

Centers for Medicare & Medicaid Services
Rural Health Open Door Forum
Moderator: Darling, Jill
May 22, 2019
02:00 PM ET

Operator: Ladies and gentlemen thank you for standing by and welcome to 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'd 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, press the pound key. Now, I'll turn the call over to Jill Darling to begin.

Jill Darling: Hi. Thank you Lori. 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, you 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 do have any enquiries, please contact CMS at press@cms.hhs.gov. And I'll hand it off to our co-chair John Hammarlund.

John Hammarlund: Thanks very much, Jill. Hello everybody. This is John Hammarlund, the Regional Administrator for the CMS Regional Office out in Seattle. On behalf of myself and the co-chair, Carol Blackford from the Center for Medicare. It's our pleasure to welcome you to the CMS Rural Health Open Door Forum Call. Boy, have we got a call for you today! It's a jam-packed agenda filled with lots of information that we think you need, and you will be hearing from a lot of the CMS experts on these topics today. So, we hope you find the information useful. I want to thank all of the CMS colleagues in both headquarters and among the 10 regional offices for joining the call today to be our technical experts and with that I will hand it back to you Jill. Thank you.

Jill Darling: Thanks, John. First on the agenda, we have Pauline Lapin who has an overview of primary care's initiative, the primary care first and direct contracting model option.

Pauline Lapin: Thank you Jill. Good afternoon everyone. The primary care's initiative is a part of a set of models that the CMS Innovation Center has recently announced to use the redesign of primary care to drive broader delivery system reforms that results in improved health and reduce costs. As you all know primary care is central to a high functioning healthcare system. And our portfolio in the innovation center has included some primary care models such as the comprehensive primary care plus model and the next generation ACO model and we have

taken the learnings from those two models as well as from the Medicare shared savings program and from experiences of physicians and other clinicians who participate in risk sharing arrangements in Medicare advantage and the result has been to create this new set of initiatives aimed at primary care.

So I'm going to first talk about the primary care first set of options and then talk about the direct contracting options. But, before I do that I want to remind folks about the charge of the CMS Innovation Center which is to test innovative payment and service delivery models to reduce program expenditures while at the same time either preserving or enhancing quality of care and so, our goal in testing these initiatives is to find ways that we can improve how we deliver and pay for care and through the test potentially reach a point where we are able to expand whatever the policy that we're testing is to a broader set of clinicians.

So, to begin primary care first, we have two sets of options that we are testing. One is really focused on sort of a general population and the second focuses on a more seriously ill population. And I make that distinction because in both primary care first and in the direct contracting options you will see an emphasis on care for seriously ill complex chronic populations. We think that we can do better to target the needs of those patients and hope that the options that we offer in both primary care first and direct contracting will be attractive to providers who take care of those patients, manage their needs, and hopefully attract them to participate in our models.

Under the primary care first payment model or primary care first payment, primary care first model, there's a lot of words here. Primary care first, we really have three goals. One to promote patient access to advanced primary care both in and outside of the office especially for the complex chronically ill. Number two is to transition primary care from fee-for-service payments to value driven population based payments and I will talk more about that with regards to the design of the payment methodology. And number three to reward high quality patient focused care that reduces preventable hospitalizations.

In terms of the payment structure for primary care first, we have a professional population based payment and a flat primary care visit fee that we'll be paying practices that participate in the model. So, that's really the payment methodology. So, this really is a major step forward away from fee-for-service in terms of thinking about providing a population based payment that replaces probably about 60% of what primary care practices get paid through fee-for-service today with a monthly capitated payment.

In addition, practices will continue to bill Medicare a flat visit fee approximately around 50 dollars for visits if they need to do in person with their patients. And what we're hoping is that this combines sort of hybrid payment methodology will really help to provide flexibility to practitioners to deliver advanced primary care and consider innovative care

delivery approaches not dependent on office based face-to-face care including Telehealth, using care managers and 24x7 access. And so, that's one of the goals of moving away from a strictly fee-for-service payment model to this hybrid methodology that includes this population based payment and flat visit fee methodology.

In addition, the model includes a performance based adjustment that has the potential to increase the practices' payment by as much as 50% percent or decrease it by up to 10%. And to be eligible for the positive performance based adjustment, a participating practice must exceed a quality gateway. So, we will have a small set of clinical quality inpatient experience measures that a practice must meet or exceed to be able to be eligible for this as positive adjustment up.

We're also looking at using acute hospital utilization for making that adjustment. So once the practice exceeds the quality gateway that small core sort of quality measures, we will be looking at the practices performance on inpatient hospitalization. And based on that we will be assessing a performance based adjustment as I said it could be as much as 50% above or 10% below. And the intent here is to help primary care practitioners who maybe ready for the next step in risk and value based arrangements to get their toe a little bit in a downside risk arrangement with us.

In addition, the model has a seriously ill population component. Practices can come in and say that they would either want to take care of the general population or seriously ill population or a combined general population and seriously ill population. And the reason we're focused on this population is that they're very high risk and have unmanaged illness, a fragmented care pattern with visits to numerous primary care providers and specialists, but not really one central provider who's quarterbacking their care. So our goal is really to help those patients find a way into primary care home and so that is another component of this model that practitioners can apply to be part of.

The model will be tested in 26 regions of the country including the 18 current CPC plus regions as well as eight new regions that include Alaska, Virginia, Delaware, Florida -- I'm going to blink on a few of them, but they're all up on our website and we will be able to share with you the whole list on the website where we have a nice map of all of the regions that you can see. Finally, we will be posting a request for applications for the model and that will be going live soon. The model begins in 2020, payments will start in April of 2020 to practices that apply to participate in the model. But please be on the lookout for the request for applications if you are a practice in one of these regions that can meet the eligibility requirements that we will have included in the request for applications.

This is a five year model and like comprehensive primary care plus, we expect it to be

multipayer. So, our intent just like in CPC plus is to have multiple payer supporting practices that come into participate and so, we will be doing a practice application first this time followed by a payer application. We're in the process now talking to many payers who're interested and there's been a lot of enthusiasm for the model. So, we expect to have really good participation by multiple payers both existing CPC plus payers as well as new payers that are interested in participating in this model.

There's a lot more that I could share, unfortunately I'm limited in time, but we do have information on our website and Jill will be website where you can send questions to us on primary care first. I'm going to switch to direct contracting which has three payment model options. Direct contracting as I mentioned earlier was built off of lessons we learned from the next generation ACO model on the shared savings program as well as what we've heard physician groups participating in risk sharing arrangements and Medicare advantage and other organizations that are interested in going into risk sharing arrangements with Medicare.

This option this set of options move clinicians further towards a risk. So, where the primary care first model has a 10% downside risk potential, direct contracting starts at 50% in the professional population based option. And then transitions to a 100% downside risk in our global population based payment options as well as our geographic population based payment option.

So, direct contracting offers three voluntary risk sharing options. The third one that I mentioned the geographic population based payment option is currently under design and we have a request for information posted on our website to solicit public feedback on design parameters and I encourage you to please share your perspectives with us. The good news is that we are extending the request for information to May 30th, it was actually to close tomorrow, but we know that there is a lot of interest in that option and folks still wanted to be able to provide feedback to us. So, please take a look at that requests for information.

The other thing that I was saying about the geographic option and then I'm going to turn to the first two options. The geographic option is unlike the other two because it will have an organization take 100% risk for Medicare beneficiaries in a defined geographic region. So, in many of our other models that are risk sharing models, we use something called attribution or alignment where we associate beneficiaries to an organization like and ACO based on their claims pattern.

We also use voluntary alignment. In the geographic model, we will still have voluntary alignment, the ability for a beneficiary to identify their physician or primary care provider of choice. In the geographic option, the direct contracting entity will be

accountable for a beneficiary population that's defined by target region rather than strictly through sort of the claims attribution logic that we use in other models.

Going backward now to the professional and global population options, common themes in both that impacted sort of the design of these two options included an interest in a perspective bench marking system that aligns with Medicare advantage, flexible beneficiary alignment options, which I was just referring to before about how beneficiaries can associate with certain providers moved towards capitation.

We've heard a lot of interest from our ACO's in having capitation kind of model, more benefit enhancements and payment roll waivers to provide care coordination and service delivery. So, today the next generation ACO model as well as a Medicare shared savings program, we allow certain waivers and Medicare payment rolls such as the requirement that there be a three-day stay for before skilled nursing facility admission. We also have some Telehealth expansion. So, in the next generation ACO model for example next generation ACO providers are able to bill us for a Teleophthalmology and Teledermatology services, we waive the set of service that can be a beneficiary's home and does not have to be rolled.

We are looking to expand upon those NGACO model waivers in the direct contracting model and potentially add some new ones potentially around allowing more flexibility for nurse practitioners to do some things that today only physicians can do related to plan of care. Under direct contracting, we also like primary care first have options for focusing on complex chronic seriously ill and duly eligible populations. So, organizations such as Medicaid Managed Care Organizations can come in and either be a direct contracting entity on their own or they can affiliate with a direct contracting entity for the management of Medicare and Medicaid dual eligible. And so, we are hoping that this combination and coordination will really improve the health and care coordination of that very vulnerable population of beneficiaries.

And finally, we have options in the direct contracting model for organizations that have not participated in Medicare fee-for-service risk sharing arrangements previously. We have heard that there are many physician groups that currently have Medicare advantage arrangements and are doing some really innovative care delivery models and would like to be able to bring those to Medicare fee-for-service beneficiaries. And so, we are creating a pathway for those organizations to participate in this model as well.

In terms of payment model, I mentioned capitation and under the professional option, organizations will be paid a primary care capitation equal to 7% of their total cost of care to be used for enhance primary care services. The professional option as I mentioned earlier is the option that has a 50% shared savings or shared losses arrangement with CMS.

Under the global option which is a 100% shared savings or shared losses with CMS, organizations that have a choice between the primary care capitation or total care capitation. And so, those are the two payment model options in the global and professional tracks of direct contracting.

Finally like a primary care first, we also will be focusing on a core set of measures that are relevant actionable and are intended to reduce clinician burden and so we will be providing more information on those quality measures and you know the coming weeks when they request for applications. Finally, one other note about direct contracting in the global and professional options, a letter of intent is required to participate in the model.

The letter of intent is on our website and is open until August 2nd, and so we require organizations that are interested in being a direct contracting entity in either the professional or global option to submit a letter of intent. It's not binding. So, if you submit one and decide that you do not want to participate, you're not found to submit an application. However, if you do you want to apply and you want to participate, you must submit a letter of intent. So, we encourage organizations that are interested potentially in participating to submit the letter of intent.

We're doing a series of webinars on both primary care first and direct contracting. We do not have any dates right now that I can give you for either of upcoming webinars, so I can say that we anticipate to have some in the month of June. On direct contracting, we anticipate having some really focus on the financial methodology for the model given that there has been a lot of interest in the financial methodology.

Another question that we've been getting is around overlaps with existing models and we will be providing further guidance on what the overlaps policies are in coming weeks for both primary care first and direct contracting.

The request for information for direct contracting will be out a little bit later than the primary care first one. They will both be out, you know, have some overlap, but the primary care first request for application will come out sooner given that that model starts in 2020. Direct contracting actually has what we call a performance year zero or an alignment period and the performance period for direct contracting actually starts in 2021 where it will be considered an advanced alternative payment model.

So, in 2020 that year is really meant for organizations to ramp up for the model. And for those new entrants who have not participated with us and maybe need some more time to enroll and identify beneficiaries, it really gives an opportunity to use that year or that period to do

that. And so, primary care first is first and then direct contracting will come. Organizations will have the option of choosing to participate in the performance year zero or not.

We anticipate for example that our next generation ACO participants will want to participate in 2021 given the next generation ACO ends in December 2020. And so, that's sort of a timeline for both primary care first and direct contracting. They're both five-year models. And then finally on the geographic population based option of direct contracting that's on a little bit of a more delayed timeline, although we do expect that it will have the same start of January 2021 for its first performance year where payments begin.

And so, we anticipate all three options of direct contracting in terms of payments to begin in January 2021. We have two places for people to send us questions. So, if you have questions on primary care first, you can send them to primary care apply at telligen.com. And if you have questions on direct contracting, you can email them to DPC at cms.hhs.gov. And with that I will stop and look forward to hearing questions and any feedback that you give us through our request for information. Thank you.

Jill Darling: Great. Thank you Pauline and if questions do pop up, we will give out those email addresses that you provided. So, thank you again. Up next, we have Michelle Oswald who has an announcement about upcoming maternal health care in rural communities' forum.

Michelle Oswald: Great. Thanks, Jill. Hi everyone. We are excited to announce an upcoming forum that we're holding called A Conversation on Maternal Health Care in Rural Communities: Charting a Path to Improve Access, Quality, and Outcomes. That forum will be held on Wednesday, June the 12th from 8:30 AM to 4:30 PM. We do have a couple of options - one is an in person option at the Barbara Jordan Conference Center at the Kaiser Family Foundation which is in DC. This will be an interactive event and we are excited to be able to provide an overview of the state of maternal healthcare in rural communities with a focus on access to maternal health services before, during, and after pregnancy.

The objectives will be to provide an overview of the state of maternal health in rural communities. We're going to share existing and promising practices in areas of opportunities to achieve health equity within rural communities and also develop priority the next steps for plan of action to improve access to maternal health services and improve maternal health outcomes in rural communities as well as reduce disparities.

So, this forum is actually sponsored by the Centers for Medicare & Medicaid Services in collaboration with the Health Resources and Services Administration, the Office of Women's Health at the Department of Health and Human Services and also our Centers for Disease Control and Prevention and some of our partners - the American Academy

of Family Physicians, the American College of Obstetricians and Gynecologists as well as the National Birth Equity Collaborative and the National Rural Health Association.

So, again you can register for this either in person or to participate virtually on our website. The website was added to your agenda that I will give it to you here, its go.cms.gov/ruralhealth. And if you have any follow up questions about the forum, you can contact us in our rural health mailbox which is ruralhealth@cms.hhs.gov. Thank you, back to you, Jill.

Jill Darling: Thank you Michelle. Up next, we've have some highlights on the fiscal year 2020 inpatient prospective payment system or IPPS rule and to start off we have Don Thompson.

Don Thompson: Thanks, Jill. So, April 23rd of this year, CMS published fiscal 2020 Medicare hospital inpatient prospective payment system and long term care acute hospital prospective payment system propose rule. It is available on the CMS website. It is also available on [federalregister.gov](https://www.federalregister.gov), the roll number is CMS-1716-P. We have a 60-day comment period and the comment period will be closing on June 24th, 2019. We encourage all interested members of the public to read the proposals and comment on the rule.

We're going to highlight a couple of sections and then I'll talk a little bit about the update to the payment rates. Tehila Lipschutz is going to talk a little bit about some of our wage index proposals. Kimberly Go is going to talk a little about new technology and then Renate Dombrowski is going to talk a little bit about some of the critical access hospital proposals.

For the rate update under the inpatient prospective payment system, overall we expect an increase in IPPS payments of approximately 3.7%. A big portion of that 3.7% is the market basket update to the rates. We the market basket for this year to the update for inflation is 3.2% and then it is adjusted by productivity adjustment as required by statute and that adjustment is a decrease of a half a percentage point. But, there's another statutory adjustment that increases the update by half a percentage point. So for fiscal 2020 those two will wash out at least based on the information that we have at the time of the proposed rule and it will be updated in the final.

So the market basket update net of the productivity and the other statutory adjustment his 3.2% and then there are other payment changes to uncompensated care payments, new technology add on payments, low volume hospital payments, and capital payments and when you take those into account that's where you get the overall payment increase of 3.7. So, 3.2% on the rates and then overall payments under the inpatient perspective payment system going up by 3.7% and that roughly translates

into 4.7 billion dollar increase in fiscal 2020. I'm going to turn over to Tehila now. She is going to talk a little bit about some of the wage index proposals.

Tehila
Lipschutz: Hi. Thank you, Don. So, in last year's proposed rules, as you know, we invited comments on changes to the Medicare wage index and many of your responses reflected a concern that the current wage index system perpetuates and exacerbates the disparities between the high and the low wage index hospitals. You said the high end was getting higher, and the low end, lower and lower. So to help address the wage index disparities, we proposed changes to the wage index calculation including a methodology to increase the wage index for certain low wage index hospitals and to change how the statutory rural floor wage index values are calculated.

In addition, we also proposed to provide a transition for hospitals that experience significant decreases in their region index values as a result of our proposal.

So to address the disparities between the high and low wage index hospitals, CMS proposed to increase the wage index for hospital with the wage index value below the 25th percentile. These hospital wage indexes will be increased to half the difference between the otherwise applicable wage index value for the hospital and the 25th percentile across the wage index value across all hospitals. So our proposal would be effective for - if we finalize, it would be effective for at least four years beginning with fiscal year 2020 in order to allow employee compensation increases implemented by these hospitals sufficient time be reflected in the wage index calculation.

Now CMS is proposing to decrease the wage index for hospitals above the 75th percentile, so that Medicare spending will not increase as a result of the proposal.

CMS is also proposing changes to the wage index rural floor calculation. Under the law, the IPPS wage index value for urban hospital cannot be less than wage index value applicable to hospitals located in rural areas of the state. That's known as the Rural floor provision.

Now, it appears that hospitals in a limited number of states have used urban to rural hospitals reclassification to influence the rural floor wage index values and that's a lot of the comments we got as you know, were deeply concerned about this, because all the hospital across nationally are funding this increased wage index for states where hospitals have reclassified. So, to address that, CMS proposed to remove urban to rural hospital reclassification from the calculation of the rural floor wage index value beginning with the fiscal year 2020. In addition, to mitigate payment decreases due to this proposal, CMS proposed a 5% cap on any decrease in any hospitals wage index from the final wage index value from fiscal year 2019. So, that is under this proposal of hospital final wage index for fiscal year 2020 will not be less than 95% of a final wage index in fiscal year 2019. And now, I

will - in terms of the comment period is open, so I'll stop there. So if you want to tell us how you feel about this proposal and how it impacts your hospital, you can submit a comment, and specifically for how rural hospitals are impacted as a result of this proposed policy. And our proposal impact analysis, we -- estimate that the proposed adjustments for a hospital with a wage index value below the 25th percentile wage index and above the 75th percentile wage index and the proposed 5% cap for any decrease in a hospital wage index would increase payments to rural hospitals by an average of 0.4%.

Now I will turn it over to my colleague Kim Go.

Kimberly Go: Thanks. Hi, thanks Tehila. So, I'm going to talk a little bit about our proposals for new technology and our proposed rule, we announced proposals that would ensure Medicare beneficiary is continued to access to the latest Transformative Medical Technologies and would remove barriers to innovation and competition in order to expedite access to break their technology. Specifically, we are proposing to increase the new technology add-on payments or add-on payments to hospitals for high cost new technologies from 50% to 65%.

Second for medical devices to have certain FTA designations that either entry into the market. We are proposing to waive a substantial clinical improvement criteria, which is one of the criteria required for NTAP, that's that. Applicants would only need -- would only have to meet the cost criteria on.

In addition, we are soliciting stakeholder feedback on potential revisions to the substantial clinical improvement criteria, used to evaluate applications for NTAP including specific changes or clarification as well as the type of additional detail and guidance to public and applicants for new technology add-on payments, would find useful.

Finally, in the proposed rule represents 17 new applications for new technology add-on payments for fiscal-year 2020 and we are proposing to continue -- continue these payments for 10 out of 13, technology is currently receiving NTAP including two types of CAR T-cell therapy. I'll turn it over to my colleague Renate.

Renate Dombrowski: Thanks Kim. So I'm going to briefly summarize two proposals specific to Critical Access Hospitals or CAHs. The first is related to a payment for CAH ambulance services. Currently payment for ambulance services provided by CAH or by an entity that is owned and operated by a CAH is 101% of the reasonable cost, but only if the CAH or the entity is the only provider or supplier of ambulance services within a 35 mile drive of the CAH. So it has been brought to our attention that there may be providers or suppliers of ambulance services that are located within a 35 mile drive of the CAH that are not owned or operated by the CAH and are not legally authorized to transport individuals either to or from the CAH.

In this situation, the CAH receives payment under the ambulance fee schedule even though the ambulance provider or supplier cannot provide ambulance services to individuals living within the CAH's service area. What our proposal does, is it removes ambulance providers and suppliers that are not legally authorized to provide ambulance services to transport individuals to and from the CAH, from the determination of whether there is any provider or supplier of ambulance services located within a 35 mile drive of the CAH.

Specifically we are proposing that payment for ambulance services furnished by a CAH or by an entity that is owned and operated by the CAH is 101% of the reasonable cost of the CAH or the entity, but only if the CAH or the entity is the only provider or supplier of ambulance services located within a 35 mile drive of the CAH, excluding ambulance providers or suppliers that are not legally authorized to furnish ambulance services to transport individuals either to or from the CAH.

The second proposal is related to residency training at CAHs. In general, hospitals can count residents training in settings, which we refer to as non-provider settings, like Community Health Clinics for example, for graduate medical education payments, if the hospital pays the residents' salaries and fringe benefits, while the residents are training in the non-provider setting. Under current policy, CAHs that train residents are not considered non-provider settings and instead are paid at 101% of the reasonable cost associated with training the residents.

This policy was the result of the use of the term "non-provider" as part of the Affordable Care Act. We have heard concerns related to CMS's current policy that CAHs are not considered non-provider settings for purposes of graduate medical education payments to hospitals. In light of these concerns, we reexamined the statutory language associated with this policy, issues raised in prior rule making related to this policy, and the intent of the changes made by the Affordable Care Act.

As a result, in order to support the training of residents in rural areas, we're proposing that a hospital may include residents training at a CAH in its count of residents as long as the hospital meets the non-provider setting requirements, which includes paying the residents' salaries and fringe benefits while the residents are training at the CAH. We did not propose to change our policy with respect to CAHs incurring the cost of training residents. That is, CAHs may continue to choose to incur the cost of training residents in approved programs directly and receive payment based on 101% of the reasonable costs. And I'm going to turn it back to Jill.

Jill Darling: Great, thank you Renate. Next, we have Cara James who will provide an overview of proposed standardized social determinants of health data elements and LTAC, SNF, and earth proposed rule.

Cara James: Thank you Jill and Good afternoon to everyone, Good morning for those still in the West coast. We're here today to talk about some of the proposed standardized social determinants of health data elements. Those of you may be familiar with the impact act that required that we align our post-acute care patient assessment tools across each of our setting and in doing so is the impact act also requires that we take a look at the relationship between social determinants of health or social risk factors and Medicare quality outcomes and resources.

So since the impact act passed, there's been a growing interest in social determinants of health and in an effort to understand how these relate to health outcomes, resource utilization as well as cost. We are proposing a new category in standardized patient assessment data elements of the social determinants of health. And that this category includes seven elements, two of which are update and those are our race and ethnicity data elements that are getting updated to be in line with the current HHS data standards.

We also are incorporating preferred language and interpreter services that are currently in utilization on the LCDS and the MDS across all post-acute care settings and we are also proposing to add a single element for health literacy that is related to the single item literacy screener as well as an element for transportation that it aligns with the prepare tool and what we are currently utilizing in our accountable health communities model assessment and finally an element on social isolation that is a subset of what we're utilizing in our Accountable Health Communities Model and comments for these rules closed for the earth on June 17th, for SNF on June 18th, and for LTAC on June 24th. We are also seeking comment on additional areas of interest that stakeholders would like to see captured and with that, I will turn it back over to Jill. Thank you.

Jill Darling: Thank you. And last on the agenda, we have Danielle Miller who will go over the hospital co-location guidance.

Danielle Miller: Hi everyone. On May, the 3rd CMS released draft guidance in our QSO memo 19-13 related to colocation of hospitals with other health care entities. This guidance was released as draft because we wanted to ensure that there was a broader awareness of how this guidance would impact hospital providers and we do have a 60-day comment period on that, which ends July, the 2nd. So what is guidance's focused on isn't you know primarily ensuring the health and safety of patients as it relates to hospital center co-located with a focus on staffing contracted services, the provision of emergency service and the use of shared space between hospitals.

That maybe colocated with another hospital or another health care entity. So the goal with this guidance, which previously did not exist, is to provide a clarity and inconsistency for our State Survey Agencies, our regional offices, Accreditation organizations for when they survey these hospitals, which are colocated as well as providing information to hospitals that would help them make decisions about how they partner with other providers in the health care system to deliver their high quality of care.

Any comments on this are welcome, you know we want to make sure that we are considering all situations and which colocation is occurring and how that would impact, not only the providers, but also our patients.

We're accepting comments at our hospital mailbox, which is hospitalseg@cms.hhs.gov. And once again those comments are we have a comment period open until July, the 2nd and these -- and as far as you know this is completely in draft at this point, if -- I'm not sure if there's anyone on the phone that has any comments for questions we can take those.

Jill Darling: All right. Thanks Danielle. We are about to open up the lines for Q&A. So thank you and to all of our speakers. Lori, you please open the lines for our Q&A please.

Operator: As a reminder, if you'd like to ask a question, please press star then the number one on your telephone keypad. If your question has been answered and you wish to remove yourself from the queue, press the pound key. Once again to ask a question, please press star one.

Our first question comes from a line of Mike Schafer of Spooner Health.

Mike Schafer: Good afternoon and thanks for hosting this call. I'm directing this towards Danielle Miller in the issue of the co-located space. I actually had an opportunity to discuss this with Mr. Hammarlund, a couple of years ago, The role of Wisconsin Health COOP meeting and I'm wondering why the direction on colocation is silent towards the issue of time sharing of space. Example, we have some shared space that we lease out to visiting specialists. it's the only way we can get some of these specialty services in our small rural critical access hospital, yet by some interpretations, we cannot turn around to use that space for hospital related activities like after our urgent care, which is the number one sided need in our Community Health Needs Assessment, so I was real disappointed to see that it -- that didn't go as far as talking about time sharing of space and wondering if you have any insight as to that. Thank you.

Danielle Miller: So with that, that is something that has been coming up and coming in through comments. So that is the advantage of this being addressed is that we can -- we have the opportunity to look

at these comments and consider some of those things when we are drafting our final guidance. So, we are hearing that and hopefully we'll be able to address that in our final guidance.

Mike
Schafer: Okay you're going to get my written comments too, so thanks.

Danielle
Miller: Absolutely.

Operator: Our next question comes from the line of Tim Wolters of Citizens Memorial Hospital.

Tim Wolters: Yes, thank you very much. My questions concerning the Wage Index Proposal in the inpatient PPS rule. Thank you very much for the proposal, you mentioned an impact of 4 times per percent, which overall as an average that's certainly not going to solve what's going on with the closures rural hospitals and the financial distress many or under, but I do appreciate the effort. My question relates to the carryover of this proposal to the outpatient PPS rule. If it is finalized for inpatient PPS, is it reasonable to assume that you would do the same thing on the outpatient PPS side or what's the status of that issue?

Don
Thompson: So that the outpatient proposed rule has not come out yet, but certainly when that is released in the not too distant future, then any proposals that are in there with respect to the wage index. You'll be able to comment on those, separate from the inpatient prospective payment system rulemaking. But you are correct that historically the outpatient hospital wage index adjustments have matched what happens on the inpatient from a historical context. But you will be able to comment on the proposed rule when it comes out for outpatient hospitals.

Tim Wolters: Okay. Thank you.

Operator: Our next question comes from a line of Geri Paul of UnityPoint Health. Geri, your line is open. Please state your question. Your phone is on mute. Please unmute it. That questioner has disconnected.

Once again if you'd like to ask a question, please press star one. I'm showing no further audio questions at this time.

I'm sorry. You now have a question from Brock Slabach, NRHA. Brock, your line is open.

Brock
Slabach: Thank you. I have a question on the direct primary care in the primary care first programs and the eligibility of providers practicing in Rural Health Clinics paid under part A for participation in that program.

Jill Darling: Hi, there are so Pauline had to step off after she spoke, but I would give out a few email, so for the primary care first. Its primarycareapply@telligen.com. So, please send an email.

Brock Slabach: Okay, thank you.

Jill Darling: No problem.

Operator: Your next question comes from a line of Kathryn Miller of The Wisconsin Autism.

Kathryn Miller: Hi, can you hear me alright?

Jill Darling: Yes, go ahead.

Kathryn Miller: Okay, thank you. I was questing the colocation document that came out. I thought that did not apply to Critical Access Hospital. I thought I heard that at the entry to a conference last week in the CMS session, but I may be confusing it with another piece that came out.

Danielle Miller: This does not apply to you Critical Access Hospitals.

Kathryn Miller: Okay, great. Thanks for clarifying.

Operator: And I'm showing no further -- I'm sorry. Now you have a question from Marc Hartstein of Health Policy.

Marc Hartstein: Hi, this is Marc Hartstein, Health Policy Alternatives. I just want to follow up on the first question that was asked about distinct stink space versus shared space. First, I would also like to say it's very helpful that you mentioned that this is new guidance and it's not replacing any current guidance because I was looking for the current guidance that this was modifying and since most of it was in red and it looked like it was in new guidance.

The guidance that I think a lot of people have been following has been an overhead a PowerPoint presentation by David Edinger from 2016 from what I have as April 11th, 2016 and in that document, there is a slide that says certain time sharing arrangements where the hospital rents a space for certain periods of time to another entity such as a physician practice when the spaces rented is not part of the landlord hospital.

So, I think it would be helpful to provide examples like that in the final guidance just to make clear when is the space shared and when is a space distinct I mean to me this language from the power point presentation suggested that the situation in Montana would potentially have been permissible the one that was described by the first questioner, however when I read the guidance that came out recently, I concluded the opposite. So to the extent of that guidance is being used.

I would suggest that you review that guidance and to the extent that any policies and consider whether any of that any policies are changing and just examples are always very helpful, I think in helping making sure these issues are clear.

Female Speaker: And we are looking into that, but just to give a little bit of clarification about shared space and we're really talking about shared clinical space in which two separate -- two separately Certified Health Care Facilities whether it be a hospital or health clinic, what have you-- would be sharing the same clinical spaces as in where patient care is being provided. That is what we're in our draft guidance that we currently have that is not permissible and like you say we have kind of remained silent on those time sharing, leasing options, which we can address in our final guidance.

Marc Hartstein: Yeah, okay. Well, yes, thank you. I appreciate that. I guess it depends on how you're going to address it. If you addressed in a way that's going to suggest that those arrangements aren't permissible, it probably be better to stay silent, I would just stay silent--.

Female Speaker: Remain silent.

Marc Hartstein: Anyway, I'm not speaking for any particular client. I'm just making an observation.

Female Speaker: No and what we're trying to accomplish with the overall guidance's. You know we want hospitals to understand that there you know they have to -- they have to have some flexibility in you know and how they operate and you know to make sure that we are not being so prescriptive that you know everybody's kind of locked into a situation and you know part of the question had come up previously you know or we going to have, is this going to require construction is you know what does this actually mean and you know I think that's part of the advantage of doing this in draft as sort of looking at some of those other situation that we may not have considered to be able to allow hospitals to have some flexibility and how they apply this. As you know one colocation situation is one colocation situation and you know we don't want to be you know extremely prescriptive you know we want to stay within the guys of being able to meet the hospital conditions on participation and making sure that each co-located entity meets them independently.

Marc Hartstein: Yeah, thank you. I appreciate you providing guidance where there previously wasn't, and that certainly is very helpful and I also appreciate the sentiment about flexibility. I worked at the agency for a very long time and I understand that more prescriptive rules can reduce flexibility potentially to the point where you're having to address situations in ways that are not desirable from a policy or a public health or public safety standpoint, so appreciate all of the sentiments.

And I also want to say thank you for releasing the guidance and draft. I do think that's very helpful to allow for provide -- for you know the interested stakeholders to provide comments before the guidance finalized. Thank you for all of that.

Female Speaker: Thank you.

Operator: Once again if you'd like to ask a question, please press star one. I'm showing no further questions.

Jill Darling: All right and I'll hand the call back to John or Carol.

John Hammarlund: Carol, would you like to let folks know how they can send in agenda items for future calls?

Carol Blackford: Absolutely and thank you everyone for the great questions today and for all of the CMS folks who participated on the call. It was a great conversation with information that we hope is helpful to you. If you have agenda items that you would like to see included on future calls or if you had a question that you were meaning to ask, but we're not able to, please send those to our Rural Health Open Door Forum Mailbox and the address is ruralhealthodf@cms.hhs.gov. Thank you.

Operator: Thank you for participating in today's conference call. You may now disconnect.