Centers for Medicare & Medicaid Services

Open Door Forum: Rural Health

Moderator: Jill Darling

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2:00 pm ET

Coordinator: Good afternoon, and thank you all for holding. Your lines have been placed on a listen-only mode until the question-and-answer portion. And I would like to remind all parties, the call is now being recorded. If you have any objections, please disconnect at this time. And I would now like to turn the call over to Jill Darling. Thank you. You may begin.

Jill Darling: Great. Thank you, (Yvonne). Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications, and welcome to today's Rural Health Open Door Forum. We have a really great lengthy agenda, so I will be very brief.

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 Co-Chair, John Hammarlund.

John Hammarlund: Thanks so much, Jill. Hi, everybody. Thank you so much for joining our call today. As Jill said, we have quite an agenda for you today. Around here, we call it payment rule season. This is the time of year when a lot of proposed

rules come out, the inpatient prospective system rule, the hospice proposed rule, inpatient site facility rule, rehab rule, SNF PPS rule.

And we've got all the right experts on today to tell you about what's in some of those, to draw your attention to them. We, of course, always urge our stakeholders, especially underheard and underserved voices, we want to have your story told to those who make policy for our agency. So, we definitely want to make sure that you will comment on the proposed rules that you hear about today.

Before we get to those, though, we wanted to make sure you were up to speed on all that's going on with the transition moving forward at the end of the public health emergency. So, we brought in an expert to talk to you about how that's all going to play out.

As you all know, we made quite an effort during the beginning of the PHE to put waivers and flexibilities in place. And now, it's time to start talking about what gets unwound, if you will, at the end of the public health emergency.

So, a big agenda for you today. We're delighted to have all of our colleagues from headquarters on, as well as staff from our regional offices. So, without any further ado, I'll hand it back to Jill to get the agenda going, and thanks again for joining this call. Jill?

Jill Darling: Thanks, John. Up first, we have Kelly Dinicolo, who will speak on the CMS waivers, flexibilities, and the transition forward from the COVID-19 public health emergency. Kelly?

Kelly Dinicolo: Hi. Thanks, Jill, and thanks to everyone for inviting me to speak today. I'm going to speak to you in general about the disposition of the CMS Medicare flexibilities that will be occurring at the end of the public health emergency on May 11th.

When I use the word flexibilities, I'm really referring to waivers and guidances such as in our quality, safety, and oversight memos, as well as the emergency interim regulations. So, since March of 2020 is done, talk to you about at the top of the call, CMS has issued literally hundreds of flexibilities.

And in general, these were issued in response to the PHE, and are really only appropriate as emergency measures. And thus, while COVID-19 remains a priority for CMS and HHS, we are now in a better position to end the PHE and begin transitioning away from the emergency phase, and thus end some of the emergency flexibilities.

The regulations that were in place prior to the pandemic were really there to ensure the health and safety of our patients and residents that we serve, and we want to make sure that that continues. That being said, we also did learn during the pandemic, and are going to be applying those learnings.

For example, a few of the CMS flexibilities will continue for a period after the end of the PHE, and I'll be touching on those in a few moments. We actually began preparing for the end of the PHE a while ago, and have been providing ongoing information regarding flexibilities that will end or have been made permanent.

And you can find all of this information on our website at CMS.gov. And much of what I'm going to speak about today, or actually all of it, can be found there. So, once you're there, just go to CMS.gov, click on about a quarter of the way down, there's a header titled Coronavirus 2019, and you'll be taken to the emergency page.

So, in August last year, we developed a CMS roadmap, as well as several fact sheets for the end of the PHE waivers and flexibilities. And those are categorized by specific provider types.

So, depending on the provider type that you're interested in, you can click on a very detailed fact sheet that goes over all of the waivers and flexibilities and what will be happening.

Additionally, we have two really great new resources. One is a couple of weeks ago, and that's found at the top - towards the top of the emergency page. It's titled, What Do I Need to Know, CMS Waivers, Flexibility, and the Transition Forward from the COVID-19 Public Health Emergency.

And then just yesterday, and I'm really excited about this, we posted frequently asked questions. And those are questions that, quite honestly, we've gotten from stakeholders on calls like this. Some of them have found their way through email to us. And so, we went through all of them and put the most popular ones.

And I'm sure we'll be adding to it as we move towards May 11th. But you'll be

able to find a lot more detail there than what I will be able to provide in the time we have today. So, as I mentioned earlier, depending on our authority, a few of our flexibilities will continue for a period after the PHE ends.

And a good example of this is the Consolidated Appropriations Act of 2023 extended certain telehealth provisions through December of 2024. During the PHE, individuals with Medicare had broad access to telehealth services, including in their home, without the geographic or location limits that usually apply as a result of waivers that were issued by the Secretary.

And that was, again, facilitated by the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020, as well as the Coronavirus Aid, Relief, and Economic Security Act.

So, when I say telehealth, I'm including services provided through telecommunications systems, for example, computers and phones, that allow healthcare providers to give care to patients remotely in place of an in-person office visit. And they definitely - that became very, very popular during the PHE and continues today.

So, some of the extended telehealth flexibilities that will be extended through December 31st of 2024, include people with Medicare can continue to access telehealth services in any geographic area in the United States, rather than those just living in rural areas.

Additionally, people with Medicare can stay in their homes for telehealth visits that Medicare pays for, rather than traveling to a healthcare facility. And

certain telehealth visits can be delivered audio-only, such as using a telephone, if someone's able to use both audio and video, such as a smartphone or a computer. Many people with Medicare just have traditional home phones, or they have the old flip phones, so they can't do the fancy camera stuff.

And additionally, Medicare Advantage plans may offer additional telehealth benefits. Individuals in a Medicare Advantage plan should always check with their plan about coverage for telehealth services.

After December 31, 2024, when these flexibilities expire, some accountable care organizations may continue to offer telehealth services that allow the primary care doctor to care for patients without an in-person visit, no matter where they live.

So, if you have a healthcare provider that participates in an ACO, it's best to check with them to see what telehealth services may continue to be available. For Medicaid and CHIP, I know we're mainly here to talk about Medicare, but I want to touch on this briefly.

Telehealth flexibilities were never tied to the end of the PHE and have been offered by many State Medicaid programs long before the pandemic. And coverage will often vary by State, and we encourage States to continue to cover Medicaid and CHIP services when they are delivered through telehealth.

To assist States with the continuation, adoption, and expansion of telehealth

coverage, CMS released the State Medicaid and CHIP Telehealth Toolkit as a supplement that identifies for States, the policy topics that they should be addressing to facilitate the widespread adoption of telehealth. And we can send out that link. I'm not going to read it to you because it's incredibly long, but happy to share it after the call.

In terms of private insurance and telehealth, as is currently the case, during the PHE, coverage for telehealth and other remote care services varied by private insurance plan, and will continue to do so after the end of the PHE.

When covered, private insurers may impose cost-sharing, prior acts, or other forms of medical management on telehealth and other remote care services. So, again, for information specific on a private issuer, it's best to contact the customer service information that's located on the back of your insurance card.

One other thing I want to touch on is the Act provided an extension to the Acute Hospital and Home Initiative, which was extended through December 31st, 2024. Through this program, hospitals can continue to apply and participate in the initiative if they meet the requirements that were spelled out in the Act.

CMS reporting requirements for hospital and critical access hospitals to report data to CDC's COVID-19 module of its National Healthcare Safety Network, also known as the NHSN, will continue through April 30th, 2024, but reporting may be reduced from the current elements and from daily reporting

to a lesser frequency. The requirements to report nursing home COVID-19 through the NHSN will continue through December of 2024.

Touching on beneficiary costs for the COVID-19 vaccine, as long - and this is for Medicare beneficiaries, as long as the federal government continues to provide COVID-19 vaccines to healthcare providers under the CDC COVID-19 vaccination provider agreement, the vaccines will remain free and available to all beneficiaries.

Let's see. And then access to medically-necessary laboratory COVID-19 PCR and antigen tests will also continue without cost-sharing as long as the test is ordered by a physician or other clinician.

However, the program that currently provides people eligible for Medicare with free over-the-counter tests, will be ending at the end of the PHE, at the end of the day on May 11th.

One of the final areas I'm going to talk about is related to scope of practice for advanced practice clinicians other than physicians. In most instances, CMS defers to State law regarding the licensing and scope of practice.

Under Medicare Part B, there are certain types of services required to be furnished under the direct supervision by a physician or practitioner. CMS temporarily changed the definition of direct supervision to allow the supervising professional to be immediately available virtually.

This flexibility will end at the end of the calendar year in which the PHE ends,

so in that case, December 31st of this year. And while the flexibilities may end, please know that we routinely review our regulation even in the absences of emergencies.

And then one final area that I want to touch on is the training related to nurses' aides in nursing homes. We initially provided discretion related to the time to complete the training, and that discretion will end at the end of the PHE.

So, at the end of the PHE, nurses' aides will have four months to complete the required certification training. All waivers for States and facilities related to that will end on May 11th, 2023.

And then at that time, facilities will have four months, so until September 10th, I believe, 2023, to have all nurses' aides that were hired prior to the end of the PHE to complete the State-approved NATCEPs training.

And then nurses' aides who are hired after May 11th, will have four months from the date of their hire to complete the required training. So, I gave you a lot of information in a really short time. Again, much of this information and even more can be found on the emergency page on CMS.gov.

So, with that said, I am going to pass it over to Mr. John Kane, who will be talking to you about the 2024 Skilled Nursing Facility Proposed Rule. Thank you.

John Kane: Thank you very much, and good day, everyone. On April 4th of 2023, CMS had issued CMS-1779-P, or the FY 2024 SNF PPS Proposed Rule. Just a note

that the comment period for this rule will be closing on June 5th. So, please make sure that you get any of your comments on this rule in by that date.

I'm just going to be speaking about a couple of the Medicare payment policy-related aspects of the proposed rule, and then I'll turn the call over to some of my colleagues from CCSQ to talk about their portions of the rule.

So, in relation to the overall updates for the payment rates in FY 2024, CMS estimated that the aggregate impact of the payment policies in this proposed rule would result in a net increase of approximately 3.7% or $1.2 billion in Medicare Part A payments to SNFs for fiscal year 2024.

This estimate reflects a number of different factors, including a 6.1% net market basket update to the payment rates that is based on a 2.7% SNF market basket increase, plus a 3.6% market basket SNF forecast error adjustment, and less a 0.2 percentage point productivity adjustment, as well as reduced by a negative 2.3% to account for the decrease associated with the second phase of the priority adjustment recalibration related to the patient-driven payment model being implemented.

The second aspect of the payment policies that I want to address is related to the ICD-10 code mappings that we use under PDPM. PDPM utilizes ICD-10 codes in a variety of ways, most notably in relation to the patient's primary diagnosis in assigning patients to clinical categories.

In response to stakeholder feedback and to improve consistency between the ICD-10 code mappings and the current ICD-10 coding guidelines, we have

proposed several changes to the ICD-10 code mappings in this rule, and we invite you to go through the rules to identify each one of those different kinds of changes that we have proposed.

That's all from me for now. And with that, I'm going to pass the call to Chris Palmer to talk about the SNF Value-Based Purchasing Rule updates. Thank you.

Chris Palmer: Thanks, John. The Protecting Access to Medicare Act of 2014 authorized the SNF VBP program. The program was initially restricted to one measure, the Skilled Nursing Facility 30-Day All-Cause Readmission Measure or SNF RM.

Similar to the hospital VBP program, funding was based on a 2% withhold from Medicare fee-for-service payments, while also including a provision that CMS was only to pay back 50% to 70% of the withhold, of which, currently CMS redistributes 60% to SNFs based on quality performance.

The Consolidated Appropriations Act of 2021, the CAA, authorized the Secretary to apply up to nine measures that may include measures of function, care coordination, safety, patient satisfaction, and measures of the IMPACT Act, as well as a measure validation process to SNFs VBP program.

This year, we are proposing the addition of four new measures to the four current measures, three of which were added last year. We are proposing to add the following measures, a discharge function measure, a nurse staffing turnover measure, a percent of residents experiencing one or more falls with

major injury measure, and a number of hospitalizations per 1,000 long stay resident days measure.

We are also proposing a replacement of the Skilled Nursing Facility 30-day all-cause readmission measure, with the Skilled Nursing Facility within stay potentially preventable readmission measure, the SNF WS PPR, for performance year 2025, program year 2028, which fulfills the requirement in the original SNF VBP legislation in PAMA.

We believe that all of these measures help capture quality of care dimensions that SNs are responsible for, and fulfill the requirements of the CAA. We are also proposing the addition of the audit component of the validation process in this year's rule, beginning in FY 2025 for the two MDS measures being added to the program, and intend to use the process for both SNF VBP and SNF QRP, as per the CAA.

We intend to establish the pass-fail scoring methodology and how the results will be incorporated in the SNF VBP program and the QRP program in next year's rule. This year's rule also proposes a health equity adjustment to the SNF VBP program.

We propose to adopt a scoring methodology change to reward excellent care for vulnerable populations by SNF providers in the SNF VBP program. Specifically, we are proposing to award bonus points to high-performing, higher dual SNFs.

This health equity adjustment will begin in performance year 2025 and impact

FY 2027 program year payments. More specifically, the health equity adjustment will have two points allocated for each of the eight measures where the SNF is in the top tier of performance for that measure compared to all SNFs.

The points are aggregated and then multiplied by an underserved multiplier. The underserved multiplier is defined by the proportion of duals served by the SNF to determine the amount of bonus points that are added to the total performance score that is used to calculate the payment adjustment.

The underserved multiplier is based on the adjusted proportion of duals that a SNF provides care for. For higher dual proportions will receive a higher proportion of points using logistic exchange function. For SNFs whose proportion of duals is under 20%, they are assigned zero for the underserved multiplier, and do not receive bonus points.

The application of the logistic exchange function and the 20% minimum underserved adjustment requirement help ensure that the majority of the bonuses go to SNFs that serve the highest proportion of underserved beneficiaries.

Additionally, CMS is proposing to increase the payback percentage from the current 60% so that the bonuses provided to the high-performing high dual SNFs, do not come at the expense of the other SNFs.

Finally, this year, we are requesting comment on potential health equity approaches that could address the underserved more directly, as well as

specific components of a potential methodology, like whether we should continue to utilize dual status or use other indicators of disparities like ADI, LIS, or a combination thereof as part of the SNF VBP program.

We look forward to receiving your comments submitted to regulations.gov. And now, here's Heidi with some updates about the SNF QRP program.

Heidi Magladry: Thanks, Chris. This is Heidi Magladry, and I'll quickly run through the proposals for the SNF Quality Reporting Program. This year, we're proposing three new measures. We have a measure modification. We have three measure removals, and a couple of administrative proposals.

Our first measure proposal is the COVID-19 vaccine percent of patients' residents who are up-to-date measure. This measure is calculated using a raw rate for the number of residents who are up-to-date with their COVID-19 vaccinations per the latest guidance of the CDC. Data would be collected using a new standardized assessment item on the minimum data set, or the MDS.

The second measure proposal is the discharge function score measure. This assessment-based outcome measure reports the functional status of SNF patients who meet or exceed an expected discharge function score, and is based on self-care and mobility items already collected on the MDS.

The third measure proposal is the CoreQ short-stay discharge measure. The CoreQ short-stay discharge measure is a patient-reported outcome measure that utilizes four questions. The areas of care assessed include rating the staff,

the care received, the facility overall, and how well the resident's discharge needs were met.

The fourth measure proposal is actually a measure modification to the currently collected COVID-19 vaccination coverage among healthcare personnel measure. The prior version of this measure is being updated to align with recommended COVID-19 vaccinations per the latest guidance of the CDC. There will be no increase in reporting burden for this measure modification.

Moving on to measure removals, we're proposing to remove three measures in this year's rule. The first measure is the application of percent of long-term care hospital patients with an admission and discharge functional assessment and a care plan that addresses function.

The other two measures for removal are the application of the IRF Functional Outcome Measure Change in Self-Care Score for medical rehabilitation patients, and the application of the IRF Functional Outcome Measure Change in Mobility Score for medical rehabilitation patients.

Additionally, we have two administrative proposals this year. First, we are proposing to increase the SNF QRP data compliance threshold for MDS data items. We are proposing that SNFs must report 100% of the required quality measure data and standardized patient assessment data collected using the MDS on at least 90% of the assessments they submit.

The current data completion threshold for the MDS is 80%. We noted when

we adopted the 80% compliance threshold in the fiscal year 2018 rule, our intent to raise the threshold in future program years. Second, we are also proposing the public reporting of the two transfer of health information measures, beginning with the October 2025 Care Compare Refresh.

We adopted these measures in the fiscal year 2020 SNF PPS final rule. Data collection for these two assessment-based measures will begin with patients discharged on or after October 1, 2023.

Finally, for the SNF QRP, we are including a request for information on future measure concepts for the SNF QRP, and we provide an update on the health equity work in the SNF QRP. And with that, I will pass it off to Kim Schwartz to discuss the fiscal year 2024 inpatient rehab facility rule.

Kim Schwartz: Thanks so much, Heidi. This is Kim Schwartz. On April 3rd, 2023, CMS issued the fiscal year 2024 IRF PPS proposed rule to update the IRF PPS payment rates and the IRF Quality Reporting Program. We encourage you to review the rule and submit formal comments by June 2nd, 2023.

CMS is proposing to update the IRF PPS payment rates by 3.0% based on the IRF market basket update of 3.2%, less a 0.2 percentage point productivity adjustment.

CMS is proposing that if more recent data becomes available, for example, a more recent estimate of the market basket update or productivity adjustment, we would use these updates, if appropriate, to determine the FY 2024 market basket update and the productivity adjustment in the final rule.

In addition, the proposed rule contains an adjustment to the outlier threshold to maintain outlier payments at 3.0% of total payments. This adjustment will result in a 0.7 percentage point increase in our outlier payments. We estimate that overall, IRF payments for FY 2024 would increase by 3.7% or $335 million relative to payments in the FY 2023 year.

Secondly, we are proposing to amend our regulations at 412.25C1 to allow hospitals to open a new IRF unit at any time during the cost reporting period. This proposal would allow hospital units start being paid under the IRF PPS as long as (unintelligible) advance notice is provided to the CMS regional office and Medicare administrative contractors.

We believe this will alleviate unnecessary burden and administrative complexity placed upon hospitals. We also note that these regulations also apply to the excluded units paid under the inpatient psychiatric facility PPS.

Lastly, for the FY 2024 IRF rule, we are proposing to rebase and revise the IRF market basket to reflect a 2021 base year. The current IRF market basket reflects a 2016 base year and was very effective for the FY 2020 IRF final rule. We typically rebase the market baskets every four to five years.

The primary data source used to derive the proposed 2021-based IRF market basket cost weight is Medicare cost report data for both freestanding and hospital-based IRFs.

The proposed FY 2024 market basket increase based on the proposed 2021-

based IRF market basket, is currently forecasted to be the same as the increase based on the 2016-based IRF market basket at 3.2%.

We also propose that if more recent data becomes available after the publication of the proposed rule and before the publication of the final rule, again, for example, a more recent estimate of our market basket increase factor, we would use such data, if appropriate, to determine the FY 2024 market basket increase in our final rule.

We are also proposing to determine the labor-related share based on the proposed 2021-based IRF market basket. This results in a proposed labor-related share for FY 2024 of 74.1%, which is about one percentage point higher than the FY 2023 labor-related share, which was based on the 2016-based IRF market basket of 72.9%.

The increase in the labor-related share is due to an increase in the compensation cost weight, specifically the contract labor cost weight, which was derived using the Medicare cost report data.

This concludes our update for the IRF payment program, and I will now turn the call over to my colleague, Ariel Cress, to discuss the IRF quality reporting updates. Thank you.

Ariel Cress: Thank you, Kim. For this year's rule, the IRF QRP will be proposing the addition of two new measures, one measure update, three measure removals, and one public reporting policy.

The first measure is the COVID-19 vaccine percent of patients/residents who are up-to-date measure, which is calculated using a raw rate for the number of patients who are up-to-date with the COVID-19 vaccine within a facility.

The second measure is the discharge function measure, which is a cross-setting functional outcome measure that assesses functional status by looking at the percentage of IRF patients who meet or exceed an expected discharge function score.

Our proposed measure update is the modification to the COVID-19 vaccination coverage among healthcare personnel measure. And this update would report the cumulative number of healthcare personnel who are up-to-date with the recommended COVID-19 vaccinations per the latest guidance of the CDC.

Our proposed measure removals are the application of the percent of LTCH patients with an admission and discharge function assessment and care plan that addresses function, and the IRF function outcome measures, which is the change in self-care measure and the change in mobility measure.

Additionally, we are proposing public reporting of the transfer of health information to the provider measure and to the patient measure, which began collection October 1 of 2022.

And finally, we have included a request for information on future measure concepts and a brief health equity update for the IRF QRP. And now, I will

hand it over to (Marissa Kellam), who will give you an update on the FY 2024 inpatient site facility PPS proposed rule.

(Marissa): Thank you, Ariel. I will be discussing the proposed update to IPF payment rates. The total estimated payments to IPF are estimated to increase by 1.9% or $55 million in FY '24, which are relative to the IPF payments in FY '23. For FY '24, CMS is proposing to update the IPF PPS payment rates by 3%.

This is based on the proposed market basket increase of 3.2%, reduced by 0.2 percentage points for the productivity adjustment. Additionally, CMS is proposing to update the outlier thresholds so that estimated outlier payments remain at 2% of total payments.

CMS estimates that this will result in a 1% decrease to aggregate payments due to updating the outlier threshold. And now, I will turn it over to my colleague, David Pope.

David Pope: Thank you, (Marissa). First, I'll talk about the proposal to revise and rebase the IPF PPS market basket. For the FY 2024 IPF rule, we are proposing to rebase and revise the IPF market basket to reflect a 2021 base year. The current IPF market basket reflects a 2016 base year.

About 80% of the proposed 2021-based IPF market basket cost weights are derived from Medicare cost report data for both freestanding and hospital-based IPFs.

The proposed FY 2024 market basket increase using the proposed 2021-based

IPF market basket is currently forecasted to be the same as FY 2024 market basket increase using the 2016-based market baskets at 3.2%.

We are also proposing that if more recent data become available after the publication of the proposed rule and before the publication of the final rule, we would use such data, if appropriate, to determine the FY 2024 market basket update in the final rule.

We are also proposing to determine the labor-related share based on the proposed 2021-based IPF market basket. This results in a proposed LRS of 78.5%, which is about one percentage point higher than the FY 2023 LRS, which was based on the 2016-based IPF market basket of 77.4%.

This increase in the LRS is due to an increase in the compensation cost weight, specifically to the contract labor cost weight, which was derived using the Medicare cost report data.

Next, I'll discuss the proposal regarding changes to the status of excluded psychiatric units during the cost reporting period. In response to increased mental health needs, including the need for inpatient psychiatric beds, EMS is proposing changes to the regulations to allow greater flexibility for hospitals to open and bill Medicare for a new inpatient psychiatric district part unit - distinct unit, sorry.

Beginning in FY 2024, CMS is proposing to amend the regulations at 412.25c to allow hospitals to open a new IPF unit at any time during the cost reporting period. This proposal would allow a hospital unit to start being paid under the

IPF PPS as long as 30-day advance notice is provided to the CMS regional office and Medicare Administrative Contractor.

CMS believes this proposal would alleviate unnecessary burden and administrative complexity based upon hospitals when opening new psychiatric units, helping to expand access to behavioral healthcare in line with the CMS behavioral healthcare strategy.

Finally, I will discuss the request for information to inform the revisions to the IPF PPS required by the Consolidated Appropriations Act of 2023. Part of ongoing work to refine the IPF PPS, CMS has continued to analyze more recent IPF costs and claim information.

In the FY 2023 IPF PPS proposed rule, CMS issued a technical report and sought comments on the results of the latest refinement analysis in preparation to propose IPF PPS patient-level and non-regression-derived refinements to be effective in FY 2024.

Subsequently, new provisions in the CAA of 2023 require CMS to revise payments under the IPF PPS for rate year 2025, which under the IPF PPS is FY 2025, as Secretary determines appropriate. Accordingly, CMS is including a request for information that will be used to inform future payment revisions.

Also, in the proposed rule, CMS is addressing the specific types of data and information that the CAA 2023 suggests CMS may collect, as well as soliciting comments on additional data and information that could be collected to inform future payment revisions.

That concludes my part. I will pass it on to Renate Dombrowski, who will discuss the FY 2024 IPPS proposed rule.

Renate Dombrowski: Thank you. We will be reviewing two provisions included in the fiscal year 2024 IPPS proposed rule. The comment period for this rule closes on June 9th. The first provision is the REH GME proposal. This proposal has to do with how Medicare may pay for physician residency training at rural emergency hospitals or REHs.

In response to the proposed rule for the new provider type rural emergency hospital, CMS received a request to treat REHs similar to critical access hospitals for graduate medical education payment purposes.

Consistent with the request received, and to support flexibilities for training residents in rural areas, we are proposing to treat REHs similar to critical access hospitals for graduate medical education payment purposes.

We are proposing effective October 1st, 2023, an REH can function as a non-provider site, in which case a hospital can send residents to train at an REH and be paid for those residents, if the hospital pays the resident salaries, or the REH can receive payment at 100% of reasonable cost for the direct costs of training residents. I'm now going to turn it over to (Michael) who will discuss the Safety Net RFI.

(Michael): Thank you, Renate. As Renate observed, the other item we're discussing in the IPPS proposed rule is a request for information focused on safety net

hospitals. As we observed in the RFI, there is currently a lack of consensus about how safety net hospitals should be defined, but it is generally agreed that safety net hospitals furnish a substantial share of services to low-income and uninsured patients.

As such, safety net hospitals play a crucial role in the advancement of health equity by making essential services available to these and other populations that face barriers to accessing healthcare.

However, because they serve a greater share of low-income patients, safety net hospitals may also experience greater financial challenges compared to other providers. We note in the RFI that the financial position of safety net hospitals is one of the topics discussed by MedPAC in its recent report to Congress.

MedPAC also observes that safety net hospitals may have trouble competing with other providers for resources and technology and are also at a higher risk for closure. MedPAC discusses safety net index, which is a metric that they have developed for the purpose of identifying safety net hospitals.

In this request for information, CMS is seeking public feedback on the unique challenges faced by safety net hospitals, including rural safety net hospitals, and on potential approaches to help these hospitals meet their challenges.

We also seek input on whether MedPAC's safety net index or some other metric would be appropriate to use for the purpose of identifying safety net hospitals. As Renate mentioned, the comment period for the proposed rule

ends on June 9th, and we strongly encourage interested parties to provide feedback on this important topic. I will now be turning it over to Amanda Gardner to discuss the fiscal year '24 hospice proposed rule.

Amanda Gardner: Thank you, (Michael). On March 31st, CMS issued the Fiscal Year 2024 Hospice Proposed Rule that would update Medicare hospice payments in the aggregate cap amount for fiscal year 2024 in accordance with existing statutory and regulatory requirements.

The fiscal year 2024 proposed hospice payment update percentage is 2.8%, which is an estimated increase of $720 million in payments from fiscal year 2023. This is a result of the 3% market basket percentage increase reduced by a 0.2 percentage point productivity adjustment.

The Consolidated Appropriations Act of 2021 changed the payment reduction for failing to meet hospice quality reporting requirements from two to four percentage points.

Therefore, beginning in fiscal year 2024, and for each subsequent year, hospices that fail to meet quality reporting requirements receive a four-percentage point reduction to the annual hospice payment update percentage for that year.

The proposed fiscal year 2024 rates for hospices that do not submit the required quality data would be updated by the proposed fiscal year 2024 hospice payment update percentage of 2.8%, minus four percentage points, which results in a negative 1.2% update.

The fiscal year 2024 proposed hospice payment update also includes a statutory aggregate cap that limits the overall payments per patient that is made to a hospice annually.

The proposed hospice cap amount for fiscal year 2024 is $33,396.55, which is equal to the fiscal year 2023 cap updated by the fiscal year 2024 hospice payment update percentage of 2.8%.

Additionally, this rule includes information on hospice utilization trends and solicits comments regarding information related to the provisions of higher levels of hospice care, spending patterns for non-hospice services provided during the election of the hospice benefit, ownership transparency, equipping patients and caregivers with information to inform hospice election decision-making selection, and ways to examine health equity under the hospice benefit.

Finally, this rule proposes conforming regulations text changes related to the expiration of the COVID-19 public health emergency. Public comments on the proposals will be accepted until May 30, and we encourage all interested parties to submit their comments before then. Thank you. I'll hand it back over to Jill.

Jill Darling: Thank you, Amanda. We'll actually pass it back to John for some comments.

John Hammarlund: Yes, thanks a lot, Jill. So, I've been listening to all of this and reflecting on something I was told many times when I would go to rural communities out in

Region 10 where I'm from. And I would ask rural providers, are you feeling like you're getting enough information from CMS?

And almost inevitably they would say, that's not the issue. The issue is it's a firehose of information that we are receiving from CMS, and we're trying to tease out what's important to us.

We hope you appreciate that what we tried to do today is to find those sections of these various proposed rules that we think are of greatest importance to you, might have the most impact, et cetera, and sort of distill those down into digestible ways so that you can appreciate what we're trying to accomplish with these proposals, to pique your interest in case you want to look into them more deeply.

But we hope we've achieved what we wanted to do, which was to give you the most salient points, the most important points that we thought you should be knowing about and commenting on from these rules.

And you notice that each of the presenters gave you the deadlines for the comment period and urged you to comment. And I just want to reflect on that as well. This is an awful lot to take in, and it's an awful lot to review.

And it would be tempting to say, well, there are others who are going to comment on these rules. There's no way we can possibly review these and provide written comments ourselves. But I want to suggest to you, if you possibly can, that it is worth the effort to do that.

First of all, you need to know, we review every single comment that we receive. That is our obligation. And sometimes they change our minds. Sometimes they prompt us to think about things we were not able to think about when we were proposing them.

And telling your story, your own community story, your facility's story, is the most compelling thing you can do. If you give us insights into how our proposals are going to impact you, impact your ability to provide quality care, impact access, impact the economy of your rural town, for example, that's a compelling story.

And we're not going to get that from others. So, we really do urge you, if you possibly can, to learn a little bit about these rules and then do your best to submit written comments by the deadline to help inform us and to tell your story.

And the other thing that's really useful is, if you give us an idea of an alternative that would achieve the same goal we're trying to achieve with this policy, but maybe do so in a way that would be less impactful for you.

So, for example, you could say, CMS, I see what you're trying to do here, but it's not going to work in my community and here's why, but if you considered this alternative instead, you'd be able to achieve your goal, and it would have less of an impact on our business or our bottom line or our patients or our community. That's really, really useful to us.

So, I just wanted to pull back the lens a little bit and urge you to take a look a further look at these NPRMs and do all you can, please, to send in your comments in by the deadlines. We appreciate it. We want to hear your stories, and we'd like to have you inform our thinking. So, that's it, Jill. Thanks a lot. I'll hand it back to you.

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

Coordinator: Certainly. At this time, if you would like to ask a question, please press Star 1, please unmute your phone, and record your name. Once again, that is Star 1 if you would like to ask a question. Our first question is from Dale Gibson.

Dale Gibson: Yes, ma 'am. This is Dale Gibson. I'm dealing with a couple of hospitals, the new REH designation. Both of them have their designations, but we're having problems with the intermediaries. The intermediaries do not know how to receive the claims. They're not mapping them correctly.

The intermediaries are immediately turning off the old PTAN. Normally, you have 120 days to clean up your old claims. And there are other major issues, like some of the payers like Medicare and some of the States have no idea what's going on.

So, these REHs that I'm dealing with, are basically - their cash has stopped almost immediately. And I'm having - trying to reach out to the two different MACs that I'm trying to deal with, I'm getting nowhere.

John Hammarlund: Do we have anybody on from headquarters who could address some of those concerns? Remind us what State you're from.

Dale Gibson: I live in Florida, but one of the hospitals is in Georgia and one of them is in Mississippi.

John Hammarlund: Okay. I don't know if Lana is on today. We have a regional rural health coordinator in Region 4 based in Atlanta who might be able to take this issue and see what she can do to help. Lana, are you on? She's not on today. Okay.

Dale Gibson: Is that Lana Dennis?

John Hammarlund: Yes, exactly. You know Lana?

Dale Gibson: Yes, I had sent her an email about this. So, I mean, I just need someone who knows how to deal with these MACs.

John Hammarlund: Yes. All right. Thank you so much for this. Let me see what I can do to contact Lana and see what we can do to help. So, we'll try to get back to you as soon as we can, in contact with you. And you say you've written to Lana recently, right?

Dale Gibson: Yes.

John Hammarlund: Okay. And your name again is?

Dale Gibson: Dale Gibson.

John Hammarlund: Okay, great. Thank you, Dale.

Coordinator: Thank you. Our next question comes from Tee. Sir, your line is open.

Tee Faircloth: Thank you so much. This is Tee Faircloth. Actually, if I could follow up a quick question on Dale Gibson's question because we're concerned about the economic impact of these rural emergency hospitals in both Georgia and Florida.

And have you all looked at the economic impact on these rural economies now that you actually have some data by taking away the healthcare and replacing it with these rural emergency hospital "clinics"? And have you looked at that and how it's impacted the economy so far? That was my first question.

John Hammarlund: Jill, do we have anybody on from CCSQ?

Tee Faircloth: Don't think so.

John Hammarlund: I'll tell you what. Jill, if you want to give this gentleman the address, the email address to send in this question and comment, we'll take it from there. I just don't know if we have anybody on the phone today, unfortunately, who is able to answer the question here on the spot. I apologize for that.

Tee Faircloth: But is CMS - I mean, I just meant CMS as a whole. Has CMS looked at the economic impact of these?

John Hammarlund: So, again, I don't know if we've had anybody on who is involved in the rural emergency hospital rulemaking or the process of bringing them online. So, I'm afraid we don't have anybody who can answer that question today.

Tee Faircloth: Okay. Who would be the person who would know if they've looked at the economic impact?

John Hammarlund: Well, I think, again, if you can submit to - Jill will give you the email address to submit your question.

Tee Faircloth: I get that, but is there - like, who's the person in charge who would be the person who could - I mean, I'm just trying to find out if you've looked at the economic impact, if it's going to be a frigging disaster and a mass casualty event, and - in our models at least, but I'm just wondering if CMS has looked at it.

John Hammarlund: Right. And what I want to ...

(Ing-Jye): John, this is (Ing-Jye), and let me step in here real quick, and I appreciate your question, sir. You know, part of what we do in every rulemaking is, we're required to look at the impact of the rules that we propose to the public, and then when we finalize them after we review the public comments, also include that impact.

So, in the rules related to the rural emergency hospitals, there is an impact analysis. I don't know if that broadly addresses kind of what you're looking for. It may not be quite as broad as - and it sounds very much like you are taking a very global view, not just that kind of the healthcare piece.

I mean, obviously, you're very interested in healthcare. I can hear the passion in your voice, but you're also more broadly interested in the rural communities and their economic viability. Our impact analysis may not quite go that far in terms of overall economic health and projections of a community.

There are so many factors beyond what Medicare and Medicaid are doing that can influence that, obviously, as you know. But in those rules, all the way in the back are what we call impact analyses, regulatory impact analyses, and they review both in sort of a narrative form, and also charts by region of the country and by type of facility, how we think payments will change.

Again, that may not be quite as broad as I think the question you were asking. And I think where John is trying to lead the conversation was to make sure we're putting you in touch with the folks at the agency who might be able to speak a little bit more broadly on the quality and access question that I think you're also asking. Is that (unintelligible).

((Crosstalk))

Tee Faircloth: We're asking on an economic question and mortality. We're looking at it from a macroeconomic perspective. And, you know, economics is healthcare in

rural underserved America. And we're looking at it from a macro perspective, and we're trying to look at any increased mortality from the closing of hospitals. This has happened historically, and we're trying to see what's coming in reality.

Ing-Jye : No, and I appreciate that, and I think that's really important work, and I think our qualities - our colleagues on the quality side, yes, I work on the payment side, so we do - we crunch the numbers when we look at payment rates, but I think our colleagues on the quality side would be best positioned to either answer more directly on the mortality question, or point you to other resources within the federal government who may be taking a somewhat different view, because this goes beyond just Medicare.

I know Medicare is kind of the triggering event, right, and the triggering set of circumstances that have prompted a broader review that you seem to be doing. But I think, if you're willing to send an email to us at that rural health ODF, excuse me, I'm losing my voice, ODF email, we'll be able to connect you with the right people at the agency on the mortality question and to try to figure out if there's others within HHS that can help take sort of a broader view and facilitate the work you're doing.

Tee Faircloth: Thank you so much. I really appreciate the help.

Ing-Jye: Sure.

Jill Darling: Yes, you can email ruralhealthODF@cms.hhs.gov, and it's listed on the agenda. We'll take our next question, please.

Coordinator: All right. Our next question is from Jeremy Levin. Sir, your line is open.

Jeremy Levin: Thank you. And this is a question probably for John or Kelly, as it relates to the disposition of the waivers. And Kelly, the FAQs is definitely helpful. Call out number 12 that deals with the three-day hospital stay and gets into a little bit more detail.

So, one of the other blanket waivers that is going away is the 96-hour average length of stay. And that isn't, I guess, as clear-cut of a, you know, drop day because obviously it deals with a year. Curious how CMS will potentially enforce that blanket waiver going away.

Kelly Dinicolo: This is Kelly. I'm very much a journalist. I am hoping one of my colleagues from CM can step in to help with that. If not, we'll definitely take your question back and see if we can add to the FAQs.

Jeremy Levin: Okay, thank you.

Coordinator: Thank you. Our next question is from Priscilla Frost.

Jill Darling: And this will be our last question.

Priscilla Frost: Hi. Thank you for taking my call. My question is concerning the licensed professional counselors and family marriage counselors and their ability to perform services and for us to get reimbursed. In our reading of this, it appears

that it will have to be an incident 2, a provider who can bill. Is that correct? Hello?

John Hammarlund: I think we're waiting to see if there's anybody on the call who is able to answer that question directly. And if not, we're going to have to ask that you submit that to the same email address that Jill said earlier, and we'll get it to the right person. Sorry, we just don't have everybody on the call that we might have needed today.

Priscilla Frost: Oh, and I appreciate that. I just thought maybe that it might be something that someone was there available for.

Jill Darling: That email again is Rural Health ODF.

Priscilla Frost: I've got it.

Jill Darling: Okay, perfect. Well, that concludes today's call, everyone. I know we didn't have that much time for questions, but that email address is there for you to use to submit some comments or questions that you may have. It's RuralHealthODF@CMS.HHS.gov.

Again, thank you to all of our speakers today. Really appreciate your time and to everyone who dialed in. That concludes today's call. Thank you.

Coordinator: Thank you. This does conclude today's conference. You may disconnect at this time.

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