Centers for Medicare & Medicaid Services

Open Door Forum: Rural Health

August 10, 2021

2:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen-only mode. During today's Q&A session, if you'd like to ask a question please press star then 1. Today's call is also being recorded. If you have any objections you may disconnect at this time. I would now like to turn today's meeting over to your host, Miss Jill Darling. Thank you. You may begin.

Jill Darling: Great. Thanks (Cedric). Good morning and good afternoon everyone and welcome to today's Rural Health Open Door Forum. I hope you were able to join last week's and this is a continuation to discuss more of the final rules that have come out recently.

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 have any inquiries please contact CMS at press@cms.hhs.gov. And I will hand the call off to John Hammarlund.

John Hammarlund: Thanks so much Jill. Hi everybody and welcome back. As we stated last week at the August 5th Open Door Forum, we have so many things we need to cover that we needed to have two open door forum calls in a row. We are delighted to have you back.

And you will see that today's call has yet another robust agenda. We're delighted to have so many of our colleagues from our headquarters on the phone today to educate you about some critical policies you need to know about.

We're also delighted to have some of our regional rural health coordinators on the line as well. As you know, they are your 'speed dial' contacts you should be reaching out to you if you've got questions of CMS. Your local rural health coordinator can help find the answers for you.

I also want to remind you that, while we are very happy to build the agendas based on the information we believe that you're probably interested in hearing, we're equally as interested in having you help us build the agendas.

So, as always, I extend a warm invitation to you to let us know what sort of things you would like to hear from CMS in the future. And at the end of today's call, Jill Darling will give you the address where you could send in agenda items and we definitely encourage you to do so.

So without any further ado -- to make sure we get through today's ambitious agenda -- I'll hand it back over to Jill. Thanks again for joining us today.

Jill Darling: Thank you John. First, we have (Jessica Adiyiah) who will go over the fiscal year 2022 hospice final rule for payment.

(Jessica Adiyiah): Thank you Jill. Good afternoon and good morning to callers on the West Coast. My name is Jessica Adiyiah and I'm a Policy Analyst for the Division of Home Health and Hospice under the Center of Medicare.

For today I'll provide you an overview of what we finalized under the payment section for the fiscal year 2022 hospice final rule. For this rule we updated the labor share for the four levels of care to reflect the 2018 Medicare cost report data for freestanding hospices.

For the final fiscal year 2022, labor shares are 56% for routine home care, also known as RHC, 75.2% for continuous home care, also known as CHC, 61.0% percent for inpatient respite care, also known as IRC, and lastly, 63.5% for general inpatient care, also known as GIP.

We also updated the hospice wage index and payment rates, so here are the updated payment rates for the four levels of care starting with RHC. From Day 1, today 60, it will be $203.40 and then from 61 days or more it will be 160 days or, sorry, $160.74.

For CHC it is $1462.52 and then for GIP it's $473.75. And lastly, IRC - it's $1068.28. In addition, we updated the hospice cap amount. The hospice cap amount for the fiscal year 2022 cap year will be $31,297.61, which is equal to the fiscal year 2021 cap amount updated by the fiscal year 2022 hospice payment update percentage of 2%.

Lastly, we finalized several regulation text changes to certain aspects of the hospice addenda. To read the full hospice final rule please Google CMS-1754-F and the full rule itself will come up.

If you have any general questions regarding the hospice policy, please feel free to contact us at hospicepolicy@cms.hhs.gov. Thank you for calling in today and I will pass this back to Jill.

Jill Darling: Thank you (Jessica). Next, we have (Nicholas Brock) who will go over the fiscal year 2022 inpatient psychiatric facility PPS final rule.

(Nicolas Brock): Thanks Jill. Good afternoon and good morning everybody. My name is (Nicolas Brock) and I'm going to walk through the payment policy updates for the fiscal year 2022 inpatient psychiatric facilities prospective payment system final rule.

These updates will begin on October 1, 2021 and the final rule went on display July 29 and was published on August the 4th. The inpatient psychiatric facilities prospective payment system, or IPF PPS, pays a per diem rate for furnishing inpatient hospital and psychiatric services to patients of inpatient psychiatric facilities or IPF.

IPFs include Medicare-participating psychiatric hospitals and certified psychiatric units and acute care hospitals and critical access hospitals. For fiscal year 2022 we finalized annual payment policy updates. We finalized an update to our teaching policy and we published an updated impact analysis.

The finalized annual payment updates include updating the IPF PPS payment rates for FY 2022 by 2.0%, which is based on a final IPF market basket update of 2.7% minus a statutorily required 0.7% adjustment for multifactor productivity.

We also updated the IPF wage index values to reflect the hospital inpatient wage index without reclassifications. We updated the outlier threshold to maintain estimated outlier payments at 2% of total payments, decreased the labor-related share from 77.3% to 77.2% and updated the cost of living adjustment factors for IPFs located in Alaska and Hawaii.

In addition to the annual updates, we finalized for FY 2022 and for subsequent years to adopt conforming changes to the IPF teaching policy with respect to IPF hospital closures and displaced residents to align the IPF teaching policy with changes that were finalized for inpatient acute care hospitals for FY 2021.

These changes include clarifying which residents are considered displaced when an IPF hospital closes and the timeline when residents actually become displaced, as well as clarifying how to count FTEs of displaced residents and who is responsible for assigning the number of FTEs per resident, and limiting the amount of personally identifiable information that's required in submission letters to the Medicare administrative contractor when requesting a temporary increase to the IPF's resident cap.

Lastly, the FY 2022 IPF PPS final rule includes an impact analysis. We estimate that the total impact of the changes in this final rule would be a net increase of approximately $80 million in payments to IPFs, which includes a 2.1% increase in payments to urban IPFs, and a 2.2% increase in payments to rural IPFs with a 2.1% increase in overall payments. Now I'll turn it back to Jill to continue the agenda. Thank you.

Jill Darling: Thank you (Nick). Next, we have Catherine Cooksey who will go over the fiscal year 2022 inpatient rehabilitation facility PPS final rule.

Catherine Cooksey: Thank you Jill. I will be giving a quick overview covering the payment portion of the IRF final rule. On July 29, 2021 CMS issued a final rule that will update Medicare payment policies and rates for facilities under the inpatient rehabilitation facility prospective payment system and finalize policies under the IRF Quality Reporting Program for fiscal year 2022.

For FY 2022 CMS is updating the IRF PPS payment rates by 1.9% based on the IRF specific market basket estimate of 2.6%. That's a .7 percentage point productivity adjustment.

In addition, the final rule contains an adjustment to outlier threshold to maintain outlier payments of 3% of total payments. This adjustment will result in a .4 percentage point decrease in outlier payments.

We estimate that overall IRF payments for fiscal year 2022 would increase by 1.5% or $130 million relative to payments in fiscal year 2021. Thank you. I will now turn it back to Jill to continue the agenda.

Jill Darling: Thank you. And next, we have Ariel Adams who will go over the IRF Quality Reporting Program updates.

Ariel Adams: Thank you Jill. So for the IRF QRP this year CMS is adapting one new measure, updating the denominator of one existing measure, and updating the public reporting of quality measures.

CMS is adopting the COVID-19 vaccination coverage among healthcare personnel measure in the ongoing effort to address the COVID-19 public health emergency.

This measure is designed to help assess whether IRFs are taking steps to limit the spread of COVID-19 among their healthcare personnel, reduce the risk of transmission within their facilities and help sustain the ability of IRFs to continue serving communities through the PHE and beyond.

Public reporting of the COVID-19 vaccination coverage among healthcare personnel measure will begin with the September 2022 Care Compare refresh,

or as soon as technically feasible based on data collected for Q4 2021 and that is October 1, 2021 through December 31, 2021.

CMS is updating the transfer of health information to the patient's post-acute care quality measure. Currently the measure denominators for both the TOH information to the patient PAC and to the provider PAC quality measures include patients discharged home under the care of an organized home health service organization or hospice.

In order to avoid counting these patients in both TOH measures, CMS is removing this location from the definition of the denominator for the TOH information to the patient PAC measure.

Finally, CMS is updating the public reporting of quality measures for IRFs using fewer than the standard number of quarters due to the COVID public health emergency exemptions.

In March of 2020, in response to the COVID-19 PHE, CMS granted an exception to the IRF QRP requirements for calendar year - for Q1 2020 and for Q2 2020. CMS also stated any IRF QRP data that might be significantly impacted in terms of measure portability and reliability by these exceptions would not be publicly reported for Q1 and Q2 of 2020 due to the absence of usable data these exceptions created.

For the excepted refreshes to the Care Compare Web site affected by the quarters, CMS will calculate IRF QRP measures using three quarters, Q3 2020 through Q1 2021, and data for assessment-based measures - for data for assessment-based measures and six quarters for claims-based measures. I will now hand it back over to you Jill. Thank you.

Jill Darling: Thank you Ariel. Next will be Ing-Jye Cheng who will go through the fiscal year 2022 skilled nursing facilities final rule.

Ing-Jye Cheng: Thank you Jill. On July 31, 2020, CMS issued another final rule that I will - I'll be telling you about, and we issued that rule for the fiscal year 2021 to update Medicare payment rates and the value-based purchasing program for skilled nursing facilities.

So the final rule includes routine technical rate-setting updates to the skilled nursing facility prospective payment system. We finalized updates that will increase aggregate Medicare payments to skilled nursing facilities by $750 million or 2.2% in 2021 compared to 2020.

This reflects the 2.2% market basket increase adjusted by productivity this year of 0. For labor market adjustments we also adopted the revised Office of Management and Budget statistical area delineations and applied a 5% cap on wage index decreases from 2020 to 2021.

Finally, in response to stakeholder feedback we also finalized changes to the International Classification of Diseases Version 10 code mappings effective October 1, 2020. Jill, back to you.

Jill Darling: Thanks Ing-Jye. Next will be Heidi Magladry who will go over the SNF Quality Reporting Program.

Heidi Magladry: Hi. Good morning and good afternoon. For the SNF Quality Reporting Program, in this final rule we adopted two new measures. We updated another measure for the SNF QRP and we made a modification to the public reporting of the SNF quality measures.

You'll notice several of my updates reflect proposals also that were present in the IRF Quality Reporting Programs. In our first proposal, CMS adopted a - new claims-based measures, the SNF healthcare-acquired infections, to this SNF QRP.

The SNF HAI measure uses Medicare fee-for-service claims data to estimate the rate of HAIs that are required during SNF care and result in hospitalization. Some of the HAIs identified in this measure include sepsis, urinary tract infection and pneumonia.

The goal of the measure is to be able to assess those SNFs that have a notably higher rate of healthcare-associated infections when compared to their peers and to the national average rate.

Implementation of this measure provides information about a facility's adeptness in infection prevention and management and encourages improved quality of care.

Similar to the IRF QRP, CMS adopted the COVID-19 vaccination coverage among healthcare personnel measure beginning with the fiscal year 2023 SNF QRP.

This measure will require SNFs to report on COVID-19 healthcare personnel vaccination of their staff in order to assess whether SNFs are taking steps to limit the spread of COVID-19 among their healthcare personnel, reduce the risk of transmissions within their facilities and help sustain the ability of SNFs to continue serving their communities throughout the COVID PHE and beyond.

SNFs must report the vaccination data through the Centers for Disease Control and Prevention National Healthcare Safety Network beginning October 1, 2021. The measure will be publicly reported on Care Compare beginning with the October 2022 refresh.

CMS updated the denominator of the transfer of health information to patient post-acute care quality measure. As noted earlier, in the past the measure denominators for both the TOH information to the patient pack measure and the TOH information to the provider pack measure includes the patients discharged under the care of a organized home health service organization or hospice.

Again in order to avoid counting the patient in both of the TOH measures, CMS is removing patients discharged home under the care of an organized home health service organization or hospice from the definition of the denominator for the TOH information to the patient pack measure.

Finally, again as noted in the IRF QRP presentation - public reporting of quality measures with fewer than standard number of quarters due to the COVID-19 public health emergency exemptions.

Again in March 2020, due to the COVID PHE, CMS granted an exception to the SNF QRP reporting requirements for Q - Quarter 1 2020 and Quarter 2 2020. CMS also again stated it would not publicly report any SNF QRP data that might be greatly impacted in terms of measure reportability and reliability by the exceptions from Quarter 1 and Quarter 2 of 2020 and the absence of usable data these exceptions created.

This exception affected the standard number of quarters that CMS currently uses to display the SNF QRP data. CMS updated the number of quarters used

for public reporting to account for this exception. And that is it for the SNF Quality Reporting Program. With that, I'll pass it off to my colleague, Tim Jackson.

Timothy Jackson: Thanks Heidi. My name is Tim Jackson and I will be briefly reviewing the Skilled Nursing Facility Value-Based Purchasing Program updates for the fiscal year 2022 rule.

So in brief, we had two items of note. The first was the measure suppression and special scoring policies for the program, and as finalized in the rule CMS will suppress the skilled nursing facility 30-day all-cause readmission measure for the program FY 2020 U because of - circumstances with the public health emergency for COVID-19 have significantly affected the measure and the ability to make fair national comparisons of SNFs' performance scores.

So as part of scoring for this FY 2020, CMS will assign a performance score of zero to all participating SNFs irrespective of how they performed using finalized scoring methodologies to mitigate the effect that the PHE impacted measure results would have otherwise had on performance scores and incentive multipliers.

CMS will reduce the otherwise applicable federal per diem rate for each SNF by 2% and award SNFs 60% of that withhold, resulting in a 1.2% payback percentage to those SNFs.

Additionally, SNFs that qualify for the low volume adjustment will continue to receive 100% of that 2% withhold. And our second item is the expansion of the SNFs Value-Based Purchasing Program.

We sought stakeholder input on the identified list of measures in the proposed rule and sought feedback on any other measures that we should consider, including measures to assess residents' views of their healthcare, measures assessing staff turnover, and we will take these comments into account in developing an expanded SNF Value-Based Purchasing measure stats, which will begin in FY 2024 as was provided under the Consolidated Appropriations Act. That concludes my portion and I'll be turning it over to I believe (Jim Mildenberger).

(Jim Mildenberger): Yes. Thank you very much. So yes, I'll be speaking today on the fiscal year 2022 IPPS and LTCH PPS final rule. This final rule is being issued in multiple parts.

I'll be speaking today on the payment updates that were included in the first part of the rule published on August 2. Our proposal's related to DSH payments, organ acquisition costs and the provisions of the Consolidated Appropriations Act related to GME and IME payments will all be addressed in forthcoming parts.

So the first topic I will be addressing is the payment updates for IPPS hospitals. In this rule we finalized our proposal to set IPPS payment rates for 2022 using data from prior to the COVID-19 PHE.

For 2022 ordinarily we would use data from 2020 to approximate the expected inpatient utilization in 2022. However, the 2020 data reflects changes in inpatient utilization driven by the COVID-19 PHE.

The vaccinations in the Medicare population coupled with the effectiveness of the vaccines leads us to believe that there will be significantly

lower risk of COVID-19 infection and fewer hospitalizations for COVID-19 in 2022 than occurred in 2020.

Therefore, we finalized our proposal to use 2019 data to approximate the expected inpatient hospital utilization when we determined rates for 2022. As for the rates, the increase in operating payment rates for IPPS hospitals that successfully participate in the hospital inpatient quality reporting program and are meaningful electronic health record users is approximately 2.5%.

This reflects the projected hospital market basket update of 2.7%, reduced by a 0.7 percentage point productivity adjustment and increased by a 0.5 percentage point adjustment required by legislation.

Before taking into account Medicare DSH and uncompensated care payments, the increase in hospital payments for fiscal year 2022 due to increases in the operating payment rates, capital and new medical technology payments and other changes is $3.7 billion or 3.1%.

We project Medicare DSH and uncompensated care payments to decrease in fiscal year 2022 by approximately $1.4 billion and overall, CMS estimates hospital payments will increase by $2.3 billion.

Under this final rule CMS will distribute roughly $7.2 billion in uncompensated care payment, a decrease of approximately $1.1 billion from fiscal year 2021. CMS will use a single year of data on uncompensated care costs from hospitals' fiscal year 2018 cost reports to distribute these funds.

CMS is continuing the policies adopted in previous rulemaking to address wage index disparities, including the low wage index hospital policy. Under this policy we increased the wage index for hospitals with a wage index value

below the 25th percentile wage index value by half the difference between the hospital's wage index value and the 25th percentile wage index value.

Another wage index policy included in this rule is the extension of the fiscal year 2021 wage index transition policy. In 2021, in conjunction with our adoption of the OMB delineations in the OMB Bulletin 1804, we adopted a policy to place a 5% cap for fiscal year 2021 on any decrease in the hospitals' wage index from 2020.

After consideration of public comment, we are applying an extended transition to this fiscal year 2022 wage index for IPPS hospitals. Specifically for IPPS hospitals that received the transition in fiscal year 2021, we are continuing a wage index transition for fiscal year 2022 under which a 5% cap on any decrease in the hospital's wage index compared to its wage index for fiscal year 2021 - will be applied to mitigate significant negative impacts of the CMS decision to adopt the revised OMB delineations in OMB Bulletin 1804.

The last topic I'll be discussing is the payment updates for long-term care hospitals. Similar to the IPPS we primarily used data from fiscal year 2019 to determine the LTCH rates for fiscal year 2022.

We applied a 1.9% annual update to the LTCH PPS standard federal payment rate. This is based on our current estimate of the FY 2022 LTCH market basket increase for inflation of 2.6% and a 0.7 percentage point adjustment for productivity.

We are estimating that overall LTCH PPS payments in fiscal year 2022 would increase by approximately 1.1% or $42 million. This estimated change reflects an estimated increase in payments to LTCH PPS standard federal

payment rate cases of approximately $31 million, and estimated increases in payments to LTCH site-neutral payment rate cases of approximately $11 million.

So that concludes my updates on the FY 2022 IPPS and LTCH PPS final rule and I will turn it back to Jill.

Jill Darling: Thanks (Jim) and thanks to all of our speakers today. (Cedric), will you please open the lines for Q&A? (Cedric), will you please open the lines for Q&A?

Coordinator: Sure. As a quick reminder if you'd like to ask a question please, press star then 1, remember that - to unmute your line and record your name clearly when prompted. If you'd like to withdraw that question you may press star 2. Again if you'd like to ask a question please press star then 1. One moment to see if we have any questions - currently showing no questions in queue at this time.

Jill Darling: Okay. Well, great. I guess everybody is up-to-date so that's wonderful. I just want to let everybody know again that if you do have suggestions for future topics for the Rural Health Open Door Forum, please send them into the email that is listed on the agenda, ruralhealthodf@cms.hhs.gov.

We'd love to hear from you. Any questions and comments - please send it that way and we will give you some time back to your day. So thank you to all of our speakers again and everyone have a great day.

Coordinator: Thank you and that concludes today's conference. You may all disconnect at this time.

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