Centers for Medicare & Medicaid Services

Rural Health Open Door Forum

Moderator: Jill Darling

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2:00 pm ET

Coordinator: Welcome and thank you for standing by. Today's call is being recorded. If you have any objections you may disconnect at this time. All participants are in listen only mode until the question and answer session of today's call. At that time, you may press star 1 to ask a question. I would now like to turn the call over to Jill Darling. Thank you. You may begin.

Jill Darling: Thank you, (Kelly). Good morning and good afternoon everyone. Welcome to today's Rural Health Open Door Forum. We have a pretty packed agenda, so I will be brief with my announcement. This Open Door Forum is open to everyone. So if you are a member of the press, you may listen in, but please refrain from asking questions during the Q&A portion of the call. If you do have any inquiries please contact CMS at Press@cms.hhs.gov. And I'll hand the call to our co-chair, Ing-Jye Cheng.

Ing-Jye Cheng: Hello, everyone. Good afternoon to those of us on - in the Midwest and on the East Coast. And good morning to our colleagues on the West Coast. I wanted to welcome you to a very excited Open Door Forum today. We have quite a few updates. We've been busy here at Medicare. Quite a few updates for you all and a long agenda.

So I do want to make sure we get to our Q&A at the end. But if you're not able to get to your question during this call today, I just wanted to flag for everybody that we do have an email box that we monitor, and we'll make sure we address your questions through email if you don't have chance to ask it today. And that email is RuralHealthODF, so R-U-R-A-L-H-E-A-L-T-H-O-D-F at C-M-S dot H-H-S dot G-O-V.

So with that, I'm going to turn to the first of three speakers who will tell you more about the rural emergency hospital provision that the agency is implementing. And the first of those speakers is Kianna Banks. Kianna?

Kianna Banks: Thank you Ing-Jye. Again, I'm Kianna Banks. I'll be providing an overview of the Rural Emergency Hospital Proposed Rule that contains the proposed conditions of participation for this brand new provider type as well as proposed conditions of participation for critical access hospitals. Just for clarity, I just want to start out by highlighting that the Rural Emergency Hospital Proposed Conditions of Participation were published in their own separate rule, which is separate from the payment rule that will be discussed later in this call. And the conditions of participation rule is titled Medicare and Medicaid Programs Conditions of Participation for Rural Emergency Hospitals and Critical Access Hospital (EOC) Updates.

So just to give you a little bit of background on this brand new provider type and how it came to be, the Consolidated Appropriations Act of 2021 established rural emergency hospitals as a new Medicare provider type to allow for continued access to emergency care in rural areas.

In accordance with the statutory requirement a facility is eligible to become a rural emergency hospital if it was a critical access hospital, or a rural hospital with not more than 50 beds on or before the date of enactment of the Consolidated Appropriations Act. And that date of enactment is December 27, 2020. The statutory does allow for RNH's to receive payment for items and services furnished on or after January 1, 2023. And our goal is to get all the rural emergency hospital policy finalized before that date.

All rural emergency hospitals must provide emergency services and observation care and they may not provide inpatient services. Rural emergency hospitals may provide skilled nursing facility services and a separately certified distinct part field nursing facility unit. And rural emergency hospitals may provide additional outpatient medical and health services as specified by the Secretary through rule-making. And also the staff (unintelligible) does allow the secretary discretion to establish additional requirements for rural emergency hospitals in the interest of health and safety.

So in order to address the growing concern over closures of rural hospitals, this proposed rule will create a pathway for convergence for certain critical access hospitals and rural hospitals to (unintelligible) provider type in accordance with the statutory requirement. And the overall policy goal of the proposal to establish the health and safety standards for rural emergency hospitals in the most efficient manner possible and in accordance with the statute, while considering the access and quality of care needs of the patient population they'll serve.

Also, the proposal as I mentioned, contains some provisions for critical access hospitals and needs to provide clarity and consistency for critical access hospitals regarding compliance with a location and distance requirement. And increase flexibility for critical access hospitals who are part of a larger health system.

So, we closely model the proposed rule emergency hospital requirements after the critical access hospital conditions of participation, based on comments we've received on the request for information that we published last year, that generally encouraged us to align the conditions of participation for rural emergency hospitals with the existing conditions of participation for critical access hospitals. And those comments have encouraged CMS to consider challenges associated with the purposes of healthcare services to rural communities.

The rural emergency hospital proposals for staffing, medical records, emergency preparedness, laboratory services, infection control, discharge planning, and quality assessment and performance improvement program requirements, generally reflect the critical access hospital standards. And in some cases they're less stringent than the critical access hospital requirements.

This is due in part to the statutory requirements, but also in part, based on the fact that this is a different provider type, and given the fact that critical access hospitals provide inpatient services while rural emergency hospitals are an outpatient only provider.

Some key differences between the critical access hospital requirements and the proposed rural emergency hospital requirements are that rural emergency hospitals are prohibited again, from providing inpatient services, rural emergency hospitals are required by the statute to have an agreement with a level 1 or level 2 trauma center.

And rural emergency hospitals must have someone on site at the facility at all times. The existing critical access hospital emergency services requirements state that a practitioner with training or experience in emergency care, has to be on call and immediately available by telephone or radio contact and available onsite within 30 minutes or within 60 minutes depending on if the facility is located in a (frontier) area.

We proposed this for rural emergency hospitals in accordance with the statutory requirement and we have also included a request for comment on the appropriateness of this level of onsite presence for practitioners in the rural emergency hospital and the feasibility of implementing more stringent requirements in rural communities. Rural emergency hospitals may provide additional outpatient services.

And we specifically note in the proposed rule that these services may include but are not limited to, radiology, laboratory, outpatient rehab, surgical, behavioral health which includes substance use disorder treatment, and maternal health services. And we'd just like to note that we are also taking comment on the appropriateness of allowing rural emergency hospitals to provide low risk labor and delivery services.

We are proposing to establish specific rural emergency hospital requirements as separate COP for medical staff, radiological services, and pharmaceutical services. And we just point that out because there is a difference - you won't see that in a critical access hospital, COPs. However, the requirements that we propose for rural emergency hospitals, aren't anything that critical access hospitals aren't already expected to be providing.

CMS is proposing updates to the critical access hospital conditions of participation to provide additional flexibility and clarity in the requirement for the location and distance requirements. We are adding a definition of primary roads to those requirements to allow for a consistent method of measuring distance between the critical access hospital and another hospital or critical access hospital. And we are proposing to establish a patient's right condition of participation to mirror the hospital patients right condition of participation. We note that this is also something that we propose for the rural emergency hospital conditions of participation.

And we are proposing to allow a critical access hospital that is a part of a multifacility health system. So using unified and integrated models for its organized medical staff, as well as for its infection, prevention and control and antibiotic stewardship programs, and quality assessment and performance improvement program. The health system must have a single governing body that is legally responsible for all of the facilities in the system in order to take advantage of that flexibility.

And just to tack on the timing of the proposed rule and when it will be finalized, all of the final policies for rural emergency hospitals including the

conditions of participation, the enrollment and payment requirements, and the quality emergency and quality reporting requirements, will be published in the calendar year 2023 Outpatient and Ambulatory Surgery Center Final Payment rule in the fall. And the proposed COP policies will also be finalized in that same rule.

The comment period for the rural emergency hospital conditions of participation proposed rule, closes on August 29th. And that is all I have, so I'll pass it over (Josh McFeeters) for a discussion of the proposed REH payment policies.

(Josh McFeeters): Thank you, Kianna. REHs will receive payment from two sources. The first source is payment for individual services performed. REHs will be paid at the OPPS payment rate for service plus an additional 5% payment. This additional 5% payment will be excluded from beneficiary cost sharing. In order not to limit the types of services that REHs can provide, CMS is also proposing that REHs may provide certain outpatient services beyond those paid under the OPPS, which would be paid at the applicable fee schedule amount without the additional 5% payment.

The second payment source for REHs is a monthly facility payment. We estimated a proposed monthly facility payment for each individual REH of $268,294, which translates into an annual facility payment for each REH of $3.22 million for calendar year 2023. As noted just before this payment amount, will be the same for all REHs. In subsequent years the payment amount will be updated by the hospital market basket percentage.

As Kianna mentioned earlier, the REH statute allows an entity that is owned and operated by a REH that provides ambulance services to receive payment for those services. And those services will be paid under the ambulance fee schedule. We are also proposing to update ambulance regulations to ensure that ambulances can service REHs.

The REH statute also allows REHs to include a unit that is a distinct part of the facility licensed as a skilled nursing facility to furnish post-hospital extended care services. Payment for services provided by a REH at such a unit will be made using the skilled nursing facility prospective payment system. Next, my colleague (Meredith Larson), will discuss the REH Stark exceptions.

Meredith Larson: Thanks, (Josh). As (Josh) said, I'll be discussing proposed changes to the physician self-referral law related to rural emergency hospitals. As a reminder, the physician self-referral law prohibits a physician from making a referral for certain designated health services to an entity with which the physician or an immediate family member of the physician has a financial relationship. In addition, the entity is prohibited from billing Medicare or any other party, for designated health services that it furnishes pursuant through a prohibited referral.

However, the statute and our regulations provide exceptions to the referral and billing prohibitions. As anticipated, rural emergency hospitals will provide designated health services for purposes of the physician self-referral law. Without an applicable exception, the physician self-referral law would prohibit referrals of REH services that are also designated health services, by physicians who have financial relationships with rural emergency hospitals.

To ensure that the physician self-referral law does not thwart the underlying goals of ensuring access to care in rural areas through the establishment of the new rural emergency hospital provider type, we are proposing a new exception for ownership in a rural emergency hospital. We are also proposing modifications to some existing exceptions to make them applicable to compensation arrangements between rural emergency hospitals and physicians or immediate family members of physicians.

Essentially, these proposals support the policies established for rural emergency hospitals. Elsewhere in the OPPS and conditions of participation. And with that, I will pass to (Erick Chuang) to discuss updates to OPPS and ASC payment rates.

(Erick Chuang): Thank you. For the OPPS update CMS is proposing to update OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2.7%. This update is based on the projected hospital market basket, percentage increase of 3.1% reduced by 0.4 percentage points for the product readjustment. For the ASC update - in the calendar year 2019 OPPS ASC's final rule, CMS applied the product to be adjusted hospital micro basket update to ASC payment system rates for an internal period of five years from calendar years 2019 through 2023.

Using the proposed hospital market basket update, CMS is proposing to update the ASC rates for calendar year 2023 by 2.7%. And with that, I'll turn things over to Gift Tee to discuss the calendar year 2023 Physician Fee Schedule NPRM.

(Gift Tee): Thanks, (Eric). Good afternoon. Good morning, everyone. You know, there is a lot in the PFS this year, so I will be brief and just touch on some of the topics. But I wanted to remind folks that the comment period for the CY 2023 proposed rule, PFS proposed rule, ends on September 6th, so please send in your comments as soon as you can. We look forward to hearing from you.

So for this year in the 2023 PFS rule, we are proposing a series of standard technical proposals involving practical expense including implementation of a second year of the clinical labor pricing updates. Per statutory requirements, we're also updating data we use to develop a geographic practice cost indices (unintelligible) and malpractice RVUs. We've also included a comment solicitation seeking public input as we developed a more consistent predictable process incorporating new data and setting PFS rates.

We hope to implement these changes or changes that will promote transparency and predictability in payment amounts. With the budget neutrality adjustment they are required by law to ensure payment rates for individual services don't result in changes to estimated Medicare spending. They require statutory updates to the convergence act for CY 2023 of 0%, and the aspiration of a 3% increase in PFS payments for CY 2022. The proposed CY 2023 PFS conversion factor is $23.08. That's an increase of $1.53 to the CY 2022 PFS conversion factor of $34.61.

In this year's rule we're also proposing to rebase and revise the Medicare economic index cost share weights for CY 2023. We're soliciting comments regarding the rebasing and revision of the MEI which measures the input price

pressures of providing physician services. We're proposing a new methodology for estimating base year expenses that relies on publicly available data from the US Census Bureau, Office of Physicians.

This proposed methodology allows for the use of data that are more reflective of current market conditions of physician ownership practices rather than only reflecting costs of self-employed physicians. And will also allow for the MEI to be updated on a more regular basis.

I want to point out that using the new MEI cost wage (unintelligible) rates will not change overall spending on PFS services, but will likely result in significant changes to payment among PFS services.

In consideration of our ongoing efforts to update the PFS payment rates with more predictability and transparency in the interest if ensuring payment stability, we're proposing not to use the proposed updated MEI cost share (unintelligible) PFS payment rates for CY 2023. But we are soliciting comment on potential use of the proposed updated MEI cost share wage to calibrate payment rates and updated (unintelligible) fees under the PFS in the future.

Now I'll touch on our E&M proposals. As part of ongoing updates to E&M visits and related coding guidelines our intent is to reduce the administrative burden of the AMA CPT editorial panel approved revised coding and updated guidelines for other E&M visits. Effective January 1, 2023 similar to the approach (unintelligible) finalizing CY 2021 PFS final rule, the (unintelligible) outpatient E&M visit coding and documentation.

For CY 2023 we are proposing to adopt most of the changes in coding and documentation for the other E&M visits which include hospital and inpatient, hospital observation, emergency department, nursing facility, home of resident services, and cognitive impairment assessment, effective January 1, 2023. This revised coding documentation framework would include CPT code definitions, revisions to the other E&M code descriptors including new descriptor terms where relevant, provide interpretive guidelines, choice of medical decision-making or time to select code level, and the elimination of the use of history and exam to determine code level.

We're also proposing to maintain current billing policies that apply to the E&Ms while we consider potential revisions that may be necessary in future rule making. We are also proposing to create Medicare specific coding for payment of other E&M prolonged services similar to what CMS adopted in CY 2021 for the payment of office outpatient prolonged services.

Also in the proposed rule, we are proposing to delay the split or share business policy we finalized in CY 2022 for the definition of substandard portions as more than half of the total time for one year with a few exceptions. Therefore, for CY 2023 as in CY 2022 the substantive portion of a visit may be met by any of the following elements - history, performing physical exam, medical decision-making, or time.

There are proposal (unintelligible) to furnish split of shared visits will continue to have a choice of history, physical exam, medical decision-making,

more than half of the total practitioner time spent to define the substantive portion instead of using total time to determine that portion until CY 2024.

We've also made some proposals in our behavioral health services space. CMS set a goal to improve access to the quality and mental healthcare services, in light of current needs among Medicare beneficiaries to improve their access to behavioral health services, we have considered a regulatory business that may help to reduce existing barriers and make greater use of the services of behavioral health professionals such as licensed professional counselors and licensed marriage and family therapists.

Specifically, we're proposing to make an exception to direct supervision requirements under our incident 2 regulations to allow behavioral health services to be provided under the general supervision of a physician or non-physician practitioner. Rather than under direct supervision when these services or supplies are provided by auxiliary personnel incident to the services of the physician or non-physician practitioner. We believe that this proposed change will facilitate utilization and extend the reach of behavioral health services.

We're also requesting information about how community health workers are involved in Medicare Part B services furnished by eligible practitioners and providers. We're specifically interested in learning more about the role of CHWs in light of the benefits that the services involving CHWs can potentially have on the health of Medicare beneficiaries including reduction in health disparities. We are proposing new HCPCS codes and valuations for chronic pain management and treatment services for CY 2023.

We believe that proposed (CPM) codes if finalized, would facilitate payment for medically necessary services, prompt more practitioners to welcome Medicare beneficiaries for chronic pain into their practices. And encourage practitioners already treating Medicare beneficiaries who have pain, to spend the time to help them manage their condition.

In our telehealth space we're proposing a number of policies related to Medicare telehealth services, making several services that are temporarily available to telehealth services for the PHE available through CY 2023 on a category 3 basis, which would allow more time for collection of data that could support their eventual inclusion as permanent additions to the Medicare telehealth services list.

We're proposing to extend the duration of time that services are temporarily included on the telehealth service list during the PHE, but are not included on a category 1, 2, or 3 basis, for a period of 151 days following the end of the PHE, in alignment with the Consolidated Appropriations Act of 2022. We're proposing to implement the telehealth provisions in the CAA 2022 via program instruction of the sub regulatory guidance, to ensure smooth transition after the end of the PHE.

These policies extent certain flexibilities in place during a PHE for 151 days after the PHE ends allowing for all services to be furnished in any geographic area and in any originating site setting including a beneficiary's home, allowing certain services to be furnished via audio only telecommunication

systems, allowing physical therapists, occupational therapists, speech language pathologists, and audiologists, to furnish telehealth services.

The CAA 2022 also delays the in person visit requirements for mental health services furnished via telehealth until 152 days after the end of the PHE. We're proposing mental health claims will require the appropriate place of service indicator to be included on the claim rather than Modifier 95 and after the period of 151 days following the end of the PHE. And that Modifier 93 will be available to indicate that Medicare telehealth service was furnished via audio only technology where appropriate.

We are also proposing to allow beneficiaries to have direct access when appropriate, to an audiologist without a physician referral, by creating a new HCPCS code for audiologists to use when billing for audiology services that they already provide, that are defined by other codes. The service encompassed by the new HCPCS code would be personally furnished by the audiologist and would allow beneficiaries to receive care for non-acute hearing or assessments, unrelated to disequilibrium or hearing aids for examinations for the purpose of prescribing or change in hearing aids.

We're proposing to permit audiologists to bill for this direct access without a referral once every 12 months. Medicare currently pays for dental services in a limited number of circumstances such as when that service is an integral part of specific treatment for a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following accidental injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation.

We are proposing to clarify and modify certain aspects of our current policy for dental services. We are proposing and seeking comment on payment for other dental services such as dental exams, and necessary treatments prior to organ transplants, cardiac valve replacements, and valvuloplasty procedures, that may be inextricably linked to or substantially related, or integral to clinical success of an otherwise covered medical service.

We're also requesting comments on other types of clinical scenarios where dental services may be inextricably linked or substantially related or integral to the clinical success of other covered medical services, and the potential establishment of a process to review public submissions of recommendations for identifying the circumstances when these policies would apply. Finally, we are also seeking comment on potential future payment models for dental and oral healthcare services, and other impacted policies.

And finally, under the PFS again, not touching on everything although it sounds like I may be, we are proposing several changes to our policies for skin substitute products to streamline the coding, billing, and payment rules, and to establish consistency in how we code and pay for these products across various settings.

Specifically, CMS is proposing the change of terminology of skin substitutes for wound care management products, in order to accurately reflect health clinicians use these products to provide a more consistent transparent approach to coding for these products and the treatments, pay for these

products (unintelligible) supplies under the PFS, beginning on January 1, 2024.

We are soliciting feedback on our key objectives related to skin substitutes which include ensuring consistent coding and payment approach for skin substitutes across the physician office and hospital outpatient setting, ensuring that all skin substitute products are assigned an appropriate level to HCPCS code, and also using a uniform benefit category cross products within a physician's office regardless of whether their product is synthetic or comprises of materials, so that we can incorporate payment methodologies that are more consistent.

And finally, also maintaining clarity for interested parties on CMS's skin substitute policies and procedures. Finally, for 2023 we're also proposing updates on Medicare coverage policies for colorectal cancer screening, in order to align with recent United States preventive services taskforce's recommendations. First, we are proposing to expand Medicare coverage for certain colorectal cancer screening tests by reducing the minimum age payment limitation to 45 years.

And second, we are proposing to expand the regulatory definition of colorectal cancer screening tests to include a follow on screening colonoscopy after Medicare covers non-invasive stool-based colorectal cancer screening test returns a positive result. And with that, I believe I will turn it over to my colleague, Michelle Franklin. Thank you.

Michelle Franklin: Thank you, (Gift). Again, I'm Michelle Franklin, and I will go over the sections of the PFS and (PRN) that impact HCs which are chronic pain management, behavioral health integration services, and specified provider based RHC payment limit per visit. For this proposed rule we are proposing to add the new chronic pain management and behavioral health integration services to the RHC and FQHC specific general care management HCPCS code G0511, to align with the proposed changes made under the PFS for CY 2023.

Since the requirements for the new chronic pain management and behavioral health integration of services are similar to the requirement for the general care management services furnished by RHC and FQHC, the payment rates for HCPCS code G0511, will continue to be the average of the national non-facility PFS payment rates for the RHC and FQHC care management and general behavioral health codes. And they will be updated annually based on the PFS amounts for these codes.

Regarding the specified provider based, RHC payment limit per visit, in the CY 2022 PFS Final Rule, CMS finalized their specified provider based RHC that did not have an all-inclusive rate or AIR, established for services furnished in 2020 with half their payment limit per visit, established based on their AIR determined by (MACs) using the RHC final settled cost report ending in 2021.

The interim rates estimate will be reconciled at cost report settlement for the cost reporting period ending in 2021, which is used to establish the RHC payment limit per visit for services furnished in 2021. As publication of the

CY 2022 PFS Final Rule, interested parties to collect the clarification regarding the timing of cost reports. Specifically, if the payment limit could be set using a short cost report, less than 12 consecutive months.

Since we did not specifically address requiring the cost reports to span the full 12 consecutive month period or whether MAC following their interim rate setting process, could establish the payment limit using a specified RHC short period cost report. We are providing clarification and discussion in this proposed rule on the use of 12 consecutive month cost reports versus short period cost reports, to establish the payment limit for specified provider based RHC.

We believe 12 consecutive months of cost reporting data will more accurately reflect the cost of providing RHC services and will establish a more accurate base from which the payment limits will be updated going forward. I look forward to your comments. Thank you. And now I'll turn it over to (Ashley Standridge).

(Ashley Standridge): Great. Thanks, (Michelle). Good morning and good afternoon everyone. I'll be giving an update on the proposed rule for home health. On June 16, 2022 CMS issued the calendar year 2023 Home Health Respective Payment System Rate Update Proposed Rule, which would update Medicare payment policies and rates for home health agencies. In accordance with existing statutory and regulatory requirements, this rule includes a proposed 2.9% increase in home health payments based on the proposed market basket for calendar 2023.

A proposed permanent 5% cap on negative wage index changes, a proposal to recalibrate the case-mix weights, functional levels, comorbidity adjustment levels, and LUPA thresholds for home health services, as well as an update to the home infusion therapy service, payment rates for calendar 2023. In addition, CMS is proposing to apply a permanent prospective payment adjustment of a decrease of 7.69% to the home health 30-day period payment rate.

This adjustment is required by law to account for the differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures due to the implementation of the Patient-Driven Groupings Model and 30-day unit of payment. However, the overall estimated impact is negative 4.2% in calendar year 2023. CMS is soliciting comments on how best to implement a temporary payment adjustment, estimated to be $2 billion for excess expenditures for calendar year 2020 and 2021.

CMS is also soliciting comments on the collection of telehealth data on home health claims to allow CMS to analyze the characteristics of the beneficiaries utilizing services furnished remotely. All comments must be received no later than 5:00 pm on August 16, 2022. And with that, I'll turn it back to Jill.

Jill Darling: Great. Thank you, (Ashley) and thank you to all of our speakers today. (Kelly), will you please open the lines for Q&A? (Kelly), we are ready for Q&A, please. To our operator, (Kelly)?

Coordinator: Hi. I'm sorry. I was answering a line. I apologize. Are we ready for Q&A?

Jill Darling: Yes, we are. Thank you.

Coordinator: Great. Thank you so much. If you would like to ask a question, please press star 1, unmute your phone and record your name. If you would like to withdraw your question you can press star 2. And again, star 1 to ask a question. And it can take a moment or so for the questions to come through. Okay. So it looks like our first question is going to be (Eric Hagan). (Eric), your line is open.

(Eric Hagan): Thank you. Yes, this is just a question regarding the new rural emergency hospital. If a critical access hospital has a provider based rural health clinic that already has an established rate, would the rural emergency hospital be able to I guess, essentially assume or take on that rural health clinic at that established rate, or would they have to get decertified for rural health clinic? Well let me back up? Would the rural emergency hospital be able to have a provider based rural health clinic first? And if so, do they have to get decertified or would they be able to maintain the existing rate?

(Josh McFeeters): Hello. This is (Josh McFeeters). I think the best thing right now - we don't have the people who could speak best to the 603 provisions for REHs would be to submit your question to the email box. And, you know, someone will get back to you on how that all will work out. It is also in the proposed rule as well, if you want to read it there.

(Eric Hagan): Thank you.

Coordinator: The next question comes from (Helen Kubler). (Helen), your line is open.

(Helen Kubler): Thank you. Again, on rural emergency hospitals, I was trying to figure out and didn't see a definition for the 50 beds. Do you guys have a definition of that?

Kianna Banks: Hi. This is Kianna Banks. There is language in the statute and you can pull it up, that speaks to a specific requirement. It doesn't - it speaks to the rural requirement though. It doesn't speak to the 50 beds. The statute just says that it needs to be - the facility needs to be located in an area that's considered rural or that has not more than 50 beds.

(Helen Kubler): Right. But is 50 beds based on the final cost report at that time, staff beds, state licensed beds? The definition that they use for rural health clinics at a (sole) community provider?

Kianna Banks: And that's something that's policy that would still be under development at this time. So that would be forthcoming. And we would encourage you to submit that, you know, if you have that question, submit that as a comment on the proposed rule. (Josh), do you have anything to add on that?

(Josh McFeeters): No. I defer to you, Kianna, on that.

Kianna Banks: Okay.

(Helen Kubler): Okay. Thank you.

Coordinator: Our next question comes from (Brenda Quaring). (Brenda), your line is open.

(Brenda Quaring): Good afternoon. This is also in regards to the rule of emergency health, or rural emergency hospitals. In regards to quality, I read over some of the proposed quality measures. Just a question on some of them, without having inpatient services, things like oh, CAUTI and CLABSI and that stuff, kind of still looks like it's in there. Would that still be - how does that work in relation to a REH versus an inpatient hospital or CAH?

((Crosstalk))

(Josh McFeeters): Go ahead, Kianna.

Kianna Banks: Oh. I was just going to say I'm not sure if we have anybody from the quality measures team on the line.

(Josh McFeeters): I don't think we do. I think the best thing would be to submit this question to the email box. We do have a quality measures team and somebody will get back to you on that.

(Brenda Quaring): What is the email for that?

Jill Darling: So, on the Rural Health ODF agenda is the email. If you have it, it's in the middle right after the agenda. But it's RuralHealthODF@cms.hhs.gov.

(Brenda Quaring): Thank you.

Jill Darling: You're welcome.

Coordinator: Our next question comes from (Steve Feraquat). Your line is open.

(Steve Feraquat): Thank you very much. This is (Steve Feraquat). I have a question on the rural emergency hospitals. For the past 20 years the federal government has told rural America that the way to (unintelligible) prosperity is to sell it, hospitals, large health systems. That's led to slashing of services and increase in rural mortality. Now rural America from a rural perspective, it looks like CMS is paying these large health systems. $2.9 million a year to close their already viable health systems.

We're working with rural towns who are interested in acquiring their system back so it doesn't get turned into a rural emergency hospital which we know increases the local mortality. So CMS has - is there anything CMS is doing to ensure that the shareholder (will) matter or the ones in rural America and they're the ones making the decision, not the shareholders in the New York Stock Exchange. But rural America should be making these choices.

Does CMS have a way for rural America to get its community owned hospital back? Because you tell us to sell them to them and now they're trying to shut them down, and they're viable. That's just my question. Thank you.

Ing-Jye Cheng: Thanks very much. And I definitely appreciate the passion with which you speak and the fact that you are serving very important populations. I think our presenters today really were walking you through how the agency is implementing a new statutory provision to pay for these new rural emergency hospitals, describing the definitions, the conditions for participation with the Medicare program, as well as the payment rates. Under that program these are

currently proposals. They're two separate proposed rules as the speakers mentioned.

And we would love to hear those comments to those proposed rules either on the payment side or the conditions side, and also the Stark exception side. But I definitely appreciate the passion with which you speak.

(Steve Feraquat): You know, it's going to kill people and it's...

Coordinator: The next question comes from (Karen Wood). (Karen), your line is open.

(Karen Wood): Hi. My question is rural health clinic related. In the spirit of trying to expand behavioral and mental health to our communities, I'm just wondering if there is any anticipated movement towards expanding billable providers in the RHC setting beyond the license and independent clinical social workers to counselors or (unintelligible) or the like?

Ing-Jye Cheng: This is Ing-Jye. I'm not sure we have anybody on the call with the expertise to answer that question. Would you be so kind as to submit that to email so we can get it to the right person's agency and they can respond? And the email address is RuralHealthODF all one word, at CMS dot HHS dot gov.

(Karen Wood): Thank you. Yes.

Ing-Jye Cheng: Thanks.

Coordinator: Our next question comes from (Tammy Asher). (Tammy), your line is open.

(Tammy Asher): Hello. My question is since these are proposed rules, is there somewhere on I don't know, the Web site, or somewhere I can locate the specifics that you went through today? Or will that be sent out to participants?

Ing-Jye Cheng: Kianna and (Josh), would you mind both just restating in turn, where people can find the respective proposed rules including the dates of the Federal Register notices?

Kianna Banks: Sure. This is Kianna. For the rule containing the proposed rural emergency hospital conditions of participation, well for both, you can go to the Federal Register, it's FederalRegister.gov. And if you search for the title of the rule it'll come up. You can probably just search for rural emergency hospitals and that should return your search. The date of publication for the Proposed Rule for the Conditions of Participation was July 6th. And I'll defer to (Josh) on the details for the publication for the payment rule.

(Josh McFeeters): Yes. The payment rule is with the OPPS proposed rule. The rule went on display last Friday, July 15th. I apologize, I don't have it right immediately at my fingertips. But it will display roughly two weeks later, after that, in finalized form in the Federal Register.

(Tammy Asher): Okay. Thank you very much.

(Josh McFeeters): Yes.

Coordinator: There are no other questions in the queue.

Jill Darling: Well, thank you everyone, for joining us today. I'll pass it over to Ing-Jye for closing remarks.

Ing-Jye Cheng: Thank you very much, everybody, for participating in today's Rural Open Door Forum. I know as you digest the amount of information that has been provided today, if there are further questions, please do send them over email to us at RuralHealthODF@cms.hhs.gov. I'll also note that we reviewed materials related to four different proposed rules that CMS has put forward.

And for your comments to those rules and your thoughts on how the agency should consider the proposals it made in those rules, to be considered formally by the agency as they look to finalize later on in the year, please do submit public comments to those rules. Each rule is in the Federal Register and we'll have an email address and due date associated with that rule on how to submit comments. So thank you again, for your time today. And I appreciate being able to serve you (unintelligible).

Coordinator: That concludes today's call. Thank you for participating. You may disconnect at this time. Speakers, please allow for a moment of silence and standby for your post conference.

END