Centers for Medicare & Medicaid Services
Rural Health Open Door Forum
Thursday, April 25, 2024
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Webinar recording:
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Jill Darling: Great, thank you so much. Good morning and good afternoon, everyone. My name is Jill Darling, and I am in the CMS Office of Communications. Welcome to today's Rural Health Open Door Forum (ODF). Thank you for your patience and waiting as we got more folks in. So, before we begin with our agenda, I have a few announcements. This webinar is being recorded. The recording and transcript will be available on the CMS Open Door Forum podcast and transcript webpage. That link is on the agenda, and I will provide it in the chat for you. If you have any questions, please, I'm sorry, if you are a member of the press and you have a question during the webinar, please email press@cms.hhs.gov. All participants are muted upon entry. For those who need closed captioning, I will provide a link in the chat function throughout the webinar.

For today's webinar, you will see the agenda slide, and one of our speakers will have slides that I will share as well. And then, we'll have a resource slide at the end for Q&A time. We will be taking questions at the end of the agenda today, and we note that we will be presenting and answering questions on the topics listed on the agenda during today's Rural Health Open Door Forum. We ask that any live questions relate to the topics presented during today's call. If you do have questions unrelated to these agenda topics, we may not have the appropriate person on the call to answer your questions. As such, we ask that you send any of your unrelated questions to the appropriate policy component, or you can send your email to the ODF resource mailbox, and we'll try to get your question to the appropriate component for a response. You may use the raise hand feature at the bottom of your screen, and we will call on you when it is time for Q&A. When the moderator says your name, please unmute yourself on your end to ask your question and one follow-up question, and we'll do our best to get you your questions.

One more announcement. Earlier in this week we did have a major announcement on three rules. So, we do have one speaker today who will talk about a portion of one of the rules, and I will also provide some helpful links in the chat to everyone regarding all the rules. So now I will turn the call over to our Co-Chair, John Hammarlund.

John Hammarlund: Thanks so much, Jill. Hi, everybody. Thank you so much for joining us today. Greetings from, well, kind of rainy Seattle, what else is new? Anyway, we have a really big agenda today, as you can see here. Really delighted to have so many speakers join us today. And as Jill said, some really critical rules came out on Monday from our agency. We'll be

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covering some of that today. We'll be covering some of them at the next Rural Health Open Door Forum call. But in the meantime, feel free to click on some of the links that Jill's putting into the chat so you can read up on those topics. I'm sure many of you are probably familiar with some of the major rules that came out on Monday. I just want to thank everybody who's from CMS for joining us today and helping us build these agendas and remind you, our audience, that you can help us build these agendas. So, at the end of today's call, we'll show you a box where you can send in and submit your ideas for future agenda items. We'd like to have you help us build the agendas in the future. Finally, I want to tell you I am absolutely delighted to be joined by a new Co-Chair on this Rural Health Open Door Forum call, and that is Heather Grimsley, and she's the Acting Director of the Provider Billing Group in the Center for Medicare. It's just great to have her along as a partner, and I'm going to turn it over to Heather so she can introduce herself to you. So Heather, take it away.

Heather Grimsley: Thanks, John and hello, everyone. Thanks for joining us today. I am in Baltimore. It's a little cloudy today, but we're looking for sun, I think, coming this weekend. I'm excited to be serving as the Co-Chair for the Rural Health Open Door Forum. A little bit of background about me. I've been at CMS for over 20 years, focusing on delivery system reform, value-based care, price, transparency, and Medicare fee-for-service (FFS) claims processing. As John said, I'm currently the Acting Director of the Provider Billing Group in the Center for Medicare, focusing on accurate and timely claims processing of institutional, professional, and supplier claims. My group writes the operational instructions that the Medicare Administrative Contractors and the claims processing system Shared System Maintainers use to process Medicare fee-for-service claims.

Prior to going on detail, I was the Deputy Director of the Performance Based Payment Policy Group, leading the policy and operations for the Medicare Shared Savings Program and the Hospital Price Transparency Initiative. So, I've spent a lot of time working closely with rural providers interested in participating in ACOs (Accountable Care Organizations). So, I'm looking forward to continuing to work with this incredible community, and I now want to turn it to Jennifer Bowdoin because we have a very full agenda. So, she's going to start by sharing some information on the HCBS (Home- and Community-Based Services) provisions in the Access Rule.

Jennifer Bowdoin: Thanks, Heather. And hi, everyone. Thanks so much for your time today and for the opportunity to talk with you. So, I'm Jen Bowdoin with the Medicaid Benefits and Health Programs Group in the Center for Medicaid and CHIP Services (CMCS). So, folks already mentioned, we issued three final rules on Monday: The Ensuring Access to Medicaid Services Final Rule, also called the Access Rule, the Medicaid and Children's Health Insurance Program, Managed Care Access Finance, and Quality Final Rule—we commonly refer to that as the Managed Care Rule—and the Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting Final Rule.

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So, the Ensuring Access to Medicaid Services Final Rule, the Access Rule, and the Managed Care Rule really go together to advance accessing quality of care and improve health outcomes across fee-for-service and managed care delivery systems. The Minimum Staffing Rule sets, for the first time, national minimum staffing requirements for nursing homes. It also requires states to report on the percentage of Medicaid payments for certain institutional services—specifically, nursing facility services and services in intermediate care facilities—that is spent on compensation for direct care workers and support staff. So, on today's call, I'm going to talk at a very, very high level about the Medicaid Long-Term Services and Support (LTSS) provisions in the Access Rule and the Minimum Staffing Rule. And then we'll discuss the other provisions in future calls, including future Open Door Forums. And just a note for folks who participate in the CMCS all-state calls, we will be covering the Access Rule in more detail on the all-state call coming up on Tuesday.

So first, the Access Rule. So, the Access Rule includes a number of provisions focused on Medicaid Home- and Community Based Services. Essentially, what we're doing in that rule is establishing a new strategy for oversight, monitoring, quality assurance, and quality improvement for Medicaid HCBS programs and to promote consistency across Medicaid HCBS authorities. The requirements apply with a few exceptions to home and community-based services to HCBS under all the major 1915 authorities. So, Sections 1915 C, I, J, and K authorities as well as to Section 1115 demonstrations. In general, there's one notable exception to this—they apply to HCBS delivered under both fee-for-service and managed care. So, we're really trying to level the playing field, create some consistency in Medicaid HCBS requirements.

So just at a very high level in terms of what we've included for those requirements. So first, we are strengthening oversight of person-centered service planning in HCBS by establishing new reporting requirements and minimum performance levels related to those reporting requirements. We're doing a lot related to incident management systems and what states are expected to do related to monitoring critical incidents and addressing critical incidents. So we are, for the first time, really setting nationwide incident management system standards for states' HCBS programs, including a minimum standard definition of what a critical incident is. So, this includes various types of abuse and neglect, exploitation, unanticipated unexplained deaths, and things like that are now required by states to be considered—or they will be when that particular provision becomes applicable—states will have to consider those critical incidents. We're requiring states to have electronic incident management systems. We're requiring provider reporting of critical incidents in first states to use other data sources such as claims to identify critical incidents. We're requiring information sharing on the resolution of incident investigations, and we're establishing new reporting requirements in minimum performance levels related to critical incidents. In terms of another beneficiary protection, we are also requiring that states establish grievance or complaint systems in their fee-for-service HCBS programs. Similar requirements already exist in managed care. And so, we want to ensure that for Medicaid beneficiaries receiving HCBS through fee-for-service delivery systems, that they really have those same opportunities as people enrolled in managed care to file complaints

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related to a state or provider's compliance with person-centered planning and HCBS settings requirements.

We have also set a number of new reporting requirements, including that states report annually on waiting lists and Section 1915(c) waiver programs, that states report annually on access to personal care, homemaker, home health aide, and rehabilitation services. And also, that states report every other year on a standardized set of HCBS quality measures. And this includes phased-in requirements for states to stratify their data by demographic and other factors, including rural and urban status. And that will help states to assess disparities in their HCBS programs.

And then there's some notable provisions related to compensation for direct care workers. These are the provisions that get the most attention by far, but they are certainly not the only provisions in the rule. So essentially what we are requiring, we phase this in over time, we are requiring that states report on the percentage of Medicaid payments for homemaker, home health aide, personal care, and rehabilitation services that are spent on compensation to direct care workers. There are some exceptions to that. And then in six years, generally, there are some exceptions, states will have to generally ensure that a minimum of 80% of Medicaid payments for homemaker, home health aide, and personal care services be spent on compensation for direct care workers. And then, we did add some new flexibilities that were not included, they were not proposed requirements, but we did include them in response to public comment. So, the first was to allow states to establish hardship exemptions, and we are also allowing states to set separate performance levels for small providers. And then there's also in the final rule, including an exemption from complying with both the reporting requirements and the minimum performance level for the Indian Health Service in certain Tribal health programs. And then we've made some other adjustments to how certain costs are treated. And then lastly, in the Access Rule related to HCBS, we are promoting public transparency by requiring that states publicly report all of the data that they report to us, and then we will publicly report the data and information across all states. So that was a lot.

Shifting gears to the Minimum Staffing Rule. There is one provision specific to Medicaid that's included in this rule, and it's specifically the Medicaid institutional payment transparency reporting requirement. So, that final rule requires states to report annually at the facility level on the percentage of Medicaid payments for certain institutional services that are spent in compensation for direct care workers and support staff. That provision applies specifically to nursing facility services and services in intermediate care facilities for individuals with intellectual disabilities, and the requirement applies regardless of whether those services are delivered through fee-for-service or managed care delivery systems. So, that provision probably sounds very similar to what is in the Access Rule. It is very similar, but there is no minimum performance requirement on the institutional side. This is, at this point, solely for reporting only, and we'll use that information then to assess whether there should be policy changes in the future. Similar to the Access Rule, though, we are promoting public transparency and in the Minimum Staffing Final Rule by requiring that states publicly report the data that they report to

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us, and then we will publicly report the data reported by each state. So those are the highlights on the LTSS provisions in those two rules. So, I will now turn it over to the next speaker. Thank you.

Jermama Keys: Thanks Jennifer, and good afternoon, everyone. My name is Jermama Keys, and I'll be providing some updates on the Home Health and Hospice QRPs (Quality Reporting Program). First, I would like to share some updates about the Home Health QRP. The next Care Compare refresh is actually taking place this month, in April of 2024. The preview reports for the April 2024 refresh of home health data on Care Compare were released to providers this January. As a reminder, the new Discharge Function Score measure is planned to be reported on the Home Health Review and Correct Reports, Outcome Reports and Outcome Tally Reports in 2024, this April. The application of the Functional Assessment and Care Plans That Address Function measure will be removed from the Review and Correct Reports, the Process Reports, and the Process Tally Reports in April of 2024 as well. In addition, the HQRP or HHQRP (Home Health Quality Reporting Program) risk adjustment models have been recently updated for 2024. The updated specifications are available for download on the quality measures webpage for Home Health QRP.

Next, I wanted to share a quick update about OASIS (Outcome and Assessment Information Set) and that CMS will host an OASIS technical information call for software vendors and developers on Tuesday, April the 30th. This vendor call will cover such topics as the OASIS-E guidance manual changes, OASIS-E1 Data Specifications and system and validation utility tool, or the VUT updates, as well as any submitted Q&As. So, everyone can visit the HHQRP Spotlight and Announcement webpage for all of that call-in information, and that page is actually in the chat.

Next, I wanted to give a quick update related to the Home Health Value-Based Purchasing Program (HHVBP). The preliminary April interim reports, or IPRs, will be available in iQIES (Internet Quality Improvement and Evaluation System) folders very soon. We want to remind everyone to just please check your iQIES folders for those April IPRs once they're available. The final IPRs are expected to be available by June of 2024, and as a reminder, that final IPR would override any of the preliminary IPRs once that final is published in June. We do have some updates in reference to resources on the CMS website. So, the quarterly Home Health VBP Model (Home Health Value-Based Purchasing Model) newsletter is available for download, and we want you to keep an eye out for additional Home Health VBP webpage resources. Finally, we wanted to update an announcement or give you an update in reference to certain events that'll be happening related to the HHVBP. CMS will actually be hosting a new web-based training regarding the 2025 HHVBP measures very soon. In August, they'll actually be holding a webinar to discuss the HHVBP Annual Report, so you can look out for those things.

Next, we'll be discussing the Hospice QRP and the Hospice Final Rule. The final rule for the fiscal year 2025 Hospice Proposal Rule which was actually posted on March 28. This rule is going to be providing updates related to the Hospice Quality Reporting Program, or HQRP, and its future measures.

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We include a proposal for HRQP quality measures, the collection of new data instrument, the Hospice Outcomes and Patient Evaluation, or HOPE, tool. We are requesting information or feedback related to Social Determinants of Health, or SDOH, items. We will also be providing updates on health equity activities and efforts, future measures, and public reporting requirements. Some of those changes to the CAHPS (Consumer Assessment of Healthcare Providers and Systems) or the Hospice CAHPS survey would also be located in this rule. As a reminder, the rule is still open for public comment through May 28, 2024. That actually ends my updates for home health, and I can pass it to the next speaker.

Renate Dombrowski: Thank you. This is Renate Dombrowski. We're going to be reviewing two provisions included in the fiscal year 2025 IPPS (Inpatient Prospective Payment Systems) Proposed Rule. The rule went on display on April 10, and the comment period closes on June 10. The rule contains a proposal to implement Section 4122 of the Consolidated Appropriations Act of 2023. Section 4122 requires the distribution of 200 residency CAHP slots in fiscal year 2026. In order to qualify, a hospital must meet at least one of four categories. Number one, hospitals in rural areas or reclassified as rural; number two, hospitals training over their CAHP; number three, hospitals in states with new medical schools or branch campuses; and number four, hospitals serving geographic HPSAs (Health Professional Shortage Areas). In addition, Section 4122 requires that at least half of the slots go to psychiatry or subspecialties of psychiatry. Each qualifying hospital must receive one slot or a fraction of one, and no hospital can receive more than 10 slots. We are proposing to distribute up to one slot to each qualifying hospital, and if any slots remain, we would prioritize the distribution based on the HPSA score associated with the program for which the hospital is applying. We are also seeking comments on an alternative proposal which would place greater emphasis on distributing slots to hospitals serving geographic or population HPSAs. I'm now going to turn it over to Ted for the next issue.

Ted Oja: Thank you, Renate. CMS believes that it is critical to develop policies that can help curtail shortages of essential medicines and better insulate hospitals from the detrimental effects of such shortages. In the fiscal year 2025 [inaudible] Long-Term Care Hospital Proposed Rule, CMS is proposing a separate payment to small, independent hospitals of a hundred beds or fewer to establish and maintain access to six-month buffer stocks of one or more of 86 essential medicines. These small, independent hospitals can be particularly vulnerable to supply disruptions during shortages because they lack the resources of hospitals that are larger or a part of a chain organization. The separate payment would be for the IPPS shares of the additional resource costs of establishing and maintaining access to the buffer stocks but would not include the cost of the medicines themselves. We are requesting comment on all aspects of this proposed separate payment. And now I'll turn things over to Carmen Irwin. Thank you.

Carmen Irwin: Good afternoon. So, my name is Carmen Irwin, and I will be providing an update regarding hospital price transparency. So, CMS finalized the new hospital price transparency requirements in the calendar year 2024 OPPS (Outpatient Prospective Payment System) ASC (Ambulatory Surgical Center) Final Rule. In that final rule, one of the

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requirements was improving automated access. So, as of January 1, hospitals must ensure their public website posts the machine-readable file and establishes and maintains, in the form and manner specified by CMS, a TXT file. In addition, a link to the footer of the hospital's website, including but not limited to the homepage that is labeled Price Transparency. This link must link directly to the publicly available webpage that hosts the MRF, or machine-readable file. That information, and I'll put it in the chat, can be found at the CMS.gov GitHub tools page. In addition, there are new requirements that will become required on July 1 for the hospital's machine-readable file to conform to the CMS template, layout data specifications, and data dictionary. CMS has made the CMS template available in three non-proprietary formats: CSV "tall," CSV "wide," and JSON.

In addition, CMS has created a GitHub repository, which houses not only the required CMS templates, but it also provides a data dictionary and technical instruction on how the hospitals must encode standard charges information into the machine-readable file. In addition, CMS has just launched the online validator on this HPT (hospital price transparency) tools website. This validator tests machine-readable files against the required CMS template layouts and data specifications. The online validator runs in the user's web browser and is recommended for non-technical users. In addition, there's also a command line interface, or CLI validator, which can also be found on the HPT tools website. Now, this also tests the machine-readable files against the required CMS template layouts and data specifications. The CLI is a downloadable tool that runs locally in the user's terminal. All this information is available and can be reached at the Hospital Price Transparency Tools page. That is my update today, and I'll pass it on to the next speaker.

Emilie Thomas: Thank you. Hello, my name is Emilie Thomas, and I work on the Medicare Shared Savings Program, and we wanted to share some brief information about the Shared Savings Program itself today, along with highlighting advance investment payments ahead of our application cycle opening this May. Next slide.

So, to start, here's just a very brief overview of the Shared Savings Program. The Shared Savings Program offers providers and suppliers an opportunity to either create or join an accountable care organization, or ACO. ACOs are groups of doctors, hospitals, and other health care professionals that work together to give patients high-quality, coordinated care and health care to improve health outcomes and manage costs. So, under the Shared Savings Program, when an ACO succeeds in delivering both high-quality care and spending health care dollars more wisely, the ACO can be eligible to share in the savings that it achieves with the Medicare program and, in some instances, may owe losses if it increases cost. The Shared Savings Program has different participation options, known as tracks, that allow ACOs to select an arrangement that really makes the most sense for their organization. Next slide.

So, the Shared Savings Program now offers a payment option known as Advance Investment Payments, or AIP. So, these are an advance of the Shared Savings Programs that are paid out in two ways. First, all ACOs that are participating in AIP will get an upfront payment of $250,000

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at the start of that agreement period. And then quarterly for a total of two years, ACOs receive payments that are based on their beneficiary population. So ACOs can use these funds to build the infrastructure they might need to help facilitate their participation in the Shared Savings Program. They can also be used to promote health equity by holistically addressing those beneficiary needs, and these funds can be used to build partnerships with community-based organizations and be tailored to meet the needs of the community served by that ACO. And the availability of these funds is really meant to encourage health care providers in rural and in underserved areas to join together and form an ACO. And lastly, I'll just note that CMS then recoups these funds through the shared savings that the ACO eventually achieves in the program. Next slide.

So, just quickly looking at the eligibility requirements to participate in AIP. So, first, ACOs must apply and be eligible for the Shared Savings Program itself. And then additionally, this option is open to a subset of ACOs that meet the criteria on the screen here. So, it must be a new Shared Savings Program ACO. It cannot be a renewing ACO or an ACO that may have participated in the program previously. ACO must be applying to Level A of the BASIC track. The ACO must be inexperienced with performance-based risk Medicare ACO initiatives overall. And then lastly, the ACO must be low revenue. So, if an ACO meets all of these criteria and then is interested in receiving AIP funds, ACOs are required to submit a spend plan where they would detail how they would plan to use those funds over their five-year agreement, and they're going to need to fall into these three buckets: increased staffing, health care infrastructure, and the provision of accountable care for underserved beneficiaries. Next slide.

So, taking a look at how the very first cohort of AIP ACOs in the Shared Savings Program is spending these funds—the first group started their participation on January 1 of this year. So, 64% of projected spending for 2024 is for increased staffing. So, some examples of what these positions include are case managers, community health workers, licensed social workers, and health equity officers. And then, we see that ACOs have made investments in building their health care infrastructure as well, accounting for 31%. Some examples include case management systems and screening tools. And then lastly, 5% of funds are being directed toward the provision of care for beneficiaries, and some examples include vouchers for ride shares and nutritional support. Another thing I'll note is that ACOs have that full five-year agreement period to allocate those funds. So, CMS estimates disbursements of $26.1 million this first year, and then ACOs are projected to spend around half of that this year.

Next slide. So, just to wrap up, if you are interested in joining or forming an ACO or an AIP, there are some very important dates upcoming. So first, the Shared Savings Program application cycle opens on May 20 and all applications are due by June 17. There will be the opportunity for ACOs to continue to add providers until August 1 at noon. And then the actual supplemental information required to receive advance investment payments is collected during the second phase of our application. But only applicants who have successfully completed that first phase and are eligible, based upon the criteria I mentioned, will have the opportunity to submit that information to CMS, including the spend plan. I would highly encourage you to review both the

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application types and timeline webpage and the application toolkit for a wealth of very detailed information about the process and all of the requirements. So, thanks for taking the time to learn a little bit more about the Shared Savings Program and advance investment payments. I'll turn it back over for the Q&A.

Jill Darling: Great, thank you, Emilie, and thank you to all of our speakers today. We will take a moment to see if anyone has questions, and please use the raise hand feature at the bottom of your screen, and we'll wait a moment until we see some hands. Or if you would like us to provide any emails or links into the chat for you, please raise your hand for that matter as well. OK, I see a couple of hands.

Zoom Moderator: We have John. John, you can speak now.

John Supplitt: I am really just pursuing the slide deck that was just shared. Can we get copies of that, or the link to it, or whatever?

Jill Darling: Emilie?

Emilie Thomas: I will find out.

John Supplitt: Because I could have taken screenshots.

Emilie Thomas: If you submit a ticket to the help desk, we can follow up with you. And then also the Advance Investment Payments guidance document that's posted on the toolkit has all of that information and much more details as well. That would probably be a very helpful resource.

John Supplitt: Right. Is that link in the chat?

Emilie Thomas: Yeah, so I can put it in the chat. It's also on the screen here, the shared savings application toolkit. On that page is the guidance, and I'll drop it in the chat right now, too.

John Supplitt: Thank you.

Zoom Moderator: We have Cait Ausink. You can speak now.

Cait Ausink: Hey there. So, I work at Health Catalyst, a SaaS company and we've had a few questions in regard.

John Hammarlund: Lost her.

Zoom Moderator: Hello? Cait, you need to unmute yourself.

Cait Ausink: Well, there it is. Can you hear me now? Sorry about that.

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John Hammarlund: There you go.

Cait Ausink: All right. So, I work for a Health Catalyst, a SaaS company, with a handful of clients helping them maintain their machine-readable files and compliances. We're struggling a little bit with the TXT files. We have a handful of clients that are unable to put it at their root of the hospital, so we're trying to figure out a subdomain on our application. Is there any resources or anything that you guys have heard that can help us direct our clients with those TXT files?

Carmen Irwin: This is Carmen. I would ask that you submit that question to the HBT mailbox. However, I can say that this topic has been brought up and is being looked into. I don't have detailed information at this time, but we would ask that you submit that to the HPT mailbox, and we'll get that information to you.

Cait Ausink: Awesome. Thank you, Carmen.

Carmen Irwin: Thank you.

Zoom Moderator: Next caller is Barbara Link. You can speak now, Barbara.

Barbara Link: I was just wondering about the slides as well. So, my question was answered. Thank you.

Zoom Moderator: There are currently no more raised hands at this time.

Jill Darling: All right everyone, I will pass it to our chairs for closing remarks.

John Hammarlund: Thanks. Welcome again, Heather, to this great group. Delighted to have you co-chair. We had a really good meeting today, lots of information. And as we said earlier, there'll be more information at the next Open Door Forum call, especially about some other aspects of the rules that were published on Monday.

Finally, I want to draw your attention to the far left-hand top corner of this Helpful Resources. That's where we have our resource box. We're always happy to take questions from you. And moreover, if you have ideas for future agendas, please suggest them and send them our way. So, with that, I'll hand it back to Jill for any other closing. But thank you all so much for joining us today, and thanks again to my CMS colleagues around the country and in headquarters who joined us today and presented. We really appreciate your participation.

Jill Darling: Great, thank you, John. I just provided the Open Door Forum podcast and transcript webpage for you. That is where we post the transcripts, the recording, and the Q&A documents. And also, I've added the Rural Health ODF email for you as well. So please utilize that. So, we thank you for joining us today, and this concludes today's call. Thank you everyone.

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