Centers for Medicare & Medicaid Services

Open Door Forum: Rural Health

Moderator: Jill Darling

Thursday, January 26, 2023

2:00 pm ET

Coordinator: Welcome, and thank you for standing by. At this time, all participants are in a listen only mode until the question and answer session of today's conference. At that time, you may press star 1, unmute your phone, and record your name to ask a question. I would like to inform all parties that today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the conference over to your host, Ms. Jill Darling. Thank you. You may begin.

Jill Darling: Thank you, (Vanessa). Good morning and good afternoon everyone. And I'm Jill Darling in the CMS Office of Communications. And welcome to our first Rural Health Open Door Forum of 2023. Before we get into the 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 hand the call off to our co-chair, Ing-Jye Cheng, who has some quick opening remarks.

Ing-Jye Cheng: Good afternoon, everybody. And good morning to our colleagues on the phone. I just wanted to say welcome and Happy New Year to everybody. We've got a wonderful agenda today. And we'll turn the microphone over to Joe Brooks, to start us off.

Joe Brooks: All right. Good afternoon, everyone. This is Joe Brooks from CMS. And I'd like to begin by discussing Section 126, 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, I wanted to make sure that we got the information to you. So as a reminder, Section 126 of the Consolidated Appropriations Act makes available an additional 1000 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 - hospital 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 can receive more than 25 cap slots.

This month we announced distribution of the first 200 slots which will be effective July 1, 2023. And within those first 200 slots 3/4ths of the positions will be for primary care and mental health specialties. If you'd like more information regarding the specific distribution of cap slots and which hospitals received those cap slots, we have the information available on our Web site. I believe the Web site is located in the agenda, if you have that. If not, I'll just quickly read the Web site to you so you can refer to that Web site. CMS - so that's basically - hold on a second. I want to make sure I have the correct Web

site here. So, it's CMS.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME. (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/DGME) I said that kind of fast. If you have any questions regarding the specifics of the Web site, then we can get more information to you. And if you have any questions about the distribution of round one, please don't hesitate to reach out and ask. You can refer to the contact information within the Rural Open Door Forum Web site.

And I should also note that within the distribution of slots for round one, we had 291 applications in total. And very few of those applications were from applicants that were rural hospitals or associated with hospitals that trained residents in rural areas. So, we wanted to make sure - that's one of the reasons we wanted to make sure folks have the information about Section 126 and the ability to apply for slots in round two. There are far more rural hospitals, rural teaching hospitals and teaching hospitals that affect rural areas than the amount of applications that we actually received in round one.

So, we thought that folks may not be aware of the fact that there was an application available to apply for slots. And we wanted to make sure we got the word out, you know, regarding round two. The information about applying for slots under round two is also available at that DGME Medicare Web site. It will take you to a page that says direct graduate medical education at the top. If you scroll down to about the middle of the page there will be another header that is a drop down type header. And it's titled Section 126 Distribution of Additional Residency Positions.

And within that area of the Web site you'll find various Section 126 resources, which include a link to the Section 126 application itself, as well as the submission process and the specific questions that can be found within the Section 126 application before you actually proceed, you know, to apply. So that will sort of help prepare you, you know, before you jump into the application. You'll be able to get a good look at which questions you'll be asked ahead of time.

In addition, there's also the (HPSA) public ID and score information that will be applicable for the round two application period. And we have - we built a decent amount of frequently asked questions 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. That's all I have regarding Section 126. And thank you very much for your time. And now I'll turn it over to the next discussion. And I believe our next speaker is (Katie), if I'm not mistaken. Thank you.

(Danielle): Hi. This is (Danielle). And I'm going to talk about the update for CAH distance and location. The definition of primary roads for CAH distance and location, was released in the 2023 OPPS Final Rule in November 2022. This rule codifies previous interpretive guidance that defines primary roads for the purpose of determining the distance between a CAH and another CAH, or short term acute care hospital.

In addition, to promote consistency in the evaluation of distance and location, a committee was developed to perform a systematic review for all CAH distance and location requirements. In the definition of primary roads CMS

defines primary roads at 485.610(c), as any state or federal numbered highway including interstates, intrastates, and expressways, with two or more lanes in each direction. This definition will be used to determine the 35-mile driving distance between a (car) or any other (car) or short term acute care hospital, including the main campus for any provider-based location.

Codifying this definition does not change any previous regulatory distance and location requirements. As for the CAH distance location and review, the committee was developed to perform a systematic review of compliance for each CAH's distance and location prior to recertification or any initial Medicare certification. CMS will review each CAH prior to the due date for its triennial recertification or re-accreditation service.

For CAHs that have not had any new CAHs or hospitals within a 50-mile radius of the main location within that time period, that CAH will receive an automatic recertification based on distance, as long as they continue to meet the requirements as a rural designation. Cost provider-based locations will be reviewed on site during a survey. And final dissemination of the location and distance will be determined prior to the final survey report. For CAHs that do not meet the distance and location requirements when reviewed by the committee the case will be elevated to CMS leadership prior to rendering an enforcement decision.

If a CAH has been determined to be noncompliant with a distance and location requirement, the CAH will have one year from the end of their Medicare participation as a CAH provider to make a decision either to convert

to another Medicare provider or terminate their participation in Medicare. And with that, I will turn it over to Kianna.

Kianna Banks: Hi. Thank you, (Danielle). My name is Kianna Banks. I am a technical advisor in the Clinical Standards Group where we handle the health and safety standards for providers that include critical access hospitals and rural emergency hospitals. So back in November 2022, we published a final rule for rural emergency hospitals. And in that final rule we included some condition of participation updates for critical access hospitals. So, there were a few changes that we made for the critical access hospital conditions of participation.

We took this opportunity to revise the cost COP based on feedback. We received some stakeholders and to make the COPs more consistent with current standards of care. So, for starters, we established a separate COP for patients' rights for CAHs, as previously there was not a patients' right provision in the CAH COPs. And we also moved the requirement for the patient with the patient rights under the newly established patients' rights COP.

And in the patients' rights COPs there are no provisions for a notice of rights, the exercise of rights, privacy and (unintelligible), confidentiality of patient records, restraint and seclusion, which includes staff training requirements and death reporting requirements. And lastly, we moved - again, we moved patients' rights for the patient COP requirements from the provision of service COP to the patients' rights COP.

We also updated - included a requirement for critical access hospitals by establishing that they can allow - that they are allowed to have unified and integrated medical staff, infection control, and (unintelligible) programs. So, this allows CAHs who are part of a hospital system to have unified and integrated programs shared by multiple hospital CAHs and rural emergency hospitals within healthcare systems. This is consistent with the current hospital requirements, and this is also a requirement we establish for rural emergency hospitals and the Rural Emergency Hospital Final Rule.

And we also recently published a correction notice for the Rural Emergency Hospital Final Rule. That published on January 4th. And it corrects some language in the final rule under the Rural Emergency Hospital COP for physical environment, in which we use the term CAH when we intended to use the term REH. It doesn't change what the requirement is for REHs, but it just clarifies that it is for REHs. And also, in the correction notice, we included a CAH for - a change for the CAH COP related to the CAH location and distance requirements.

The changes that we finalized in the Rural Emergency Hospital Final Rule regarding primary roads, were intended to also apply to the distance requirements for off campus locations of the CAH. And so now those requirements are consistent regarding the use of the definition for primary roads and the application of the primary road position. And now I will turn it over to Jennifer Milby for an overview of some of the REH requirements.

Jennifer Milby: Thank you, Kianna. And good afternoon to all our participant today. We are excited to announce that the initial guidance for rural emergency hospitals was

released today, and is now available on the CMS Web site. The guidance includes a QSO memo, a newly developed state operations manual Appendix O that is specific to rural emergency hospitals, model templates for the action plan and attestation of compliance, and an FAQ document.

These documents were developed in response to the fiscal year 2023 OPPS rule, which established rural emergency hospitals as a new Medicare provider based on the statutory amendments in the Consolidated Appropriations Act of 2021 and codified the final COPs that REHs must meet in order to participate in the Medicare and Medicaid programs, along with the CMS payment and enrollment policies. The documents are intended to provide essential guidance to assist eligible providers in navigating the enrollment and certification process to convert to a rural emergency hospital.

The QSO memo outlines the specific details for eligibility, enrollment, and the conversion and certification process to assist providers, CMS locations, and state agencies, in initiating and processing these requests. Appendix O of the State Operations Manual provides a survey process to evaluate the REH's compliance with the requirements, and includes the COP regulatory text.

At this time, we are still working on development of the interpretive guidance, which will be provided in future updates. A FAQ document was also developed to address the anticipated questions from the provider community, such as necessary provider designation for CAHs that convert to an REH, the process for converting back to a CAH or hospital, and REH-related services.

Additionally, we developed model templates for the attestation of compliance and the action plan requirements. These are optional forms. And facilities also have the option of submitting the same information on facility letterhead, if they choose not to use the templates that were developed. Additionally, another important detail to share is the availability of technical assistance through HRSA, which also aims to assist prospective providers in navigating this process as well. So that concludes, the additional updates for REH. And I'll turn it back over to Jill.

Jill Darling: Great. Thank you, Jennifer. And thank you to Kianna, (Danielle), and to Joe. (Vanessa), will you please open the lines for Q&A?

Coordinator: Thank you. We will now begin the question and answer session. If you would like to ask a question, please press star 1, unmute your phone, and record your name. Your name is required to ask a question. If you need to withdraw your question, press star 2. Again, to ask a question, please press star 1. (Tanya), your line is open. One moment. (Tim), your line is open.

(Tim): Yes. The Consolidated Appropriations Act extended the Medicare Dependent Hospital and Low Volume programs, through 9-30-24. Could you provide an update of when CMS is going to issue instructions for the (MAC)s to begin reprocessing claims for those programs?

Joe Brooks: Hi. This is Joe Brooks. If you would - so basically, we don't have a specific date forecast at this time regarding when the information about the update or extensions, would be available. But just so we don't lose your question and

can get back to you when that information is available, would you please shoot us an email at the RuralHealthODF@cms.hhs.gov email address?

(Tim): Okay. Will do. Thank you.

Coordinator: (Dale Gibson), your line is open.

(Dale Gibson): Yes. Thank you. I want to ask a question about the rural emergency hospitals. How does that impact with commercial payers and managed cares? Does the hospital retain their designation as a regular - I mean a regular hospital, or do the managed cares and commercial have to process services the same way as the rural emergency health hospital?

Ing-Jye Cheng: Hi. This is Ing-Jye Cheng. I'll start and then also defer to my colleagues here on the phone, on the payment side, and also on the health and safety standards side. The rural emergency hospital designation is a Medicare designation, so it would be for your Medicare - original Medicare patients. As far as commercial payers, I don't know that that necessarily extends to them. But I think I'll open the floor to my other colleagues.

Kianna Banks: Hi. This is Kianna Banks. I can't speak to the payment portion, but I can just sort of clarify that. Rural emergency hospitals are a separate provider type from hospitals as far as the health and safety standards are concerned, and certification is concerned. So, facilities that are seeking and then obtain rural emergency hospital designation convert from either a critical access hospital or a rural hospital with less than 50 beds. And they cease to be that type of provider and then become a rural emergency hospital and are treated as such.

Ing-Jye Cheng: And that's for the Medicare program. So, it doesn't necessarily extend to commercial. So, you'd have to follow up with the payers that you're working with, to find out how they would be dealing with those designations. Does that answer your question?

(Dale Gibson): Yes.

Coordinator: (Catherine), your line is open.

(Catherine): As far as the distance for the CAHs, if you have an existing CAH does that distance apply to the existing CAH? That's my question.

(Danielle): So, the distance and location requirements would apply to all CAHs and it's reviewed prior to their recertification date.

(Catherine): So, if you have an existing building you're going to be potentially told that you can't stay a CAH any longer?

(Danielle): If that location does not meet the distance and location requirement, and it's not a necessary provider, there is the potential. That's why - I mean main campuses, we will review the main campuses. There could be provider-based locations that could be affected. But that - and that will just occur upon survey. But there is the potential that if, you know, that some CAHs may, you know, may no longer meet the distance requirements. And when we come across those we would elevate those and see what alternatives there are.

And if a decision can't be reached to maintain CAH status, then they would have one year to convert to another type of provider.

(Catherine): Thank you.

Coordinator: Okay. We show no further questions in queue.

Jill Darling: All right. Well, thanks everyone, for joining. I'll pass it back to Ing-Jye for some closing remarks.

Ing-Jye Cheng: I just wanted to thank everybody for joining us today and the questions of us that helped us understand what you need to know to better interact with the Medicare program, and all the programs we have here at CMS on behalf of your patients and beneficiaries. If you do have questions that you think are - or things you'd like to hear more about, please send us an email at RuralHealthODF, R-U-R-A-L-H-E-A-L-T-H-O-D-F at CMS dot HHS dot gov, (RuralHealthODF@cms.hhs.gov) and we will expand the agenda and endeavor to address your concerns. Thank you very much everybody, for your time and we'll talk to you very soon. Jill?

Jill Darling: Great. Thanks everyone, for joining. And that concludes today's call.

Coordinator: Thank you. That concludes today's conference. You may disconnect at this time. Hosts, please stand by for your post conference.

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