Centers for Medicare and Medicaid Services
Rural Health Open Door Forum
Moderator: Jill Darling
Tuesday, March 6, 2018
2:00 p.m. ET

Operator: Good afternoon. My name is (Amy) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare and Medicaid Services Rural Health Open Door Forum.

All lines have been placed on mute to prevent any background noise. After speakers' remarks, there will be a question-and-answer session. If you would like to ask a question during this time, simply press star then the number one on your telephone keypad. If you would like to withdraw your question, you may press the pound key.

I would now like to turn the call over to Jill Darling. You may begin.

Jill Darling: Thank you. (Amy). Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications. And thanks for joining us today for the Rural Health Open Door Forum. So I before I hand the call off to our co-chair, Carol, just one announcement from me.

This Open Door Forum is not intended for the press, and the remarks are not considered on the record. 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 do have any inquiries, please contact CMS at press@cms.hhs.gov. And I'll hand it off to Carol Blackford.

Carol Blackford: Thank you, Jill. And as Jill mentioned, this is Carol Blackford. I'm one of the co-chairs of these Rural Health Open Door Forum calls. And on behalf of John Hammarlund, who is the other co-chair of the call, and myself, we'd like to welcome you to our call today. We really, greatly appreciate your participation in these calls. And as for those of you who have participated on these before, you will be familiar with the sentiment of these calls for you, and

we look forward to making sure that we are providing information that is useful and helpful to all who are providing health care to rural beneficiaries. So we appreciate your participation.

Since our last calls, Congress (had) passed and the President signed the Bipartisan Budget Act of 2018. And as I'm sure you know, several Medicare expired legislative provisions were extended as a part of that piece of legislation. We are hoping to run through some of those provisions today. However, there was a lot in the bill. So we're not going to be able to touch on every provision included in the bill. I would like to draw your attention to a special edition of the e-provider news that went out Wednesday, February 28th, that included a summary of those expired legislative provisions and in a little more detail, then we'll probably be able to get in today – into today. So if you have not taken a look at that special edition of the e-provider news, I encourage you to do so.

And also, if you have specific claims processing type questions regarding any of those provisions, I would recommend that you reach out to your Medicare contractor. Of course, you can always contact us with those questions as well, but oftentimes the MACs are in the best position to answer specific claims processing questions.

Also, we want to draw your attention to several up coming events, several calls, upcoming calls that the agency is sponsoring. And these, again, are all spelled out in our regular MedLearn Connects and e-provider news articles that go out every week. We have an upcoming call next week on the low volume appeals settlement option. And that's scheduled for March 13th. There is a call on open payments, the program and your role, scheduled for March 14th.

And there is a call on E&M services documentation guidelines and a burden reduction listening sessions scheduled for March 21st. The registration for all of these calls is available on our MLN Events page on the CMS website. So I would encourage you to take a look at those upcoming calls, register for the ones that you find interesting, and please take advantage of those opportunities to participate and provide us with feedback.

So, with that, let's go ahead and dive right into our agenda.

Jill Darling: All right, thanks, Carol. First, we have, as Carol said, some of the Medicare extended provisions under the Bipartisan Budget Act of 2018. We have Marge Watchorn who will go over the physicians and Michele Hudson for the hospital. So (over to you), Marge.

Marge Watchorn: Great, thank you so much, Jill. This is Marge Watchorn. I'm the Deputy Director for Division of Practitioner Services here in the Center for Medicare. I just wanted to highlight a few of the provisions in the Bipartisan Budget Act that impact physician reimbursement.

First, in Section 50201, there was an extension of the Work GPCI floor for the additional two years through January 1, 2020. And you may be wondering what's; the Work GPCI floor. GPCI stands for Geographic Practice Cost Index. This is the part of the payment methodology under the physician fee schedule where we account for geographic differences in practice cost from one part of the country to another. Under prior law, there had been a floor for that index of 1.0 for all localities. The intent of that provision as I understand it is to raise the floor for rural areas that otherwise would be subject to a lower GPCI, below 1.0. That provision had expired as of January 1, 2018, and now that provision has been extended for another two years, so the rates, in effect, for calendar years 2018 as well as the ones that will promulgate for 2019 will include that floor for the GPCI for the work component of the physician fee schedule rate.

The next provision I wanted to highlight was Section 50202. This is an interesting provision that repeals the outpatient therapy caps. That repeal went into effect retroactive to January 1, 2018. So the caps are repealed as well as the exceptions process is also repealed. Instead, the statute has established a new threshold above which claims for medically necessary therapy services must continue to have the KX modifier that therapy providers had previously been using to denote services that we're above the therapy caps for services that qualify for the exception. And the amounts for those thresholds are $2,010 for occupational therapy and a combination of $2,010

physical therapy as well speech language pathology services. There's – I'm sorry, in effect for calendar in 2018 and also establishes in that Section 50202 a lower threshold amount of $3,000 in effect for 2018 through and including 2027 above which therapy services are subject to a targeted medical review.

Also, I wanted to highlight for you, too, services that essentially expand Medicare telehealth. Section 50302 provides for telehealth, for services – dialysis services that are provided in the home. That provision goes into effect January 1, 2019, and we will certainly be addressing the applicability and changes necessary to our rules and manuals for that provision in short order but certainly we have a lot more work to do as we look at the legislation and consider the implementation there.

There's also an extension of telehealth for strict services which goes into effect January 1st of 2021. So we will be looking to do some work there to implement that provision as well. There was a freeze on radiation therapy rates. That's in Section 51009 under prior statute. The payment rates that we pay for radiation therapy services under the physician fee schedule had been frozen at the 2016 rates, which was in effect for 2017 as well as 2018. That provision would have expired at the end of 2018. So now the freeze is in effect through for 2019 as well. So we will be addressing that through future rulemaking this year.

There's also reduction in the conversion factor that we use to update rates paid under the physician fee schedule. That's in Section 53106. Prior law had included an increase of 0.5 percent for calendar year 2019. The Bipartisan Budget Act reduced that update amount from 0.5 percent down to 0.25 percent, so it's a quarter percent increase. We'll be addressing that to our rule as well.

There's also several changes that are coming up for occupational therapy and physical therapy services that are provided by a therapy assistant. Those changes are addressed in Section 53107. And there's a couple of different implementation dates associated with that provision. As of January 1, 2019, CMS is required to establish a modifier. And then as of January 1, 2020, claims for services that are provided by a therapy assistant will need to

include that modifier; so one year after we establish the modifier. And then two years later, effective January 1, 2022, the statute requires that payment for services that are provided by therapy assistant will be paid at a reduced amount and the statutes defines that amount as 85 percent.

And, Jill, that's all I have for this physician and non-physician practitioner provision.

Jill Darling: All right. Thank you, Marge. Next we have Michele Hudson for the hospitals.

Michele Hudson: Hi. Thanks, Jill. There were two extender provisions that were included in the legislation that affect payments to predominantly rural hospitals that are paid under the IPPS. The first provision is the extension of the increased payments to certain low volume hospitals and that's under Section 50204. This new law extends on the temporary increases to that provision that had originally been provided under the Affordable Care Act. And then had subsequently been extended several times through legislation and had been in effect through fiscal year 2017 prior to the enactment of the BBA. This provision provides for an extension for one year for 2018 of those policy criteria and payment formulas that had been in effect for FYs 2011 through 2017. And then it also includes a modification to those payment increases for FYs 2019 through '22.

So for FY ’18, a hospital can qualify for a low volume hospital add-on payment if it has fewer than 1,600 Medicare discharges; is located more than 15 miles from the nearest subsection (d) hospital; and then the payment formula is based on the sliding linear scale up to a maximum of a 25 percent add-on. Beginning in fiscal year 2019, that payment formula is modified to be based on total discharges and a hospital will need to have fewer than 3,800 total discharges in order to qualify. There is no change for – in the mileage requirement during that period. And, again, there will be a sliding linear scale formula in effect for 2019 through 2022 based on your total number of discharges.

So to implement the temporary increase provided for FY 2018, CMS expects to issue further implementation information including updated discharge data consistent with how that's been handled in the past. So stay tuned for that. Once that information has been issued, CMS will provide further detailed instructions on how hospitals should submit a written request to their Medicare administrative contractor and provide any supporting documentation to verify that they meet the mileage requirements.

The second provision is the extension of the Medicare Dependent Hospital program, which provides some enhanced payments to hospitals. This provision had – prior to the enactment of the legislation had expired on September 30th, 2017. The legislation has extended this provision through FY 2022. Most hospitals that had MDH classification as of September 30th, 2017, won't need to take any action. That status will be retroactively restored and claims will be reprocessed.

However, there are two circumstances where that MDH status may not automatically be reinstated, and those would be in circumstances where the hospital prior to October 1st took some sort of action so that it no longer meets the MDH criteria that are outlined in the regulations. Generally, the two circumstances where that occurs is if a hospital had been meeting the rural requirement through urban to rural reclassification under 412103 in the regulation, and the hospital had subsequently canceled that rural redesignation, then there may be some additional steps that hospital may need to take if they want that MDH status – they want to return to that MDH status. Similarly, if a hospital converted from MDH to a sole community hospital before October or since October 1st, again, if they want to resume their MDH status, they would have to come back into compliance with the MDH regulations.

And so, like I said, hospitals generally won't have to take any action for that, and claims will be reprocessed. Thanks, Jill.

Jill Darling: All right. Thanks, Michele. And Carol has a rural health add-on.

Carol Blackford: Yes. Yes, thank you, Jill. So this is Carol Blackford again and I just wanted to provide a quick update on the Home Health PPS rural add-on, the extender provision that was also included in the Bipartisan Budget Act of 2018. This was section 50208, and this section extends the Home Health PPS rural add-on payments.

So, for calendar year 2018 payments for Home Health Services provided to beneficiaries who reside in rural areas, those payments will be increased by 3 percent. In the near future, CMS will be publishing a change request to address the extension of the rural add-on for calendar year 2018. And that change request will include the updated calendar year 2018 payments rates for rural areas. The revised Home Health PPS Pricer should be implemented with the April release. So I just wanted to provide that update to everyone as well.

And so, I think that covers all of the Medicare extender provisions that we were hoping to touch on, on this call.

Jill Darling: Thank you, Carol. And up next, we have Shonte Carter and Corinne Axelrod who will go over some RHC updates. So, Shonte?

Shonte Carter: Good afternoon, everyone. My name is Shonte Carter. I am the Central Office Program Lead for Survey and Certification of Rural Health Clinics. And I just wanted to introduce to you a memo we issued back on December 27th – sorry December 22nd, 2017. The policy memo title is S&C-18-09-RHC. And the purpose of the memo was to introduce a comprehensive update to the interpretive guidelines for rural health clinics. We also referred to this document as Appendix G. There were a few elements to the revisions that we conducted on Appendix G.

The first thing we did was, for the first time, we introduce a survey process component for the RHC program and then the purpose of this was to hopefully employ some national consistency with regards to how the RHC surveys are conducted. The second thing we did was to organize the part two of the Appendix G to now line the regulatory language with the interpretive guidelines, which also followed by the survey procedures associated with that regulatory language. And that is something completely new for our

surveyors. And, again, we hope that this formatting, having all of the conditions, the interpretive guidelines, and the associate survey procedures in line will help employ, again, a more streamlined survey process.

Another thing we did with this memo is basically we renumbered all of the; what we call (tag) numbers which are utilized by our surveyors. So there's a completely new number system. And the most important thing we did, which I believe you are more interested in is the update of the interpretive guidelines. We actually provided clarity, which we hope with regards to a number of ongoing issues, we kind of had questions for over the years with the RHC program.

I will now just give you a re snapshot of some of the items we have hopefully provided clarity on. The first thing we took a look at was the mobile unit regulations. We provided clarity on the mobile units in terms of hours of operation and the posting of those hours. We provided clarification on the location where services can be provided in mobile units.

Another thing we elaborated on was the relocation of an RHC. That's a question we've answered a number of time over years. So we have documented our standing policy on relocation. And I'll give you a brief snapshot of what's that language is saying. We are basically saying that when a RHC relocates to a new location, the grandfather in provision that they had at the old location does not automatically transfer to the new location. We have clarified via policy that when an RHC has relocated, we will take a look or we are required by law to take a look at the new location to ensure that location also meets the location requirement. This additional language in Appendix G that elaborates on that (is) just a brief snapshot of what we've done with regard to relocation.

We've also provided guidelines regarding infection control which is something we hadn't had in the past in the interpretive guidelines. However, we do have a regulation that required a clean and orderly environment. So, we provided language under that reg in interpretive guidelines that kind of gives our survey an idea of some of the things that we should be looking at when out on survey, with regards to infection control practices.

We also provided just some basic national standard information regarding the (storage) of drugs in biological. So none of that information is new. We're basically stating that you would still be required to follow standard practices provided by other agencies such as the CDC and FDA. We also added language regarding the medical director and locum tenens that has been an ongoing issue for years whether or not a locum tenens would be allowed to be being medical director of an RHC. And we're basically saying that, yes, the medical director can, however, to ensure a continuity of care. We are requesting that same medical director has a contractual agreement that will have them at the RHC for a minimum number of months. And, again, that is strictly to ensure continuity of care with regard to the treatment of patient there in the RHC.

So those are the main points that we have elaborated on. We – another point, which we're taking a look at this language again based on feedback we've received since the issue of the memo is regard to the emergency medicine requirement for an RHC. Currently, the language states that for those five categories of medication that are listed that the RHC would be required to have old stock at least. Well, actually, we allow the RHC to determine the volume of medication that they keep on stock within these categories as long as something is captured within each category. And again, the RHC is allowed to determine exactly what volume based on their patient volume, how much medication they would need from that category. Even if it's one bottle, then that would be sufficient if that is what that RHC feels is enough based on its patient volume.

So I invite you all if you haven't already taken a look at the Appendix G to do so. We think it does provide a lot of helpful information with regards to your clinic. And if for some reason you're taking a look at the guidance and you have some questions or things aren't as clear to you as we hoped they would be, I also invite you to e-mail our mailbox with any questions that you have. And I can provide that mailbox number. It is (rhc-fqhcfcg@cms.hhs.com).

And that is all I have at this time. Thank you.

Jill Darling: All right. Thank you, Shonte. And next we have Corinne Axelrod.

Corinne Axelrod: Hi. Thanks, Jill. This is Corinne. And I just have some very quick updates on our Rural Health Clinics Center website. We have posted the 2018 update to the Medicare Benefit Policy Manual Chapter 13. We try to do updates on this every year just to keep it current, and this year there's a new section on care management. We have had some formatting issues on that document, so I apologize if it doesn't print out looking perfect but hopefully we'll get that fixed at some point. But there's a new chapter 13, the 2018 version of chapter 13.

And then we also have care management FAQs posted on our website that we just updated on February 27th. Some of those are in response to questions that we've gotten, and we've just tried to make things more clear, for those of you that are developing care management programs, which include chronic care management, general behavioral health integration, and the psychiatric CoCM model programs. So I just wanted to call your attention to the updates from the website. And if you have any questions, please let us know. Thank you.

Jill Darling: Thank you, Corinne, and thank you to all of our speakers today. And, (Amy), well go into our Q&A please.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please go ahead and press star then the number one on your telephone keypad. If you would like to withdraw your question, you may press the pound key. Please limit your question to one question and one follow-up to allow other participants time for question. If you require any further follow-up, you may again press star one to rejoin the queue.

Your first question today comes from the line of (Christine Hudson) of Audubon County Memorial. Your line is open.

Cristie Knudsen: Yes. This is Cristie Knudsen from Audubon County Memorial Hospital in Iowa. And my comment today is regarding the MedLearn Matters that was just released last week regarding the criteria for advanced diagnostic imaging. And in reading that, it would appear that the determination is to whether you

need to do a consultation under that program is dependent upon where the testing will be done. And it would appears that the – if a test is sent in a critical access hospital which is paid under cost-based reimbursement, we would not have to report those modifiers and the provider would not need to have to do that consultation. And I'm just looking for verification of that.

Carol Blackford: Hi, Cristie, this is Carol Blackford. I apologize for the delay. We were struggling with the mute button here. I don't have a copy of that MedLearn article in front of me. If you could send it to me with your question, what you need clarification on, we can get that back to you. And if you want to go ahead and send it to me directly, that would be great.

Cristie Knudsen: OK.

Carol Blackford: My e-mail is carol.blackford@cms.hhs.gov.

Cristie Knudsen: OK, thank you very much.

Carol Blackford: You're welcome.

Operator: Your next question close in the line Dawn Jackson of RiverView Health. Your line is open.

Dawn Jackson: Yes. We are a rural health and critical access hospital. Do we qualify for the add-on payment bonus for the volume, low volume hospitals?

Female: The low volume hospital payment adjustment only applies to hospitals, subsection (d) hospitals, which is generally those hospitals paid under the IPPS. So proximity to a critical access hospital wouldn't affect the hospitals ability to qualify. Does that help?

Dawn Jackson: A little bit. But are you saying we are eligible or we are not?

Female: A critical access hospital, no, it's not eligible to receive the low volume hospital adjustment. That's just for subsection (d) IPPS hospitals.

Dawn Jackson: OK, thank you.

Operator: And, again, to ask a question, please go ahead and press star then the number one on your telephone keypad.

Your next question come from the line of (Karen Robinson). Your line is open.

(Karen Robinson): Hi, I was a few minutes late getting on to the call; actually quite a bit late. But did you – did I understand that there is a separate memo for surveyors from the Appendix G?

Shonte Carter: Hi, this is Shonte Carter. It is – no. There was a memo which introduced Appendix G. So the memo had an attachment, and that attachment is Appendix G. And that memo number is S&C-18-09-RHC. So although the memo is geared to our state surveyors in the state survey agencies, it is a very useful resource for facilities as well to take a look at the interpretation of a regulation in how that actual regulation would be surveyed.

(Karen Robinson): OK. And, again, did you say that that memo number was S as in Sam EC18-09-RHC.

Shonte Carter: It is S as in Sam and C, survey and certification is …

(Karen Robinson): OK …

(Inaudible)

Shonte Carter: It's also, if I'm not mistaken, there's a link to the memo attached to the agenda for today's call.

(Karen Robinson): OK, thank you.

Shonte Carter: You're welcome.

Operator: And, again, that is star then the number one in order to ask a question.

Your next question comes from the line of Tillie McCoy of Singing River Health. Your line is open.

Tillie McCoy: Yes. I would like to know when we file claims for Medicare Rural Health, when it's – the member's first time for their visit (next), their charges are going towards their deductible. And for our Rural Health Clinics, their deductible is being processed at that time. So if we charged $200, their full deductible (of) $183 even though there's charge obligation. It's coming back onto their as patient responsibility. My questions is why is it being processed that way?

Simone Dennis: Hi, this is Simone Dennis. If possible, could you – maybe just give me an e-mail. I think we would love to see those examples and maybe we can talk more about it offline. Is that all right?

Tillie McCoy: Yes, that's perfectly all right.

Simone Dennis: All right, my e-mail is first name Simone.Dennis@cms.hhs.gov.

Tillie McCoy: I got it. I'll do it.

Simone Dennis. Great.

Operator: And there are no further questions left in queue at this time. I turn the call back to the presenters.

Jill Darling: All right. Well, thank you, everyone, and I'll hand the call to co-chair, John Hammarlund.

John Hammarlund: Thanks so much, Jill. Well, hi, everyone. This is John Hammarlund. Again, thanks to my co-chair, Carol Blackford, for opening today's call. It's my pleasure to bring it to a close. I will do so first by thanking all of the presenters who joined us today. Secondly, I want to thank the CMS Regional Rural Health coordinators who joined the call from the regional offices dotted across the country. And a reminder to all of you that those persons are designated point of contact for you if you have questions and don't know where the proverbial needle is buried in the CMS haystack. Just feel free to reach out to the Regional Rural Health coordinator in the region in which you're located.

And then, finally, to say that, as always, we invite you to help us craft the agenda topic for these calls. Now, today's call, it was very clear. We needed to talk about the Bipartisan Budget Act of 2018 since that had been passed, and we knew that there are some important elements that we needed to bring you up to speed on as well as the Rural Health Clinic updates. But sometimes we have a more open flowing agenda. And it's based on the input that we receive from you about the topics that you would like to hear about from CMS.

So I just want to remind you that the way you can submit agenda items for future calls is to write to us and our address is RuralHealthODF@cms.hhs.gov. We certainly would appreciate your input and we would hope to be able to address any questions or comments you have in future ODF calls.

So, with that, I will bring this call to a close. Thank you all very much for joining today. And I'll hand it back to Jill and our moderator.

Jill Darling: All right. Thank you, John. Thanks, everyone, for joining today's call and have a wonderful day.

Operator: Thank you for participating in today's Rural Health Open Door Forum Conference Call. This call will be available for replay beginning March 6, 2018 at 5:00 p.m. Eastern Time through March 9, 2018 at midnight. The Conference ID for the replay is 31624745. The number to dial for the replay is 855-859-2056. This concludes today's conference call. You may now disconnect.

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