Centers for Medicare & Medicaid Services
Open Door Forum: Hospital Quality Initiative
Moderator: Jill Darling
Tuesday, February 7, 2023
2:00 pm ET

Coordinator: Welcome, everyone, and thank you for standing by. Today's conference will be recorded. If you have any objections, you may disconnect at this time. All participants will be in a listen-only mode until the question-and-answer session. During that time, if you'd like to ask a question, please press Star 1 to get into the queue.

I'd now like to turn the call over to your host, Ms. Jill Darling. Thank you, and you may begin whenever you're ready.

Jill Darling: Great, thank you so much, (Becca). Good morning, and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications, and welcome to our first Hospital Quality Initiative Open Door Forum of 2023. Welcome. Happy new year. Even though we are in February, still want to wish you a happy new year.

Before we get into today's agenda, I do 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 now hand the call off to our chair, Emily Forrest.

Emily Forrest: Thanks, Jill, and hope everyone is having a good afternoon. We have a few updates today that I hope that you will find beneficial. But before we jump into the updates, I just wanted to highlight that on January 30th, the Biden Administration did announce its intent to end the COVID-19 national emergency, and also the Public Health Emergency declaration, on May 11th of 2023.

So, I wanted to note, we will continue to execute the process of a smooth operational wind-down of the flexibilities enabled by the COVID emergency declarations and the PHE, and are committed to also updating our supporting resources and providing updates to you as soon as possible.

So, please continue to use the provider fact sheet for information about the COVID-19 PHE waiver and flexibilities. We will continuously be updating these materials as we, again, approach the end of the PHE. So, we encourage you to frequently visit the CMS Emergencies page again for most - for up-to-date information there.

And we can definitely include the link to that page for folks who aren't unfamiliar, in the transcript following today's call. So, following the presentations as well from the speakers today, we'll also reserve some time for questions. But without further ado, I will turn it over to (Michael) for an update on the upcoming wage index deadline.

(Michael): Thank you, Emily. Good afternoon, everybody. So, on January 30th, 2023, we just recently posted the public use file for the FY 2024 wage index. This is the desk-reviewed and audited data that was posted.

Hospitals have until February 15th, 2023, to send an appeal to their MACs for corrections or errors to the January PUF we recently posted in January, as well as request revisions or desk review adjustments to their wage data that was posted in the PUF. MACs have to receive the request and the supporting documentation by this date. And just a note, there is an upcoming deadline after February 15th, much further down in April, to submit an appeal to CMS if you're not satisfied with the resolution with the MACs and the appeals being sent February 15th.

And those appeals in April to CMS must be sent through the MEARIS system online at https://mearis.cms.gov/public/home, which is a new twist for this year of submitting these appeals to CMS. So, complete details of everything are included in the wage index timeline on the CMS website.

An easy way to just search for that is to Google wage index 2024 or visit https://www.cms.gov/medicare/medicare-fee-service-payment/acuteinpatientpps/wage-index-files/fy-2024-wage-index-home-page. You'll come to the home page of the 2024 wage index, and over there will be the timeline, which includes details about the appeals process for the wage index, all the upcoming deadlines, and also includes the January public use file that hospitals should carefully review to ensure all the data for the wage index - that they're going to use for the wage index for 2024, is accurate. And with that, I'll turn it back to Emily.

Emily Forrest: Great. Thanks, (Michael). I think next we have Joe to talk about Section 126. Joe?

Joe Brooks: Hey, good afternoon, everyone. Thanks, Emily. This is Joe Brooks from CMS, and I'll be discussing Section 126, the distribution of additional residency positions. Many of you may already be familiar with the distribution, but just in case there are some of you that have yet to hear about it, we wanted to make sure we got the information to you.

So, as a reminder, Section 126 of the Consolidated Appropriations Act, makes available an additional 1,000 CAP slots, which are phased in at a rate of no more than 200 slots per year, beginning in fiscal year 2023. Section 126 requires that in order to receive additional CAP slots, a hospital must qualify at least one of the following four categories.

Hospitals in rural areas or treated as being in a rural area under the law, hospitals training a number of residents in excess of their GME cap, hospitals in States with new medical schools or branch campuses, and hospitals that serve areas designated as health professional shortage areas.

Additionally, Section 126 requires at least 10% of the CAP slots go to hospitals in each of the four categories, and that no single hospital receives more than 25 CAP slots. On January 9th, we announced distribution of the first 200 slots, which will be effective July 1st, 2023.

Within those first 200 slots, 75% were for primary care and mental health

specialties. The information about applying for slots under round two is also available at the DGME Medicare website. It will take you to a page that says direct graduate medical education at the top.

And if you scroll down to about the middle of the page, there's a header there that is a drop-down type header, and it's titled Section 126, Distribution of Additional Residency Positions. And within that area of the website, you'll find various Section 126 resources, which include a link to the Section 126 application itself, the submission process, and the specific questions that can be found within the Section 126 application. You can review these questions ahead of time before you actually proceed to apply.

In addition, the website also has the HPSA public ID and score information that will be applicable for the round two application period. Finally, there is a frequently asked questions document related to Section 126 based on our experience with reviewing round one applications, as well as hearing from various applicants and the public regarding their questions and concerns from round one.

If you'd like more information regarding the specific distribution of CAP slots under round one, the information is available on our website. And the website should be located in the agenda for this Open Door Forum. But if you don't have that, I'll just quickly read the website to you.

It's https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME. And if you have any questions regarding the specifics of the website, then we can get more information to

you. And if you have any questions about the distribution of round one or applying for round two slots, please don't hesitate to reach out and ask.

You can reach us in a couple of ways. One way is by using the Hospital Open Door Forum email address, Hospital_ODF@cms.hhs.gov. And you can also reach out to us through the Section 126 application website known as MEARIS™. That's M-E-A-R-I-S. You can access MEARIS at https://mearis.cms.gov/public/login.

And then from within that website, you'll want to click on useful links at the bottom left and then select resources. And then within that area, you'll be able to see a contact option that you can use to send a message to the CMS point of contact for Section 126.

Please take a look at the documents on the CMS DGME website, and don't hesitate to reach out to us if you have any questions. That's all I have regarding Section 126. Thank you all for your time. And now, I'll turn it over to Wil for the next discussion. Thank you.

Wil Gehne: Thanks, Joe. My name is Wil Gehne, and I work in the Provider Billing Group. On the last two Open Door Forums, I provided updates on our efforts to modernize Medicare systems by converting legacy software to Java. Today, I want to give you the latest and call your attention to an important deadline.

By now, all hospitals and software vendors must be aware that for fiscal year 2023, beginning with version 40 in October, we posted only the Java version

of the inpatient programs on the CMS website. Now, we are in the last weeks of a transition period for the Integrated Outpatient Code Editor, or IOCE.

In July 2022, we released the test version - test mainframe version of the Java software for IOCE based on version 23.1. In October, we released a standalone Java version. Last month, on January 12th, 2023, we issued the January 2023 IOCE version 24.0 in a package that includes both the current version and the Java version.

This release provides hospitals and vendors a one-quarter parallel testing period. To access the January release of these programs, go to the regular IOCE quarterly release page and click the link to test versions on the left-hand menu.

To date, we've received very few inquiries based on parallel testing. We strongly encourage all hospitals and their software vendors to work with these test versions as soon as possible. And please send any questions to our mailbox, which is grouperbetatesting, it's all one word, grouperbetatesting@CMS.hhs.gov.

Please note that the April 2023 IOCE release, that is version 24.1, will be Java only. So, if your systems rely on the legacy version, you'll be unable to run the IOCE at that time. So, it's critical to take advantage of the transition period currently in progress so you're prepared on April 1st, 2023. That's only seven weeks away, so please act now. Thank you. And with that, I'll turn it over to Bill Lehrman.

Bill Lehrman: Thank you, and good afternoon. Happy to be here. This is Bill Lehrman. I work on the HCAHPS survey at CMS. And I'm joining this call just to encourage hospitals that participate in the HCAHPS survey to consider the effect of mode of survey on who responds to the survey.

In particular, I'd like to draw everybody's attention to a new podcast on our HCAHPS online website. That, again, is hcahpsonline.org. This new podcast is entitled, Improving the Representativeness of the HCAHPS Survey. And we encourage hospitals to view this because hospitals choose which mode to use for their HCAHPS survey.

Most hospitals choose mail mode or telephone mode. But there's also a mixed mode, which is a mail survey followed by a telephone call. CMS would like to share some of the research done on how mode of survey affects who responds to the survey.

We've discovered that both response rates and which patients respond to the survey, or how representative the patients are of the hospital's patient population, varies by survey mode. And we encourage hospitals to think about how their choice of mode affects who responds to the survey.

So, it's a very interesting short podcast. And some of the important conclusions are these. High response rates for all patient groups promote CMS's health equity goals. Black, Hispanic, Spanish-preferring, younger, and maternity patients, are more likely to respond to the HCAHPS survey in telephone mode, which also includes the mixed mode.

Older patients are more likely to respond to a mail survey, including also the mixed mode of the survey. So, we encourage hospitals to choose a mode that resonates with its patient population, and provides the best representation of patient experience of care in the hospital.

So, again, that podcast is called, Improving the Representativeness of the HCAHPS Survey. And it can be found under the podcast button on our HCAHPS online website, which again is hcahpsonline.org.

And we encourage hospitals to view this podcast, as well as the other podcasts on our website, but this one especially because it'll help you choose a mode that will give you the best representation of your patient population responding to the HCAHPS survey. And with that, I'll pass it over to Heidi.

Heidi Magladry: Thank you. Good afternoon. I'm Heidi Magladry, the Skilled Nursing Facility Quality Reporting Program Coordinator. I just wanted to take a moment to discuss the SNF QRP and provide some resource information.

As a reminder, as finalized in the fiscal year 2016 SNF PPS final rule, non-critical access hospital swing beds providing SNF-level services, are subject to the SNF QRP requirements, and failure to meet the SNF QRP reporting requirements, may be subject to a two percentage point reduction in the annual payment update for SNF Medicare Part A patients.

For more information, I invite you to check out the SNF QRP pages, which can be accessed using the link provided in the agenda. One particular item I

would like to note for the non-critical access hospital swing bed providers that are subject to the SNF QRP requirements, is that our annual payment update support contractor, Swingtech, sends informational messages to those providers that are not meeting the annual payment update thresholds on a quarterly basis, ahead of each data submission deadline.

If you would like to add or change the email addresses to which these messages are sent, please email the QRP help desk and be sure to include your facility name and CMS certification number, along with any requested email updates. That link to that page can also be found on the agenda that's included. And that's my brief update. And with that, I'll hand it off to Camille.

Camille Kirsch: Thank you, Heidi. I'm Camille Kirsch. I'm a No Surprises Act Coordinator at CMS. I'm going to present two brief updates on No Surprises Act issues. So, firstly, CMS recently issued two pieces of guidance related to good faith estimates for uninsured and self-pay patients.

Those are good faith estimate FAQs three and four, and they can be found on the CCIIO regulations and guidance page, as well as on the No Surprises Act website, and the link in the agenda. FAQ three extends enforcement discretion pending future rulemaking for situations where good faith estimates for uninsured or self-pay individuals do not include expected charges from co-providers or co-facilities.

This extension of enforcement discretion will allow time to establish standards for the creation of comprehensive good faith estimates, and will give providers and facilities sufficient time to implement such standards. Any

rulemaking in the future to fully implement the requirements will include a prospective applicability date that gives providers and facilities a reasonable amount of time to comply.

FAQ four, the second FAQ, is for providers and facilities that offer sliding fee discounts based on an individual's income and family size, as well as for providers and facilities that do not expect to bill uninsured or self-pay individuals for items and services.

For sliding fee discount providers, CMS is providing additional flexibility to, in certain circumstances, provide a good faith estimate to a new uninsured or self-pay patient that lists the undiscounted rate for items and services. In cases where a provider or facility does not expect to charge a patient for any items or services, CMS recognizes that a full good faith estimate may not be appropriate.

Therefore, as specified in the guidance, providers who know in advance that they will not bill a patient for any items or services may provide an abbreviated version of the good faith estimate. And a sample abbreviated good faith estimate along those lines is available in the guidance.

The second No Surprises Act item I want to present to you today is that on December 23rd, HHS, Labor, and the Department of the Treasury, released an initial partial report on the Federal Independent Dispute Resolution process under the No Surprises Act, covering the second and third quarters of 2022.

That report is available online at CMS.gov/nosurprises, and is also linked in the meeting agenda.

The Departments have previously published data on IDR throughput in August 2022 in a status update, and have also published additional data on throughput in December 2022 as part of the guidance establishing fees for the federal IDR process for 2023.

While those previous publications included data on the high volume of disputes in the independent dispute resolution system, and data on the delays in achieving payment determination, this new report provides information for the first time on the parties engaged in disputes, the types of services under dispute, and the states in which disputed items and services were provided.

Moreover, the Departments are providing additional detail and context to help stakeholders understand the data being provided in this initial report. The departments chose to publish a partial report now rather than prioritizing manual data processing needed for a full report in order to allow certified IDR entities to focus on issuing eligibility and payment determination, and to give the Departments time to continue automating the federal IDR portal to improve and speed dispute processing.

The Departments intend to later supplement this report with a full report for each of these two calendar quarters. The Departments are committed to transparency in implementing the No Surprises Act, and believe this report will help stakeholders and the public better understand the status of the federal

IDR process, as well as some of the factors that have contributed to the issues experienced by disputing parties thus far.

Finally, I'm going to wrap up by making you aware of some additional IDR resources recently posted. The federal IDR YouTube playlist was recently updated to include new demos of additional parts of the IDR portal. In addition, a new job aid for the IDR entity selection response form has been added to the NSA website rules and fact sheets page.

And finally, we recently posted updated charts showing Federal vs. State independent dispute resolution applicability. We will send out links to the guidance documents and the newly posted resources after the meeting. That's everything from me, so I'm going to hand it back to Jill.

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

Coordinator: If you'd like to ask a question at this time, please press Star 1. Again, that is Star 1. Our first question comes from Ronald Hirsch. Your line is open.

Ronald Hirsch: Hi, Jill. In CMS 4201, you propose to codify the regulation that the Two-Midnight Rule 42 CFR 412.3, is applicable to Medicare Advantage plans. By saying that you want to codify that, it does suggest that that rule is actually in place now, and they are bound by the Two-Midnight Rule, that you're simply putting it into regulation. Is that true?

Emily Forrest: Hi, Dr. Hirsch, this is Emily Forrest. I don't think we have someone who specifically works on the Two-Midnight Rule on the call today, but we're happy to provide an update to you after the call.

Ronald Hirsch: Thank you.

Emily Forrest: Thank you.

Coordinator: Looks like there's no further questions at this time. Again, as a reminder, if you would like to ask a question, please press Star 1.

Jill Darling: (Becca), has any questions come through?

Coordinator: No further questions.

Jill Darling: Okay, great. Well, thanks, everyone. This is Jill Darling. We appreciate your time as always calling in. And as always, for any questions or comments, please send them into our Hospital Open Door Forum email, and it is always listed on the agenda, but I will say it here.

It is Hospital_ODF@cms.hhs.gov. Again, thank you for taking your time out today, and we will talk to you next time. Thanks, everyone.

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