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

Coordinator: Thank you for standing by. All lines have been placed in a listen-only mode for today's presentation until the question-and-answer session. The call is being recorded. If you have any objections, you may disconnect at this time. I will now introduce your conference host, Miss Jill Darling. You may begin.

Jill Darling: Great. Thank you, (Catherine). 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. Before we get into our lengthy agenda today, 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 have any inquiries, please contact CMS at press@cms.hhs.gov. And I will hand the call off to our chair, Emily Forrest.

Emily Forrest: Thanks, Jill. This is Emily Forrest, and thank you for joining us today. First and foremost, I do want to apologize to the soccer fans on the line who have (dueling) 2:00 p.m. Eastern Standard Time appointments today. But as Jill mentioned, we do have a full agenda. Hopefully, we'll get through everything and then also have some time for questions.

We're going to be talking about the policy that were finalized in the 2023 OPPS final rule, which was issued on November 1st. I also want to highlight that the 2023 physician fee schedule final rule was also issued on that same day on November 1st. As many of you are aware, this rule also includes policies for services furnished in multiple care settings.

But in particular, I just wanted to note that the physician fee schedule final rule did finalize a policy to clarify and codify certain aspects of our current payment policy for dental services, along with a policy to pay for dental services in specific circumstances in both the inpatient and outpatient setting. Just wanted to highlight that.

Those specific circumstances also include, beginning in 2023 in the payment for dental services prior to organ transplants, a couple of different types of cardiac procedures. And then also beginning in 2024, dental services prior to the treatment for head and neck cancer.

So, again, just wanted to highlight that payment for those specific things would be made in both inpatient and outpatient settings. In addition to a full agenda, we're also going to provide some time at the end for questions from issues that are presented today.

And then also if there are some questions that you guys have for other topics, we'll be more than happy to answer those questions offline. So, without further ado, I am going to turn it over to Terri for an update on hospital price transparency. Terri –

Terri Postma: Great. Thanks. This is Terri Postma, and I just wanted to make sure everybody was aware that the hospital price transparency initiative has posted some sample formats on our website. So, just a little bit of background. The hospital price transparency regulations became effective January 1st, 2021.

It requires each hospital operating in the United States to provide standard charge information online about the items and services that each hospital provides in two ways. First, a comprehensive machine-readable file with all items and services and all standard charges. And two, as a display of 300 shoppable services in a consumer-friendly format.

In CY 2022, hospital OPP - or the OPPS/ASC payment system proposed rule, last year we sought comment on recommendations for improving standardization of the machine-readable file. We subsequently held a technical expert panel was organized, comprised of industry experts from various hospitals, technology, and academia, to provide input and best practices for making public hospital standard charge information in a machine-readable file format.

And this standardized set of data elements that we're making available to you, reflects the input of the technical expert panel. We really believe these sample templates will assist hospitals in complying with the requirements under the hospital price transparency regulations, and also provide some consistency in how those disclosures are viewed by consumers.

I want to emphasize that the use of these sample formats is voluntary. The sample formats and associated data dictionaries are available for you to download at the hospital price transparency website at https://www.cms.gov/hospital-price-transparency/resources. *(UNDER RESOURCES)* And I will share that link with the coordinators of this call.

With that, I'd like to turn you over to discuss this year's OPPS ASC final rule policies. Kianna Banks will kick us off.

Kianna Banks: Thank you, Terri. I'm Kianna Banks. I'm a technical advisor in the Clinical Standards Group of the Center for Clinical Standards and Quality. Our group is responsible for developing and maintaining the health and safety standards for Medicare and Medicaid participating providers and suppliers, such as hospitals, critical access hospitals, long-term care facilities, ambulatory surgical centers, and a host of others, which now includes rural emergency hospitals.

So, rural emergency hospitals were established by Congress in the Consolidated Appropriations Act of 2021. They're an outpatient-only provider that may only convert from either a critical access hospital or a rural hospital with not more than 50 beds.

And they are required by the statute to provide emergency care observation services, and they may also provide additional outpatient services. There are some additional specific statutory requirements for REHs. For instance, rural emergency hospitals must have an average annual per-patient length of stay that does not exceed 24 hours.

They must have an agreement with a level one or level two trauma center, and they must meet the critical access hospital emergency services requirements. So, we propose a comprehensive set of conditions of participation for rural emergency hospitals based on the statutory requirements, and based on comments we received on the request for information that was published last year, which we did use to help inform our policymaking.

On the proposed rule, we received over 4,000 comments, which were generally supportive of our proposals, and we finalized the majority of the provisions as proposed, with only some slight modifications. So, we've mirrored the rural emergency hospital standards after the critical access hospital standards where appropriate, of course, keeping in mind that rural emergency hospitals are outpatient-only providers, and critical access hospitals must provide inpatient services.

And we also mirrored some of the standards after the hospital requirements and also after the ambulatory surgical center requirements, which is another outpatient-only provider. I'd just like to highlight some of the key provisions, with the first being the staffing requirement, as the statute requires that the emergency department of the rural emergency hospital be staffed at all times.

We highlighted in the rule that rural emergency hospitals have the flexibility to determine who is best to fulfill the 24/7 onsite staffing requirement based on the scope of services provided by the rural emergency hospital and the population served.

We also added skills that this individual is expected to have that include effective communication and the ability to recognize life-threatening emergencies, and provide cardiopulmonary resuscitation to patients presenting to the emergency department if necessary.

Another provision I'd like to highlight is the emergency services provision. As I stated earlier, the statute requires that rural emergency hospitals meet the critical access hospital requirements for emergency services. So, they must have a practitioner on call at all times, and the practitioner must be on site within 30 or 60 minutes, depending on if the facility is located in an area that is considered frontier.

And regarding CRNA oversight, we proposed and finalized the requirement that CRNAs be supervised by physicians. Of the 4,000 comments we received on the proposed rule, about 3,000 were from CRNAs who suggested the removal of the physician oversight requirement.

However, we finalized this provision as it's an existing provision in hospitals, critical access hospitals, and ambulatory surgical centers, and now for rural emergency hospitals. And we'd like to note that States have the option to opt out of this oversight provision.

The rural emergency hospital conditions of participation rule also includes standards for a governing body, medical staff, nursing services, quality assessment, and performance improvement, infection control, patients' rights, and emergency preparedness, to name a few.

We did also finalize updates to the critical access hospital conditions of participation in this final rule. For the location and distance requirement, we included a definition of primary roads in the regulations text. And based on comments on the proposal, we modified the definition of primary roads to require numbered federal highways to have two or more lanes each way to be considered a primary road.

We believe that this change is responsive to the comments we received. We believe it provides a clear description of primary roads of travel, and we believe that it allows for flexibility for providers. We also included a standard for patients right, which is consistent to what we finalized for rural emergency hospitals.

And we also provided flexibility for critical access hospitals that are part of a larger health system, by allowing them to have a unified and integrated governing body, medical staff, infection control programs, and quality assessment and performance improvement program. This is consistent with the hospital conditions of participation, and now for the rural emergency hospital conditions of participation as well.

Now, I'll turn it over to Josh McFeeters for the discussion of the rural emergency hospital payment requirement.

Jill Darling: Hi, everyone. This is Jill. We might have lost Josh, but we'll go right into Alisha Sanders.

Alisha Sanders: Hi. Thank you.

Jill Darling: We'll come back.

Alisha Sanders: Hi. My name's Alisha Sanders. We finalized several updates to our existing (federal) Medicare provider enrollment regulations in 42 CFR Part 424 Subpart P in (reference) to address enrollment requirements for rural emergency hospitals. We finalized the provision that the facility may submit a CMS A55A change of information application, rather than an initial enrollment application, in order to convert from a critical access hospital or a rural hospital to a rural emergency hospital.

We believe that by not requiring an initial application, which generally takes longer for the Medicare administrative contractors to process than a change of information application would help expedite the conversion process. We also finalized a technical clarification that rural emergency hospitals must comply with our enrollment requirements to the same extent as all other provider and supplier types.

And now, with that, I'll turn it over to Lisa Wilson, and Meredith Larson, to talk about the REH physician self-referral law.

Jill Darling: Hi. This is Jill again. I think we have Josh back.

Josh McFeeters: Can you hear me?

Jill Darling: Yes.

Josh McFeeters: I don't know what happened there. That's weird. Okay. Let me try again from the start. Okay. This - hi, I'm Josh McFeeters. I'm an analyst in the Division of Outpatient Care, and we are talking about payment for REHs. REHs will receive payment from two sources.

The first source is payment for individual services performed. REHs will be paid at the OPPS payment rate for a service plus an additional 5% payment. This additional 5% payment will be excluded from beneficiary cost sharing.

In order not to limit the type of services that REHs can provide, REHs may provide certain outpatient services beyond those paid or the OPPS, which will be paid under the applicable fee schedule with that amount without the additional 5% payment.

The second payment source of REHs is a monthly facility payment. For 2023, the REH monthly facility payment will be 2,700 - okay. $272,866, which translates into an annual facility payment of $3.27 million for 2023. This payment amount will be the same for all REHs.

In subsequent years, the payment amount will be updated by the hospital market basket percentage. The REH statute allows an entity that is owned and operated by an REH that provides ambulance services to receive payment of the ambulance fee schedule.

We are also updating ambulance regulations to ensure that ambulance can service REHs. The REH statute will allow REHs to include a unit that is a distinct part of a facility licensed as a skilled nursing facility to furnish post-

hospital extended care services. Payment for services provided by an REH in such a unit, will be made through the Skilled Nursing Facility Prospective Payment System.

Finally, regarding section 603, we finalized our policy for both non-accepted off-campus provider-based departments that exist prior to an entity's conversion to an REH, and any new off-campus PBDs created post-conversion, that section 603 payment reductions do not apply to REHs.

And next, I'll turn over to the next speaker to - I guess, it will be David Rice to discuss OPPS payment policies.

Jill Darling: Hey, Josh. This is Jill. We'll turn it over to Meredith Larson. We just got a little mixed up in the agenda today.

Josh McFeeters: Okay. Sorry about that.

Jill Darling: No worries. Meredith?

Meredith Larson: Thank you, Jill. This is Meredith Larson from the Division of Technical Payment Policy, and I will be discussing changes to the regulations for the physician self-referral law related to REHs. As many of you know, the physician self-referral law, also known as the Stark law, prohibits the physician from making referrals for certain designated health services payable by Medicare to an entity with which the physician or an immediate family member of the physician has a financial relationship, which includes

ownership, investment, or compensation relationships, unless all requirements of an applicable exception are satisfied.

We anticipate that REHs will provide some designated health services. And as a result, we made changes to the regulations for the physician self-referral law to reflect the creation of the REH provider type. First, we finalized proposed changes to several of the exceptions to the physician self-referral law that applied to compensation arrangements between a physician and an entity to ensure the providers that were using exceptions prior to conversion, can continue to do so after conversion.

We also proposed, but did not finalize, an exception for physician ownership of REHs. For reasons explained in detail in the final rule, we concluded that the proposed ownership exception may not meet the statutory standard for secretary-developed exceptions.

However, as we also discussed extensively in the proposed - in the final rule, the exception for rural providers will continue to be - will be available to hospitals that convert to REHs. Thank you. And with that, I will pass to David Rice.

David Rice: Thanks, Meredith. So, I'll be kicking off the discussion of the outpatient prospective payment system with the annual rate update. In accordance with Medicare law, CMS is updating OPPS payment rates for hospitals that need applicable quality reporting requirements by 3.8%.

This update is based on the projected hospital market basket percentage increase of 4.1%, reduced by 0.3 percentage points for the productivity adjustment. And I'll pass it over to Emily Yoder to discuss remote behavioral health services.

Emily Yoder: Thanks, Dave. So, for CY 2023, we are finalizing our proposal to consider behavioral health services furnished remotely by clinical staff of hospital outpatient departments, including the staff of CAHs through the use of communications technology to beneficiaries in their homes as covered outpatient services for which payment is made under the OPPS.

Currently, this flexibility is available through the pandemic-specific policy referred to as hospitals without walls. We are requiring that payment for behavioral health services furnished remotely to beneficiaries in their homes, may only be made if the beneficiary received an in-person service within six months prior to the first time hospital clinical staff provides the behavioral health services remotely, and that there must be an in-person service without the use of communications technology within 12 months of each behavioral health service furnished remotely by hospital clinical staff.

We will, however, permit exceptions to the in-person visit requirement when the hospital clinical staff member and beneficiary agree that the risks and burdens of an in-person service outweigh the benefits of it, among other requirements.

We're also clarifying that in instances where there is an ongoing clinical relationship between practitioner and beneficiary at the time the PHE ends,

that the in-person requirement for ongoing, not newly initiated treatment, will apply.

CMS is also finalizing our proposal that audio-only interactive telecommunication systems may be used to furnish these services in instances when the beneficiary is unable to, does not wish to use, or does not have access to two-way audio-video technology. With that, I will pass it over to (Gil) for 340B.

(Gil Ngan): Thank you, Emily. Section 340B of the Public Health Service Act, 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 with comment period, CMS reexamined, the appropriateness of paying the average sale price, ASP, plus 6% for drugs acquired through the 340B program, given that 340B hospitals acquire these drugs at deep discounts.

Beginning January 1st, 2018, CMS adopted a policy to pay an adjusted amount, generally, AFP minus 22.5% for certain separately payable drugs or biologicals acquired through the 340B program. CMS continued this policy in CY 2019 through 2022.

For statewide 2023, in light of the Supreme Court's decision in American Hospital Association vs. Becerra, CMS is finalizing a general payment rate of ASP plus 6% for drugs and biologicals acquired through the 340B program, consistent with our policy for drugs not acquired through the 340B program.

As required by statute, CMS is implementing a negative 3.09% reduction to the payment rate for non-drug services to achieve budget neutrality for the 340B drug payment rate change for CY 2023. CMS will address the remedy for 340B drug payment from 2018 to 2022 in future rulemaking prior to the CY 2024 OPPS ASC proposed rule.

We note that claim for 340B acquired drugs paid after the district courts September 28th, 2022 ruling, are paid at a default rate, generally ASP plus 6%. I'll be followed by Elise Barringer on clinic visits for - in rural sole community hospital exemptions.

Elise Barringer: Thanks, (Gil). CMS currently pays a physician fee schedule equivalent payment rate for the clinic visit service when provided at an accepted off-campus provider-based department paid under the OPPS as a method to control the unnecessary increases in volume CMS had observed for that covered outpatient department service.

The PFS equivalent payment rate is approximately 40% of the OPPS payment rate, as the clinic visit is the most frequently billed service under the OPPS. In order to maintain access to care in rural areas, CMS finalized its proposal to exempt rural sole community hospitals from this policy and pay for clinic visits furnished and accepted off-campus provider-based departments of these hospitals at the full OPPS rate.

CMS believes that implementing this exemption will help to maintain access to care in rural areas by ensuring providers - by ensuring rural providers are paid for clinic visit services provided at off-campus provider-based

departments at rates comparable to those paid on - paid by on-campus departments.

This exemption for rural sole community hospitals is in keeping with prior CMS policies to provide rural sole community hospitals with 7.1% add-on payment for OPPS services to account for their higher costs compared to other hospitals. And now I will turn it over to Jim Mildenberger to discuss N95 masks.

Jim Mildenberger: Thank you, Elise. CMS has finalized OPPS and IPPS payment adjustments for surgical N95 masks. These payments will reimburse hospitals for the additional costs they incur when choosing to purchase domestic surgical N95 masks over less expensive non-domestic masks.

These payments will support domestic PPE production, which we believe is important for future emergency preparedness. To determine their payments, a hospital will need to report on its cost report, the aggregate costs and quantity of masks it purchased that were domestically made and those that were not.

Based on the Berry amendment, we are defining a mask as domestic if the mask and all of its components were produced in the United States. To identify domestic masks, a hospital can rely on a certified written statement from the mask manufacturer.

The information provided by the hospitals, along with existing information already collected on the cost report, will be used to calculate the IPPS and OPPS payments. Using our exceptions and adjustments authority, the IPPS

payments will be non-budget neutral. However, since we do not have the same authority under the OPPS, the OPPS payments will be budget-neutral. These payments will start for cost reporting periods beginning on or after January 1st, 2023.

I will now turn it back to Dave Rice for a discussion on ASC payment policies.

David Rice: Thanks, Jim. So, to kick off the discussion on the ASC payment policies, in the calendar year 2019 OPPS ASC final rule, CMS finalized a proposal to apply the productivity-adjusted hospital market basket update ASC payment system rates for an interim period of five years, which was calendar year 2019 through calendar year 2023.

Using the hospital market basket update, CMS is finalizing a productivity adjusted hospital market basket update factor for the ASC rates for calendar year 2023 of 3.8%, the same as on the hospital or on the outpatient prospective payment system. It is an update based on the hospital market basket percentage increase of 4.1%, reduced by a 0.3 percentage point update for the productivity adjustment. And with that, I'll pass it to Cory Duke.

Cory Duke: Great. Thanks, Dave. Again, this is Cory Duke from the Division of Outpatient Care, and I'll briefly cover the ASC payment policy for non-opioid products under section 6082 of the Support Act. So, the statute requires that the secretary must review payments for opioids and evidence-based non-opioid alternatives for pain management under the outpatient prospective payment system, as well as the ambulatory surgical center, with the goal of

ensuring that there are not financial incentives to use opioids instead of non-opioid alternatives.

For calendar year 2023, CMS is maintaining its current policy to provide separate payments for these non-opioid pain management drugs and biologicals that function as supplies in the ASC setting, once CMS determines that they are FDA-approved, have an FDA-approved indication for pain management or as an analgesic, and have a per day cost above the OPPS drug packaging threshold.

So, CMS finalized two technical clarifications to the criteria, which are found in the regulation text to reflect the current policy that non-opioid drugs and biologicals that are currently paid separately, or have transitional pass-through status, would not qualify for separate payment under this policy, as they are already paid separately.

So, under this policy for calendar year 2023, CMS finalized separate payments in the ASC setting for five non-opioid pain management drugs that function as surgical supplies, including certain local aesthetics and ocular drugs. These drugs meet the criteria previously described and which are included in 42 CFR 416.174.

So, that concludes this topic overview. And now, I'll pass it over to Nick Brock to discuss partial hospitalization program policies.

Nick Brock: Thank you, Cory. Hi, this is Nick Brock. I'm going to just give a brief overview of partial hospitalization for background. Partial hospitalization is an

intensive, structured outpatient program as an alternative to psychiatric hospitalization.

Partial hospitalization programs consist of a group of mental health services paid on a per diem basis under the OPPS based on PHP per diem costs. Medicare pays for PHP services furnished in hospital outpatient departments and community mental health centers, or CMHCs within a single PHP APC for each provider type.

So, hospital (outpatient) departments and CMHCs, each have their own APC for days with three or more services per day. For CY 2023, we're maintaining our existing rate structure for PHP. Based on public comments and in order to protect access to PHP services in CMHCs, we are using the equitable adjustment authority under section 1833(T)(2)(E) of the act to maintain the CY 2022 CMHC APC payment rate of $142.70 as the CY 2023 CMHC APC final payment rate.

Additionally, CMS is clarifying that remote behavioral health therapy services that are being established for CY 2023 under the OPPS, will not be recognized as partial hospitalization services, but would be available to patients in a partial hospitalization program. And so, with that, I will pass it over to Amanda Michael for organ acquisition.

Amanda Michael: Thanks, Nick. Thank you. CMS finalized two policies on organ acquisition payment. Our first policy is relative to counting research organs. We proposed a method of accounting for research organs to codify the existing sub-regulatory reporting instructions for organ procurement organizations, create

consistent reporting among transplant hospitals and organ procurement organizations, improve payment accuracy, and maintain organ availability for the research community.

In response to comments, we finalized our proposal for a method of accounting for research organs with modification, to clearly convey that the acquisition costs for organs intended for transplant, but determined unsuitable for transplant and furnished for research, are allowable organ acquisition costs.

Additionally, we finalized a modified version of our proposal that will provide transplant hospitals and organ procurement organizations flexibility to account for research costs consistent with their accounting practices.

We also finalized our proposal that organ acquisition costs include hospital services authorized by the organ procurement organization when there is consent to donate and death is imminent. These costs are for services that are necessary for organ donation that cannot be provided after death.

This is typical, but not limited to cases involving donation after cardiac death. This policy would remove a potential financial barrier to organ donation, promote health equity, honor the patient's wishes to donate organs, and support organ procurement. I will now hand the call off to Wil Gehne to discuss modernizing CMS payment software.

Wil Gehne: Thanks, Amanda, my name is Wil Gehne. On the August Open Door Forum, I called everyone's attention to our efforts to modernize Medicare claims

processing software. Today, I want to provide an update. The inpatient - the hospital inpatient claim programs, that is the Medicare Code Editor and the MS-DRG grouper, were converted to Java last year.

To allow time for transition, we made version 39 of these programs available to the public throughout fiscal year 2022 in the COBOL assembler version, along with the new Java version. By now, all hospitals and software vendors must be aware that for fiscal year 2023, beginning with version 40 in October of 2022, we posted only the Java version of the programs on the CMS website.

Now we are in a similar transition period for the Integrated Outpatient Code Editor, or the IOCE. In July, we released a test mainframe version of the Java software for IOCE based on version 23.1 on the CMS website. On October 3rd, we released a revised mainframe Java version to correct some testing issues, and a standalone Java version.

To access these programs, go to the regular IOCE quarterly release page and click the link to test versions on the left-hand menu. We believe many hospitals and vendors were waiting for the standalone version to begin their testing, but we've received very few inquiries since it was posted.

All hospitals and their software vendors are strongly encouraged to experiment with these test versions as soon as possible, and please send any questions to our mailbox, which is GrouperBetaTesting@cms.hhs.gov. That's all one word, GrouperBetaTesting@cms.hhs.gov.

This year's January 2023 IOCE release, which is version 24.0, will include both the current mainframe COBOL assembler version and the Java version. These programs will be posted in early December. This will provide hospitals and vendors a one-quarter parallel testing period.

Please note that the April 2023 IOCE release, which is version 24.1, will be Java only. So, it's critical to take advantage of the transition currently in progress so that you're prepared for April 1st, 2023. Thank you. Back to you, Jill.

Jill Darling: Hey, thanks, Wil, and thank you to all of our speakers today. (Catherine), will you please open the lines for Q&A?

Coordinator: We will now begin our formal question-and-answer session. If you would like to ask a question at this time, please unmute your phone, press Star 1. Only record your first and last name. To withdraw your question at any time, you may press Star 2.

Once again, to ask your question, please press Star 1 on your telephone keypad. One moment for the first question. The first question is coming from Ronald Hirsch. Your line is open.

Ronald Hirsch: Hi there. You guys did not discuss the inpatient-only list changes, but since it's part of the OPPS, I'll ask my question. The Medicare Advantage plans continue to claim that the inpatient-only list, which is supposed to protect the safety and health of Medicare beneficiaries, doesn't apply to them.

Aren't the risks the same if a patient has Medicare traditional or Medicare Advantage plan, and doesn't the same thing apply to surgeries that are not on the ASC CPL, but which MA plans are insisting be done at an ASC?

Emily Forrest: Thanks, Dr. Hirsch. Dave, do you - is this something you can handle today, or do you think we should handle offline?

David Rice: Well, I can respond in as much as that, you know, for this 2023 OPPS final rule, the policies apply to services provided under the OPPS or correspondingly, under the ASC payment systems. And, you know, that's sort of as much as we can say about that comment.

Ronald Hirsch: Okay. Thank you.

Coordinator: The next question is coming from (Lisa Powell). Your line is open. (Lisa Powell), your line is open. You may ask your question. We'll go on to the next. Carrie Lynne, your line is open.

Carrie Lynne: Hi. I wanted to confirm with you earlier in the dialogue that I heard correctly, that you did provide the two sample price transparency formats. You had, I think it was a tall version and a wide version, but you also indicated that it would not be mandatory for institutions to follow this exact sample format, just that this is provided as a sample only. Is that correct?

Terri Postma: Hi, thanks for the question. Yes, there's a CSV tall and wide, along with your corresponding data dictionaries, as well as a JSON schema. So, you are free to use those. We would prefer that if you choose to use them, you use them as

they are. Although, like I said, there's no requirement for you to be using sample formats. You are free to use your own format.

Carrie Lynne: Okay. Thank you.

Coordinator: The next question is coming from (Terry Whit). Your line is open.

(Terry Whit): My question involves the REHs as far as applying through PECOS. I know they're effective 1/1 of 2023. How long do we have to make a decision and apply in order for it to be retroactive to 1/1?

Alisha Sanders: Hi, this is Alisha. You can start submitting your applications now so you can begin the enrollment process. Because there is the survey and certification process involved, your effective date will be based on when all requirements are met, which is generally the date the survey is completed.

(Terry Whit): Okay. So, if - for example, if it was approved in let's just fictitious date of February, could it be retroactive to 1/1, or is it from the date approved?

Alisha Sanders: From the date approved.

(Terry Whit): Okay, thank you.

Coordinator: The next question is coming from (Mary). Your line is open.

(Mary): Yes. Hi. I have a question regarding the PHP policy for the partial hospitalization program. For a hospital outpatient program, you mentioned

that the services are three or more per day, with a payment rate of 142.70 plan for 2023. I just wanted to clarify that, does the PHP, is it acceptable to do three a day? Because that would be 15 services if we do it five days a week. My understanding is that it required 20 hours a week for the PHP.

Nick Brock: Yes. Hi, this is Nick Brock. So, it's - there's one APC payment amount per day. And so, the 142 is for community mental health centers. The hospital payment amount is actually - I'm sorry, I don't have the (standard) in front of me, but it's higher than the CMHC payment amount.

But the - your question about the services, so there's a list of recognized partial hospitalization HCPCS codes. And so, those are the three services that count towards the partial hospitalization day. So, there's one in the payment of the APC amount per day. It's three of those services per day would result in one payment of the partial hospitalization APC, either the hospital-based or CMHC payment amount.

(Mary): Okay. All right. Thank you very much

Coordinator: At this time, we have no further questions in queue.

Jill Darling: All right. Great. Well, thanks everyone for joining us today. As always, please send your questions, comments into our Hospital Open Door Forum email at hospital_ODF@cms.hhs.gov. It is listed on the agenda for you. Again, we thank you for attending, and that concludes today's call. Have a wonderful day.

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