

Centers for Medicare and Medicaid Services
Rural Health
Open Door Forum
Moderator: Jill Darling
August 24, 2017
2:00 p.m. ET

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

All lines have been placed on mute to prevent any background noise. After 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 then the number one on your telephone keypad. If you would like to withdraw your question, please press the pound key. Thank you.

Jill Darling, you may begin your conference.

Jill Darling: Thank you, (Megan). Good morning and good afternoon everyone. Thank you for joining us today for the Rural Health Open Door Forum. Before we begin, I have one brief announcement as always.

This open door forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press you may listen in but please refrain from asking questions during the Q&A portion of the call. If you do have any inquiries, please contact CMS at press@cms.hhs.gov.

So now I'll hand the call off to our co-chair, John Hammarlund.

John Hammarlund: Thanks so much, Jill. Well, hi, everyone. Thank you very much for joining us today. We have a really interesting agenda two, three important items that we need to bring your attention and we hope that – and so doing we

inspire some good discussion today with you. So we look forward to the question, answer and discussion period after the presentations.

We're really pleased to have some of our colleagues from the CMS headquarters on the call today, as well as the regional rural health coordinators calling in from each of 10 regional offices.

So, without any further ado, I'll hand it back to Jill so we can launch right in to the agenda. Again, thanks everybody for attending today. We really appreciate your time.

Jill Darling: Great. Thank you, John. First, we have Michele Hudson who will be going over some highlights of the Inpatient Prospective Payments System, IPPS Final Rule for fiscal year 2018.

Michele Hudson: Hi, good afternoon. On August 2nd, CMS issued a final rule that updates Medicare payment rates and policies for patient discharge from acute care hospitals for the upcoming fiscal year 2018 for discharge that occur October 1st, 2017 through September 30th, 2018.

In that final rule, we updated the payment rate for acute care hospitals based on the most recent estimate of the hospital market basket adjusted for some other required statutory factors. Then there are also some adjustments for hospitals that do not successfully participate in the hospital Quality Reporting Program or are meaningful user of electronic health records.

Based on the update established in the final rule, CMS projects that the increase to payment for hospitals will be an increase of approximately 1.3 percent then there's also an additional increase in operating IPPS payment to hospitals of 0.7 percent based on an increase in payment under the uncompensated care provision.

In addition, there are other payment adjustments that will continue under some of the pay-for-performance program such as the Hospital Acquired Condition Reduction Program, the Hospital Readmission Reduction Program, and the Hospital Value-Based Purchasing Program.

So overall, based on all of the updates and rates that were established in the final rule, CMS is expecting to increase payments to hospitals overall by about \$2.4 billion in FY '18.

One of the bigger provisions addressed in the rule this year was CMS's payment adjustment for Medicare Uncompensated Care Payments. CMS distributes a prospectively determined amount to uncompensated care payments to Medicare disproportionate share hospitals based on their relative share of uncompensated care.

As required under law, the amount available to distribute is equal to 75 percent of the amount that otherwise would have been paid as Medicare disproportionate share payment, and that except that amount is adjusted for the change in the rate of (un-insurance) and other factors.

So in the final rule for FY '18, CMS is distributing approximately \$6.8 billion in uncompensated care payment, and this is an increase of approximately \$800 million from the amount available for distribution in 2017 amount.

Another big change related to uncompensated care payments established in the final rule is that CMS adopted a policy to begin incorporating uncompensated care cost data from the S-10 Worksheet on the Medicare Cost Report and its methodology for determining the distribution of these uncompensated care payments.

Specifically for '18, CMS is using the Worksheet S-10 data from FY 2014 cost report in combination with Medicare and Medicaid low income days from the two preceding cost reporting period to determine the distribution of uncompensated care payments.

In addition, CMS also noted that in efforts to continue to ensure accurate Worksheet S-10 data are available for potential use in calculating uncompensated care payments in the future, CMS has provided hospitals with an additional opportunity to resubmit certain S-10 Worksheet data to their –

on their cost report, to their Medicare Administrative Contractor or MAC by the end of September, so that would be September 30th, 2017.

There are also two provisions in the final rule that include information about the expiration of two statutory provisions. The first is the statutory expiration of the Medicare Dependent Hospital Program. Under the current law the Medicare-dependent, Small Rural Hospital Program is set to expire at the end of this current fiscal year.

So beginning with discharges occurring on or after October 1st, 2017, all hospitals that have previously qualified as Medicare-dependent hospital which is the provision that provides certain payment adjustments to qualifying hospitals under the IPPS. Those hospitals will no longer have that status and therefore will no longer be eligible for those additional payments, unless there's a change in the law.

Similarly, there's also – there's also an expiration of the temporary expansion of the low-volume hospital payment adjustment that was provided for originally in Affordable Care Act that has been extended through subsequent legislation through the end of this fiscal year.

So, currently, hospitals that have fewer than 1,600 total Medicare discharges and are more than 50 miles from the nearest subsection of the hospital can qualify for that add-on payment. Those criteria revert back to the original criteria for when that provision was established in 2005. And so beginning for FY '18 under current law, hospitals will have to have 200 or fewer total discharges, and be more than 25 miles from the nearest subsection of the hospital in order to qualify for those payments.

In addition, CMS also made – adopted a policy change under the low-volume hospital payment adjustment regarding the proximity and (Indian) Health Service Hospital. And some of the main highlights from this year's IPPS rules in payments for 2018.

Jill Darling: All right. Thank you, Michele. And next we have Shonte Carter who will go over some of the RHC Emergency Preparedness

Shonte Carter: Thank you. Good afternoon, everyone. I'd like to take this opportunity to review the CMS Emergency Preparedness Requirements specifically as it pertains to Rural Health Clinics. As a brief background, the purpose of the emergency preparedness rule is to establish national emergency preparedness requirements to ensure adequate planning for natural and man-made disasters, and to ensure coordination with federal, state, tribal, regional and local emergency preparedness systems.

On September 8, 2016, CMS published in the Federal Register the emergency preparedness final rule. The effective date of the rule was November 16, 2016. However, all providers and suppliers affected by this rule which does include rural health clinics, have one year from the effective date to comply and implement requirements of the emergency preparedness rule. Again the rule was effective on November 16, 2016.

However or therefore all affected providers and suppliers must comply and implement the emergency preparedness requirement by November 15, 2017 of this year.

Each provider and supplier type has its own set of Emergency Preparedness regulations which are incorporated within its set of Medicare requirements. The RHC emergency preparedness regulations are located at 42 CFR 491.12. There are four core elements of the emergency preparedness regulation. I will briefly provide a description however for more specific details, please visit 42 CFR 491.12.

The four core elements include a risk assessment and emergency plan, and community plans, policies and procedures for the emergency plans, and training and testing.

The emergency preparedness regulation also includes requirements for provider and suppliers with integrated healthcare systems who elect to participate in a unified and integrated emergency preparedness program. The rule also provides details on what in this unified and integrated emergency preparedness program must demonstrate. As a reminder, detailed emergency

preparedness requirements for rural health clinics are provided at 42 CFR 491.12.

In an effort to inform and assist the provider and supplier community with the emergency preparedness requirements, CMS issued the following S&C memos. On October 28, 2016, S&C 17-05 was issued. This memo provides an information on the implementation plan for the Emergency Preparedness requirements. Within this memo, we discuss things such as training on the Emergency Preparedness plans and the upcoming release of interpreted guidelines for the Emergency Preparedness regulation.

On March 24th, 2017, we issued two memo, S&C 17-21 and S&C 17-22. S&C 1721 provided information to assist providers and suppliers with meeting the new training and testing requirements into the emergency preparedness role. S&C 1722 introduced save the date for a national provider conference call. During this call, we review the Emergency Preparedness training and testing requirements. The call actually took place on April 27th of this year.

Finally, we issued S&C 17-29. This memo was issued on June the 2nd, 2017. S&C 17-29 provided an advance copy of a new Appendix, Appendix Z of this data operation to manual. Appendix Z contains interpretive guidelines and survey procedures with the Emergency Preparedness regulations. Appendix Z applies to all providers and suppliers affected by the emergency preparedness role.

In addition to these S&C memos, CMS developed an S&C Emergency Preparedness website. A link to the website is attached to today's agenda. The website provides a wealth of additional information and resources to assist date survey agencies, states, tribal, regional, local emergency management partners, and healthcare providers and suppliers developing effective emergency plans.

After reviewing the survey and certification, Emergency Preparedness website provided, if you have additional questions, e-mailed may be sent to the Emergency Preparedness website. That e-mail address is S-C-G which stands

for Survey and Certification Group. That's
SCGEmergencyPrep@cms.hhs.gov.

And as a reminder, all the providers and suppliers that are affected by this rule and it does include the rural health clinic community must comply and implement the Emergency Preparedness requirement by November 15th of this year. Thank you. And I will turn the call back over.

Jill Darling: Thank you, Shonte, and thank you to Michele. So (Megan), we will go into our Q&A please.

Operator: Certainly. 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 your questions to one question and one follow-up to allow other participants time for questions. If you require any further follow-up, you may press star again to rejoin the queue.

And at this time, we have no questions.

Again, it's star one if you would like to ask a question. Your first question is from Jeff McCarthy with the Katahdin Health. Your line is open.

Jeff McCarthy: How will the emergency preparedness guidelines be – I guess governed? Like who is the governing body over it?

Shonte Carter: CMS state survey agencies will survey on behalf of CMS to determine whether or not the emergency preparedness requirements are met. And as of November 15th, 2017, any new provider or supplier or existing providers and suppliers that are approaching every certification survey would be required to comply with those requirements.

Jeff McCarthy: OK, thank you.

Shonte Carter: You're welcome. And I just want additional piece to that. There are also accrediting organizations who foster programs through prevent through CMS

and the AOs, the Accrediting Organizations, also are required to implement the Emergency Preparedness requirement.

Any other question?

Operator: Your next question comes from the line of Julie Quinn with HSA. Your line is open.

Julie Quinn: Hello. Two quick questions. Number one, I didn't get the address for the website, Emergency Preparedness website. And then secondly, what we're truly struggling without here is, to find a simple enough risk assessment that a small rural health clinic can complete, can comprehend. And if anyone has any ideas on, no I seen one on Kaiser Permanente, I've been told that the L.A. County Sheriff Department has a few things out there. But if anybody – do you guys have any suggestions, recommendations, the good things you've seen, the community would be more than thrilled to hear that.

I mean I heard a lot of, you know, we gave this memo, we gave that memo. But, we're just struggling out here getting something that is simple enough for the RHCs to understand the risk assessment it will be great.

Shonte Carter: Thank you for that feedback. I'll start by responding to the mailbox. It is S as in sand, C as in Charlie, G as in George, emergencyprep@cms.hhs.gov. With regards ...

Julie Quinn: I'm sorry. Was there a website too?

Shonte Carter: I'm sorry, yes. The website is actually a link to the website, should be attached to this agenda item, to this topic under state agenda.

Julie Quinn: Thank you.

Shonte Carter: And then the link is out there, we can definitely provide it after the call. It's definitely important to have access to that link because the link does provide a number of other resources as I mentioned. And one of the resources is a list of templates and checklist. And I do believe the information that you are

requesting under the templates, you'll see array of different examples of things to help assist with preparing and planning that emergency plan.

So that the website is a wealth of information. So, if you don't have that link, we definitely ensure that you get the link so you have access to the tools and templates and checklist that we've provided.

Julie Quinn: Yes, I hit the link. I'm just not seeing the, you know, anything like on a – yes as anybody has – and I've been on ask for (Tracy) as well. If anybody has a great simple – simple, again, simple enough that a small rural health clinic can use it – use risk assessment? I know the National Association of Rural Health Clinics would be glad to hear that as well and to put that up to our community. Again, if anybody has any suggestions, we would greatly appreciate those.

Operator: Your next question comes from the line of Gary Luker with Luker Pharmacy Management. Your line is open.

Gary Luker: Yes, I've got a question. The memo I got said that you guys would be discussing the new proposed guidelines on 340(b), and the new Medicare requirements. Is that not the case in this form?

Shonte Carter: I'm sorry, which memo are you referring to?

Gary Luker: It was one that was sent out by the Texas Hospital's – Texas Organization of Rural and Community Hospitals of Texas.

Shonte Carter: No, I'm not exactly sure what form that is. But the last form that I was – or the last memo that I was referring to introduces the interpretive guidelines which are basically at in the survey procedures for Emergency Preparedness rule.

Gary Luker: Right. And that's my understanding. And my understanding was that they also going to be discussed in this forum. I mean if that's not the case then, you know, we can drop this question and move to another forum ...

(Crosstalk)

Shonte Carter: I'm sorry, not sure if you heard me. No, I do not believe that is the case. That memo simply introduces an advanced copy of the Appendix Z, interpretative guidelines for EPA requirements.

Gary Luker: OK. Well, I just worked with a lot of small hospitals and that is going to be extremely burdensome and almost impossible for them to do. So, I'll look for other forms to get involved in them. Sorry to take up your time.

Operator: And there are no further questions at this time.

Jill Darling: All right. Well thank you everyone for joining today's Rural Health. You will get some of your time back, your morning or afternoon back. So thank you everyone and we'll send out the next agenda when – in about six or so weeks. So just be on the lookout for that one. Thank you, everyone.

Operator: Thank you for participating in today's Rural Health Open Door Conference Call. This call will be available to replay beginning today at 5:00 p.m. Eastern to midnight in August 28th. The conference ID number for the replay is 60589813. 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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