Centers for Medicare & Medicaid Services
Rural Health Open Door Forum
Moderator: Jill Darling
April 22, 2021
2:00 pm ET

Coordinator: Welcome and thank you for standing by. I would like to inform all participants that your lines have been placed on a listen-only mode until the question-and-answer session of today's call. Today's call is being recorded. If anyone has any objections, you may disconnect at this time.

I would now like to turn the call over to Jill Darling. Thank you. You may begin.

Jill Darling: Great. Thank you, Amanda. 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. Before we dive into today's 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 now, I would like to pass it on to our new chair member, Ing-Jye Cheng.

Ing-Jye Cheng: Thank you very much, Jill. My name is Ing-Jye Cheng, and I'm very excited to be here today on this Rural Open Door Forum. These are issues that I've worked on for my entire career here at CMS. I am the Director Of The Chronic Care Policy Group here at CMS, the Center for Medicare.

I'm stepping into the role that many of you have heard Carol Blackford play over the years. Carol, as you know, currently manages the Hospital And

Ambulatory Policy Group, the physician fee schedule and the hospital fee schedules for the Center Of Medicare.

And over the last year, she has taken on a number of agency level leadership roles in an acting capacity, including leading the agency's COVID response, and now the Center for Medicare's fee-for-service work during the first part of the transition to the new presidential administration.

And while she's committed to this work and remains committed to this work, it makes room for others like myself to play this particular role so we can ensure that the agency continues to develop its leadership in this very important body of work. I'm delighted to be here today. I know we have a number of exciting agenda items with rules and several areas on our agency's continuing response around COVID.

And with that, I'm going to turn it over to my co-chair, John Hammarlund, who has been just fantastic in this area. And, John, over to you.

John Hammarlund: Thanks, Ing-Jye, and it's just my pleasure to welcome you as co-chair of the Open Door Forum call. Delighted to have you as a partner. Hi, everybody. This is John, and I just have a quick announcement before we launch into the agenda.

And this announcement is on behalf of our colleagues at CMS's Center for Medicare and Medicaid Innovation, or CMMI. So, you are all aware, I know, of the Community Health Access and Rural Transformation model or the CHART model.

And I have two updates regarding revised CHART deadlines for you. One is regarding the ACO track. The ACO transformation track Request for

Application, or RFA, the release date is now going to be in the spring of 2022. And CMS looks forward to sharing additional information with you when available, and you can be sure that one of those places will be here at an upcoming Rural Health Open Door Forum call.

And then the second deadline announcement from CMMI is regarding the CHART community track. So, in response to feedback from stakeholders like you, the community track application deadline has been extended until May 11 - May 11, 2021.

And if you have any questions leading up to your submission, please reach out to the following email address. It's CHART model, and that's all one word, at cms.hhs.gov. So, CHARTmodel@cms.hhs.gov. And if you haven't already, I strongly suggest that you sign up for the CHART listserv so that you can receive timely updates directly from CMMI.

And you can do that by going to innovation.cms.gov – innovation.cms.gov -- and then clicking on the Stay Connected with the Innovation Center button, and you will be able to join the listserv. So, that's all the announcements I have from my colleagues at CMMI.

And I'm going to hand the microphone back over to Jill Darling. Thanks.

Jill Darling: Thanks, John. Next, we have Brian Slater, who will give a few updates on the fiscal year 2022 hospice proposed rule.

Brian Slater: Thanks, Jill. Good afternoon, everyone. This is Brian Slater. For those of you that have heard this before on my Home Health and DME ODF, I apologize in advance for the redundancy. But for those of you that we haven't gotten to, we wanted to make sure that we provided the update.

So, for the FY 2022 hospice proposed rule that went on display a couple of weeks ago, the first proposal that we have is data analysis that we had presented at our monitoring section. We solicit comments from the public on hospice utilization and the spending patterns. This could potentially inform any future policy development from the agency. So, it's very important to get feedback on this.

The second, we have an actual proposal to rebates and revise the labor shares for all four levels of care. So, that would be continuous home care, routine home care, inpatient respite care, and general inpatient care. And we're going to update this based off of the 2018 Medicare cost report data for freestanding hospice facilities.

And then lastly, we have several clarifying regulation tax changes pertaining to the hospice election statement addendum requirements that were finalized for hospice selections beginning on or after October 1, 2020.

Now, to the payment portion of it, the estimated net impact of the proposed role is an increase in Medicare payments to hospices of about 2.3% or approximately $530 million for FY 2022. This is the result of the 2.5% market basket, reduced by the 0.2 percentage point multi-factor productivity adjustment.

For hospice, there's also a statutory aggregate cap that limits the overall payments per patient that's made through a hospice annually. The cap is always updated using the previous year number, which was for - it was $30,683.

So, we're going to update that by the update percentage of 2.3%. So, the cap

for FY 2022 is $31,389.66. Now, if you would like to make comments on the rule, I'll note that they must be submitted by June 7 by 11:59:59 pm.

And with that, I'll turn it back to you, Jill. Thanks for letting us give an update. Appreciate it.

Jill Darling: Thank you, Brian. Next, we have Captain (Sherlene Jacques), who will give a brief overview of the fiscal year 2022 inpatient psychiatric facilities PPS proposed rule.

(Sherlene Jacques): Thanks, Jill. Hi. My name is Captain Jacques, and I'm going to give the payment policy update for the FY'22 Inpatient Psychiatric Facilities Prospective Payment System and quality reporting proposed rule, and which we abbreviate as IPF PPS.

These updates will begin on October the 1st 2021. This proposed rule displayed on April the 7th, with a 60-day comment period ending June 7. The IPF PPS applies to about 1,600 inpatient facilities, and is the payment system associated with furnishing covered inpatient psychiatric services, including services in psychiatric hospitals, and excluding psychiatric units of an acute care hospital or critical access hospitals.

In this proposed rule, we propose our annual update of the IPF PPS payment rate, an update to the IPF PPS teaching policy, and an update to the IPF quality reporting, which Lauren will go over after I finish with this. For our annual IPF PPS rate updates, we propose to update the IPF PPS payment rates for FY'22 by 2.1%.

The 2.1% update is based on the FY IPF market basket update of 2.3%, less a 0.2 percentage point multifactor productivity adjustment required by the

Social Security Act. We also propose to update the IPF wage index values to reflect the hospital inpatient wage index without any reclassifications.

We propose to update the outlier threshold amount to maintain estimated outlier payments at 2% of total estimated payments. We propose to decrease the labor related share from 77.3% to 77.1%. And we propose the updated cost of living adjustment factors for Alaska and Hawaii.

The total impact of the IPF in FY'22 is 2.3%, which is an estimated $90 million increase in IPF payments. The total impact on rural IPF is a 2.4% increase. And the total impact on urban IPF was a 2.3% increase relative to FY 2021 payment.

Lastly, we propose for FY'22, and for subsequent years, to adopt conforming changes to the IPF teaching policy, with respect to the IPF hospital closures and displaced residents to align the IPF teaching policy with changes that hospitals inpatient finalize in their FY'21 final rule.

These changes include, clarify when a IPF hospital closes, and when the resident actually becomes displaced, clarifying on house count FTEs of displaced residents, and who was responsible for assigning the number of FTEs per resident, and limiting the amount of Personal Identifiable Information, PII, required in submission letters to the MAC when requesting temporary increase in the residents cap. These teaching updates will not have any impact on the IPF in rural areas.

Now, I will turn it over to Lauren to go over the updates in quality.

Lauren Lowenstein: Okay, thank you very much. My name is Lauren Lowenstein, and I'm happy to give you brief updates about the Inpatient Psychiatric Facility

Quality Reporting Program. This is a pay for reporting program and the facilities that do not complete all program requirements, receive a 2.0 percentage point reduction to their annual payment update. Each year, approximately 97% of participating inpatient psychiatric facilities, meet all of the program requirements, and receive their full payment updates.

There are currently 14 quality measures in the IPFQR program. And in this year's fiscal year 2022 proposed rule, we proposed to remove three CHART-abstracted measures, because we believe that the costs associated with each of these measures outweigh the benefit of their continued use in the program.

The three measures that we proposed for removal are titled, alcohol use brief intervention provided or offered, tobacco use treatment provided or offered, and lastly, timely transmission of transition records. We also proposed to remove one claims-based measure that is the follow up after hospitalization for mental illness measure.

And we proposed to remove that one because we believe that the Follow-Up after Psychiatric Hospitalization Measure, which we are proposing for adoption, is a broadly more applicable measure. And we believe that this measure is more broadly applicable than the current FUH measure, because it adds patients with substance use disorders to the measure cohort, which expands the cohort from only evaluating follow-up rates for patients with mental illness, to evaluating patients with both mental illness and substance use disorders.

This measure has no information collection burden associated with it because it is claims-based. So, we don't believe it will add any additional burden to rural facilities. We also propose to add one other measure. This is the COVID-19 healthcare personnel vaccination measure, which will assess the

percentage of healthcare personnel employed at the facility that received a vaccination for COVID-19. And facilities will report this measure data through the CDC's National Healthcare Safety Network web-based surveillance system.

So, those are all of our measure-related proposals. We also have an administrator proposal to transition the inpatient psych quality reporting program from having aggregate data reporting, to patient level reporting, beginning first on a voluntary basis, and then moving to mandatory data reporting at the patient level by summer 2023.

Finally, we are requesting comments on a number of topics. First, we are soliciting comments on addressing health equity in the IPFQR program. Specifically, we are requesting comments on teacher potential stratification of quality measure results by dual eligibility and other social risk factors and facility specific reports, ways to improve demographic data collection, and the potential creation of a facility equity score to synthesize results across multiple measures and social risk factors.

The IPFQR program is also soliciting stakeholder input on several topics to inform future rule-making. These are stakeholder experiences with the transition record with specified elements measure, including potential feasibility to report this measure electronically, stakeholder input regarding a patient experience of care data collection instrument, stakeholder input on implementation and timing of a potential data validation pilot, and lastly, preferences regarding a functional outcome instrument for future development of a patient reported outcome measure related to patient functioning.

That is all for the IPS quality reporting program. So, I will now turn things back over to Jill.

Jill Darling: Thank you, Lauren, and thank you, (Sherlene). Next, we have Brenda Mullens, who will talk about the COVID-19 Accelerated and Advance Payments Program.

Brenda Mullens: Thank you, Jill. Hi, I'm Brenda Mullens. I am the Acting Deputy Division Director for the Division of Financial Services and Debt Management in the Office of Financial Management, Financial Services Group. And our group has been administering the COVID-19 Accelerated and Advance Payments Program.

The program was initially stood up in March of 2020 to help provide financial relief to providers and suppliers across the country. Over the course of the program, CMS issued $107 billion to over 50,000 providers and suppliers. In our recent announcement, through the MLN Network, we announced that providers and suppliers would be entering repayment of these loans starting as soon as March 30, 2021.

The repayment terms for COVID-19 Accelerated and Advance Payments (CAAP) were outlined by the Continuing Appropriations Act 2021 and Other Extensions Act. Under the terms of repayment, repayment begins one year, starting from the date the CAAP payment was issued to the provider or supplier.

Beginning one year from the date on which we issued the CAAP, and continuing for 11 months, Medicare will recoup 25% of claims payment amounts due to the provider or supplier who received the CAAP. After the initial 11 months of recoupment, the recoupment rate increases to 50% for an additional six months.

At the conclusion of the six months recruitment rate of 50%, CMS will issue a demand for any remaining balance owed on the CAAP. 30 days after the date any demand is issued, interest will accrue on any remaining balance in the amount of 4%.

To help providers and suppliers with ease of access to the information pertaining to the COVID-19 Accelerated and Advance Payments Program, CMS has stood up a website located on cms.gov, under the Medicare tab, under Medicare fee-for-service payments, COVID-19 Accelerated and Advance Payments Program.

For additional information on the program, providers and suppliers are encouraged to navigate to that site. The site includes information from our press releases, our previously published fact sheet, our frequently asked questions document, and a link to the Medicare Learning Network article.

That concludes our update on the COVID 19 Accelerated and Advance Payments Programs, and I will be handing the mic back to Jill. Thank you.

Jill Darling: Thank you, Brenda. And thank you to all of our speakers today. Amanda, will you please open the lines for Q&A?

Coordinator: Thank you. At this time, we will now start our Q&A session. If you'd like to ask a question, please press Star 1. Please unmute your phone and record your name slowly and clearly when prompted. Your name is required to introduce your question. Again, that's Star 1 if you'd like to ask a question. One moment, please. Our first question comes from (Blake Framer). Your line is open.

(Blake Framer): Yes, ma'am. Had the two questions. One was, has there been any discussion that you all are aware of about moving the project deadlines for the expenditure of CARES Act funds from June 30 to later? And the other question is, is there an expected date for release of proposed rules for the Rural Emergency Hospital Designation? Thank you.

Ing-Jye Cheng: Thanks so much for your question. This is Ing-Jye Cheng, or the two questions I should say. I'm not sure we have anybody on the line who can address the first question. So, we may need to take that one back. As far as anticipated dates for the proposed rule-making related to the new Rural Emergency Hospital Designation, I don't think the agency has a specific date yet, but that will be forthcoming.

Brenda Mullens: With regard to the first question, this is Brenda Mullens again, I believe you're referring to the CARES Act distribution from the provider relief fund. If so, those funds are administered by HRSA. So we can circle back, and if you were to email providerreliefcontact@hrsa.gov with questions regarding the administration of the HRSA fund, they would be able to address your questions. And that is provider -- P-R-O-V-I-D-E-R -- relief -- R-E-L-I-E-F -- contact -- C-O-N-T-A-C-T -- at HRSA -- H-R-S-A -- dot gov.

Coordinator: Does that conclude your question, Blake?

(Blake Framer): Yes, it does. Thank you very much.

Coordinator: Okay. Thank you. As a reminder, if you'd like to ask a question, please press Star 1. Our next question comes from (Stephanie Katz). Your line is open.

(Stephanie Katz): Hi. My apologies, this is likely in the same lane as what you were just asked, but my curiosity was about the rurally based provider relief funds mentioned

in the end of your package. We've had a lot of questions about when those providers in need will be able to access those funds, and thus far unable to get any information on that.

Brenda Mullens: Funds related to rural hospitals specifically, I would have to circle back because I'm not certain. But if they were administered as part of the CARES Act funds from the provider relief fund specifically, all of the provider relief fund dollars that were part of the larger CARES Act appropriation are fully administered by HRSA.

So the best contact for them is to speak directly with HRSA at that provider relief contact email address that I have provided.

(Stephanie Katz): Right. Thank you so much. I appreciate it.

Coordinator: Thank you. And at this time, we have no further questions on the audio line. But as a reminder, if you would like to ask a question, please press Star 1. One moment. We did have another question come through. One moment, please. Our next question comes from (Robin Hare). Your line is open.

(Robin Hare): Yes. My question is related to the inpatient psychiatric facility under the administration section. I know that you mentioned the aggregate, which is the current collection process with a numerator, denominator and percentages. When I heard you go to the patient level requirements, you mentioned the summer of 2023. Is that for the required piece, or is that for the summary piece? I mean, for the voluntary piece. I'm just trying to determine, what is the summer of 2023, the requirement?

Lauren Lowenstein: Hi. This is Lauren Lowenstein, and I can answer that. So, summer 2023 is when we are currently planning to have the mandatory patient level

reporting. Prior to that, in summer 2022, we are planning to have patient level reporting as an option, but it would be voluntary. So if facilities want to practice, that would be a good time to do so.

(Robin Hare): Absolutely. Thank you.

Coordinator: Thank you. And at this time, we have no further questions on the audio line.

Jill Darling: Well, thank you, everyone. I'll pass it to John.

John Hammarlund: Yes. I just wanted to remind folks that we're always eager to have you help us shape the agendas of these Open Door Forum calls. And so, you can help let us know what you'd like to hear about. I'm going to defer to Jill to remind me and you of the special email address we have that you can send those to. But we would be very anxious to hear what you want us to talk about at the next opportunity we have to gather. So, Jill, can you remind everybody of the email address they can send proposed agenda items to?

Jill Darling: Sure. It's rural health ODF, all one word, at cms.hhs.gov. And we'll take comments and questions and anything you would like to see on future agendas. So, we thank you, everyone, for your time, and we look forward to speaking to you on our next Open Door Forum. Thank you.

Coordinator: That concludes today's conference. Thank you for participating. You may disconnect at this time.

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