoplasty, botulinum toxin injection, panniculectomy, rhinoplasty, and vein ablation.

Effective July 1, 2021, CMS added two new service categories to the Prior Authorization List. These services are cervical fusion with disc removal and implanted neurostimulators.

CPT Codes 63685 and 63688, which are implanted spinal neurostimulator codes that were initially in last year's final rule were temporarily removed from the list of Outpatient Department services requiring prior authorization.

In addition to the new codes that have been added, beginning May 1, 2021 hospital Outpatient Departments who have demonstrated compliance with Medicare rules were exempt from prior authorization requirements. Every six months, MAC will calculate the affirmation rate of initial prior authorization requests and notify hospital Outpatient Department providers through a Notice of Exemption if their affirmation rate is 90% or greater. MAC will evaluate exempt providers continued compliance with post-payment reviews. Providers who did not meet the 90% compliance rate threshold for prior authorization requests should continue submitting prior authorization requests as usual.

If you have any questions about anything that I discussed, please feel free to email opdpa@cms.hhs.gov.

And I'll turn it back to you, Jill.

Jill Darling: Great. Thank you, Sabrina, and thank you to all of our speakers today.

(Katrina), will you please open the lines for Q&A?

Coordinator: Thank you. Once again, if you would like to submit a question or a comment, please press star 1 on your phone, record your name, and your line will be open. That is star 1. To withdraw your question, you may press star 2. One moment as questions queue up, please.

Our first question comes from Anne Hubbard. Your line is now open.

Anne Hubbard: Hi. Good afternoon. I'm Anne Hubbard with the American Society for Radiation Oncology. 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.

Marcie O'Reilly: Hi Anne. It's...

Emily Forrest: Marcie, do you want to answer that question?

Marcie O'Reilly: Yes. I'm here. 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.

So it's all - that's all related. Those proposals that we have, if those proposals, you know, are not finalized, that savings estimate will change.

Anne Hubbard: Okay. So just real quick follow-up, does that not include the estimated impact of the 2022 Medicare Physician Fee Schedule cuts that are proposed? They would flow through the transactor.

Marcie O'Reilly: That - I believe it does not because we base that estimate on things that are finalized.

Anne Hubbard: Okay, got it. That helps. Thank you.

Coordinator: Once again, if you would like to submit a question or a comment, please press star 1 on your phone, and record your name, and your line will be open.

Our next question comes from Katie Oricco. Your line is now open.

Katie Oricco: Yes, hi. This is Katie Oricco with the American Association of Neurological Surgeons. And I have sort of, I guess, a question, or a comment related to the new prior authorization application for the two sets of spine procedures, neurostimulator, and the ACDFs.

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.

And really, you know, I guess maybe it's a plea. I don't know. 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.

Going forward, I guess 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?

And how is how - you know, how are we supposed to interface with that information? Because up to now, it's been very difficult.

Emily Forrest: Thank you Katie for that...

Sabrina Betts: Hi.

Emily Forrest: ...comment. It's Emily Forrest. Sabrina, I don't know if you have anything else to add.

Sabrina Betts: So, 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.

Katie Orrico: Okay. 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.

Sabrina Betts: Oh well, It would be - 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.

Katie Orrico: Okay. Well, I won't take up your time. I'll follow up online because this wasn't exactly.

Sabrina Betts: Thank you. I'm sorry. It was...

Katie Orrico: Thank you.

Emily Forrest: (Unintelligible).

((Crosstalk))

Katie Orrico: That's okay. No. I know there's a lot of people online so.

Emily Forrest: Katie, this is Emily. Katie, this is Emily Forrest. If you have suggestions in terms of how to best disseminate this information, you know, please do let us know. There is an inbox for the open door forum that we can also provide in addition to the one that...

Katie Oricco: Okay.

Emily Forrest: ...Sabrina had provided too.

Katie Oricco: Okay. We will. And we're collecting comments from our members and that kind of thing. We're trying to be organized about it. So we'll get back to you all. Thank you.

Emily Forrest: Thank you.

Coordinator: Okay. At this time, there are no further questions in queue.

Jill Darling: All right. Thank you, everyone. I'll hand it back to Emily for closing remarks.

Emily Forrest: Great. Thanks, Jill. this is Emily Forrest. If you guys have any other questions, I know we went through a ton of information today on a bunch of different topics, but if you have any further questions, please feel free to email the Hospital ODF email. Again, that's hospital underscore O as in - well, odf at cms dot hhs dot gov. It's also listed in the agenda for folks on the phone.

Also, just a reminder, the CY 2022 OPPS ASC/PPS proposed rule comment period, that closes on September 17th of 2021. So please feel free to submit comments on any of the proposals that we provide as an overview today.

But with that, that concludes today's call. Thank you, everyone, for joining today, and hope you have a good rest of your afternoon.

Coordinator: Thank you all for your participation. This concludes the call. You may disconnect. Speakers remain on the line, please. Thank you.

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