

Centers for Medicare & Medicaid Services
Rural Health
Open Door Forum
Moderator: Jill Darling
Thursday, May 17, 2018
2:00 p.m. ET

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

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

Ms. Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Shantel). Good morning and good afternoon everyone and welcome to today's Rural Health Open Door Forum. I'm Jill Darling, I'm the CMS Office of Communication and before we get into today's agenda, one brief announcement from me and then I'll go hand it off to our chair Carol Blackford.

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 have any inquiries please contact CMS at press@cms.hhs.gov and now off to Carol Blackford.

Carol Blackford: Thank you and welcome everyone to the call on behalf of John Hammarlund, my fellow co-chair of the Rural Health Open Door Forum Call. We're delighted to have you on the call participating with us today.

As you noticed, we have a very full agenda today. So I will keep my opening remarks pretty quick. As you can see, CMS has recently released all of our annual fiscal year Medicare payment rules and we're hoping today to, kind of, touch on some of the key highlights in all of those rules. Our intention is not to get down into the details, not to get too weedy but rather to give you a highlight and, kind of, an overview with some of the key provisions that we think you will be interested in. I think one thing you will notice in all of our fiscal year payment rules, you see some broad key themes across the rule this year dealing with interoperability, transparency, meaningful measures, burden reduction and other issues as well.

So we're going to try to touch on some of those key themes today. The agenda does have information around where you can get more detail on all the specific rules. You'll see there are links to our press releases and fact-sheets and in those links, you can actually access the entire document.

So if there is a particular provision that we talk about today that you would like to get some more information on, those links will take you there and I would encourage everyone to take advantage of the common periods that are associated with all of the rules.

I think one thing that you will see in our rules this year is we've – our beginnings to analyze and response to all of the really thoughtful comments that we've received in response to the burden reduction request for information that were – that were included in last year's rule making. So I think that's a really good example of how you're commenting your feedback are very helpful to us and how they can actually help shape the direction of our programs. So please take advantage of the opportunity to comment.

I also wanted to point out really, very quickly, we have a late addition to our agenda. We're going to be spending a little bit of time talking about the collocation requirements. And so we're going to try to slip that in before we get into some of the meat of the fiscal year payment rules.

But first, I think we're all very excited to spend a little bit of time talking about CMS's newly released Rural Health Strategy and John Hammarlund,

our co-chair for this call is going to talk a little bit about that document. So John?

John Hammarlund: Great, thanks Carol. Well, hello everyone. Yes. So we were very pleased last week ago, Tuesday when we were able to announce and launch the agency's very first Rural Health Strategy to help improve access to high quality and affordable health care in rural communities. The strategy is intended to provide a pro-active and a strategic focus for us on the health care issues across rural America to ensure that all the rural residents have access to care to meet their needs.

The CMS and the administration clearly understands that one of the keys to ensuring to those who call rural America home are able to achieve their highest level of health is to advance policies and programs that address their unique health care needs.

And in fact the strategy really builds on several overarching priorities that the agency has already launched including reducing regulatory burden and empowering patients and their healthcare providers to make more informed choices about their health care.

For the first time, CMS is organizing and focusing our efforts to apply rural lands to the vision and work of the agency. So it's really going to enhance our efforts to look at the impacts of our proposed policies on rural communities, providers and patients alike and to consider those impacts.

We're focusing particularly on five objectives to achieve our vision for (acute care) health care in rural America. One is to apply rural lands to CMS's programs and policies. The second is to improve access to care through provider engagement and support. The third is to advance telehealth and telemedicine.

The fourth is to empower patients in rural communities to make decisions about their healthcare. And then the fifth is to leverage partnerships both across the government and the private sector to achieve the goals of our strategy.

And there is a direct relationship between the strategy we announced and the listening sessions that CMS did with a lot of rural constituents. Some of you were on the phone. It was really from those listening sessions that we conducted a year or so ago that we concluded that the policies or the intentions announced by the strategy were the right avenues to pursue.

I will note that when we announced the strategy last week, we didn't at that time, articulate any major policy changes rather I think of the strategy is more of a frame of reference for CMS to help shape our efforts in the near and the more distant future as we consider policies as well as initiatives such as innovation ideas and pilots, et cetera that might occur in the rural areas.

We hope you will have a chance to take a look at the policy and get to know some of the supporting documents further. There is a lot of information available online at go.cms.gov/ruralhealth, rural health being all one word. And I anticipate that we will be using this call and other forms in the future to discuss the policy and the strategy more in depth and as you see future announcements from CMS policy changes, et cetera.

I think you will be able to see a link between those announcements and the framework that has been established by the Rural Health Strategy. So that's all I want to talk about it today but as I say, I think we will further have the dialogue with you all about the strategy in the coming months, and so with that, I will hand it back to Jill. Thank you.

Carol Blackford: Actually, this is Carol Blackford and I'm going to go ahead and before we get into the fiscal year payment rules, I wanted to quickly mention an item related to Durable Medical Equipment, fee schedule adjustments in rural areas.

So CMS issued an interim final rule the comment period on May 9th to increase the adjusted scheduled rates for certain Durable Medical Equipment and enteral nutrition furnished in rural and noncontiguous areas, areas of the country that are not subject to the DME competitive bidding program and this would be from June 1st, 2018 through December 31st, 2018.

The rule aims to prevent potential problems with access to medically necessary DME in rural and noncontiguous areas of the country and just with a little more background here on this one, in 2016 and 2017, as you know information from the DME post competitive bidding program was used to adjust Medicare payments for DME and enteral nutrition and certain areas of the country where bidding did not occur.

Beginning in January 1st of 2017, the fully adjusted fee schedule rates were on average 50 percent lower than the unadjusted rate in those non bid areas based on the average reduction of payment for all of the items and services subject to the adjustments.

In 2016 prior to the fully adjusted fee schedule rates going into effect, the blended rates were 50 percent of the amount based on the competitive bid rates and then 50 percent of the traditional fee schedule amounts and that was implemented for the trans – for a transitional period.

So this interim final rule we comment resumes these blended rates from June 1st, 2018 to December 31st, 2018 in rural and noncontiguous areas of the country that are not subject to competitive bidding.

We are continuing to engage with stakeholders regarding the competitive bidding program, including the national mail order program and going forward CMS will continue to review data and information about rates for (DME) post items and services as required under the law. And we intend to undertake subsequent notice and comment rulemaking to address rates for DME and enteral nutrition products furnished in 2019 and abroad.

So the comment period for this interim final rule with comment closes July 9th, 2018 and there are – there is a link on the agenda that will take you to the actual document itself. So just wanted to make sure everyone was aware of that.

So now let's get into the meat of the agenda which is really, kind of, touching on the fiscal year 2019 payment rules that were recently released. Oh, I'm

sorry. We had our late addition item. (Lisa) is going to talk about collocation requirements, so (Lisa)?

(Lisa Marunycz): Hi everyone. This is (Lisa Marunycz). I am from the division of Acute Care Services within the division of quality, safety and oversight group with (CCFQ) and I was asked just to briefly touch today on the distance requirements with a CAH when a CAH has off campus location or the next closest provider, the next closest CAH or hospital also has off campus locations of that provider type. And so I'm just going to give to a brief explanation without going into all of the CAH eligibility requirements because that's not what we're here for today.

So as everyone should know and if you don't know you'd be eligible to participate in Medicare as a critical access hospital. There are certain distant location requirements that have to be met and one of those requirements is that the potential CAH applicant have to be so many miles away from the our next closest CAH or hospital.

And so that measurement has to be taken and there's all sorts of rules and exception when it comes to mountainous terrain, secondary roads but it really is not important that the 35 mile or 15, it's really concept of the CAH itself is made up of all location that file and bill under that (CAH) safety and number.

So all locations, the CAH and so any rotation of the CAH is essentially the CAH whether it is right there on the main campus or it is three miles down the road, 10 miles away that is still the CAH. And so that is a location of the CAH and so from that location – from that particular location you have to measure the distance to the next closest provider that type which is a CAH or a hospital.

And so that is where the location, the distance requirement comes in for those off campus because again it is part of that CAH. And again that it's very simple, it's part of the CAH. It bills under the CCN and that's the requirement and, of course, those distance requirements are put in place just like the rural requirement because it's a – if the intent is access to care and so if you have another provider CAH or hospital that is only a few miles from the

CAH off-campus location, there aren't access to care issues. There is another provider very close by within the distance requirement.

And so I just wanted to remind everyone of that and also back in 2016, it was September 2016, we did issue revised an (SNC) memo on the Critical Access Hospital Recertification Checklist which provides a lot of detailed information of how the distance location and rural requirements are addressed and considered by each CMS regional office before they make a determination on the eligibility of a hospital to become a CAH or for a currently providing CAH to maintain it's CAH status.

And I will – so I'm just going to leave it at that and I will stay on the line after the rest of the presentation are done to take any questions. Thank you.

Carol Blackford: All right. Thank you. Thank you, (Lisa). I appreciate that, all right. So now let's turn the agenda to the Medicare fiscal year 2019 payment rules and we're going to start with talking about interoperability and the EHR program and (Kathleen)?

(Kathleen): Thank you. So today we're going to provide a high-level overview of the proposals as well as two announcements that were in the FY 2019 IPPF and PRM. So first for the two announcements we are renaming the Medicare and Medicaid EHR incentive programs to the promoting interoperability programs.

New name will be applicable to the Medicare fee-for-service, Medicare Advantage as well as Medicaid. This is effective immediately. Additionally, in 2016 or – excuse me, the (inaudible) required beginning with an EHR reporting period in 2019. We are reiterating this. This is not a new change or a proposal.

As for the proposals we are proposing the EHR reporting period in calendar year 2019 and 2020. It will be a minimum of any continuous 90 days that is for all new and returning participants attesting CMS or their state Medicaid agency.

Additionally, we are proposing a new performance-based scoring methodology that will include fewer objectives and measures that moves away from the threshold base scoring that's currently in use. In addition, we are proposing multiple changes to the existing objectives and measures. We are proposing to add three new measures, two of which are related to opioid prescriptions and we are removing six measures and changing the name of two objectives and measures.

Also, we are proposing to remove the exclusion criteria from all the measures, except for those associated with the e-prescribing objective and the public health and clinical data exchange objective. We are requesting public comment on two new potential measure options under the health information exchange objective which would include healthcare providers and settings beyond those currently participating in the program.

Those providers would include long-term care facilities and post acute care providers. We note that we are proposing all of these changes would apply to eligible hospital and CAH that attest to CMS under the Medicare permitting interoperability program, beginning with an EHR reporting period in calendar year 2019.

We are proposing the same CQM reporting requirements and criteria for calendar year 2019 that was finalized in the fiscal year 2018 IPPS final rule. Beginning with the calendar year 2020 reporting period, we are proposing to reduce the number of CQMs from 16 to 8.

And lastly, we are proposing to codify the program instructions. We previously issued to Subsection D, Puerto Rico hospitals, and to amend the regulations under Part 412 and 495 to include them unless otherwise noted. Thank you.

Carol Blackford: Ok and now we will talk a little bit about meaningful measures and we have Kim Rawlings here to walk us through some of the themes around meaningful measures.

Kim Rawlings: Thank you. So my name is Kim Rawlings and I'm with the Quality Measurement and Value-Based Incentives group and we put out many of the Medicare quality reporting and Value-Based Incentive programs along with compare sites, et cetera.

And so as you review not only some of the rules listed in the agenda but all of the rules coming out in the coming months, you will see meaningful measures mentioned throughout. This is a fairly new initiative that first launched in October of 2017 and it was in direct response to the CMS's administration's priority to really remove obstacles that get in the way of the time that clinicians are able to spend with their patients and really trying to reduce burden.

And so for measurement, this led us to look towards or it led us to the development of the meaningful measures initiative which is guided by CMS's for strategic goals around empowering patients and doctors to make decisions about their healthcare, ushering in a new era of state flexibility in local leadership, supporting innovative approaches to improve quality accessibility and affordability and of course improving the overall CMS customer experience.

And we recognize – and each one of these goals really informs meaningful measures. We recognize that there are too many measures that can be difficult to understand how these measures fit together which can lead to lack of focus and then there is also the administrative work burden of actually reporting the measures.

And so a main goal of the meaningful measures initiative is to really focus everyone's efforts on this same quality area and really ensure that all of our measures that we put out are high-impact patient centered and aligned where possible. And we do this by identifying six crosscutting principles for all measures and then categorizing our measures into six quality priorities in 19 meaningful measure areas.

I won't go over obviously all of these in detail but just as an example one of our crosscutting principles is around access to rural communities and some of

our – two examples of our 19 meaningful measure areas are prevention and treatment of opioid and substance use disorders and a second example being patient experiencing care.

And so you'll see in the rules how we take this framework of crosscutting principles combined with these focused quality meaningful measure areas to really evaluate the measures that are currently in our programs and see where they fit within our priorities, and where possible, removing measures from our programs to decrease the burden.

But also in some cases identifying where perhaps there's a gap that needs to be filled. So please, I really encourage you to go to the meaningful measures one site on cms.gov. You'll see the diagram which will make the linkage or help make the linkage make a little bit more sense as well as there are some great videos fact-sheet et cetera. Thank you.

Carol Blackford: Thank you, Kim. I think one of the other themes that you will see particularly in the IPPS rule is around price transparency. As you know our current guidelines require hospitals to make publicly available, a list of their standard charges or their policies for allowing the public to view a list of those charges upon request and our fiscal year 2019 IPPS and PRM updates these guidelines to specifically require hospitals to make public a list of their standard charges via the Internet.

We're also seeking information from the public regarding barriers preventing providers from providing information to patients that help, kind of, I think inform what their out-of-pocket cost obligations will be, what changes would be needed to support greater transparency around patient obligations for their out-of-pocket costs.

And what can be done to better inform patients of these obligations and what role should providers play in this effort. So please take a look at that request for information and take advantage of the comment period to provide feedback to us on those points around price transparency.

You'll also see in the rule several proposals around reducing burden by easing documentation requirements and providing flexibility in specific areas and a lot of these proposals, I won't go into all of them because there are – there are quite a few but I would emphasize that a lot of these proposals were informed by your feedback specifically in response to our burden reduction RFIs and last year's rulemaking and all of the subsequent conversations, the agency has been having with external stakeholders around patients over paperwork and burden reduction.

Two specific proposals to highlight, one to remove the requirement that Part A certification statements detail where specifically in the medical record the required supporting certification information can be found and one proposal to reduce the number of denied claims for clerical errors in documenting physician admission orders by removing the requirement that are written in patient admission order be present in the medical record as a specific condition of Medicare Part A payment.

So please take a look at those proposals again and take advantage of our comment period. And with that I'm going to turn it over to Michelle Hudson, who was going to go into some of the payment specific proposals that are included in the IPPS rule.

Michelle Hudson: Thanks, Carol. Two additional proposals in the proposed rule that I wanted to highlight, one's a proposal and one's another solicitation for more input from the public is that we have a discussion in the proposed rule, where we're seeking comments and feedback and information from the public or in potential wage index disparities and for the hospital wage index.

In the rule we present a multi – a summary of studies and analysis and report on disparities between the wage index values for individual hospitals and the wage index value among different geographic areas and some other suggestions and feedback that we've received to address a reduce wage index disparities such as concern that have been expressed between disparities between high and low wage index areas are becoming too great, particularly for rural hospitals or financially struggling hospitals.

So in the rule, we invited public comment, for further comments, suggestions, recommendations for regulatory and policy changes to the Medicare wage index that would address these issues, the type of feedback we would be interested in receiving could include specific recommendations, additional data support and where novel legal questions are involved, suggestion when CMS's authority would be welcome for our consideration. So we look forward to receiving the additional public input on potential disparities in the hospital wage index.

Another proposal that I wanted to highlight concerns the effective date of the status for community hospitals and Medicare dependent hospital. Currently when a hospital qualifies to become a Medicare dependent hospital or a sole committee hospital, that status is effective 30 days after CMS approves that status.

In the proposed rule, we included a policy – a proposal where we would change that affected date to the date that CMS receives the completed application. So instead of the effective date being 30 days after CMS makes the determination, the effective date would be the date that the completed application is received once the Medicare contractor determines that the hospital has in fact met the qualifying criteria to become MDH or an SDH.

We also highlight and its part of that proposal that in order for an application to be complete all the criteria must be met as of the date CMS were to receive the application for a hospital to become an MDH or an SDH.

In addition to the proposed rule on the same day in the Federal Register CMS also issued a notice announcing its implementation of a few of the IPPS extension provisions that were included in the Bipartisan Budget Act.

Section 50204 of that act extended for FY 2018, the temporary increases to the low volume hospital payment adjustment that had originally been provided by the Affordable Care Act and extended through subsequent legislation.

For FY 2018 the definition of a low volume hospital and the methodology for calculating low volume hospital payment adjustment that had been in effect for years 2011 through 2017 was expanded into 2018.

Prior to the package the bipartisan budget act, those temporary extension to that policy had expired and the qualifying criteria had reverted back to a much more narrow set of criteria. Now for 2018 in order for a hospital to meet – to qualify the low volume hospital, the hospital must be located 15 or more miles from the nearest IPPS hospital and have 1600 or fewer Medicare discharges.

We included additional details on our implementation of this program in a Federal Register notice that was issued the same day as the proposed rule and but it was published on April 26th in the Federal Register. We also recently issued a change request number 10547. It was issued on May 10 that provides information and instructions on how qualifying hospital payments will be reprocessed.

In addition, in the April 26th Federal Register notice, we also outlined a process for hospitals to request other low volume hospital payments for 2018. In order to receive those payments a hospital must notify and provide documentation to Medicare administrative contractor that it meets the mileage criterion by sending a written request for low volume hospital status, that is received by the MAC no later than May 29th.

So it has to be a written request that's received by May 29th and then that request should include documentation that the hospital meets the mileage criterion. If it's for written request that are received after May 29th then the low volume hospital adjustment will be applied prospectively within 30 days of the date of that request. But in order to be processed back to October 1st 2017, that request must be received by the max by May 29th.

CMS also updated the Medicare discharge information that's used for the FY 2018 low volume hospital adjustment that's available on the CMS website on FY 2018 final rule table's webpage. Some of you may be familiar with this data being in table 14 because this data was issued as part of a standalone notice and not as part of the final rule. The table has actually this time titled

CMS-1677-N for notice table 1 and that's where you'll find the discharge information for FY 2018.

In addition in that same notice, we also discussed the extension of the Medicare hospitals dependent program for 2018 through FY 2022. So prior to the enactment of the bipartisan budget act, the MDH program had expired and now it's been extended again for an additional five years.

As discussed in the change request as well as the notice, most hospitals that had previously had MDH status before it had expired won't have to take any action that that status will automatically be reinstated. There are a few exceptions in cases where a hospital may have taken in action since the expiration of the program that would make it no longer meet the criteria to become an MDH that are outlined in the regulations under 412.108.

Carol Blackford: OK. Thank you, Michelle. So now we're going to shift gears a little bit and talk about the fiscal year 2019 skilled nursing facility PPS and PRM and John Kane is going to walk us through some of the highlights of that rule.

John Kane: Thank you, Carol, and thanks everyone for being on the call today. On Friday, April 27th, CMS released CMS-1696-P, proposed rule which outlines proposed Medicare payment updates for fiscal year 2019 and proposed program changes associated with the SNF PPS. Comment period on this rule closes on June 26th. So please be sure to get new comments into us by then.

With regard to the proposed SNF PPS market basket update and associated rate changes for fiscal year 2019, we estimate the payments to SNFs in FY 2019 will increase by \$850 million, as result of the FY 2019 SNF Market Basket increase factor of 2.4 percent as required by the Bipartisan Budget Act of 2018.

You would know that absent the application of the statutory requirement the FY 2019 SNF market basket update factor would have been 1.9 percent which reflects the FY 2019 SNF Market Basket Index of 2.7 percent reduced by the multifactor productivity adjustment of 0.8 percent. This 1.9 percent update

would have resulted in an estimated aggregate increase of \$670 million in Medicare payment just announced.

Moving now to the propose changes to the SNF PPS case-mix classification system, we are happy to announce the proposed Patient Driven Payment Model or PDPM. As you may recall, in May of 2017, CMS released an Advanced Notice of Proposed Rule Making or ANPRM which outlined a new case-mix model called the Resident Classification System Version 1 or RCS-1 that we were considering to replace the existing RUG-IV case mix model, used to classify patients in a covered Part A stay into payment groups under the SNF PPS.

So if the ANPRM CMS continues to stakeholder engagement efforts to identify and address the concerns and questions raised by commenter based on these comments we've made significant changes to the RCS-1 model, resulting in the proposed PDPM.

We proposed that this model be effective beginning on October 1, 2019. We believe the PDPM represents a marked improvement over the RUG-IV and RCS-1 models most notably because it improves payment accuracy and appropriateness by focusing on the patient's needs rather than the volume of services provided, significantly reduces the administrative burden on providers thereby allowing greater contact between clinicians and patients and reallocates the payments to currently underserved beneficiaries without increasing total Medicare payments or compromising access for any other SNF patients.

We additionally know the CMS released with the proposed rule, a technical report on the development of the PDPM along with a number of other helpful materials available on our program website to support commenters in developing comments on the proposed rule.

Their number of aspects of the proposed model that we wish to highlight on this call, first, we would like to note that PDPM significantly reduces the administrative burdens associated with SNF PPS specifically, the burdens associated with patient assessment.

While the current system requires substantial paperwork to track the volume of service utilization over time, PDPM eliminates the need for these frequent patient assessments and allows clinicians to focus more time on treating the patient.

We estimate that based on the proposed changes to the assessment schedule associated with the PDPM, providers will benefit from approximately \$2 billion and reduce the administrative cost over the next 10 years.

Next, we would like to highlight the PDPM as far less complex than RCS-1 which is a direct result of provider feedback on the RCS-1 model. You're able to reduce the number of payment group combination by approximately 80 percent with very minimal loss in payment accuracy.

This was great concern to commenter on the RCS-1 model and feel this is a significant improvement in PDPM. Additionally, we simplify the variable per diem adjustment by having and operate on a weekly rolling basis rather than the schedule discussed in ANPRM.

Looking back to RCS-1, the number of commenter had expressed concern with how that model would align with other CMS initiatives notably the IMPACT Act. We hope that the proposed rule provides further clarity on how PDPM would interact with these other CMS initiatives focused on improving value driven and high-quality care.

It was specifically highlight as this was also a source of comment on the ANPRM, the functional scores used to classify patients under PDPM are based in section GG of the MDS rather than section G as the current system usage and RCS-1 was designed to use.

We believe that using section GG as the basis for functional assessment in classification of SNF patients rather than section G better aligns PDPM with other (PAC) systems and with other CMS initiatives.

Another aspect of the proposed PDPM to which we would like to draw your attention is the proposed limit on concurrent and group therapy. A number of commenters in the ANPRM and since have commented to us regarding the need under a model such as PDPM to ensure accountability for providers to deliver the highest quality of therapy services to SNF patients.

To ensure the SNF patients receive therapy that is best attuned to their individual needs and characteristics, we proposed similar to that discussed in the ANPRM, a limit on (concurrent) group therapy. Specifically, we proposed under PDPM to no more than 25 percent of the therapy provided to SNF patients may be delivered in either in concurrent in group setting.

We believe this proposal will help to ensure that SNF patients continue to receive the highest caliber of rehabilitation services are still allowing flexibility for therapist to determine the most appropriate course of treatment for given patient. We also plan to monitor closely the amount and way in which therapy service will be delivered under PDPM to finalize and take actions, should we discover that the patient's unique needs and characteristics are not the basis for clinical decision-making under the revised model.

Finally, we will draw your attention to the impact analysis associated with PDPM. While we proposed to implement PDPM in a budget neutral manner the policies and revisions proposed in the PDPM reallocate and realign how money is paid out under the SNF benefit are distributed.

For example, nonprofits SNFs and hospital-based SNFs which typically treats some of the more medically complex patients, they're better under the proposed PDPM. Further facilities in rural communities do better under the proposed PDPM.

Finally Medicare beneficiaries are also enrolled into the state Medicaid program often referred to as duly enrolled beneficiaries who also tend to be the most expensive and medically complex to treat, they're better under the proposed PDPM under their current state panel model. We believe this reallocation of funds will help to ensure a greater access to high-quality care under the SNF benefit.

As stated above, we're proud to propose this improvement to the SNF PPS and hope this paves the way for future value and data driven improvements and Medicare payment. With that, I'll turn the call back over to Carol.

Carol Blackford: Thank you, John. All right. So the comment period for the IPPS rule closes June 25th, 2018 for the skilled nursing facility. It is June 26th. Is that correct June of 26th, 2018? And I believe the other payment rules listed on the agenda also have similar comment periods closing June 26, 2018.

So with that I will turn the call over to John Hammarlund for our closing remarks.

John Hammarlund: Thanks very much. Yes. I just want to amplify something that Carol said at the outside of the call about noticing comment rulemaking. It's really, in our view, a critical opportunity for you to give us your thoughts about our proposals to educate us and to possibly change our minds.

And I think I would imagine if you are, sort of, a standalone provider in a very rural part of America you might be thinking, "My comment can't really matter." And I want to argue to you that they do. We read and internalize every single comment we get and your story that you can tell through – tell us so we would notice in comment rulemaking can have an impact on us.

So the most valuable sorts of comments we can get are not the general ones but the ones that can go into some specifics that can talk specifically about how our proposals are going to affect your bottom line, your ability to provide care for your patients.

So go into the details if you can and moreover, if you have a suggestion for us as to how we could achieve the goals we've articulated in the preamble but do it in a different way that would be very useful for us to know. We've asked specific questions in some of these proposed rules and we're looking for answers from you but to the extent, you can let us know alternatives that we should be considering, we would greatly appreciate that.

So I just want to urge everybody it's a lot of work, I know, to read what's in proposed in the Federal Register and to take the time to comment but I want to assure you that we do read the comments and they do matter.

So with that we'll close out the call and go to the Q&A period. So I'll hand it back over to Jill and our facilitator.

Jill Darling: Thank you to John and to Carol and to all of our speakers today. (Shantel), can you please open the lines for Q&A please?

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please press star then one on your telephone keypad. If you would like to withdraw your question please press the pound key.

Please limit yourself to one question and one follow-up to allow for other participants time for questions. If you require any further follow-up you may press star one again to rejoin the queue.

Your first question comes from the line of John Supplitt with American Hospital Association. Your line is open.

John Supplitt: Great, thanks very much. Thanks for a great call, lot of substance. The reason I'm asking a question pertains to the standard on off-campus and collocation requirements for Critical Access Hospitals and this is done under 45.610E. And in that standard it says there are Critical Access Hospital cannot operate an off-campus provider-base location within 35 miles or 15 per seasonal or mountainous location unless there's two exceptions.

The first exception it's a rural health clinic or the; except – the other exception is that it was created or acquired before January 1st of 2008. So I understand that if I'm in the right standard here. The second part of this is I thought I heard you mention that if another provider put another service like a hospital outpatient department within 35 miles of a critical – of a Critical Access Hospital that too could compromise eligibility. Did I hear that correctly?

(Lisa Marunycz): Yes, you heard that correctly. Again because it is – it is located within a vicinity where there is no more access to care issues. So you did hear that correctly.

John Supplitt: Well, the access to care issue would be for inpatient care and I guess the other observation is I don't see that referenced under the standard.

(Lisa Marunycz): It doesn't matter because that off-campus location of the other hospital, that's also part of that hospital, the same concept that I discussed earlier when I was explaining. So whether it's a hospital or a CAH, it doesn't really matter. Any location of a hospital or CAH it is part of the 855. It is a location of that hospital or CAH. It bills under the CCN. We consider that to be the hospital or the CAH. And so wherever those locations are that's where we measured the distances to and from.

John Supplitt: Well and again I don't feel it as being consistent with the standard I'm reading. So if you could share that with me so I understand what standard you're working from that would help and ...

(Lisa Marunycz): We're working on the standards that are the distance and location eligibility requirements. When we talk about you have to be, it says you have to be within less than 35 miles from the next – from the closest CAH or hospital, that's the regulation.

John Supplitt: Well, that's what I'm looking at.

(Lisa Marunycz): Yes, it's right. So any location ...

John Supplitt: It doesn't reference that.

(Lisa Marunycz): ... of that hospital or CAH but it doesn't have to, it doesn't have to. Any location of that hospital ...

John Supplitt: Why not?

(Lisa Marunycz): ... because any location of that hospital or CAH is the hospital or CAH. It is under that CCN. All location are part of that hospital. We don't – we don't

parse out. It would be very different if that was a different – separately certified for of that system but it's not part of that hospital and that is how it's always been. Every location of that hospital that bills under that hospital, we consider it to be the hospital.

John Supplitt: Yes, maybe we're talking on cross purposes. I agree with what you're saying if it's the critical access hospital that creates the outpatient department and if it's not on rural health clinic after January 1st. I agree with that but it seems to – that you imply that if a competing hospital placed the hospital outpatient department within 35 miles that would compromise the eligibility of the existing Critical Access Hospital.

Carol Blackford: So John ...

(Lisa Marunycz): And you're absolutely correct. Yes, go ahead.

Carol Blackford: I was just ...

John Supplitt: So then a hospital could compromise the eligibility of a Critical Access Hospital, have that eligibility changed and then remove the hospital outpatient department and there would be no access.

Carol Blackford: So this is Carol Blackford. I would like to move on to the next question ...

John Supplitt: OK.

Carol Blackford: ... just so that we have an opportunity for others to take advantage of folks in the room and ask questions but please John, if you want to send us a note if you think we need to have an additional item on the next agenda or maybe a separate conversation on this issue, I'm certainly happy to facilitate that.

John Supplitt: OK. Thank you very much.

Carol Blackford: Thank you.

Operator: Your next question comes from the line of (Regina Gillespie) with Best Home Medical. Your line is open.

(Regina Gillespie): Hello. I just have a quick question in regard to the Durable Medical Equipment changes and when it comes to rural classifications and I ran into this under the bidding program as well, how do you all look at the areas to determine what is classified as rural and non-rural?

Carol Blackford: So there's actually a methodology that we use that I don't have here in front of me but if you want to send me your question, I can get it to our experts with the DME post competitive bidding program. My e-mail is carol.blackford, B-L-L-A-C-K-F-O-R-D @cms.hhs.gov and I'd be happy to connect you with our experts in the competitive bidding program.

(Regina Gillespie): Well, I've been talking to them for about six years. So we still haven't got that question answered and with the rural initiative in West Virginia we're pretty much all rural that very few counties are classified as rural. And actually some of our most rural counties are not classified that way. So I'm just kind of, curious how that is looked at from not only the DME side but from the hospital side. And do you use the same classification across the board to classify areas as rural whether it's for hospitals, DME, skilled, is that the same methodology for all areas?

Carol Blackford: We tend to start with the metropolitan statistical areas and the nonurban areas using the OMB designations across all of the payment systems and I know for the competitive bidding program, they have made some modifications to that but it starts with the basic MSA designations.

(Regina Gillespie): OK. We really don't have an MSA in West Virginia but we were, kind of, added into with some other states but when I did make a change, it actually made it worse for West Virginia. So that's my – that was my question. So I just wondered if the hospitals that were classified as rural also fell under the same methodology.

Carol Blackford: Well, again, I think they use it slightly different methodology for – to draw the competitive bidding areas. So it would not be across a direct match from the post-competitive within areas to the wage index areas used for purposes of hospital payment or other institutional providers.

But I would encourage you to take advantage of the comment period here, if the changes made in the ISC actually made your situation worse. Please let us know that and provide that feedback through the comment period and you can also shoot me an e-mail. Again, I'm happy to help facilitate the conversation with the competitive bidding folks so that it sounds like you've been talking with them for a while.

(Regina Gillespie): Yes, we've been talking to them for a quite a while now. So OK, I was just kind of, curious, thank you.

Carol Blackford: You're welcome.

Operator: Your next question comes from the line of Brock Slabach with National Rural Health Association. Your line is open.

Brock Slabach: Oh, thank you and good afternoon John and Carol and everyone else on the call. First of all, I want to thank CMS for the rural strategy that was released last week and the excellent points that were made in terms of the direction that CMS will be taking regarding policy. I have two questions. I guess the first one is following up on John Supplitt's questions from AHA.

We – I guess learning this afternoon, new direction in policy that I've not been aware of at least and it sounds like that others on the call aren't as well. So we'll be following up obviously in terms of our understanding of the call of distance requirements and may be seeking some reinterpretation of those per the policy that was released last week because this is going to be, I think alarming to a lot of facilities in terms of their future planning.

The second question that I have and this is maybe just putting it on the table for our consideration in terms of an answer and that is that last year, CMS made an exception for sole community hospitals on their exemptions from the cuts to the 340(b) on the 340(b) program for Medicare outpatient services.

And I just wanted to understand a little bit more about CMS's process for evaluation of whether that one year SCH, Sole Community Hospital

exemption will continue and how do we go about putting on the table the criteria – how do we know the criteria and whether those criteria will be applied for the evaluation for next – for the continued exemption.

And then secondly we'd like to see maybe the exemption expanded to other classifications of rural PPS hospitals so that they could be exempted from those 340(b) cuts as well. So thank you very much and I'll wait for the answer. Thank you.

Carol Blackford: Well, Brock, this is Carol Blackford. Thank you very much for participating on the call today. I appreciate the feedback on the strategy and it sounds like we may need to have some more conversations around the collocation requirements. And so I look forward to giving your feedback on that.

And I would suggest I have a similar feedback on the 340(b) issue. Obviously that was implemented through rulemaking. Expansions of that would also require rulemaking and given the current state of litigation, I don't want to get too far into the details here but I do. If you want to shoot me an e-mail or send a letter kind of, outlining the points that you've raised today on the call that would be appreciated.

Brock Slabach: Thank you.

Operator: Again if you would like to ask a question, please press star then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key.

Please limit yourself to one question and one follow-up to allow other participants time for question. If you require any further follow-up, please press star one again to rejoin the queue.

Your next question comes from Lisa Amerman with Mile Bluff Medical. Your line is open.

Lisa Amerman: My question has to do actually with the new Medicare card. We had a patient present today whose Medicare took effect in May and she does not have one

of the new card. She has a card with her social on it and I thought those were going to stop as of April 1st.

John Hammarlund: What state are you in? I'm sorry.

Lisa Amerman: Wisconsin.

John Hammarlund: OK ...

Lisa Amerman: So ...

John Hammarlund: Go ahead ...

(Lisa Marunycz): Well, so her birthday is in May?

Lisa Amerman: Yes, it is.

(Lisa Marunycz): So, yes, she probably should have received a new card. She can certainly request once. We can somebody locally reach out to you if you want to connect us with your patient or if you want additional information.

Lisa Amerman: I guess, I'm just curious because we're trying to educate our registration staff to be watching for these new cards and that anyone with birth date April 1st or with Medicare as of April 1st of '18 and forward is not going to have one of the cards with their social and to, kind of, watch for those and today they're telling me, well, this is a May and it started May 1st of '18 and she has a card with a social on it, so.

(Lisa Marunycz): Yes, we'd have to take a look at the specific individual and find out what happened there. She probably should have received a new card. If you want to give me your e-mail address, I can contact you and follow up further.

Lisa Amerman: Sure, it's lamerman@milebluff.com M-I-L-E, B as in boy, L-U, F as in Frank, F as in Frank dot com.

(Lisa Moronich): lamerman@milebluff.com

Lisa Amerman: Yes.

(Lisa Moronich): OK, thank you. I'll follow up with you.

Jill Darling: Hi, (Shantel), we'll take one more question, please.

Operator: Your next question comes from Bob Falkowski with Oak Hill General Hospital. Your line is open.

Bob Falkowski: Good afternoon, thank you very much. I'm just looking for the clarification here because I think like John and Brock, I'm a little confused, we're a Critical Access Hospital have been so designated since the early 2000s, are you suggesting that you're now interpreting the rules to mean that if another hospital sets up a clinic across the street from me next month, we're in danger of losing our critical access designation?

Carol Blackford: So I'm not sure that (Lisa) is on the call anymore. I know she had to jump off. She had another appointment. So if you want to send me that question and we can get (Lisa) get that question to (Lisa), my e-mail address is carol.blackford, B-L-A-C-K-F as in Frank, O-R-D @cms.hhs.gov.

Bob Falkowski: Thank you.

Carol Blackford: Thank you.

Operator: And we have no questions at this time.

Jill Darling: All right, well, thank you everyone for joining today's call and we look forward to getting your questions in and thank you 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 today at 5 pm Eastern until midnight of May 21st. The conference ID number for the replay is 33234668. 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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