Centers for Medicare & Medicaid Services
Open Door Forum: Rural Health
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Jill Darling: [*Good morning and good afternoon, everyone. I am Jill Darling from the CMS Office of Communications. Welcome to today's Rural Health Open Door Forum. Karen, could you hit record, please?]* Thank you so much. This call is being recorded. The recording transcript will be available on the CMS Open Door Forum podcast and transcript webpage. That link is on the agenda. If you are a member of the press, you may listen in but, please refrain from asking questions during the webinar. If you do have questions, please e-mail press@cms.hhs.gov.

All participants are muted. For those who need closed captioning, a link should be located in the chat for you. We will be answering questions related to the presentations provided today. You may use the raise hand feature at the bottom of the screen, and we will call on you to ask your question when it is time for the Q&A portion. And we will do our best to get to as many questions as we can. So now I will turn the call over to our Co-chair, John Hammarlund.

John Hammarlund: Thank you very much, Jill. Welcome, everybody, to the inaugural Zoom version of the Rural Health Open Door Forum call, and we are delighted to have so many of you today. Thank you for joining. We have a small agenda but a mighty one. So, thank you, Abby and Terry, and others who are here today; we have others joining us on the call today as we typically do. Our regional rural health coordinators from the regional offices across the country, a few of them are on the call here today, and we welcome them. So, I want to remind you that we do our best to come up with agendas that are useful to you and provide you with the timely information you need, but we need your input. So, we invite you always, to suggest agenda items for us to help build out the agenda in the future. So, Jill will put the e-mail address in the chat. Please note it, and I will be delighted to get your input for future Open Door Forum calls. Again, welcome, and I hope you appreciate this Zoom format of the ODF call today, and without further ado, I will hand it back to Jill so we can launch into the agenda. Thank you for joining.

Jill Darling: Thank you, John. First off, we have Abigail Ryan, her and her colleague Russell will talk about the End Stage Renal Disease (ESRD) Prospective Payment System (PPS) and the rural ESRD facilities. They will also address the calendar year 2023 ESRD PPS, and PRM proposal along with the Request for Information regarding the low volume payment adjustment.

Abigail Ryan: Thank you, Jill, and thank you, John, for that wonderful introduction. I am Abby Ryan, the Deputy Director of the Division of Chronic Care Management and the Chronic Care Policy Group within the Centers for Medicare. Every year, we put out a payment rule that updates the payment for End-Stage Renal Disease for the ESRD facilities for renal dialysis services that include ESRD patients and those patients with acute kidney injury. For the ESRD Prospective Payment system, we only have one payment, and that payment includes various payment adjustments. There are facility-level adjustments and patient-level adjustments. The facility-level adjustments include an adjustment for low-volume payment, and those include facilities that have under 4,000 treatments, along with a number of other eligibility requirements.

One of the things that we realized over the past several years is that we have gotten requests due to disasters, emergencies, and things like flooding, tornadoes, hurricanes, and fires. These facilities that are serving underserved populations, low-density areas, rural areas, and even some in urban facilities lose their low-volume payment adjustment because they close. One of the things we require is that you cannot close within that year, so we propose a provision to address this. Still, we also want to make sure the facilities that take up these patients, because the patients have lost places to get dialysis, that they are not penalized if they've been getting the low-volume payment adjustment all along. We don't want them penalized for goodwill.

So, with that, we have put out a proposal and are encouraging everyone to please write in and give us your thoughts about this proposal. Also, do we want to modify the methodology that we are currently using? Do we want to go with a tiered adjustment or a continuous payment function? I will turn this over to our very knowledgeable, wonderful subject matter expert on this, Russell Bailey, and he will speak to you about the low-volume payment adjustment for ESRD PPS for the calendar year 2024. Russell, take it away.

Russell Bailey: Thank you so much, Abby. As Abby said, I'm here to talk about the low-volume payment adjustment, or LVPA, in the End-Stage Renal Disease Prospective Payment System. As a quick disclaimer, nothing stated today by a presenter or any attendee will be viewed as a comment on the CY 2024 ESRD PPS proposed rule. To ensure consideration, parties must submit comments and any supported data in written form using the specific instructions in the published CY 2024 ESRD PPS proposed rule prior to the close of the comment periods, and there will be more information about that later on.

The LVPA is part of the End-Stage Renal Disease Prospective Payment System. The ESRD PPS was created in response to the Medicare Improvement for Patients and Providers Act of 2008, MIPPA, which required CMS to create a Prospective Payment System for the care of end-stage renal disease and required that system includes a payment that reflects the extent to which low-volume facilities face higher costs for furnishing renal dialysis services compared to other facilities. That adjustment was required to be at least 10 percent until 2014; however, in the CY 2011 ESRD PPS final rule, we finalized the original version of the LVPA, which was an 18.9 percent adjustment for facilities that furnished fewer than 4,000 dialysis treatments a year.

The LVPA has been updated several times since the CY 2011 rule. In the CY 2016 ESRD PPS rule, we updated the LVPA amount to 23.9 percent. This rule also established a rural adjustment of 0.8 percent, which is a separate payment adjustment and not established under the same authority as the LVPA. There were also some changes to the eligibility criteria for LVPA in the CY 2016 rule. A restriction was added for facilities with common ownership within five miles, and that restriction was updated in 2019 to specify that it is based on road miles. The CY 2019 rule also allowed for some facilities that changed ownership to retain the LVPA if they retain the same provider number. Most notably, the CY 2021 rule added an exception to the LVPA treatment volume requirement for facilities that furnished an excess of 4,000 treatments in a year due to the COVID-19 Public Health Emergency (PHE).

Currently, the LVPA amount is 23.9 percent for facilities that furnish fewer than 4,000 treatments in a year, and this is unchanged since the CY 2016 rule. Facilities must be within this treatment volume threshold for the past three cost reporting years and cannot have opened, closed, or changed ownership within that time frame. This requirement is referred to as a three-year look back. The treatment volume threshold is based on all dialysis treatments, not only Medicare treatments, and facilities must complete an annual attestation that meets the LVPA requirements that are listed in the regulations. In 2022, 353 facilities received the LVPA, and more than half of those facilities were located in urban areas, which brings us to some of the public criticisms of the LVPA.

MedPAC is the Medicare Patient Advisory Council, and the GAO, or the Government Accountability Office, have both recommended that CMS make refinements to the LVPA to better target ESRD facilities that are in remote or isolated areas that are critical to beneficiary access in these areas. Both MedPAC and GAO have asserted that the LVPA creates incentives for facilities to open and operate in more populated areas just under the treatment volume threshold to receive the adjustment. MedPAC has suggested that we could avoid this by using a tiered approach to avoid having just one payment for those facilities that furnish fewer than 4,000. Instead, have perhaps a different payment for those with fewer than five and six, and so on, so that it's less dramatic. MedPAC also suggested we incorporate geographic isolation directly into adjustment, which they call the low-volume isolated adjustment by incorporating geographic isolation to prevent facilities from operating in populated areas at a low volume. However, we have found that this suggested adjustment would not reconcile with statutory requirements for the LVPA, which states that the adjustment must reflect the extent to which low-volume facilities face higher costs and other facilities in furnishing renal dialysis services.

That brings us to the proposals in the CY 2024 ESRD PPS proposed rule. We are proposing two exceptions to the LVPA eligibility requirements to prevent facilities that are affected by disasters or other emergencies from losing their LVPA. As a reminder, the regulations generally require a low-volume facility furnishes fewer than 4,000 treatments in the three-year look-back periods and has not opened, closed, or received a new provider number due to a change in ownership in the three-year look-back period. The first of the two exceptions that we have proposed would allow facilities to continue receiving the LVPA if they meet or exceed the 4,000 treatments volume threshold due to treating patients displaced by disaster or emergency. The second proposal would allow

facilities to continue to receive the LVPA if they closed and reopened due to disaster or emergency.

We anticipate that if these proposals were finalized, they would help maintain ESRD patient access to renal dialysis services in crucial areas by preventing facilities from permanently closing down due to the loss of the LVPA because it's such a substantial adjustment that losing it could be disastrous for those facilities. In the CY 2024 proposed rule, we have included several requests for information, some of which are related to the LVPA. The first of which, is that we are soliciting comments on potential changes to the LVPA that have been suggested to us by MedPAC and other public commenters. These include creating a tiered payment adjustment that would have multiple payment rates and thresholds or utilizing a continuous function where payment would be based on a continuing spectrum of treatment volumes. Both of these would potentially reduce gaming by reducing the magnitude of the payment "cliff." For more information on what a tiered adjustment or continuous function could look like, we have a couple of examples of tiered adjustments in the CY 2024 proposed rule.

We are also issuing a separate request for information on a potential adjustment for facilities operating in areas with low "Local Dialysis Need." This is our attempt to estimate the geographic isolation using data; however, it's worth noting that due to statutory requirements of the LVPA that require it reflects the extent to which low-volume facilities face higher costs, a Local Dialysis Need or LDN adjustment will not be issued under that authority—it would be a separate payment adjustment. The CY 2024 ESRD PPS proposed rule went on display at the Office of the Federal Register's Public Inspection Desk earlier this week on June 26 and will be published in the Federal Register tomorrow, June 30. That means the comment period for the proposed rule will end on August 25, 2023. To ensure consideration, one must submit a comment by that date.

For more information on how to submit the comment for the CY 24 ESRD PPS proposed rule, you can see the text of the proposed rule on the Federal Register's website. In short, comments can be submitted electronically to www.regulations.gov or by mail to the CMS at this address here, and I will give anyone a moment to write it down. Thank you for coming out and listening to me talk about the LVPA in the End-Stage Renal Disease Prospective Payment System. Here are a few short citations and regulations that I referenced in this rule, including the Social Security Act and Code of Federal Regulations and some of the past ESRD PPS proposed and final rules. I do not yet have the Federal Register reference for the CY 2024 ESRD PPS proposed rule yet. But the LVPA proposals and requests for information are located in Section II.B.1.f. Thank you all for your time. I believe up next is Terri.

Terri Postma: Great, thank you for having me. I have two quick announcements for you. They are both appearing in the MLN. If you look there, you will see more details. They are in relationship to hospital price transparency, and you will recall that hospital price transparency became effective for all hospitals operating in the United States on January 1, 2021, through rulemaking. We have been actively enforcing those requirements, which are twofold—number one, hospitals must make public standard charges for the items and services provided in a comprehensive machine-readable file,

and secondly, take some of that information and put it into a consumer-friendly display for 300 shoppable services.

Since the publication of the rule, we have, as I said, been actively enforcing these requirements and, in response to stakeholder requests, recently made available several sample formats that can be found on our website to assist hospitals in meeting the requirements and displaying their standard charges and meeting the requirements. We are going to host a webinar to walk through those sample formats, and the webinar will present these machine-readable sample formats that use a standardized set of data elements and will also be introducing a new validator tool that your hospital can use to test the accuracy of your machine-readable file. You can find the sample formats and the corresponding data dictionary on the hospital price transparency resources page. The webinar is going to occur on Wednesday, July 26, from 2:30 P.M. to 4:00 P.M. Eastern Time.

And I believe Jill and I will share with you a registration link which can also be found in the MLN article. The other thing I want to mention is that in preparation for this webinar, we are seeking volunteers for the machine-readable file validator testing. So, this would be if you are interested in testing the validator tool for use with the voluntary sample formats that we made available on our website. Your current use of a sample format is not a prerequisite for you to volunteer to test the validator tool. If you are interested in providing preliminary feedback, please contact digitalservice@cms.hhs.gov with the subject heading "HPT Validator Tool Testing," and we will make the email available to Jill, and it's also available in the MLN announcement. Thank you. That's all I have. Back to you, Jill.

Jill Darling: Thank you, Terry, Russell, and Abby. We will begin our Q&A, so if you have a question, please use the raise hand feature at the bottom of the screen, and we will call on you. We will give it a moment.

Zoom Moderator Karen: Tee Faircloth, you may unmute yourself and ask your question.

Tee Faircloth: Awesome, thank you so much. The first question is directed to Mr. Hammarlund. If we can make a programming request that we have a Rural Open Door Forum about asking questions rather than 40 minutes of programs being talked about that do not apply to a lot of people in rural America and then take questions. If there's any way we can do questions at the beginning, I think you would get more people from rural America engaged in this because, for most of the doctors and hospitals we work with, end-stage renal disease payment is not our problem. We are dealing with hospitals looking to make payroll, so having to spend 45 minutes on hold, hearing stuff that only works for a few rural hospitals where everybody has three or four jobs. I've been on hold here for 35 minutes to get a statement in, and this is a short one. I love the shortness of the presentation, but if we can actually open the door at the beginning, take questions, and then present, people who just have a question in rural America and aren't consultants can speak. Like, I bet 95 percent of people on this call are located in urban America. If you check your registration, I bet it will turn out that high numbers of people on the call are in urban America because they are the only people that have the time to invest in this.

So, if we can actually not it make technical assistance for consultants until the end and answer rural America's questions first, it would help in terms of getting local engagement with CMS because it's not working in the poor rural hospitals that we serve. They would love to have direct engagement with leadership, but there is no method, and we get a quarterly call where we get talked at for 40 minutes.

My other question is about the economic impact of the price transparency rule in our hospitals. Anyone who can afford it drives right past our hospital, let's be honest. We are working with the poorest hospitals in majority-minority communities in rural America. So even something small for big health systems, like the price transparency rule, number one it does nothing but create cost and mayhem in rural America. I still have hospitals using paper, so price transparency and machine reading don't work. I will listen to the rest of the questions, but that would be my one programming suggestion. If you have a quarterly Open Door Forum with rural America, let rural America have a chance to have a voice because all it ends up being is big health systems and the consultants who serve them. So, I will stop there.

John Hammarlund: Thank you for your comments. I saw that Terri came.

Tee Faircloth: My question is, have you looked at the cost of the price transparency rule for small rural areas?

John Hammarlund: So, I will see if Terri can address that part, and I will come back on and address the rest thank you. Terri, do you have anything else to add before I come back on?

Terri Postma: Yea, we are sensitive to the burden to all hospitals, including rural hospitals, and there was a burden assessment done for the hospital price transparency rule, and I'll be happy to share that link with Jill, who can pass it on to you. I will say one of the reasons we have developed these sample templates is precisely for that reason—to assist hospitals to make it easier for hospitals to meet these statutorily required requirements, and they were developed with the assistance of rural hospitals or personnel from rural hospitals, so we are hopeful they will be helpful to you. Also, I would say that the National Rural Hospital Association, if you are a member with them, may have additional resources for you.

John Hammarlund: Thank you, Terri. With respect to your general comment, I appreciate it and heard you. I promise you this, we will take it back and talk amongst ourselves about what we can possibly do moving forward to improve these calls. I will tell you with all sincerity, and I've doing these calls for roughly 20 years, that we strive to come up with agenda items that are relevant to most rural communities. CMS has a lot of information that we push out all the time, and I have heard some of the rural constituents referred to them as a fire hose. What we try to do is figure out how to cut out all the noise and get to topics that we think are the most relevant for the communities. We want to get your input, so we do our best to come up with the right agenda items for these calls, and as I mentioned at the offset, you can help us with that. You can let us know by suggesting in the e-mail box we put in the chat what sort of topics you would like to hear about and help us build the agendas. With respect to the general comment

about how we format these calls, we will take that back and give consideration, so thank you. We appreciate it.

Jill Darling: We do not see any further questions. We will give it one more moment. I see one.

Zoom Moderator Karen: Hey, Dale Gibson, you may unmute yourself.

Dale Gibson: Can you hear me?

Zoom Moderator Karen: Yes. We hear you.

Dale Gibson: I wanted to add a comment to what the gentleman from earlier said regarding the smaller hospitals. We are having major problems with the managed care aspect. One concern is that they don't pay correctly, they reduce payments, and require a lot of documentation. These facilities don't have the resources to fight these payers, and they take advantage of the situation, and we are concerned about these facilities closing. This is one of the biggest reasons, we just don't have the facilities to fight these large companies.

John Hammarlund: I want to ask a clarifying question. Are you referring to the Medicare Administrative Contractors?

Dale Gibson: Yes.

John Hammarlund: Okay, I will tell you what. What state are you from?

Dale Gibson: At the moment, I'm speaking from small hospitals in Iowa right now.

John Hammarlund: Ok in Iowa. If you are willing to submit a comment in writing to ruralhealth.odf@cms.hhs.gov, I will make sure it gets to the right people. It might be someone in our headquarters or it might be someone in the regional office who can talk to you because if we can talk specifics about the difficulties, you may be having with respect to the MAC, let's see what we can do to sort of help you with that. So, we would need something in writing that we could share. I sense that it's not just a general comment, but you are having your own difficulties with the MAC, and I would be happy to see if we can get someone to help talk it through with you. If you are willing.

Dale Gibson: I'm not talking about MAC or Medicare. We're talking about the Medicare managed care plans.

John Hammarlund: Oh, I see, the Managed care plans. All right. Likewise, again, I'll be happy to see if we can get someone to talk specifics with you. I want to discuss it with you, we would just need to have something from you, an e-mail, so that we can get it routed to the right individuals, if you're willing to do that. Thank you.

Dale Gibson: Yes, I will. Thank you.

Zoom Moderator Karen: Kevin Calloway, you may unmute and ask your question.

Kevin Callaway: Can you hear me?

Zoom Moderator Karen: Yes, we hear you.

Kevin Callaway: Good, so as a follow-up to the last question, I wanted to clarify what he was referring to, and it was about Medicare Advantage plans. We see it quite a bit with the critical access hospitals that we work with; from a Medicare standpoint, you're paid at cost minus sequestration, so 99 percent of the cost. But the Medicare Advantage plans, in many cases in critical access hospitals, the Advantage plans are paying well below cost, and to commenter's point, that is the big challenge for these facilities. They don't have resources from a negotiation standpoint to chase each of these claims, from a reprocessing standpoint. So, I know NRHA is aware of this issue as well, and folks who I've discussed this with have referred to this point. In a perfect world, it would be nice if all Medicare Advantage plan claims for critical access hospitals are paid through the MAC so the MAC can assure they are paying them at a cost similar to Medicare traditional. So, to add to the comment, I know that is a very large sense of frustration with critical access hospitals right now. They just don't have the resources to chase this or negotiate with these Advantage plans.

John Hammarlund: Thank you very much. Understood and received, we will take that back and see what we can do. It might be something we can address in the future for Open Door Forum calls, so thank you for your feedback. I invite you, if you want to give specifics, feel free to send that to the e-mail address. We hear you and appreciate the comment. Thank you.

Jill Darling: Hey, everyone. We will give it one more moment if anyone has questions. Alright, we greatly appreciate you joining us today, and we will take your feedback from today's call. For follow-up comments or questions, please e-mail ruralhealthodf@cms.hhs.gov, which is in the chat. I put it in there a few times. Again, that's ruralhealthodf@cms.hhs.gov. Thank you so much for joining us today. We will talk with you next time. You may disconnect.