Centers for Medicare & Medicaid Services
Open Door Forum: Rural Health
Moderator: Jill Darling
June 10, 2021
2:00 pm ET

Coordinator: Welcome. Thank you everyone for standing by. Now guests are in a listen-only mode until the question-and-answer session of today's event. At that time you may press Star 1 on your touch-tone phone if you'd like to ask a question and you will be announced by name and organization. Also today's conference is being recorded if you have any objections of course you may disconnect. And now I would like to turn it over to your host, Ms. Jill Darling. Thank you so much ma'am. You may begin.

Jill Darling: Great, thank you (Fran). Good morning and good afternoon everyone. Welcome to today's Rural Health Open Forum. We appreciate your patience as always.

Before we get 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 have any inquiries please contact CMS at press@cms.hhs.gov. And I would like to hand it off to our Co-Chair, John Hammarlund.

John Hammarlund: Well thanks very much Jill. Well hi everybody. Welcome to this edition of the Open Door Forum Call for Rural Health. Thank you so much for joining us. We have built a really robust agenda for you today as you can see from the emails. And we're looking forward to forward to a great discussion and anticipate lots of questions.

So we're really delighted to have some wonderful speakers here. We also have others from our headquarters office listening in today as well as many of our regional rural health coordinators listening in from the rural offices. As always they're there to serve you. Please get - take the chance to get to know your

regional rural health coordinator. Their contact information is up on our Web site.

And then finally I just want to say on behalf of our Co-Chair, Ing-Jye Cheng and myself, we are always interested in having you help craft the future agendas of these calls. So we will encourage you at the end of this call to send in your agenda items and thoughts for our next call. And at the end of the call Jill Darling will give you the address whereby you could do that.

So once again welcome. Thanks to our speakers for joining us today. And with that I'll hand it back to you, Jill.

Jill Darling: Great, thank you John. First, we have Renate Dombrowski who will speak on the fiscal year 2022 IPPF Proposed Rule GME policies included in the Consolidated Appropriations Act of 2021.

Renate Dombrowski: Thanks Jill. I'm going to briefly review three of the Graduate Medical Education or GME provisions that are included in the Consolidated Appropriations Act of 2021 which are being proposed for implementation in the fiscal year 2022 IPPS Proposed Rule. The comment period for this rule runs through June 28.

We are proposing an application process to implement Section 126 of the CAA which makes available an additional 1000 resident caps slots phased in at a rate of no more than 200 slots per year beginning in fiscal year 2023. Section 126 requires that a hospital fit into at least one of the following four categories in order to receive slots. Hospitals in rural areas or are treated as being located in a rural area under the law, hospitals currently operating over their GME caps, hospitals in states with new medical schools or additional locations and hospitals that serve areas designated as Health Professional Shortage Areas or HPSAs.

In addition we are proposing to prioritize applications from hospitals that fit into at least one of these four categories for residency programs that serve

underserved populations in geographic HPSAs or population HPSAs.

We are proposing to implement Section 127 of the CAA which concerns Rural Training Tracks or RTTs. These are programs where residents spend more than 50% of their time training in a rural area.

Under prior law urban hospitals participating in a rural training track received an adjustment to their resident caps based on the training occurring at the urban hospital. However the statute did not provide rural hospitals with a cap adjustment for an RTT. Section 127 allows for rural hospitals participating in RTTs to receive an increase in their resident caps based on the training occurring at the rural hospital.

We are also proposing to implement other provisions included in Section 127 such as removing the requirement that RTTs be separately accredited and allowing for subsequent RTT cap adjustments for urban and rural hospitals that participate in additional RTTs.

Thirdly, we are proposing to implement Section 131 of the CAA which resets the per resident amounts or PRA and/or caps of certain hospitals that may have inadvertently set de miminis PRAs and/or caps as a result of accepting residents from other training programs.

Section 131 discusses two categories of hospitals. Hospitals that as of the date of enactment of the CAA have a PRA and/or cap that was established based on training less than one FTE and hospitals that as of the date of enactment of this CAA have a PRA and/or cap that was established based on training of no more than three FTEs.

The law requires these hospitals train a certain threshold amount of FTEs (at least one or more than three) during the five year period that begins December 27, 2020 in order to be considered for replacement PRAs and caps. This concludes my GME overview. I'll turn the call back to Jill.

Jill Darling: Thank you Renate. Next we have Kelly Vontran who will speak on the COVID-19 vaccination payment update.

Kelly Vontran: Thanks Jill. Good afternoon everyone. And good morning to those callers calling in from the West Coast. As Jill said, my name is Kelly Vontran. And I'm Deputy Director of the Division of Home Health and Hospice in the Center for Medicare. I hope everyone remains well as we continue to navigate through the COVID-19 public health emergency.

We appreciate you calling into the Rural Open Door Forum. And my colleague Brian Slater and I will be providing eligibility billing and payment information on the new home administration rate for the COVID-19 vaccine. While we will answer questions at the end of this discussion please note that some of your questions may be related to issues beyond this in-home payment information and we may not be able to provide a response on this call.

For those questions we will have to collaborate with our colleagues across CMS and the Department of Health and Human Services to furnish a response. Brian will provide the email at the end of this discussion for you to send additional questions after this call.

So now while many Medicare beneficiaries can receive a COVID-19 vaccine at a retail pharmacy or physician's office or mass vaccination site some beneficiaries have great difficulty leaving their homes or face a taxing effort getting around their communities easily to access vaccinations in these settings. So to better serve this group Medicare is incentivizing providers and will pay an additional $35 per dose for COVID-19 vaccine administration in a beneficiary’s home beginning on June 8 of 2021.

This additional payment for in-home administration of the COVID-19 vaccine will increase the total payment amount for at home vaccinations from approximately $40 to approximately $75 per vaccine dose. For a two dose vaccine this results in a total payment of approximately $150 for the administration of both doses. So that is to say Medicare will pay $35 per dose

for the in-home administration of the COVID-19 vaccine in addition to the current $40 per dose administration of the COVID-19 vaccine.

CMS will also geographically adjust the additional amount and the administration rate amounts based on the geographic location where the vaccine is administered. This additional payment is limited only to the administration of the COVID-19 vaccine. This payment does not extend to other vaccines such as those for pneumococcal pneumonia or influenza.

CMS has specific authority to implement payment for COVID-19 vaccine administration through program instruction which it does not have for other vaccines. In-home vaccine administration is a distinct service. And the additional payment amount reflects the additional cost to providers and suppliers for administering vaccine in the home such as the upfront costs associated with administering the vaccine safely and appropriately in a patient's home and the additional clinical time needed for post administration monitoring of a single patient.

The additional payment will support health care providers' efforts to reach people with disabilities or those facing clinical, socioeconomic or geographic barriers to receiving the vaccine elsewhere. We established the $35 payment amount on a preliminary basis to ensure access to COVID-19 vaccines during the public health emergency. We continue to evaluate the needs of Medicare patients and these policies and will address them in the future as needed.

So who was eligible for the additional in-home payment? The additional in-home payment for administering the COVID-19 vaccine is available for those patients who have difficulty leaving the home to get the vaccine which could mean any of the following. The patient has a condition due to an illness or injury that restricts their ability to leave home without a supportive device or help from a paid or unpaid caregiver, they have a condition that makes them more susceptible to contracting a pandemic disease like COVID-19, they are generally unable to leave the home and if they do leave the home it requires a considerable and taxing effort or the patient is hard to reach because they have

a disability or face clinical, socioeconomic or geographical barriers to getting a COVID-19 vaccine in settings other than their homes.

These patients face challenges that significantly reduce their ability to get vaccinated outside the home such as challenges of transportation, communication of caregiving. Unlike the requirements under the Medicare Home Health Benefits physicians or other allowed practitioners such as nurse practitioners or physicians assistants do not need to certify that the Medicare patient is homebound but documentation in the patient's medical records must support the clinical status or the barriers they face to getting the vaccine outside the home.

Next what qualifies as a patient's home? So many types of locations qualify as the Medicare patients home for the additional in-home payment amount such as a private residence, temporary lodging for example a hotel or motel, campgrounds, hostel or homeless shelter, an apartment in an apartment complex or a unit in an assisted living facility or group home. Additionally Medicare patients home that may provider based to a hospital during the COVID-19 public health emergency for the purposes of furnishing outpatient hospital services is still considered the home for the purposes of the additional payment for COVID-19 vaccine administration.

However, the following locations do not qualify as a home for the additional payment amount communal spaces of a multi-unit living arrangement. So for example the lobby of an apartment complex where multiple patients are being vaccinated simultaneously. Hospitals, Medicare skilled nursing facilities and Medicaid nursing facilities regardless of whether they are the patient's permanent residence and assisted living facilities participating in the CVS's Pharmacy Partnership for Long Term Care program when the residents are vaccinated through this program.

So now I'm going to pass this over to Brian Slater who will provide you with additional information on billing and payment for the home administration of the COVID-19 vaccine. Brian?

Brian Slater: Thanks (Kelly) appreciate that. I am Brian Slater. I'm the Director of the Division of Home Health and Hospice here in the Center for Medicare. And I'll be walking you through, as Kelly said, some additional information regarding the vaccine specifically what other restrictions apply, who is eligible to bill for this additional payment and how do you go for the additional payment.

So what restrictions apply? Well Medicare only pays the additional amount for administering the COVID-19 vaccine in the home if the sole purpose of the visit is to administer the COVID-19 vaccine. Medicare does not pay the additional amount if another Medicare service is provided in the same home on the same date. In those situations Medicare pays for administering the COVID-19 vaccine at the standard amount approximately $40 per dose.

Furthermore, if a provider administers the COVID-19 vaccine to more than one Medicare patient in a single home on the same day Medicare pays the additional payment amount of approximately $35 only once per date to service in that home and approximately $40 to administer each dose of the COVID-19 vaccine. So for example if the provider administers a single dose vaccine on the same date to two Medicare patients in the same home Medicare pays approximately $115. That is $35 for the in-home vaccine administration plus two of the $40 for each dose of the COVID-19 vaccine.

Now who is eligible to bill for the additional payment? Well any provider or supplier who is enrolled in Medicare has a certain institutional or non-institutional provider type eligible to administer vaccines and enrolled as a provider in the Centers for Disease Control and Prevention or CDC COVID-19 Vaccination program may administer the COVID-19 vaccine in the home and bill for the additional payment including the additional payment amount for services furnished in the home.

If a provider or supplier is enrolled in Medicare but as a provider type that is not otherwise authorized to administer vaccines the provider or supplier must

also separately enroll as the provider type allowed to administer vaccines such as a mass immunizer or COVID-19 vaccine administration including the additional payment amount for home vaccinations.

Any provider or supplier who is not enrolled in Medicare must enroll in Medicare as a provider type allowed to administer vaccines and bill Medicare in order to bill for the additional payment for administering the COVID-19 vaccine in the home. Beyond collection of COVID-19 vaccine administration fees for Medicare the vaccine recipient cannot be charged any administration fee or other out of pocket fee for such vaccination.

Now how do you bill for the additional payment? Eligible providers and suppliers who administer the COVID-19 vaccine in a then eligible beneficiary's home can bill for the additional in-home administration payment. We have created a new Level 2 HCPCS code, code M0201 which is $35.50 has been created to identify the additional payment for the home administration of the COVID-19 vaccine.

To bill the additional in-home payment amount for administering the COVID-19 vaccine to a Medicare patient the provider or supplier administering the COVID-19 vaccine in a patient's home must use both the appropriate CPT code for the product and dose specific COVID-19 vaccine administration. And also that HCPCS code Level 2 that I just mentioned before M0201 for the additional payment amount for administering the COVID-19 vaccine in the home.

The provider or supplier should only bill for an additional in-home payment amount if the sole purpose of the visit is to administer the COVID-19 vaccine. The provider should not bill for the additional amount or - and bill Medicare for another service in the same home on the same date. The provider or supplier should bill for the additional payment amount only once per date per home of service.

If the provider or supplier administers the COVID-19 vaccine to more than

one Medicare patient in a single home on the same day the provider should bill the HCPCS two, Level 2 CODE M0201 only one time for the additional payment rate. Then bill each dose administered using the appropriate CPT code for the product and dose specific COVID-19 vaccine administration.

If a provider or supplier submits roster bills for administering the COVID-19 vaccine in the home then they must submit two roster bills, a roster bill containing the appropriate CPT code for the product and dose specific COVID-19 vaccine administration and the second roster bill containing the HCPCS Level 2 code M0201 for the additional in-home payment amount. A provider or supplier may submit a single set of roster bills meaning containing - one that would contain M0201 and another containing the appropriate CPT code for multiple Medicare patients who get the COVID-19 vaccine in their individual units of a multi-unit living arrangement.

Now for more information on the home range for vaccine administration can be found on the CMS Web site. That is www.cms.gov/covidvacs-provider. Once on this Web site the coding, payment and billing pages are all in links on the left-hand side of the page. Now we're happy to answer any questions you might have but keep in mind again what Kelly said at the beginning that if there are questions that arise outside of payment and billing we might have to circle back at a later date.

So in addition to that any that cannot either address on the call or if one arrives after the call please utilize the email address partnership@cms.hhs.gov and we will be monitoring that mailbox as well. So thank you for the time and opportunity to present today. And we will hand it back to Jill.

Jill Darling: Thanks Brian and Kelly. (Fran), please open the lines for Q&A.

Coordinator: I'd be happy to. Now if you would like to ask a question please press Star then 1. Unmute your phone please if you did mute it and record your name and organization clearly when prompted. You will be announced by both. Again please press Star 1. And one moment please for our first question. We're

getting something, just one moment. Well pardon me Drew Canning your line is open. What organization are you with first please?

Drew Canning: Hello. I'm with Husch Blackwell.

Coordinator: You may ask your question. Thank you sir.

Drew Canning: Yes, thank you for putting this on. I had a question around rural health networks specific to the conditions of participation. Kind of twofold question, one, I guess very basic, what is a rural health network? And then say a few critical access hospitals or rural hospitals join together to share telecommunications or office services participation would that constitute a rural health network under the condition of participation?

Brian Slater: Do we have anybody on from CCSQ that could help put this question if not we may have to Jill have it submitted in to us.

Jill Darling: Yes please. Please submit it to ruralhealthodf@cms.hhs.gov. It's listed on the agenda if you received it. It's in the middle of the agenda. Thank you.

Brian Slater: Thank you. Thank you for your question. Sorry we didn't have anybody on today who can answer it but we'll try to get an answer to you as quickly as possible. Thank you.

Drew Canning: No worries. Thank you so much.

Coordinator: Thank you all. Again if you do have a question please press Star 1. Presently my last question is from (Eric Lee Park) with Be Healthy People. And sir, your line is open.

(Eric Lee Park): Hello. Good afternoon. I'm looking to find someone we can liaise with to create mass vaccination sites using testing as a mechanism to bring them in and a partnership with the NBA Development League. And our company is Be Healthy Hook Diagnostics formerly of Total Access MD.

Ing-Jye Cheng: Thanks for your question. This is Ing-Jye Cheng. Just some I'm a little bit more clear. Are you currently enrolled in Medicare as a provider or supplier of health care services?

(Eric Lee Park): Yes.

((Crosstalk))

Ing-Jye Cheng: What type of - I think a lot of what we would be able to offer you it really depends on what type of provider or supplier you are. And we can certainly help provide information on how you could bill for those types of services. But I may or may not be understanding your question.

(Eric Lee Park): We're looking for some type of physical support because we just locked in a contract with the NBA Summer Development Leagues which brings out a lot of the general public. And we look to turn it into a mass vaccination site utilizing testing because that is some of the protocols of safety if you're going to enter the arenas to watch the game. And it's happening everywhere from Las Vegas to Idaho and Baltimore. I we just got that contract two days ago. And we're looking for someone to liaise with...

Ing-Jye Cheng: Is your question around what type of entity you need to be enrolled as to bill Medicare and/or Medicaid for providing the testing or vaccination...

(Eric Lee Park): Yes.

Ing-Jye Cheng: ...or how you might do that? I'm not totally sure about the question.

(Eric Lee Park): Yes. That's part of the question but the major part was creating a synergy that educate the end user who gets to the event. I was looking for someone for us to liaise with to make it a very successful event in reaching persons from socioeconomically disadvantages perspective.

Beyond that I understand the billing part we'll get past that but it's more about creating that sort of connection to deliver that message to that group of people. The vaccine has - I'm looking for a name of someone that we can liaise to create that communication bridge.

Ing-Jye Cheng: And I'm thinking and the silence is trying to think about who would be the right entity within the agency to kind of have you partner with in terms of talking about how to - it sounds like a question not so much on the billing piece but on the outreach piece and how to reach some of the folks you're interested in serving.

You know what might be very helpful if this if you could -- and Jill can share that email again it's helpful -- if you could summarize kind of what your entity, what your organization does, what the - what you're hoping to gain. And we can try to find the right individual here and have them some circle back with you over email.

(Eric Lee Park): So our main objective is to push a code in minority health chronic issues and educating people from a socioeconomic disadvantaged place of understanding how valuable and important their health is so they can become responsible members utilizing the NBA Summer Leagues which are the draw mechanism to bring people within to the facility. And since we have that contract and we have to test everyone coming in I thought it would be a perfect place to also offer educated reasons for why the vaccine hesitant to get vaccinated.

Ing-Jye Cheng: Absolutely. And I just don't - and off the top of my head I'm not sure who the right people kind of at the agency would be to partner with you. And I'd like the opportunity to be able to kind of circulate that with a few folks who might be able to help us find the right piece of the organization that can work with you.

(Eric Lee Park): Okay.

Ing-Jye Cheng: All right?

(Eric Lee Park): Yes. I appreciate it. Thank you so much.

Ing-Jye Cheng: No thank you. I appreciate it.

John Hammarlund: If I may also add -- this is John Hammarlund -- might want to consider, you know, checking in with the folks at the Department of HHS, we can do this. So if you go to the Web site it's all one word we - or I should say four words brought together, wecandothis.hhs.gov. You might also be able to find some resources there in addition to our attempting to try to find a way to link you up with the right people by sending us a description. So thank you.

(Eric Lee Park): Okay.

John Hammarlund: Okay, yes next caller.

Coordinator: Thank you very much. We do have another question. So Peter Lobin with Scarab Waste Solutions. Sir, your line is open.

Peter Lobin: All right, thank you and good afternoon. Scarab offers an innovative technology that treats regulated medical waste at the point of generation. And this technology has been, you know, in the commercial market for five years. So we think it's like perfect for the rural health care centers.

My question is, is there a office and/or a unsolicited proposal procedure one could use in order to bring this to certain people's knowledge in front of them? I'm looking for innovators, early adopters. Taking it directly to the field level is it's almost impossible to find innovators, early adopters taking it directly to the field level is, you know, it's almost impossible to find innovators or early adopters. It's a needle in the haystack.

So this is, by the way this other agencies there is unsolicited proposal. There are new ideas. I haven't found that as far as CMS or specifically the rural health care centers. Did I lose anyone?

John Hammarlund: No, I think we're in the same - this is John Hammarlund...

Peter Lobin: No one wants to talk about waste.

John Hammarlund: ...I don't believe we have anybody on this call who can assist with that. So I think we're going to have to ask you to describe this in some detail and submit it to us in an email via the corporate box Jill offered earlier. And we'll offer again at the end of the call.

Peter Lobin: Great. The one that's on the invitation that was sent out...

Jill Darling: Yes.

Peter Lobin: or the email that was sent out? Perfect, I appreciate your time folks, very kind.

Coordinator: Thank you, thank you everyone. As I have no further questions in queue I would like to turn it back to Mr. Darling for any closing remarks.

Jill Darling: Well thank you everyone, for joining us today. Ing-Jye, John thank you guys. And again that email for any further questions and further agenda topics it's ruralhealthodf@cms.hhs.gov. And we appreciate your time today and have a great day to everyone.

Coordinator: Conference has now concluded. Again thank you everyone for your participation. Please go ahead and disconnect. Thank you so much.

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