Centers for Medicare & Medicaid Services
Rural Health Open Door Forum
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Jill Darling: Hi, everyone. Thank you for joining us for the Rural Health Open Door Forum. We will give it just another couple of minutes to let folks come in.

Recording in progress.

Jill Darling: Great. Thank you. Welcome, everyone. Good morning and good afternoon. I am Jill Darling in the CMS Office of Communications, and welcome to today's Rural Health Open Door Forum. Thank you for your patience in getting folks in. We do have a pretty packed agenda as you can see on the slide. Before we begin, 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 that was sent out.

If you are a member of the press, you may listen in, but please refrain from asking questions during the—during the Q&A portion of the webinar today. If you do have questions, please email press@cms.hhs.gov. All participants are muted, and for those who need closed captioning, we will provide a link for you that will be located in the chat function of the webinar.

So, we will be taking questions at the end of the agenda today. For today's webinar, you see the agenda slide, and then we will also provide a Helpful Links and Email slide for you during the Q&A as well. We will be using the raise hand feature at the bottom of your screen, and we will call on you to ask your question and one follow-up question, and we will do our best to get to your questions today.

One item I just wanted to mention, we will be mentioning the payment updates today for the Physician Fee Schedule (PFS). However, there will be a Physicians Open Door Forum next week, November 15. So now, I will hand the call off to Ing-Jye.

Ing-Jye Cheng: Hello, and it is my distinct pleasure today to introduce Jon Blum for some opening remarks for our Rural Open Door Forum. Jon currently serves as the Principal Deputy Administrator and Chief Operating Officer at CMS. In this dual role, Jon oversees CMS's program policy planning and implementation and also day-to-day operations for the entire agency. Jon has more than 25 years of public and private sector experience working in health care policy and administration. In addition to serving many roles at CMS, he has also worked as a Strategy and Management Consultant, an Executive Vice President of Medical Affairs at CareFirst Blue Cross Blue Shield, professional staff on the Senate Finance Committee, and also a Program Analyst at the Office of Budget and Management. So welcome, Jon, and thank you for taking the time today.

Jon Blum: Well, thank you very much, and thank you to the whole team here at CMS for putting together this program. I wanted to say just two or three points before turning it over to our team to walk through the various updates. First point would be that we are working harder than ever before to ensure that we are getting out throughout the country to spend time with health care providers, health care stakeholders, to really understand how CMS programs now are serving beneficiaries. We have gone to urban areas, but also to small rural areas and to frontier areas. We have heard—what we have learned—probably is no surprise to folks here on the phone today. First is, those who live in rural areas are—more often don't have health insurance coverage. They have a harder time getting access to care.

The second thing we have heard firsthand is health care providers are struggling more so than ever before. A challenge to find workers, challenge to keep certain service lines open. And so, we have been truly struck by the challenges and the—just the work ahead to ensure that all Medicare/Medicaid beneficiaries, all of those covered by CMS programs really have the same opportunity to get high-quality health care services. So that has led us through this team here to be much more intentional for how we build CMS plans and how we build CMS strategies. So we are going to work even harder to ensure that as we set policy, set payment rates, set the quality standards, for example, for how we regulate the health care industry, that it is going to be even more mindful of how we protect and how we respond to the challenges for those serving—those living in more rural parts of our country.

We have more work to do, and hopefully, as you will hear from today's presentations, that we are listening, that we are giving feedback to our policy teams, to really be a place that has deeper connection, deeper listening, but also deeper policy—policy focuses for how we respond. We have much more work to do, to be sure. We have much more traveling to do, to be sure. Next week, I travel to Washington State to really visit with some tribal communities but also some more rural communities, and that will continue going into next year to ensure that CMS truly gets it right.

With that, we will turn it over to our CMS teams. I can't thank them enough for their work, for their dedication, for their focus, and look forward to hearing their comments and to hear your questions. So with that, we will turn it back to Ing-Jye just to walk us through the agenda. Thank you for joining us here today.

Ing-Jye Cheng: Thank you, Jon. And we do have a lot to share with you today. So, I am going to turn into Emily Yoder to walk through the outpatient and the Ambulatory Surgical Center (ASC) rules. Emily?

Emily Yoder: Thank you, Ing-Jye. So I will start with the Calendar Year 2024 OPPS (Outpatient Prospective Payment System) payment updates. So, we are finalizing an increase to OPPS payments for hospitals and ASCs that meet the applicable quality reporting requirements of 3.1%. This update is based on the projected hospital market basket percentage increase of 3.3%, reduced by a 0.2 percentage point for the productivity adjustment.

With regards to rural mental health services, as a reminder, we finalized the creation of coding to describe mental health services furnished by hospital staff to beneficiaries in their homes through communication technology. For this year, we are finalizing technical changes to reflect additional information provided by interested parties regarding how these services are furnished, including the creation of a new untimed code describing group psychotherapy. These policies are intended to reduce administrative burden and increase access to behavioral health care.

Onto biosimilars. Current OPPS policy packages all drugs, including biosimilars that are below the packaging threshold. This year, for 2023, the packaging threshold is at $135. However, we believe that the packaging of biosimilars but not the reference products may create an incentive for providers to select the more expensive reference biologic or other separately paid biosimilars. For 2024, we are finalizing a policy to accept biosimilars from the OPPS threshold packaging policy when their reference biologicals are separately paid. And another packaging policy issue, this time for diagnostic radio pharmaceuticals. In this proposed rule, we solicited comments on how the OPPS packaging policy for diagnostic radio pharmaceuticals may have affected beneficiary access. We also solicited comment on five potential approaches for payment of diagnostic radio pharmaceuticals that would allow for enhanced beneficiary access while also maintaining the principles of the Outpatient Prospective Payment System. We received considerable interest in this comment solicitation, with commenters providing a wide variety of insights and potential policy changes, and we intend to further consider these points for future notice and common rulemaking.

Onto OPPS dental. For 2024, we are finalizing Medicare payment rates under the OPPS for over 240 dental codes to align with the dental payment provisions in the CY 2023 Physician Fee Schedule final rule. And we are implementing these by assigning these dental codes to clinical APCs (Ambulatory Payment Classifications). This will result in greater consistency in Medicare payment for different types of service for dental and help ensure patient access to dental services performed in the hospital outpatient setting when payment and coverage requirements are met.

Now, I will be turning to the ASC payment system. The annual update, as it is for the OPPS, is an increase of 3.1%, again, based on the projected hospital market basket percentage increase of 3.3% reduced by 0.2 percentage points for the productivity adjustment. In CY 2019, we finalized the policy to apply the productivity adjusted hospital market basket update to ASC payment system rates for an interim period of five years, from 2019 to 2023, during which time we would assess whether there was a migration in the performance of procedures from the hospital setting to the ASC setting. However, the impact of the COVID-19 PHE (Public Health Emergency) on health care utilization, especially for elective surgeries, was profound. Therefore, in this final rule, we are finalizing extending the five-year interim period an additional two years through Calendar Year 2025. This will enable us to gather additional claims data to more accurately analyze whether the application of the hospital market basket update to the ASC payment system has an effect on the migration of services from the hospital setting to the ASC setting.

I will now cover a couple of—first, opioid, and then, non-opioid—policies. So for CY 2024, we are continuing our current policy, implementing Section 6082 of the Support Act to provide for separate payment for non-opioid pain management drugs and biologicals that function as supplies in the ASC setting when those products are FDA (Food and Drug Administration)

approved, have an FDA approved indication for pain management or as an analgesic, and have a per-day cost above the OPPS drug packaging threshold. We are finalizing separate payment in the ASC setting for four non-opioid pain management drugs that function as surgical supplies, including certain local anesthetics and ocular drugs that meet those criteria. Section 4135 of the Consolidated Appropriations Act (CAA) of 2023 provides for temporary additional payments for non-opioid treatments for pain relief in both the OPPS and the ASC payment system. Addressing the opioid misuse epidemic and its impact on communities is a top priority for CMS, and we are committed to a comprehensive and multi-pronged strategy to combat this Public Health Emergency. As the additional payments are required to begin on January 1, 2025, we plan to include our proposals to implement Section 4135 amendment in the CY 2025 proposed rule.

Now, on to the CPL, or Covered Procedures List. In response to public comment, we are adding 11 additional surgical procedures to the ASC CPL, including total shoulder arthroplasty. We are also finalizing our proposal to add 26 separately payable dental surgical procedures to the ASC CPL and 78 ancillary dental services to the list of covered ancillary services. The full list of procedures included in this policy can be found in the CY 2024 ASC addendum, AA and BB.

Finally, payment for REHs (Rural Emergency Hospitals) that are IHS (Indian Health Service) facilities and a comment solicitation on the IHS All-Inclusive Rate (AIR). In this rule, we implemented a policy where IHS and tribal facilities that convert to the Rural Emergency Hospital provider type will be paid for hospital outpatient services under the same AIR, or All-Inclusive Rate, that would otherwise apply if these services were performed by an IHS or tribal hospital that is not an REH. CMS is also finalizing a policy where IHS and tribal facilities that convert to REHs would receive the REH monthly facility payment consistent with how this payment is applied to REHs that are not tribally or IHS operated.

We also sought comment on payment for high-cost drugs provided by IHS and tribal facilities. Under current regulations, IHS hospitals are excluded from payment under the OPPS and are instead, paid for the AIR for each encounter that provides outpatient services. We sought comment on whether Medicare should pay separately for high-cost drugs provided by IHS and tribal facilities and any additional payment approaches that would enhance our ability to provide equitable payment for high-cost drugs and services provided by these facilities. We received many comments supporting this, and while we are not finalizing any changes, we will consider the comments received for future rulemaking. And with that, I will turn it over to Marissa for PHP (Partial Hospitalization Program), IOP (Intensive Outpatient Program), and CMHC (Community Mental Health Center) policies.

Marissa Kellam: Thank you, Emily. I will be covering the PHP, IOP, and CMHC policies for the Calendar Year 2024 OPPS final rule. For this final rule, we are expanding access to the behavioral health care services under Medicare by establishing the intensive outpatient program payment in accordance with Section 4124 of the CAA of 2023. IOP is defined as a level of care that is more intensive than individual outpatient behavioral health services and less intensive than partial hospitalization, which is currently covered by Medicare. This final rule details the benefits, physician certification requirements, coding and billing, and payment rates under the IOP benefits.

We are finalizing a list of service codes to be included in IOP that has been and are paid for by Medicare, either as a part of the PHP benefits or under the OPPS in general. In addition, we are adding service codes to recognize activities related to care coordination and discharge planning as well as to recognize the role of caregivers and care support specialists. These finalized policies will allow these services to be furnished in hospital outpatient departments, Community Mental Health Centers, Federally Qualified Health Centers (FQHCs), and Rural Health Clinics (RHCs). For hospital-based outpatient departments and CMHCs, we are finalizing our proposal to establish two IOP and ambulatory classifications for each provider type, for days with three services per day and four or more services per day. We are also finalizing our proposal to establish consistent payment between PHP and IOP in each setting, which will align with a consistent set of services that we are recognizing under both benefits. We are also establishing PHP APCs (Ambulatory Payment Classifications) for days with three services per day and four or more services per day. As previously discussed, the CAA of 2023 added intensive outpatient services to be allowable services provided by CMHCs.

Now, we will talk about the changes to the CMHC's Conditions of Participation (CoP). In this rule, we are finalizing the proposed changes to the CMHC's Conditions of Participation to include IOP with one change to the practitioners who can lead the interdisciplinary team. Based on the comments received, we have modified the requirements of Section 485.916(a)(1), which is titled "Conditions of Participation: Treatment team, person-centered active treatment plan, and coordination of services." We specifically identified MFTs (Marriage and Family Therapists) and MHCs (Mental Health Counselors), which are Marriage and Family Therapists and Mental Health Counselor members, that may lead the CMHC interdisciplinary team. In addition, we are finalizing the requirements for Mental Health Counselor and adding the citation for Marriage and Family Therapists into the CoPs to reflect the requirements being finalized in the 2024 Physician Fee Schedule rule. Also, the finalized updates for MHCs and addition of MFTs to the CoPs are consistent with the payment requirements being finalized for these providers. I will now hand it over to Michele to discuss the payment of IOP and RHCs and FQHCs.

Michele Franklin: Thank you, Marissa. I will be going over the payment of IOP services and RHCs and FQHCs. In addition, I will cover some of the RHC and FQHC policies in the CY 2024 Physician Fee Schedule final rule. For CY 2024, CMS is finalizing performing regulatory text changes to applicable RHC and FQHC regulations related to the scope of IOP benefits and services, certification, and plan of care requirements and special payment rules for IOP services as mandated by Section 4124 of the Consolidated Appropriations Act of 2023.

The scope of IOP benefits and certifications and plan of care requirements will be the same for RHCs and FQHCs as in the hospital setting. Regarding payment of IOP in RHCs and FQHCs, CMS is finalizing payment for three IOP services per day, and according to the statute, payment is based on the hospital rate, not the RHC All-Inclusive Rate. That is, RHCs will be paid the three services per day payment amount for hospital outpatient departments. For FQHCs, payments will be the lesser of the FQHC's actual charges or the three services per day payment amount for hospital outpatient departments and not the FQHC PPS (Prospective Payment System). For grandfathered tribal FQHCs, payment will be the Medicare outpatient per visit rate as established by the IHS when furnishing IOP services, and payment is based on lesser of a grandfathered tribal FQHC's actual charges for the Medicare outpatient per visit rate.

I will now cover some of the CY 2024 Physician Fee Schedule final rule RHC and FQHC policies. In the Calendar Year 2024 PFS final rule, we have several policies in the RHC/FQHC space that focus on promoting access to behavioral health services and advancing health equity. As required by the CAA 2023, we are finalizing extending payment for telehealth services through December 31, 2024 and delaying the in-person requirements under Medicare for mental health visits until January 1, 2025. Regarding direct supervision requirements, we are finalizing adopting the definition of "immediately available" to include virtual presence through the use of real-time audio and visual interactive telecommunications through December 31, 2024. Also, as required by the CAA 2023, beginning January 1, 2024, Marriage and Family Therapists and Mental Health Counselors will be considered RHC and FQHC practitioners. In addition, we are changing the required level of supervision for behavioral health services furnished incident to a practitioner's services in RHCs and FQHCs to allow general supervision rather than direct supervision. I will now turn it over to my colleague, Lisa Parker, to go over the remaining CY 2024 RHC/FQHC final policies.

Lisa Parker: Thank you, Michele. We are also finalizing our proposal to refine our payment policy for general care management services. That is, expanding the ability for RHCs and FQHCs to bill HCPCS (Healthcare Common Procedure Coding System) code G0511, and receive a separate payment for furnishing remote physiologic monitoring, remote therapeutic monitoring, community health integration services, and principal illness navigation services. We are also finalizing our proposal to revise the methodology for calculating the payment rate for HCPCS code G0511 that takes into account how frequently the various services are utilized. Finally, we are clarifying that beneficiary consent for chronic care management and virtual communication services can be obtained under general supervision. I will now turn it over to Anita Bhatia to discuss the hospital ASC REH quality program updates.

Anita Bhatia: Thank you, Lisa. Good afternoon, everyone. There are three outpatient Quality Reporting Programs (QRPs) covered in the Calendar Year 2024 OPPS ASC final rule: the Hospital Outpatient, the Ambulatory Surgical Center, and the Rural Emergency Hospital Quality Reporting Programs, which collect and report on quality measured data to reflect the care rendered in their respective settings and to support consumer decision-making. For the Hospital Outpatient and ASC Quality Reporting Programs, we finalized four shared proposals, including three modifications to existing program measures and the adoption of one new measure for each program. Specifically, we finalized modifications to, first, a COVID-19 Vaccination Coverage Among Healthcare Personnel (HCP) measure to align with the Centers for Disease Control and Prevention's (CDC) definition of "up to date." Second, the Appropriate Follow-Up Interval for a Normal Colonoscopy in Average Risk Patients measure, to update the measure denominator from all patients aged 50 to 75 years, to aged 45-75 years. And third, the voluntary Cataracts: Improvement in Patient's Visual Functioning Within 90 Days Following Cataract Surgery measure, to limit survey collection instruments, all beginning with the Calendar Year 2024 reporting period. We also finalized the adoption of the Risk-Standardized Patient-Reported Outcomes Following Elective Primary Total Hip and Total Knee Arthroplasty measure with modification in response to commenter feedback in that the measure would have one additional year of voluntary reporting beginning with Calendar Year 2025 reporting and with mandatory reporting now beginning with Calendar Year 2028. Additionally, while we continue to believe

there is significant evidence linking volume to quality of care, after considering comments received, we did not finalize our proposals to adopt the Hospital Outpatient Department or ASC Facility Volume Data on Selected Outpatient or ASC Surgical Procedures measure so that we may assess the measure's methodology and reconsider how the data may be publicly displayed.

For the hospital outpatient Quality Reporting Program alone, in response to commenter feedback, we have finalized with modification—another long measure name—the adoption of the Excessive Radiation Dose or Inadequate Image Quality for Diagnostic Computed Tomography (CT) in Adults eCQM (electronic Clinical Quality Measure), so that it also includes an additional year of voluntary reporting so that voluntary reporting will begin with Calendar Year 2025 and mandatory reporting would now begin with Calendar Year 2027. Further, we finalized our proposal to publicly report both the overall rate and transfer of patients rate of the Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients measure. We are not finalizing our proposal to remove the Left Without Being Seen (LWBS) measure after considering the concerns raised by some commenters and to further investigate recent wait increases and measure values. Finally, we requested comment on the topic of patient safety and sepsis, behavioral health—including suicide prevention—and telehealth for this setting.

For the Rural Emergency Hospital Quality Reporting Program, we finalized the adoption of the first measures for this program. These four measures beginning with Calendar Year 2024 include three Medicare claims-based and one chart-abstracted measure. The claims-based measures are the Abdomen Computed Tomography Use of Contrast Material measure, the Facility Seven Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy measure, and the Risk-Standardized Hospital Visits Within Seven Days After Hospital Outpatient Surgery measure. The chart-abstracted measure is one that we mentioned above—the Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients measure, which we finalized to be displayed for all four strata data, for which data are collected.

In addition, we finalized the adoption and codification of a set of standard quality program policies as proposed. However, in response to commenter feedback, we modified our immediate measure removal policy to replace the word "removal" with "suspension" such that a quality measure considered by CMS to have potential patient safety concerns will be immediately suspended from the program and then addressed in the next appropriate rulemaking cycle. And finally, we requested comments on the use of eCQMs care coordination measures and a tiered approach for the collection of measures for this program. I will now pass the proceedings to the next speaker, Jason Zizzo.

Jason Zizzo: Thank you. In the proposed rule, CMS put forth a request for comment regarding separate payment under the Inpatient Prospective Payment System (IPPS) for establishing and maintaining access to a buffer stock of one or more of 86 essential medicines to foster a more reliable, resilient supply of these medicines. CMS received many thoughtful comments on this request for comment, and we appreciate the broad consensus among the commenters regarding the need to curtail shortages of essential medicines. While we are not adopting a policy regarding payment for buffer stocks of essential medicines in this final rule, we do look forward to

continuing to engage with the public on this critical issue in future rulemaking. I will now pass it on to Kelly.

Kelly Vontran: Hi, good afternoon, everyone. I will be providing an overview of the finalized payment provisions in the Calendar Year 2024 Home Health Prospective Payment System Final Rule, which was issued on November 1, 2023. This will include routine updates to the Medicare home health payment rates for the calendar year 2024 in accordance with existing statutory and regulatory requirements. Additionally, this rule finalizes a permanent payment adjustment to the calendar year 2024 Home Health 30-day payment rate as a result of the difference between assumed behavior changes and actual behavior changes due to the implementation of the Patient-Driven Groupings Model, or what we call the PDGM, and 30-day unit of payment as required by the Bipartisan Budget Act of 2018. As you may know, on January 1, 2020, CMS implemented the Home Health PDGM and a 30-day unit of payment as required by law. The PDGM better aligns payments with patient care needs, especially for clinically complex beneficiaries. The law required CMS to make assumptions about behavior changes that could occur because of the implementation of the 30-day unit of payment and the PDGM, so CMS finalized three behavior assumptions in the calendar year 2019 Home Health Final Rule related to clinical group coding, comorbidity coding, and the low utilization payment adjustment threshold.

The law also requires CMS to annually determine the impact of differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures beginning with 2020 and ending with 2026 and to make temporary and permanent increases or decreases as needed to the 30-day payment amount to make sure that payments under the new case mix system are equivalent to what CMS would have paid under the previous case mix system. CMS has stated that we interpret actual behavior changes to a compass, both behavioral changes that were previously finalized and other behavioral changes not identified at the time the calendar year 2020 30-day payment rate was calculated. In the Calendar Year 2023 Home Health Final Rule, CMS finalized the methodology for analyzing the differences between assumed versus actual behavior changes on estimated aggregate expenditures. Based on an analysis of claims data at the time of the 2023 rulemaking, CMS determined a permanent adjustment was needed and finalized implementing a 3.92% reduction to the payment rate, which represented half of the permanent adjustment estimated at that time, or negative 7.85%.

For the Calendar Year 2024 Home Health Final Rule using updated Calendar Year 2022 claims and the methodology finalized in Calendar Year 2023, CMS determined that Medicare paid more under the new system than it would have under the old system. As such, CMS finalized a permanent adjustment percentage of negative 2.89% in Calendar Year 2024 to address the differences in the aggregate expenditures, which is half of the estimated permanent adjustment of negative 5.779%. This halving of the permanent adjustment is in response to commenter concerns about the magnitude of the single-year significant payment reduction. However, CMS will have to account for the remaining permanent adjustment not applied in Calendar Year 2024 and other potential adjustments needed to the base payment rate to account for behavior change based on analysis at the time of future rulemaking. While the law also requires CMS to apply temporary payment adjustments to offset any over or under payments, the law will also provide CMS discretion to make any future permanent or temporary adjustments in a time or manner determined appropriate through analysis of estimated aggregate expenditures for calendar year

2026. While the proposed rule calculated the total temporary adjustment, which was approximately $3.5 billion, CMS did not propose any temporary adjustment for calendar year 2024.

The next finalized policies relate to the rebasing and revising of the Home Health Market Basket. Since the Home Health Prospective Payment System was implemented, the market basket used to update home health payments has been rebased and revised to reflect more recent data on home health cost structures. For calendar year 2024, CMS will adopt a 2021 based home health market basket which includes finalized changes to the market basket cost weights and price proxies. As a result of the rebasing and revising of the home health market basket, the Calendar Year 2024 labor-related share is 74.9%, which is based on the 2021 based home health market basket compensation cost weight. Currently, the labor-related share is 76.1%. Additionally, we are implementing the revised labor-related share in a budget-neutral manner.

Next are the finalized policies for disposable negative pressure wound therapy. In accordance with the law, CMS is finalizing its proposal to codify statutory requirements for negative pressure wound therapy using a disposable device for patients under a home health plan of care. Beginning January 1, 2024, there will be a separate payment for the device only. Payment for the services to apply the device is to be included in the 30-day payment under the Home Health Prospective Payment System. CMS also finalized changes that allow home health agencies to now report the disposable device on the type of home health plan most familiar to home health agencies. The next finalized payment policy is recalibration of the PDGM case mix weights. It is CMS's policy to annually recalibrate the case mix weights and loop the thresholds using the most complete utilization data available at the time of rulemaking. Therefore, CMS is finalizing its proposal to recalibrate the case mix weights using Calendar Year 2022 data to more accurately pay for the types of patients home health agencies serve. CMS estimates that Medicare payments to home health agencies in Calendar Year 2024 will increase in the aggregate by 0.8% or $140 million compared to 2023. This increase reflects the effects of the 3% home health payment update percentage and estimated 2.6% decrease that reflects the net effects of the finalized prospective permanent behavior assumption adjustment and an estimated 0.4% increase that reflects the effects of an updated fixed dollar loss ratio used in determining outlier payments.

Finally, as required by law, CMS is finalizing regulations to implement permanent coverage and payment for items and services related to the administration of home intravenous immune globulin (IVIG) in a patient's home for a patient with a diagnosis of primary immune deficiency disease. Currently, Medicare pays for the IVIG product using the average sales price methodology, and the items and services needed for the in-home administration of IVIG are paid under a Medicare demonstration program. This demonstration will end on December 31, 2023. However, these finalized policies will provide permanent coverage of payment for the items and services needed for the in-home administration of IVIG beginning on January 1, 2024. I will turn the call over now to Marcie O'Reilly.

Marcie O'Reilly: Thanks Kelly. Good day, I am Marcie O'Reilly, the Coordinator for the Expanded Home Health Value-Based Purchasing Model (HHVBP). I am joining you today to provide some updates and reminders related to the HHVBP Model. We have finalized updates to

some model policies in the Calendar Year 2024 Home Health PPS Final Rule. Those updates effective for Calendar Year 2024 include the codification of the previously finalized measure removal factors and an additional opportunity to request a reconsideration of the annual total performance score and payment adjustment included in the Annual Performance Report. Updates effective for the Calendar Year 2025 include replacing the two Total Normalized Composite measures for self-care mobility with the Discharge Function Score (DC Function) measure effective January 1, 2025. Replacing the OASIS-based (Outcome and Assessment Information Set) Discharged to Community, or DTC, measure with the claims-based Discharge to Community-Post Acute Care (DTC–PAC) measure for home health agencies also effective January 1, 2025. And replacing the claims-based Acute Care Hospitalization (ACH) during the first 60 days of home health use in the emergency department use without hospitalization during the first 60 days of home health measures with the claims-based Potentially Preventable Hospitalization (PPH) measure, and again, effective January 1, 2025.

We are also changing the weights of individual measures due to the change in the total number of measures included in the model. And beginning with the performance year 2025, we are updating the model baseline year to the Calendar Year 2023 for all applicable measures in the finalized measure set except for the two-year Discharge to Community PAC (Post-Acute Care) measure, which would be the Calendar Year 2022 and Calendar Year 2023 for baselines. Details about these policy updates will be presented during our next HHVBP-specific webinar entitled Expanded HHVBP Model Preparing for Calendar Years ‘24 and '25. This is scheduled for 2:00 to 3:00 p.m. Eastern Time tomorrow, November 9, and I have added the registration link to the chat for those who may not have registered yet. Additionally, I would like to remind home health agencies that the October Interim Performance Report, or IPR, was published in iQIES (Internet Quality Improvement & Evaluation System) on October 26. The IPRs use the most current 12 months as of data, and we encourage the many HHAs that have not yet accessed their October report to do so and for all HHAs to access each quarterly report as they are released. Please note that the recalculation request submission period for the October IPR ends this Friday, November 10. To help HHAs better understand this report, we hosted a webinar on July 27 providing an overview of the data and information available in the IPR. If you missed the webinar, you may access the slides recording and questions and answers on the model's webpage. And I would like to draw your attention to a new podcast series: HHAs Perspectives. The first is on quality, and the second one is on innovation. A panel of home health agencies share what they are doing at their agencies to improve quality and incorporate innovations to be successful under the HHVBP model. I will point out that two of the HHAs serve rural communities in Pennsylvania and Texas, so you might know them, and you can find these podcasts on the model’s webpage.

Finally, if you are not receiving emails from CMS about the expanded HHVBP model, go to our webpage and join our listserv. The link is near the bottom of the webpage, but I will add the webpage URL to the chat here in just a second. Thank you and have a great rest of your day. I will now hand it over to my colleague, Joan Proctor, to discuss the Home Health Quality Reporting Program (HHQRP).

Joan Proctor: Hi, thanks Marcie. Good afternoon, everyone. I have the following rulemaking updates relative to the Home Health Quality Reporting Program. As announced earlier, the Calendar Year 2024 Home Health Prospective Payment System Final Rule was published on

November 1, 2023. The following Home Health Quality Reporting Programs have been finalized. CMS finalized the addition of two quality measures to the HHQRP. The COVID-19 Vaccine Percent of Patients and Residents Who Are Up-to-Date, and the Discharge Function measure.

We also finalized the removal of two OASIS-based data elements. The M0110 episode timing and M2200, which was Therapy Needed. We also finalized the codification of a 90% OASIS data completion threshold policy in federal regulations. In the final rule, we also finalize the public reporting of four measures. Those measures are the Transfer of Health Information to the Provider Post-Acute Care, the Transfer of Health Information to the Patient Post-Acute Care, the Home Health Quality Reporting COVID-19 Vaccine Percent of Patients Who Are Up-to-Date, and the Discharge Function measure.

Lastly, CMS, here at CMS, we summarized feedback that we received on our Request for Information on future HHQRP measure concepts and an update on health equity in the HHQRP. That's it for the Home Health Quality Reporting Program. I am going to turn it over now to Nick and Abby for the ESRD (End Stage Renal Disease) payment.

Nick Brock: Thank you, Joan. I will talk about three key issues from the Calendar Year 2024 ESRD PPS Final Rule (End Stage Renal Disease Prospective Payment System). The first is the CY 2024 ESRD PPS and AKI (Acute Kidney Injury) payment rate updates. For CY 2024, we are increasing the ESRD PPS base rate to $271.02, which will increase total payments to ESRD facilities by approximately 2.1% overall. We estimate that for hospital-based ESRD facilities, total payments will increase by approximately 3.1%. For freestanding facilities, we project an increase in total payments of 2%. In addition, we are updating the wage index for CY 2024 using data from the FY 2024 Hospital Wage Index. We are finalizing routine updates to the outlier fixed-dollar loss threshold and Medicare allowable payment amounts to target ESRD PPS outlier payments by 1% of total payments in CY 2024. Lastly, we are updating the acute kidney injury or AKI dialysis payment rate for CY 2024 to the same rate as the CY 2024 ESRD PPS base rate and applying the CY 2024 wage index. Again, the final 2024 payment rate is $271.02.

Next, I will talk about the Low-Volume Payment Adjustment, the LVPA, which is a 23.9% payment adjustment for ESRD facilities that furnish less than 4,000 treatments annually. For 2024, we are creating an exception to the current LVPA attestation process for ESRD facilities that are affected by disasters and other emergencies. Specifically, we are establishing an exception process that will allow ESRD facilities to close temporarily and reopen in response to a disaster or other emergency and still receive the LVPA. Additionally, we will allow a facility to continue to receive the LVPA even if it exceeds that 4,000 treatment threshold if its treatment counts increase due to treating additional patients that are displaced by a disaster or emergency. We also, in the proposed rule for CY 2024, solicited comments on potential changes to the LVPA methodology, including the possible creation of a new payment adjustment that accounts for isolation, rurality, and other geographic factors. We received many comments in response to those Requests for Information, and we will take these into consideration to potentially inform future rulemaking.

Lastly, the third issue I will talk about here are two new reporting requirements that we are finalizing for the ESRD PPS, both of which are effective January 1, 2025. First, is the reporting requirement for time on machine data. We proposed to require ESRD facilities to report on ESRD PPS claims the time on machine, which is the amount of time in minutes the beneficiary spends receiving in-center hemodialysis treatment. We are finalizing this requirement effective January 1, 2025. As discussed in the final rule, CMS will use this time on machine data to more precisely estimate dialysis treatment costs for the purpose of considering future refinements to the ESRD PPS adjustment factors. Second, we are finalizing our proposed reporting policy for discarded amounts of renal dialysis drugs and biological products paid for under the ESRD PPS. We are finalizing our proposal requiring that ESRD facilities must report information on ESRD PPS claims by the total number of billing units of any discarded amount of a renal dialysis drug or biological product from a single dose container or single-use package that is paid for under the ESRD PPS. Facilities will report this amount using the JW modifier. We will require that ESRD facilities must report the JZ modifier on ESRD PPS claims when billing for any drug or biological product from a single dose container or single use package for which there is no discarded amount. We proposed to apply these requirements beginning in 2024, but in response to the comments we received on this proposal, we are delaying the effective date of the reporting requirements until January 1, 2025. Now, I will pass it over to Carmen Irwin to discuss the hospital price transparency policies.

Carmen Irwin: Thank you, Nick. Good afternoon, everybody. I will provide an update on HPT, or Hospital Price Transparency, policies. Just as a background, Section 2718(c) of the Public Health Service Act requires hospitals to make public the standard charges the hospital has established. Consistent with the law, the regulation instructs the secretary to tell hospitals how to make public the standard charges the hospital has established. As a result, the hospital price transparency regulation requires hospitals to make their standard charges public in two ways. First, as a single machine-readable file that displays five types of standard charges, including payer-specific negotiated charges the hospital has established for the items in services provided by the hospital. And second, as a consumer-friendly display of some standard charges for 300 shoppable services. Hospitals may meet the second consumer-friendly display requirement by offering an online price estimator tool.

CMS’s hospital price transparency regulations laid the foundation for a patient-driven health care system by making hospital standard charges data available to the public in support President Biden's Executive Order on promoting competition. To strengthen hospital compliance and improve the public's understanding and automated use of hospital standard charge information, CMS is finalizing modifications to the machine-readable file display requirements and enforcement policies. Specifically, CMS is finalizing the following. Each hospital must make a good faith effort to ensure that the standard charge information encoded in the machine-readable file is true, accurate, and complete as of the date indicated in the machine-readable file. And to facilitate automated access to machine-readable files, hospitals must ensure that the public website it selects to host its machine-readable file establishes and maintains informed and manner specified by CMS a txt file in a root folder that includes the hospital's name and the source page URL that hosts the machine-readable file and a link in the footer on its website that links directly to the publicly available webpage that hosts the link for the machine-readable file. Beginning July 1, 2024, the hospital's machine-readable file must conform to a CMS template

layout, data specification, and data dictionary for purposes of making public standard charge information as applicable, including the following: A statement affirming that to the best of its knowledge and belief, the hospital has included all applicable required standard charge information, and that the information encoded is true, accurate, and complete as the date indicated in the machine-readable file. General information about the hospital in the machine-readable file, each type of standardized charge, including payer-specific negotiated charges by payer and plan or payer-specific negotiated charges, the hospital must include the method used to establish the standard charge and whether the payer-specific negotiated charge should be interpreted by users of the file as a dollar amount, percentage, or algorithm. If the hospital has established a standard charge as a dollar amount or algorithm, the hospital must calculate and display an estimated allowed amount in dollars. Also, information about the item or service that corresponds to the standard charge established by the hospital, including billing and coding information.

CMS is also finalizing policies to improve and streamline its enforcement capability. These include additional methods that CMS may use to assess hospital compliance, requiring that hospitals acknowledge receipt of a warning notice, the ability to notify health system leadership when CMS determines one or more of the system's hospitals are out of compliance. CMS is also finalizing an increase in the transparency of its enforcement activities and processes by making public on a CMS website information related to CMS's assessment of a hospital's compliance, any compliance action taken against the hospital, the status of such compliance action, and the outcome of such compliance action and notification sent to the health system leadership. Finally, because disclosure of hospital standard charges is necessary but not sufficient for individuals to obtain a personalized cost estimate in advance of receiving a health care item or service, and because the consumer-friendly requirements under hospital price transparency were established before additional price transparency regulations and authority such as transparency in coverage and the No Surprises Act have allowed for more comprehensive and specific consumer-friendly pricing information for patients. CMS sought to comment on the future evolution of the hospital price transparency requirements. We appreciate the comments received, and we intend to take them into consideration in future rulemaking. With that, I will hand it back to Jill.

Jill Darling: Thanks. Thank you to everyone today. I know we are pretty much out of time. We will probably see if we can take one or two questions. Please use the raise hand feature, and if we aren't able to get to your questions today, I did send the Rural Health ODF email in the chat. I will do it again.

Moderator: Nathan should be unmuted.

Nathan Baugh: Hi, hello, thank you guys. My name is Nathan Baugh. I am with the National Association of Rural Health Clinics. My question is, is CMS planning to release guidance regarding the expanded G0511 care management codes before 2024?

Lisa Parker: Hi, this is Lisa Parker. We do plan to release guidance. I am not sure it will be before 2024. If you have any questions, please feel free to send your questions to the RHC or FQHC mailbox regarding G0511.

Nathan Baugh: Okay, thank you.

Jill Darling: Okay, we will take one more question. All right, I'm not seeing any, so we can conclude today's call. I know there was a lot of great information. Here are the helpful emails and links listed. If it is helpful, you can take a screenshot. Let me put the Rural Health ODF email in the chat for everyone if you think of a question afterwards. Again, we appreciate your time, and this concludes today's call. Thanks, everyone.