Centers for Medicare & Medicaid Services

Rural Health Open Door Forum

February 3, 2022

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 call. At that time if you would like to ask a question you may press star 1. Today's conference is being recorded. If you have any objections, you may disconnect at this time. I would now like to turn the meeting over to Jill Darling. You may begin.

Jill Darling: Great. Thank you, (Valerie). And thank you so much, everyone, for your patience as we gathered all of our speakers. Welcome to the first Rural Health Open Door Forum of 2022. Before we get into the agenda, 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 do 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. And in light of the fact that this is our first call for 2022, it's my pleasure to wish you all Happy New Year. Thanks so much for joining this call. We only have two agenda items, but they're really important ones, and we're delighted to have our headquarters colleagues on to talk about

them. We're also delighted, as always, to have many of the regional rural health coordinators on this call as well.

So without any further ado, since we've got important things to talk about, I will turn it back to you, Jill. But again, everybody, thank you again, for joining this call. I'm delighted to have you. Jill?

Jill Darling: Great. Thank you, John. First we have Joe Brooks and Renate Dombrowski, who will speak on the Fiscal Year 2022 IPPS Final Rule, with comment period, about the Graduate Medical Education Provisions of the Consolidated Appropriations Act of 2021.

Joe Brooks: Thank you, Jill. Hi everyone. This is Joe Brooks. And I'll be speaking about the Section 126 portion of the Consolidated Appropriations Act of 2021 as it relates to our final rule with comment period. So on December 17 CMS issued a final rule to implement the legislative changes to Medicare Direct Graduate Medical Education, and indirect medical education payments to teaching hospitals that were included in Sections 126, 127, and 131 of the Consolidated Appropriations Act.

In the final rule we are also seeking comment on specific aspects of the implementation of Sections 126 and 131. For the implementation of Section 126 we're seeking comment on how to account for healthcare provided outside of a HPSA to HPSA residents, and feasible alternatives to HPSA scores as a proxy for health disparities in the prioritization of additional FTE cap slots.

For the implementation of 131 we are seeking comment on the review process to determine eligibility for per resident amount or full time equivalent cap resets in situations where a hospital disagrees with the information on the cost report, in particular for cost reports that are no longer within the three-year reopening period.

To be assured consideration, comments on this final rule with comment period, must be received by February 25, 2022. And when you're commenting please refer to the file code CMS 1752 FC3.

So, Section 126 makes available an additional 1000 Medicare funded full time equivalent resident cap slots, which are phased in at a rate of no more than 200 slots per year beginning in fiscal year 2023.

The law requires that in order to receive additional slots, the hospital must qualify in at least one of four categories, which are hospitals in rural areas, or treated as being located in a rural area under the law, which means the hospital is reclassified as rural.

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. We define category 4 as serving a geographic HPSA. A hospital qualifies under category 4 if they're training residents in a program where at least 50% of the training time occurs at sites in the geographic HPSA.

Additionally, the law requires that at least 10% of the slots go to hospitals in each of the four categories, and that no single hospital can receive more than 25 spots.

In addition to implementing the statutory requirement that a hospital receiving cap slots must fall into at least one of the four qualifying categories, CMS is prioritizing the distribution of cap slots based on the HPSA score of the HPSA served by the residency program for which the hospital is applying.

What this means is that hospitals applying for programs where at least 50% of the training time occurs in HPSAs with higher HPSA scores are prioritized.

For this prioritization HPSAs used include primary care and mental health only geographic HPSAs, as well as population HPSAs. An applicant hospital also has to demonstrate and attest that it will be using additional cap slots to expand an existing program or start a new program within five years of receiving the cap slots.

So essentially, eligibility for distribution of 126 slots is a three-step process. The first step is for a hospital to determine if it meets one of the four qualifying categories. Then if it is considered a qualifying hospital, the next step is the prioritization criteria. The hospital determines whether for the residency program for which it is applying at least 50% of the training occurs in training sites in a geographic or population HPSA.

If the hospital does not meet this 50% prioritization criterion, this doesn't mean the hospital is ineligible for slots, but it receives a lower priority for distribution of slots.

Finally, the hospital has to demonstrate that it will be using the additional slots they are applying for, to expand an existing program or start a new program within five years of receiving the cap slots. The cap slots awarded for a specific fiscal year for Section 126, are always effective July 1st of that fiscal year.

For example, slots awarded under the fiscal year 2023 round are effective July 1, 2023. In terms of how many cap slots each hospital can apply for, commenters had expressed concerns about the requirement that the applicant hospital be physically located in a HPSA and the proposed award limitation of one FTE per hospital per fiscal year.

We responded to these concerns by finalizing the policy that the applicant hospital is not required to be physically located in a HPSA. But rather the hospital participants in training residents in a program where at least 50% of training time takes place at scheduled training sites in the HPSA.

In addition, under our final policy, hospitals may receive up to five FTE cap slots per hospital per year. The maximum award amount for each hospital year is contingent on the length of the program for which a hospital is applying, with up to one FTE being awarded per residency program year, not to exceed a program length of five years or five FTEs. So for example, since general

surgery is a five-year program, a hospital applying for a general surgery program can apply for up to five FTEs in a single application round.

If a hospital is applying for family medicine which is a three-year program, it can apply for up to three FTEs in a single application round.

In order for hospitals to be considered for increases in their FTE resident caps each qualifying hospital must submit a timely application and the Section 126 application is an online application. It's included as part of the Medicare Electronic Application Request Information System, or MEARIS.

The online application does not need to be submitted in a single session. The system will allow you to save your progress and you can resume your application from where you left off, at another time and/or date as you prefer.

The application deadline for the first round of the implementation of Section 126 is March 31, 2022. In accordance with the statute, CMS will award the first round of 200 FTE resident cap slots under Section 126 in fiscal year 2023. And these cap slots will go into effect July 1, 2023. And CMS will notify hospitals of the FTE resident cap slot distributions by January 31, 2023.

Applicants can view information about what's required to complete the application by accessing the Paperwork Reduction Act document associated with the application. We also hope to have a list of frequently asked questions regarding the Section 126 application available online later this month.

More information regarding Section 126 including the final rule preamble, online application system, and the Paperwork Reduction Act document mentioned earlier, is available on the direct graduate medical education Web site.

A link to this Web site is available on the Rural Health Open Door Forum Web site. We encourage you to review the application itself as well as the various information that has been made available online. If you have questions please reach out to us either through the MEARIS resources page for Section 126, or directly via email. Thank you. And now I'll turn it over to my colleague, Renate Dombrowski, who will discuss Sections 127 and 131.

Renate Dombrowski: Thanks, Joe. Good afternoon, everyone. I'm going to start with Section 127 of the CAA, which focuses on residency training in rural areas. Section 127 is related to what CMS has historically referred to as Rural Training Tracks, which are now referred to as Rural Track Programs or RTPs.

Historically, to encourage the training of medical residents in rural areas, the Social Security Act provided additional cap slots to an urban hospital that established a separately accredited rural training track program. These programs accredited in family medicine only, required that the first year of training would be spent at the urban hospital, and the second and third years would be spent at the rural hospital.

While the urban hospital could receive additional residency cap slots, the law did not provide for additional cap slots for the rural hospital. Section 127 of the CAA, made several changes to these programs to support the training of

residents in rural areas. The changes we have finalized include first, along with the urban hospital, the rural hospital may receive additional resident cap slots when participating in a rural track program.

Secondly, the urban hospital and rural hospital may also receive more resident cap slots whenever a rural training site is added to an already existing rural track program. And thirdly, the urban and rural portions of the rural track program need not be separately accredited from each other.

Instead, residents are required to spend greater than 50% of the entire program, training in a rural area. The removal from the law of the separately accredited requirement, allows hospitals to create rural track programs in any specialty, not just family medicine.

I'm now going to move onto Section 131 which relates to resetting a small per resident amount and adjustments of caps of certain hospitals. Historically, for Medicare GME payment purposes, a teaching hospital has been a hospital that trains residents in an accredited program regardless of program sponsorship or who is paying the resident’s salary.

Some hospitals have found themselves in the situation of establishing a low per resident amount for direct GME payments and low direct GME and indirect medical education caps, when they served as training sites for only a small number of residents from programs sponsored by a medical school or another hospital.

The provisions we've finalized implementing Section 131 provide us with the opportunity to reset the low or zero direct GME per resident amounts or PRAs of certain hospitals and to adjust the low indirect medical education and direct GME caps of certain hospitals.

For ease of reference, we refer to these hospitals as Category A and Category B hospitals. A Category A hospital is one that as of the date of enactment, has a PRA or cap that was established based on less than one full time equivalent resident in any cost reporting period beginning before October 1, 1997.

A Category B hospital is one that as of the date of enactment, has a PRA or cap that was established based on training of no more than three FTEs in any cost reporting period beginning on or after October 1, 1997 and before the date of enactment.

Section 131 provides that we shall establish a new PRA or a cap if the hospital trains at least one FTE in the case of a Category A hospital, more than three FTEs in the case of a Category B hospital. In order to address concerns that were expressed related to how hospitals will know whether they are eligible, we finalized policies for resets related to recent cost reports that are open, reopenable, or not yet settled.

We published files on the CMS Web site containing an extract of the cost report worksheets for hospitals to access. And in the final rule, we specified criteria to clarify which hospitals would be eligible and how hospitals can appeal any decisions they disagree with. That is all we have for GME. I'm going to pass it over to Jill.

Jill Darling: Great. Thank you, Joe and Renate. And last, we'll have (Ing-Jye Cheng) who will give an update on the CMS payment policies for administrating COVID-19 monoclonal antibodies. Excuse me. (Ing-Jye)?

(Ing-Jye Cheng): Thanks, Jill. I appreciate the intro. I just wanted to take a moment to highlight that CMS continues to update our payment policies for administering COVID-19 monoclonal antibodies. The COVID-19 provider toolkit online - and that can be found at www.CMS.gov/COVIDVAX-Provider. That's C-O-V-I-D-V-A-X dash P-R-O-V-I-D-E-R. On that Web site providers can find up to date payment coding and billing policies monoclonal antibodies and their administration in both healthcare settings and also in the home.

Medicare continues to provide payment for monoclonal antibody products at site to purchase, and continues to provide payment for administering products purchased by sites and also products distributed by the government at no cost.

There on that Web site is the most up to date list of billing codes, payment allowances, and effective dates for FDA approved an authorized monoclonal antibodies and will also continue to pay for these antibodies under the Medicare Part B vaccine benefit, until the year in which the COVID-19 public health emergency ends.

Oral infused antiviral products such as Paxlovid and Remdesivir are paid for like other Part D and Part B drugs. So those antivirals are not paid in the same way as monoclonal antibodies.

And we just wanted to make sure that you all had the information and had resources at your fingertips to see the current payment policies associated with those important treatments for COVID-19 while we're still in the public health emergency and as hopefully we get to a point where we'll be beyond it. Jill, I'm going to turn it back to you.

Jill Darling: All right. Thanks, (Ing-Jye). And (Valerie) we will open the lines for Q&A, please.

Coordinator: If you would like to ask a question please press star 1 and record your name clearly when prompted. To withdraw your question you may press star 2. One moment, please, for our first question. Our first question comes from (Sandy Sage). Your line is open.

(Sandy Sage): Hi. This is on the monoclonal antibodies. I know that some were recently removed or their EUA was removed. We were wondering where the data is that shows that those are no longer effective, and if we can have that posted on the COVID site, on the CMS Web site. Is that possible?

(Ing-Jye Cheng): So, the terms of the EUA and that information typically - this is (Ing-Jye Cheng), is listed on the FDA Web site. We can make sure we communicate that concern with our - through HHS with our colleagues to make sure that that information is widely available. If I'm understanding your question correctly.

(Sandy Sage): Yes.

(Ing-Jye Cheng): That there's concern that people don't know...

(Sandy Sage): Yes. Because it won't be effective on some of our patients. You know, some of the Delta was still remaining, which the monoclonal antibodies work (unintelligible) and then it was revoked. And so we were just kind of wondering where that data came from and if we could see it.

(Ing-Jye Cheng): Sure. I will...

(Sandy Sage): That's it. Thank you.

(Ing-Jye Cheng): Let me relay that and then we'll circle back. Do you have an email I can make sure we can get that - the - any links to Web site back to you?

(Sandy Sage): Yes. I'll provide it to the operator.

(Ing-Jye Cheng): Great. Thank you.

(Sandy Sage): Thank you.

Coordinator: Our next question comes from (Natalie Jobek). Your line is open.

(Natalie Jobek): Hi. I was hoping that you can clarify whether a critical access hospital that meets (CAH) location requirements based on being located more than 35 miles from another (CAH) or hospital, would lose its cost status if another (CAH) or hospital opened an outpatient department within 35 miles of the (CAH).

And the medical regulations are clear that the (CAH) cannot open its own outpatient department within 35 miles of another (CAH) or hospital. But I don't read the rules as it dropping the impact of another (CAH) or a hospital opening an outpatient department near the (CAH).

So, I'm hoping that you could provide some clarification on CMS's position on this issue.

(Ing-Jye Cheng): This is (Ing-Jye). John and Jill, unless I'm mistaken, I'm not sure we have the right subject matter experts on the line to address it on the phone. But certainly we can circle back either on a future call or over email.

(Natalie Jobek): Okay. That would be great. Because on a previous open door forum held in 2018, this issue came up, and CMS stated that they would follow up on that call. So we just want to get a clear answer on this moving forward.

Jill Darling: If you could send that - this is Jill Darling. Send your questions to RuralHealthODF@cms.hhs.gov. If you have the agenda it's - that email is on there.

(Natalie Jobek): Okay. We have sent it in within the last couple weeks. So should I just resend it?

Jill Darling: Yes, please.

(Natalie Jobek): Okay, great. Thank you.

Jill Darling: You're welcome.

Coordinator: I show no further questions in queue.

Jill Darling: All right. Well thanks everybody. We greatly appreciate your time and you joining us. You will get some time back. As always, please utilize the Rural Health ODF email, to send in comments and questions and future topics for the next rural health open door forums. So we again, appreciate you joining us. And have a wonderful day.

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