Centers for Medicare & Medicaid Services
Rural Health Open Door Forum
Moderator: Jill Darling
November 19, 2020
2:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all parties are in a listen-only mode until the question-and-answer segment at the end of today's conference, at which time you may press Star 1 on your touchtone phone, to ask a question.

I would also like to inform all parties that today's conference is being recorded. If you do have any objections please disconnect at this time.

I would now like to go ahead and turn today's conference to Ms. Jill Darling. Ma'am, you may begin.

Jill Darling: Great. Thank you, (Jacqueline).

Good morning and good afternoon everyone. I'm Jill Darling in the CMS Office of Communications and welcome to today's Rural Health Open Door Forum.

Before we 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 will now hand the call off to our co-Chair, John Hammarlund.

John Hammarlund: Great. Thanks very much, Jill.

Well hello everyone. Welcome to our Rural Health Open Door Forum call. And Happy Rural Health Day.

This is John Hammarlund, the Deputy Director of CMS's Office of Program Operations and Local Engagement. And Carol Blackford and I are delighted to have all of you with us today.

We have a rich agenda of important and timely information to share with you. This call is even more special today, because we're going to be joined shortly by the CMS Administrator, Seema Verma.

We're delighted to have her on this call. She has been detained slightly with another meeting and will join us shortly.

So I'm going to hand it back over to Jill. We'll launch into the agenda and then break in when the Administrator has been able to join us.

So Jill, back to you.

Jill Darling: Thanks, John. So first, we'll have Darci Graves who will go over some National Rural Health Day events.

Darci Graves: Thank you so much, Jill. And good morning and good afternoon everyone.

And as John noted, possibly most importantly, Happy National Rural Health Day. My name is Darci Graves and I sit in the CMS Office of Minority Health where I also have the pleasure of serving as the co-Chair for the CMS Rural Health Council with John.

And I'm going to share some updates regarding National Rural Health Day with you. But first, I would like to take a moment and introduce a new member to our team, Dr. LaShawn McIver. She has joined CMS as the new Director of the CMS Office of Minority Health.

Dr. McIver, would you like to introduce yourself?

Dr. LaShawn McIver: Thank you, Darci. Good afternoon and good morning to everyone. I'm so delighted to have a few moments to be a part of this important convening today, in recognition of Rural Health Day.

As Darci said, my name is Dr. LaShawn McIver and I've recently joined CMS as the newest Director of OMH, in August.

I'm a physician and I've worked in public health for the last 14 years, focusing on many issues affecting minority communities and other vulnerable populations. Most recently, I led the Government Affairs and Advocacy work for the American Diabetes Association, overseeing their federal, state, grass roots and legal advocacy on behalf of the 34 million Americans living with diabetes and the 88 million living with pre-diabetes.

Given the higher prevalence of diabetes in rural communities, I have the opportunity to advocate for solutions to address barriers experienced by many people living with diabetes and the healthcare teams providing their care. I know firsthand realities faced in many rural communities, having grown up on a farm in North Carolina and currently residing in a rural community in Pennsylvania. So I'm very excited to continue working on rural health in my new role as the CMS OMH Director.

In addition to today being the 10th anniversary of Rural Health Day, this year CMS OMH celebrated its 10th anniversary. And over this time our office has reached some significant milestones as we've worked to establish initiatives and programs like from coverage to care, connected care, health equity technical assistance programs, the mapping Medicare disparities tool.

Having launched our equity plan for Medicare many of the stratified reports and data highlights that we've produced, as well as of course the focus on rural health, social determinants of health and accessibility. I am truly honored to be stepping into this role at CMS, leading the agency into the next decade of health equity.

As we are currently continuing to face the challenges of the current public health emergency it is more evident with each passing day that minority and vulnerable populations are experiencing significant challenges and the impact of health disparities are at the forefront in healthcare as we're tackling this crisis.

I am looking forward to working alongside many of you as we continue to make rural health a priority. I am currently working to create our office's next multiyear strategic plan. And we're working to refresh our health equity plan which we intend to extend beyond Medicare.

For me it is critically important that CMS accelerate its work to eliminate health disparities in our priority populations. And that as an agency, we continue to fully leverage all the tools, resources and partnerships we have, to ensure we achieve the mission of the Office of Minority Health.

So thank you for this opportunity to share some remarks and to introduce myself to you all. And I look forward to hearing more about the great work that's being done in rural communities today.

So with that, I'll turn it back over to Darci. Thank you.

Darci Graves: Thank you so much, Dr. McIver. National Rural Health Day provides an opportunity for CMS to recognize our partners who provide quality care to nearly one in five Americans who reside in rural communities. And every year around National Rural Health Day as we work to release and update a number of resources that focused on our patients and providers that live and work in these rural communities.

Earlier this month we updated our annual Rural Urban Disparities in Healthcare and Medicare report, which compares the quality of care given to urban and rural Medicare beneficiaries. This report shows how differences in qualities vary across - vary according to race and ethnicity as well as geography.

We have also continued to update our Rural Crosswalk, CMS flexibilities to fight COVID-19, which examines the COVID-19 related provisions that CMS has issued, that impact rural healthcare facilities and how these provisions affect providers. We recently released a new data highlight on understanding rural hospital bypass among Medicare Fee for Service beneficiaries, which allows us to learn more about where residents of rural communities are going to fulfill their healthcare needs.

Very exciting. Just yesterday, we released our FY 2020 Rethinking Rural Health Annual Report, which outlines numerous activities and accomplishments. It underscores and represents CMS's commitment to the

development and implementation of programs and policies through a rural lens.

These resources and more, are located on our rural health page which is Go.CMS.gov/RuralHealth.

We also recently launched a new rural health listserv which will complement the rural ODS health ODS listserv. And you can sign up for that by going to our website and clicking on the Contact Us tab and signing up for the rural health list.

Thank you again, for your continued support of this - such an important community. And we look forward to our continued collaboration.

And with that, I will turn things back over to Jill. Thank you.

John Hammarlund: Thanks, Darci. Actually this is John Hammarlund and I'll take it from here. Thanks so much.

We are now delighted to be joined by CMS Administrator Seema Verma, and it's my pleasure to introduce her. A nationally recognized leader in health policy and operational design, Administrator Verma nominated by the President in November 2016, has led CMS since March of 2017, overseeing a $1 trillion and administering healthcare programs for more than 130 million Americans every day.

This year Administrator Verma has set a bold agenda to empower patients and transform the healthcare system to deliver better value and results for patients through competition and innovation.

CMS is focusing our efforts on 16 strategic initiatives across Medicare, Medicaid and exchanges, to move the healthcare delivery system toward value.

Administrator Verma was the major force behind the CMS rural health strategy and has been the champion of the CMS Rethinking Rural Health Strategic Initiative.

And on a personal level, I've greatly appreciated the leadership and vision she has brought to CMS, with respect to improving healthcare and health in rural America.

Administrator Verma, we are honored to have you on our call today. And now I turn it over to you.

Seema Verma: Thank you, John and thanks to the rest of the team. And it's just great hearing about all the wonderful work that's going on at CMS and a pleasure to speak with you on this 10th Annual Rural Health Day.

And let me just start by thanking all of you on the front lines for your hard work and dedication at this very difficult time in history.

It's certainly not lost on me how much rural providers have sacrificed. And you are truly heroes in this war.

Coronavirus hasn't spared any part of the world and it has been particularly challenging for rural providers which already face considerable difficulties going into the pandemic.

The good news is that there is light at the end of the tunnel.

I actually just finished up a meeting with Operation Warp Speed and it's very exciting to see the progress that we're making on the vaccine and distributing it as well. So I think this is something that's very heartening and makes us all know that life will eventually return to normal.

And as we face many difficult days ahead and all of the challenges of immunizing a nation, I'm also encouraged by the progress that the CMS team has made in addressing some of the most critical rural health issues. During my first year at CMS I traveled to a rural health center and even visited the Rural Health Association headquarters in Kansas.

And coming from Indiana, I had some familiarity with rural healthcare, but I'm indebted to those that have continued to educate me about the issues that rural communities face. And I learned about the many burdensome CMS regulations that make sense in an urban community, but really don't take into account the unique challenges in rural areas.

Rural Americans live - might live long distances from the closest healthcare providers and the providers often in turn have limited resources and tight profit margins, due to very low patient volumes and makes it difficult to maintain robust workforces.

And these problems result in a systematically fragmented rural healthcare system - limited access to important specialty services and disproportionately poor health outcomes for many of our 60 million of our fellow Americans. And that's why I made rural health one of CMS's top strategic initiatives.

And over the past four years, we've worked across the entire agency in every department, to address rural health challenges. And this has represented a

departure from established practice as rural America's pressing healthcare problems have largely been ignored for too long.

And I'm really proud of the work that CMS has accomplished over the last few years. Their efforts have laid the foundation for rethinking rural health across the country.

During my time in office, CMS has constantly sought to bring the principles of the free market and competition, to bear on the many areas of the healthcare system we oversee. We've had many successes in that effort including some that affect rural areas directly.

For example, when we came into office, insurers were fleeing the exchanges and in 2018 50% of counties in America, the majority which are rural, had the non-choice of just one health insurer in their exchange. Today that number has plummeted to 9%. And our changes to Medicare Advantage have increased plan options for our beneficiaries, many of whom have historically enjoyed limited choices due to an anemic market competition.

In 2021 Medicare beneficiaries in rural areas, will have more than double the plan options that they had in 2017. So that's great success.

And a lot of that had to do with the flexibility that we've given the Medicare plans. They're allowed to provide more innovative health plans so that they can provide supplemental benefits including transportation, mail delivery, that can help rural patients in some of their unique needs.

And we've also allowed Medicare Advantage plans to count telehealth providers in certain specialty areas, such as dermatology, psychiatry, cardiology and more, and that's towards their network adequacy requirements,

and that increased flexibility, will allow them to provide more plan offerings in rural communities across the country.

But the fact remains that compared to their urban and suburban counterparts, rural areas present a special challenge for market-based approaches in healthcare policy. Infusing competitive forces is more complicated and sometimes downright impossible, given the unique obstacles that rural areas face.

So from the beginning, given that, we've sought to address some of these issues by leveraging innovation and technology. Our historic work should promote seamless and secure flow of medical records or interoperability, is a game changer for every American, but particularly it represents an important breakthrough for rural Americans.

Access to electronic medical information removes geographic barriers that prevent them from accessing the most up to date medical providers, research studies and services that typically cluster around dense urban areas. We've also as many of you know, have expanded telehealth, because of its potential for rural areas where transportation over long distances can be difficult and providers are often in short supply.

Starting in 2017 we allowed for short, virtual check ins with patients in their home and expanded a number of services that could provided via telehealth. And we've been doing that, as I said, since 2017. But obviously since the pandemic that's increased dramatically.

Under the President's direction, we actually got rid of a lot of the restrictions and regulations around telehealth, included those that prevented telehealth from being furnished in a person's home, including nursing homes. And so

we've also allowed for different types of providers that can provide telehealth services.

And through all of these changes, we have added over 135 telehealth services such as emergency departments, mental healthcare, eye exams and many others. And just a few months ago, thanks to an executive order from the President, we have proposed to make many of these flexibilities permanent, including office visits or prolonged office visits, mental health services and more.

So stay tuned on our rules where we'll have an opportunity to give you our final determinations on our proposal to make those expansions of telehealth services more permanent.

One of the things I did want to note though, in terms of telehealth services, that we can't make every telehealth service, level of services that we have going on right now, we can't make all of that permanent because we don't actually have the authority to do that. That's something that Congress will need to step in and do.

So as we are making some of the benefits more permanent for rural health areas, it will affect the rural health areas. And the ability for patients to receive those services in their home and some of the other areas in terms of allowing different providers, that is something that Congress will need to weigh in on.

The other area that I wanted to note, and I think this is a very significant development, is the work that we did around the wage index. So just last year, to address Medicare payment disparities between rural and urban providers,

we boosted our Medicare payments for many rural hospitals, to bring payments more on par with those in urban areas.

And this is already helping hospitals to improve their financial stability and attract talent, improving access in rural America. Regulatory burden has also been a key focus. You heard about our efforts on cutting the red tape. And that means getting rid of regulatory burdens that stand in the way of patient care. And we know that rural health in particular, has been impacted by this.

And so we gave hospitals greater flexibility on physician supervision requirements for certain types of hospital services, and we've eased Medicare requirements so that practitioners like physician assistants and nurse practitioners, can independently provide more services as long as it's within their scope of practices.

And the telehealth executive order that I mentioned just a moment ago, also directed CMS to propose extending a pandemic flexibility that allows physicians to virtually supervise their staff as they provide care to patients. And thanks to these, all of these reforms, I think rural health hospitals can really make the use of more limited workforces while still maintaining patient safety.

I think one of the other points that I wanted to make is that, you know, we have made a lot of changes along the way in terms of the wage index, the regulatory changes, the expansions in telehealth, have all been very, very significant and tangible. But probably our most significant move is aimed at a more comprehensive reboot strategy for rural health. Because without it, the longstanding fundamental issues in rural health still remain.

Most recently, we announced a new avenue for local and rural communities, to take a more active role in the transformation of their care. And it's called the Community Health Access and Rural Transformation model, or CHART. And it represents a more flexible grass roots approach to rural healthcare delivery. It's different than the normal top down, one size fits all approach that has really failed the system for so long.

What CHART does is it provides upfront funding for about 15 lead organizations that could bring together local parties - state Medicaid agencies, commercial payers, local hospitals, clinics and other providers. And these organizations would be eligible to receive upfront infrastructure investments and grants of up to $5 million for a total rural health investment of about $75 million.

And the idea here is to give them the seed money to help organize the healthcare delivery system to figure out what's going to work best for them. And that could include exploring transitioning to more of a hub and spoke model in which one relatively large hospital serves as kind of a command and control center for smaller, more limited provider types.

And may also involve reducing services for some hospitals and adding more for others like maternity and home health. And it allows communities to think about what will work best in their particular area. It also requires rural hospitals to move to a stable, predictable, value-based payment and away from the current erratic volume-based system that often doesn't work for rural providers, with low patient volumes.

It represents probably some of the first steps in a radical rethinking of how we pay for care for rural communities. Contrary to the sale approach that has prevailed for so long, simply throwing more money at the problem is not

enough. And in some cases, funding increases may indeed be necessary. But how we pay is just as important as how much we pay.

All reimbursement systems in my opinion, should be structured to create incentives to produce better outcomes for patients. And so we've paired - in CHART we've paired these payment reforms with unprecedented regulatory flexibilities and program waivers, for which rural providers have been asking for, for years.

Specifically, the model waives certain conditions of participation in our program, allowing hospitals to reduce unnecessary overhead costs while maintaining their status as hospitals or critical access hospitals. And organizations can employ value-based incentives such as reducing or waiving Part B coinsurance amounts, to promote high value preventative care.

In sum, the Model C funding, combined with the regulatory flexibilities and technical support, will give rural providers what they haven't had enough of - breathing room to provide high quality care to rural patients. And in the months and years to come, CHART will promise to finally deliver the wholesale transformative rural healthcare that we've needed for so long.

If these local ventures fulfill their potential, they could serve as models for rural communities throughout the country. For far too long, policymakers have placated rural Americans with token solutions that fail to advance the systemic fundamental transformation necessary to tackle these pervasive problems.

And under our watch, that wildly insufficient approach has gone by the wayside and I am incredibly grateful and proud of the CMS team, that has spearheaded these reforms. We've gone above and beyond just merely

tinkering around the edges of policy in favor of more lasting and transformative change.

We've disrupted the status quo for the sake of the American patient and thought big and acted boldly on issue after issue. Rural Americans are already experiencing the improvements brought by our reforms and their beneficial effects will be felt in rural areas for years to come.

It's great to be with you today and I look forward to all of you, hearing from all the great work that's going on with CMS and keeping the lines of communication open. We know that there are a lot of challenges that you're experiencing now and will continue with the pandemic and beyond the pandemic and know that CMS is here to listen to your concerns and try to help resolve them.

So again, thank you for being with us today.

Jill Darling: Great. Thank you, Administrator Verma.

Up next we have Rebecca Randle, who will go over the hospital price transparency final rule.

Rebecca Randle: Great. Thank you so much.

Good morning and good afternoon everyone.

My name is Rebecca Randle from the Center for Medicare Performance Based Policy Group. And I'm also a member of the Hospital Price Transparency Team here at CMS. As she said, today I'm here to talk about the hospital price transparency final rule.

Starting on January 1, 2021 each hospital operating in the United States will be required to provide clear, accessible pricing information online about the items and services they provide. These policies finalized on November 15, 2019, advanced the Centers for Medicare and Medicaid Services commitment to increasing price transparency.

This information will make it easier for consumers to shop and compare prices across hospitals and estimate the cost of care before going to the hospital.

Each hospital is required to make this information available in two ways. First, as a comprehensive machine-readable file with all items and services. And second, in a display of shoppable services in a consumer-friendly format.

CMS has prepared a series of resources to help hospitals prepare for the January 1, 2020 effective date. We highly encourage you to visit the hospital price transparency webpage where you will find information about the details of what the final rule entails, how to be compliant, and how it can help consumers.

We would like to highlight a few of the key resources that you might of particular interest.

We have step-by-step guides and checklists. This suite of step-by-step guides and corresponding checklists, will walk your hospital through the process of complying with the requirements set forth in the rule.

We have an eight steps to a machine-readable file that explains each of the required elements of the machine-readable file of all items and services.

It will help you understand each step from identifying each hospital location with a list of standard charges, all the way to posting your file prominently on your public website.

We have a ten steps to a consumer-friendly display, which will help you understand each of the required elements related to the consumer-friendly display of shoppable services.

It will walk you through understanding how the definitions set forth in the regulation, relate to shoppable services, along with the options available for posting in a consumer-friendly format, including using a price estimator tool as an alternative approach.

We also have a quick reference checklist which is designed for use in conjunction with the step-by-step guides, to help hospitals evaluate if all the requirements have been met. This simplistic look at all the elements together in one place is a quick way to double check a hospital's price transparency information.

We also have quite a large documents of frequently asked questions in addition to these guides. So we've compiled a wide-ranging list of questions that we've received from stakeholders, since the release of the final rule. Questions cover topics including general provisions, public disclosure requirements, monitoring of compliance and appeals of civil monetary penalties.

I do want to note that we have become aware that there are a number of misperceptions about the requirements. And again, we encourage a careful review of these resources mentioned above, to help dispel concerns that may have been raised and clarify the requirements.

In order to do that, we encourage you to visit as we said, our hospital price transparency webpage, which can be accessed by going to https://www.CMS.gov/hospital-price-transparency, to review these resources along with other items.

Lastly, CMS will be holding a hospital price transparency webcast on Tuesday, December 8th from 2:00 to 3:00 pm. During this webcast, we'll provide a more in-depth overview of the resources mentioned today, to help you prepare for compliance. There will also be the opportunity to join in a question-and-answer session that follows the presentation.

To register, go to - and I'm just warning you this is a mouthful, so we are happy to send out these links afterwards. But to register you want to go to www.mlnevents.thebizzellgroup.com/events/hospital-price-transparency-webcast.

And again, we will be sending out these links so that you can have easy access to them and register accordingly. Thank you so much.

And I will hand it back to Jill.

Jill Darling: Thank you, Rebecca.

Up next is Carol Blackford who will go over the IFC rule and how it's related to rural areas.

Carol Blackford: Thank you, Jill. And thank you to everyone for joining the call today.

I'm Carol Blackford. I'm the Director of our Hospital and Ambulatory Policy Group in CMS's Center for Medicare, and I co-Chair the Rural Health Open Door Forum calls along with John. So we're pleased to have everyone participate today.

We are going to pivot just a bit and spend a little bit of time talking about our fourth interim final rule with comments, that CMS issued on October 28. This rule includes several proactive measures to remove regulatory barriers and ensure consistent coverage and payment for the administration of an eventual vaccine for COVID-19.

Specifically, the rule establishes that any vaccine that receives FDA authorization either through an emergency use authorization or licensed under a Biologic License Application or BLA, in either instance those vaccines would be covered under Medicare as a preventative vaccine at no cost to beneficiaries.

The IFC 4 also implements provisions of the CARES Act that will ensure swift coverage of a COVID vaccine by most private health insurance plan, without cost sharing from both in and out of network providers, during the course of the public health emergency.

CMS along with the rule, issued several toolkits that provide a wealth of information that we hope will help ensure that healthcare systems are prepared to successful administer COVID vaccines when they become available, by addressing issues related to enrollment, billing, payment and coverage. And Tricia is going to be walking through the toolkit in a moment, with some additional detail.

Let me just highlight a couple of points that are relevant to Medicare in terms of coding and payment. After the FDA approves or authorizes a vaccine for COVID, CMS will identify the specific vaccine codes by dose if necessary, and specific vaccine administration codes for each dose for Medicare payment.

We also released new Medicare payment rates for COVID vaccine administration. The Medicare payment rates will be $28.39 to administer a single dose vaccine. For a COVID vaccine requiring a series of two or more doses, the initial dose administration payment rate will be $16.94 and then $28.39 for the administration of the final dose in the series.

These rates will be geographically adjusted so the actual amounts in your area may be a little bit higher or a little bit lower than those national amounts, which is how we apply geographic adjustments to vaccine administration in the normal Medicare program. So you should be familiar with how that works in your area.

Before I turn this over to Tricia though, to walk through the toolkit, I also wanted to highlight another important action that the agency recently took regarding new monoclonal antibody products.

On Tuesday, November 10, following the FDA's announcement of an emergency use authorization for a monoclonal antibody product that was manufactured by Lilly, the name of the product I actually hesitate to pronounce because I won't get it right, but it is in all of the information that's available on the website.

We announced that Medicare would cover and pay for these infusions the same way that we cover and pay for COVID-19 vaccines when furnished

consistent with the associated emergency use authorization document. This means that Medicare beneficiaries can receive coverage of monoclonal antibodies to treat COVID-19 with no cost sharing, during the public health emergency.

We are finalizing a number of provider FAQs on monoclonal antibody products and that information will be available on our COVID website, included in the Medicare FAQs that are available on that site. But we also have additional information on Medicare coverage and payment for monoclonal antibodies, that can be found in the program instruction and also in the associated toolkit that was available on our website on November 10th.

So let me turn it over to Tricia now, who is going to walk through the toolkit. Tricia?

Tricia Rodgers Great. Thanks so much, Carol.

Hello everyone. I'm Tricia Rodgers and I'm the Deputy Director of the Provider Communications Group in the Center for Medicare at CMS. And as Carol mentioned, CMS recently released a set of toolkits for providers, states and insurers to help healthcare systems prepare to administer the COVID-19 vaccines once they're available.

You can find the set of toolkits at CMS.gov/COVIDVax. That's C-O-V-I-D-V-A-X. Today I'll run through some of the information available in the provider toolkit specifically, which you can reach from the URL I just gave you.

We designed the provider toolkit resources to inform providers how to enroll in Medicare if necessary, so they can administer the vaccine, and to give

information about our coding structure - and how to properly bill for administering the vaccines once they're available. There's also information on payment, beneficiary incentives, and quality reporting.

We're currently encouraging providers to prepare for administering vaccines and review the information in the provider toolkit around enrollment. We call out those Medicare enrolled provider types who don't have to do anything further to administer the vaccine once they're available.

Those - we also talk about those Medicare enrolled provider types who must also separately enroll as a mass immunizer or other provider type, to be able to administer vaccines once they're available. And then there are those entities who aren't currently enrolled in Medicare but who want to be able to administer the vaccines once they're available.

And so for those providers who must enroll in Medicare, we set up hotlines at each Medicare Administrative Contractor or MAC, to get providers through the process over the phone and within 24 hours.

There are links in the toolkit to find your corresponding MAC based on the state the providers will administer the vaccine. And then the providers can call the hotline and enroll.

There's also information in the toolkit on our coding structure. As Carol mentioned, we worked with the AMA to finalize our approach to report use of the COVID vaccine. And so that when the FDA issues an emergency use authorization or licensure of the COVID vaccine product, we'll identify the specific vaccine code by dose and specific vaccine administration codes for each dose for Medicare payment.

Also, in the toolkit is information on how to bill correctly once vaccines are available. We include information for institutional and non-institutional providers, as well as information for those providers who operate in more than three MAC jurisdictions and want to centralize bill or send their claims to just one MAC.

Please note that for COVID-19 vaccine doses provided by the government without charge, providers must only bill for the vaccine administration. That means they should not include the vaccine code on the claims when the vaccines are free.

The vaccines don't have a charge for Medicare patients. There aren't any copays or deductibles for COVID-19 vaccines.

Also, if providers participate in the Medicare Advantage Plan they'll submit COVID-19 claims to original Medicare for all patients enrolled in the Medicare Advantage Plan in 2020 and 2021. As far as payment goes for COVID-19 vaccine administration rates, Carol went through those rates during her talk but please note that those are listed in the provider toolkit under the Medicare payment section.

The rates that Carol went over recognize the costs involved in administering the vaccine, the resources involved with outreach and patient education, required public reporting and spending additional time with patients answering those questions about the vaccines.

So those - that's pretty much the main highlights of what's in the provider toolkit for now. But please know we are updating and will continue to update the toolkit with information as it becomes available. So please check back

often. And again, you can get to that at the CMS.gov/COVIDVax URL. And please take a look and check it often for new information.

And with that, I will turn it back to Jill.

Jill Darling: Thanks, Tricia. And thank you to all of our speakers today.

(Jacqueline), will you please open the lines for Q&A?

Coordinator: Absolutely. If you would like to ask a question from the phone line please press Star 1, unmute your line and record your name when prompted.

Again, that is Star 1 and record your name at the prompt if you would like to ask a question from the phone.

It will take just a few moments for those to come through.

Our first question comes from (Brock Slaybaugh). Your line is open, sir.

(Brock Slaybaugh): Oh, good afternoon and thank you for the call today. It was nice to have Mrs. Verma on giving such good comments and I'll add something to the list of accomplishments and that's the Maternal Morbidity and Mortality work that CMS has done and how much and how impactful that is for rural communities.

The question that I have goes to the subject of price transparency. We're very concerned that there's a large number of rural hospitals, especially given the pandemic, that aren't going to be able to meet the January 1 deadline for posting of the requirements under the regulation on price transparency.

And we were - and I was wondering, Mrs. Verma was on a call a week or two ago where she made the comment that we encourage hospitals that may not be able to comply with the regulation to apply for a hardship waiver. I was just wondering where that application is and how - because I've been getting lots of questions from rural hospitals on that, and how they can access that application.

Terri Postma: Hi (Brock). This is Terri Postma. I am - the final rule didn't build in any hardship exemptions or anything like that. So I'm not aware of any process that's available for price transparency.

There may be hardship exemptions for other aspects under Medicare that you could look into. But as far as the price transparency effective date goes, we're planning on implementing it on January 1.

We would also, as Rebecca mentioned earlier, really encourage participation in the December 8 webinar that's coming up, because we've heard a lot of, you know, we've gotten questions that suggest that there are misconceptions about either the definitions that were finalized in the rule, which would make things exponentially more difficult.

We did a lot of work to reduce burden. In fact, the rule largely builds on what hospitals were already required to do starting January 1, 2019. So I'm hoping that you and your folks can join us for the December 8 webinar where we'll walk through things very carefully.

And I think that potentially when folks start looking more closely at the resources that are available, and that webinar, they'll maybe dispel some of the concerns.

(Brock Slaybaugh): Oh, thanks Terri. And it would be nice to get - if somebody can circulate that URL because I was not able to write it down fast enough. So that would be great to have.

Terri Postma: Yes. We sure will. Thanks, (Brock).

(Brock Slaybaugh): Thank you.

Coordinator: Thank you. Our next question comes from (Susan Horace). Your line is open, ma'am.

(Susan Horace): My question has been answered. Thank you.

Coordinator: Thank you.

And again, as a reminder, if you would like to ask a question it is Star 1 and record your name at the prompt.

I'm showing no questions at this time. But again, as a reminder, it is Star 1 and record your name at the prompt.

Jill Darling: All right, everyone, this is Jill Darling. (Jacqueline), if there are no further questions I will hand the call off to Carol.

Coordinator: There are no questions.

Carol Blackford: Thank you, Jill. And let me thank everyone for your time today and your questions. John and I and the entire CMS team greatly value your input and your collaboration.

As always, these calls are here for you. So please continue to send us your suggestions, your ideas.

And if you had any questions that you weren't able to ask during the call or if something pops up after the call as you think about the information that was presented today, please go ahead and send those my way to - you can use two email addresses. You can send to me directly at Carol.Blackford -- B-L-A-C-K-F-O-R-D – at CMS dot HHS dot gov.

Or you can use our Rural Health Open Door Forum email box and that is RuralHealthODF@CMS.HHS.gov.

So please continue to send your ideas and your questions our way. They really do help us shape the agendas for these calls.

So thank you for your participation today.

Coordinator: Thank you for your participation in today's conference.

You may now disconnect at this time. Have a wonderful day.

End