

Centers for Medicare & Medicaid Services  
 Rural Health Open Door Forum  
 Thursday, July 18, 2024  
 2:00 – 3:00 p.m. ET

*Webinar recording:*

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**Heather Grimsley:** There we go. This meeting is being recorded. A recording and the transcript will be available on the CMS Open Door Forum (ODF) podcast and transcript webpage, where the link is on the agenda. If you are a member of the press, please refrain from asking questions during the webinar. If you have any questions, please email [press@cms.hhs.gov](mailto:press@cms.hhs.gov). All participants are muted upon entry. For today's webinar, there's an agenda slide you see on the screen. We will be taking questions at the end of the agenda today. We note that we'll be presenting and answering questions on the topics listed on the agenda during today's Open Door Forum call. We ask that any live questions relate to the topics presented during the Open Door Forum call. If you have any questions unrelated to these agenda items, we may not have the appropriate person on the call to answer your questions. As such, we ask that you send any of your unrelated questions to the appropriate policy component, or you can send your email to the Open-Door Forum resource mailbox, and we will try to get your question to the appropriate component for a response. You may use the raise hand feature at the bottom of your screen, and we will call on you when it's time for the Q&A session. Please introduce yourself and what organization or business you're calling from. And then, when the moderator says your name, please unmute yourself on your end and then ask your question and one follow-up question. We will do our best to get to all of your questions. As many of you may be aware, CMS recently released several calendar year 2025 proposed rules. Today, we are fortunate to have subject matter experts here to provide some highlights on the Physician Fee Schedule (PFS), the Home Health Prospective Payment System (PPS), and the End-Stage Renal Disease Prospective Payment System (ESRD PPS) proposed rules. I'll now turn to our first presenter, Lindsey Baldwin.

**Lindsey Baldwin:** Great. Thanks so much, Heather. Good afternoon, everyone. I am so happy to be here with you. I am Lindsey Baldwin. I'm the Director of the Division of Practitioner Services in the Hospital and Ambulatory Policy Group in the Center for Medicare. I'm pleased to report that the calendar year 2025 Physician Fee Schedule proposed rule was posted as of last week on July 10. This proposed rule aims to strengthen primary care, expand access to behavioral health, oral health, and caregiver training services, maintain telehealth flexibilities, and expand access to screening for colorectal cancer and vaccinations for hepatitis B. I'll go over just a couple of the topics in the proposed rule but would certainly encourage anyone who's interested to read the full proposals in the PFS proposed rule. Also, I just want to note that the 60-day public comment period for the PFS proposed rule ends on September 9.

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OK, so starting off with telehealth services under the PFS. For calendar year 2025, we're proposing to add several services to the Medicare telehealth services list on a provisional basis, including demonstration prior to initiation of Home International Normalized Ratio, or INR, monitoring and caregiver training services. We're proposing to continue the suspension of frequency limitations for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations for the calendar year 2025. We're also proposing that beginning January 1, 2025, an interactive telecommunication system may include two-way, real-time audio-only communication technology for any telehealth service furnished to a beneficiary in their home if the distant site physician or practitioner is technically capable of using an interactive telecommunication system, but the patient is not capable of or does not consent to the use of video technology.

We're also proposing that through 2025, we'll continue to permit the distant site practitioner to use their currently enrolled practice location instead of their home address when providing telehealth services from their home. We're also proposing that for a certain subset of services that are required to be furnished under the direct supervision of a physician or other supervising practitioner, to permanently adopt a definition of direct supervision that allows the physician or supervising practitioner to provide such supervision through real-time audio and visual interactive telecommunications. For all other services furnished under the direct supervision of the supervising physician or other practitioner, we're proposing to continue to define the term immediate availability to include real-time audio and visual interactive telecommunications technology through December 31, 2025.

And lastly, under telehealth, we're proposing to continue our current policy to allow teaching physicians to have a virtual presence for purposes of billing for services furnished involving residents in all teaching settings, but only in clinical instances when the services furnished virtually, for example, a three-way telehealth visit with the patient, resident, and teaching physician, all parties in separate locations. And that is also through December 31, 2025.

Next, I'll go over the supervision policies for physical therapists and occupational therapists in private practice. For CY 2025, we're proposing a regulatory change to allow for general supervision of physical therapist assistants, or PTAs, and occupational therapy assistants, or OTAs, by PTs in private practice and OTs in private practice for all applicable physical therapy and occupational therapy services. With that, I will pass it to my colleague, Sarah Shirey-Losso, to cover RHC (Rural Health Clinic) and FQHC (Federally Qualified Health Center) proposals in the PFS proposed rule. Thanks so much.

**Sarah Shirey-Losso:** Hey, good afternoon, everyone. Again, I'm going to touch on some of the proposals—I think for this audience, related to rural health clinics, but obviously some of these also are consistent for FQHCs as well. In terms of care coordination services, we're proposing several changes related to the reporting of care coordination services to better align with these

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services under the Physician Fee Schedule. So, starting in 2025, we would propose that RHCs can report the individual CPT (Current Procedural Terminology) and HCPCS (Healthcare Common Procedure Coding System) codes that describe care coordination services instead of the current code G0511 that encompasses multiple care coordination services. We are also proposing to adopt the coding and policies related to advanced primary care management services. In terms of telecommunication services, we're proposing to continue to allow direct supervision via interactive audio and video telecommunications and to extend the definition of immediate availability that Lindsay just touched on to real-time audio and visual interactive telecommunications. In terms of non-behavioral health services and visits furnished via telecommunication technology, under this proposal, RHCs would continue to bill for these services using HCPCS code G2025 through December 31, 2025. And we're also proposing to continue, much like under the Physician Fee Schedule, the in-person visit requirements for mental health services. For those RHCs that may have an intensive outpatient program or are thinking of starting one up, we are also proposing to allow for the four or more services option under that policy, and payment there would be consistent with the hospital outpatient departments and updated annually.

In addition, we wanted to clarify in this proposal that for those RHCs that furnish dental services, we are confirming that the clarifications and proposals made under the Physician Fee Schedule related to dental services that are inextricably linked to certain covered services could be provided by RHCs, including the adoption of a new modifier KX. Finally, we are proposing to remove the standard regarding productivity standards and adjustments. So, I will stop there. Again, that's a high-level overview. More detail can be found in the rule, and I'm going to pass it to Rachel Radzyner, who can talk a little bit about proposals in the preventive services space.

**Rachel Radzyner:** Thank you, Sarah. We have several proposals regarding preventive services in the PFS proposed rule. I'm going to start with discussing a few items related to Part B vaccines. For CY 25, we propose to allow RHCs and FQHCs to bill and be paid for Part B preventive vaccines and their administration at the time of service. We proposed that payments for these claims will be made according to the Part B preventive vaccine payment rates and other settings to be annually reconciled with the facility's actual vaccine costs on their cost reports. Due to the operational system changes needed to implement this proposal, we propose that it be effective for dates of service beginning on or after July 1, 2025.

We also proposed two items related to the hepatitis B vaccine and its administration. The rule includes a proposal to expand coverage of hepatitis B vaccines and their administration, and if that proposal is finalized, we clarify that a physician's order would no longer be required for the administration of a hepatitis B vaccine in Part B. This would facilitate roster billing by mass immunizers for hepatitis B vaccine administration. We also proposed that payment for hepatitis B vaccines and their administration be made at 100% of reasonable costs in RHCs and FQHCs in order to streamline payment for all Part B vaccines in those settings.

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That's it for vaccines, and we had another preventive proposal in this rule, and that is regarding Drugs Covered as Additional Preventive Services, and we're introducing the acronym DCAPS for those drugs. In the proposal, we proposed a fee schedule for DCAPS drugs, and we note that CMS has not yet covered or paid for any drugs under the benefit category of additional preventive services as of yet. On July 12, 2023, CMS released a proposed NCD (National Coverage Determination) regarding coverage for HIV prep drugs under Part B as additional preventive services. We proposed to determine a payment limit for these drugs, DCAPS drugs, according to the ASP (Average Sales Price) methodology set forth in section 1847A of the Act (Social Security Act) when ASP data is available for those drugs, and we propose alternative payment mechanisms if the ASP data is not available. We also propose payment limits for supplying the administration of DCAPS drugs that are similar to the Part B fees for other drugs.

And finally, we propose to use the same fee schedule for DCAPS drugs and any administration or supplying fee when those services are provided in RHCs and FQHCs. In RHCs and FQHCs, DCAPS drugs in any administration and a supplying fee would be paid at 100% of the Medicare payment amount, and they would be paid on a claim-by-claim basis. And that's it for preventive services, and I'm going to pass to Kelly Vontran for the next part of this call. Thank you.

**Kelly Vontran:** Hi, thank you. Good afternoon. My name is Kelly Vontran, and I'm the Deputy Director in the Division of Home Hospice here at CMS. So, I will be providing an update on the proposed payment policies in the CY 2025 Home Health Prospective Payment System (HHPPS) proposed rule, which was issued on June 26 of this year. This proposed rule would update Medicare payment policies and rates for home health agencies. Now, because we are in the comment period, there may be questions that cannot be answered on this call. So, starting with the first proposal, which is the proposed permanent payment adjustment to the CY 2025 30-day payment rate. As required by the Bipartisan Budget Act of 2018, this bill proposes a permanent prospective adjustment to the CY 2025 home health payment rate of negative 4.067%. This adjustment accounts for differences between assumed behavior changes and actual behavior changes when estimated aggregate expenditures due to the CY 2020 implementation of the Patient-Driven Groupings Model—or what we call the PDGM—and the change to a 30-day unit payment. For CY 2023 and 2024, CMS previously applied a 3.925% reduction and a 2.89% reduction, respectively, which were half of the estimated required permanent adjustments for those years.

The law also requires CMS to apply temporary adjustments to account for retroactive overpayments. We have not applied any temporary adjustments in previous years, but we have stated that any temporary adjustment would be proposed in future rulemaking. While we are not proposing to implement a temporary adjustment in CY 2025, the proposed rule does provide the calculated temporary adjustment based on analysis of CY 2020 to 2023 claims, and that amount is approximately \$4.5 billion. The law provides CMS the discretion to make any future permanent or temporary adjustments in a time and manner determined appropriate through analysis of estimated aggregate expenditures through calendar year 2026.

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So, the next proposal is the proposed crosswalk for mapping OASIS-D data elements to the equivalent OASIS-E data elements. The Outcome and Assessment Information Set, the OASIS-D, was the home health assessment instrument used under the prior 153 group system. In the first three years, that is, calendar years 2020 and 2022 of the current PDGM. However, the Office of Management and Budget (OMB) approved an updated version of the OASIS instrument OASIS-E on November 30, 2022, with an effective date of January 1, 2023. As part of the formalized repricing methodology to examine behavioral change and to accurately determine payments under the 153 group system, we used the October 2019 3M Home Health Grouper to assign a health insurance prospective payment system code to each simulated 60-day episode of care. This older version of the Home Health Grouper requires responses from OASIS-D. So therefore, to continue with this repricing methodology, CMS will need to propose a crosswalk from OASIS-D items for three of the items from OASIS-D that have changed in the OASIS-E. Additionally, 13 items on the OASIS-E are no longer required to be asked at a follow-up visit. So, for these items, we can use the most recent start of care or resumption of care assessment to determine a response which would not require a crosswalk. So, we are proposing a methodology to address this issue by mapping the OASIS-E items in this proposed rule.

The next proposal is the proposed occupational therapy LUPA (Low Utilization Payment Adjustment) add-on factor and LUPA add-on factor updates. So, Medicare makes an additional payment for low utilization payment, or what we call LUPA, periods, which is paid for periods that occur as the only 30 days or the initial 30-day period in the sequence of adjacent 30-day periods. The additional payment is made based on the discipline providing care through the use of a discipline-specific LUPA add-on factor. With sufficient recent claims data available and to establish equitable compensation for all home health services. CMS is now proposing to establish a definitive occupational therapy-specific LUPA add-on factor and discontinue the temporary use of the physical therapy LUPA add-on factor as a proxy. We proposed using the same methodology to establish the skilled nursing, the physical therapy, and the speech-language pathology LUPA add-on factors as described in the CY 2014 HPPS final rule. The proposed OT LUPA add-on factor of 1.7266 will be updated based on more complete CY 2023 claims data in our final rule. Additionally, we propose updating the other discipline LUPA add-on factors to more accurately reflect current health care practices and costs by proposing to use recent claims through 2023 to update the skilled nursing, the physical therapy, and the speech-language pathology LUPA add-on factors.

Next, this rule proposes to update the home health wage index and adopt the new labor market delineations from the July 21, 2023, OMB bulletin based on data collected from the 2020 decennial census. The OMB bulletin contains several significant changes. It is standard practice to adopt the latest OMB update when available, using the most recent B statistical area delineations result in a more accurate and up-to-date payment system that reflects the reality of population shifts and labor market conditions. For example, there are new CBSAs (core-based statistical areas). There are urban counties that have become rural, rural counties that have

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become urban, and existing CBSAs that have been split. We do note, however, that the existing home health regulations limit one-year wage index decreases to 5%, which will help mitigate the impact of any CBS changes on payment.

So next are the routine home health rate updates. The statute requires that home health payment amounts to be updated by the home health market basket adjusted for changes in the economy-wide productivity. The preliminary home health market basket for CY 2025 is 3% adjusted for productivity, which is a 0.5 percentage point, which results in a 2.5% increase in home health payments for CY 2025. Other proposed routine payment updates include the proposals to recalibrate the PDGM case-mix links, update the fixed dollar loss for outlier payments, update the low utilization payment of adjustment thresholds, functional impairment levels, and comorbidity adjustment subgroups for CY 2025.

Additionally, this rule includes the proposed rate update for the CY 2025 intravenous immune globulin, or IBIG, items and services payment under the IBIG benefit. The proposed calendar year 2025 home IBIG items and services payment rate would be \$430.99, which is the 2024 IBIG items and services payment rate updated by the proposed home health payment update percentage of 2.5%. And finally, this proposed rule discusses the disposable negative pressure rule therapy proposed payment rate update, but for CY 2025, we are proposing that the separate payment amount for a disposable negative pressure wound therapy device would be set equal to the calendar year 2024 payment amount of \$270.09 updated by the CPIU for June 2024 minus the productivity adjustment as mandated by the CAA (Consolidated Appropriations Act) of 2023. We note that the CIU for the 12-month period ending June of 2024 was not available at the time of this rulemaking. So therefore, the 2025 payment amount of a disposable negative pressure wound therapy device, as well as the CPIU for the 12 months ending due of 2024 and the correspondent productivity adjustment, will be updated in the final rule. The overall economic impact related to the changes in payment under the Home Health Prospective Payment System for CY 2025 is estimated to be a decrease of 1.7%, or \$280 million. The \$280 million decrease in estimated payments for 2025 reflects the effects of the proposed home health update percentage of 2.5% or a \$415 million increase, an estimated 3.6% decrease that reflects the effects of the permanent behavior change adjustment, or \$595 million decrease, and an estimated 0.6% decrease that reflects the effects of the updated fixed dollar loss or a \$100 million decrease.

The overall impact on rural providers will be a decrease of 0.3%. This proposed rule can be found in the Federal Register as well as on our HHA (home health agency) Center webpage, and the 60-day comment for this proposed rule closes on August 26. Comments can be submitted electronically via [regulations.gov](https://www.regulations.gov), and we also, I believe, have provided the direct link on the slide that accompanies this ODF. So, that concludes the payment updates in the CY 2025 Home Health PPS proposed rule. I will now turn the call over to Mary Rossi-Coajou. Thank you.

**Mary Rossi-Coajou:** Thank you, Kelly. So, I'm here to talk to you about proposed changes in the conditions of home health conditions and participation. I work in the Center for Clinical  
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Standards of Quality Clinical Standards Group, where I serve as the subject matter expert for home health. So, in this 2025 Home Health Prospective Payment System, we have one proposed change and two RFIs (requests for information) to the home health conditions of participation. So, CMS is proposing changes to the home health conditions of participation to reduce avoidable care delays by helping ensure that referring entities and prospective patients can select the most appropriate home health agency based on their care needs. These changes can support timely admission to home health services, which has demonstrated improvements for patient outcomes and reducing risk of hospital readmissions. CMS is proposing to add a new standard that would require HHAs to develop, implement, and maintain, through an annual review, a patient acceptance to service policy that is applied consistently to each prospective payment patient referred to home health care. We are proposing that the policy must address specific criteria related to HHAs' capacity to provide patient care, and at a minimum, the criteria would include anticipated needs of the referred prospective patient, the home health agency's caseload and case mix, the home health agency's staffing level, and the skills and competencies of the HHA staff.

This proposed rule would not prevent HHAs from maintaining any existing acceptance of service policy that they may have, but rather is intended to complement that. Additionally, CMS is proposing that HHAs make available to the public accurate information regarding the services offered by the HHA and any service limitations related to types of specialty services, service duration, or service frequency. HHAs will be required to review this information annually or sooner as necessary. And then, we have two RFIs or requests for information. First, we are seeking information regarding the feasibility of rehabilitative therapists to conduct the comprehensive assessment for cases where both therapy and nursing services are ordered as part of the plan of care. Second, we are seeking information regarding the HHAs' scope of services and how these services interact with HHA operations. Specifically, we are soliciting comments on the communications that occur between patients, physicians, and allowed practitioners and establishing and reviewing the plan of care. We are also seeking information on how physicians and allowed practitioners ensure patients receive the right mix, duration, and frequency of services to meet measurable outcomes and goals identified by the HHA and the patient. And now, I'm going to turn this over to Kim Roche, and Kim will cover the long-term care rider that's in the home health rule. Thank you.

**Kim Roche:** Thank you, Mary. Hi, this is Kim Roche. As Mary said, I work with her in the Clinical Standards Group, and I'm going to talk a little bit today about long-term care facility requirements for acute respiratory illness reporting, and this is part of the Home Health PPS proposed rule. So, we've recently proposed, as part of the proposed rule, to replace the current COVID-19 reporting standards for long-term care facilities that sunset in December of 2024, and we proposed a new set of requirements that will address a broader range of acute respiratory illnesses, which includes COVID-19 influenza and RSV. We have proposed a narrower set of elements to help continue sustained monitoring and surveillance while also balancing reducing the reporting burden.

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In addition to that, we also propose that in the event of a declared or a significantly likely event of a declared national public health emergency for acute respiratory illness, that the secretary could activate additional reporting requirements. So, I just would like to say, keep in mind that this proposal is for long-term care facilities, and as a few people have already mentioned, the comment period ends August 26, and we look forward to your comments. I'm not sure who I'm going to turn it back over to, but that concludes my remarks. Thank you.

**Heather Grimsley:** Thanks, Kim. We'll now turn it over to Abby Ryan. Oh, you got it. Thank you.

**Abigail Ryan:** I got it.

**Heather Grimsley:** OK, thank you.

**Abigail Ryan:** Thank you so much. Hi, I'm Abby Ryan, the Deputy Director for the Division of Chronic Care Management. Today, I'm going to share with you some important issues that would affect rural facilities regarding the End-Stage Renal Disease Protective Payment System (ESRD PPS).

So, on June 27, 2024, CMS issued a proposed rule, and it appeared in the Federal Register on July 5th. It was to update the payment rates and the policies, and it does include some requests for information under the ESRD PPS for renal dialysis services on or after January 1, 2025. Today we're going to cover the ones that most affect the, as I mentioned, the rural facilities. We have three subject matter experts on. Russell Bailey will be reviewing with you the routine annual rate setting updates along with some exciting changes about the ESRD PPS wage index changes. These are proposals, and Leone Kisler will be reviewing the proposal for changes in the low-volume payment adjustment refinement. Lisa Reese will be covering the proposed payment for home dialysis for beneficiaries with acute kidney injury. We're excited about these. We think that this will help the rural facilities, and I'm going to turn it over to Russell to share this with you. Go ahead, Russell.

**Russell Bailey:** Thank you, Abby. As Abby said, I'll be talking about the annual update and the new wage index proposal, both of which we think will improve payment accuracy and adequacy for rural ESRD facilities. For calendar year 2025, the proposed ESRD PPS base rate is \$273.20. This reflects a 1.8% productivity adjusted market basket increase. The ESRD PPS base rate is then adjusted by the geographic wage index as well as several facility level and case mix adjusters. For CY 2025, we are proposing a new ESRD PPS wage index methodology, which is based on data from the Bureau of Labor Statistics, Occupational Employment, and Wages Statistics. This new methodology uses median hourly wage data, sorry, uses mean hourly wage data from the BLS OEWS (Bureau of Labor Statistics Occupational Employment and Wage Statistics) for a variety of occupations related to the furnishing of renal dialysis services for each geographic area as defined by the CBSA in which the ESRD facility is located. And then weights

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those mean hourly wages by a national ESRD facility occupational mix, which is derived from freestanding ESRD facility cost reports.

So essentially, this new methodology takes the average wages from the area that the facility is located in and creates a weighted average based on the amount of each occupation we expect an average ESRD facility would employ. We believe that this new proposed wage index methodology would greatly improve the accuracy of payments in allocating payments to facilities based on their expected expenditures on labor. And our estimated impacts show that this would lead to an increase of 0.7% to rural ESRD facilities for 2025, which we expect to increase to 1.4% in the long run once the effects of the transitional decrease cap on the wage index decrease phases out in several years. We are also proposing to use the updated CBSA delineations from OMB, similar to other payment systems. These are in line with our past proposals on this topic. However, as we are updating the CBSAs, some currently rural facilities will be re-designated as urban to help alleviate some of the impact of the loss of the rural adjustment, which is another facility-level adjustment. Within the ESRD PPS, we are proposing a role phase out policy where facilities that are currently rural and being re-designated as urban would receive two-thirds of the rural adjustment in 2025 and one-third of it in 2026 until it is entirely phased out for those facilities in 2027. Overall, we believe that these changes will have a positive impact on rural facilities and will improve payment accuracy within the ESRD PPS. I'm going to pass it over to Leone Kisler to discuss the LVPA (low volume payment adjustment).

**Leone Kisler:** Thank you, Russell. I'd like to start with a little bit of background on the low volume payment adjustment, or LVPA, which has been monumental for increasing access to ESRD services. In 2011, an amendment to the Social Security Act allowed Medicare to provide a payment adjustment that reflects the extent to which low-volume facilities exceed the costs incurred by other facilities. Eligibility for the LVPA is currently based on the cost reports in the three years preceding the payment year. As of this year, a facility may close and reopen or exceed the 4,000 treatment threshold in response to an emergency without being disqualified from the LVPA. This was just one step towards our goal of using the LVPA to advance health equity and protect access to dialysis services, particularly for vulnerable beneficiaries in underserved communities and especially those that are rural and isolated.

A common criticism of the LVPA in recent years was the cliff effect created by the 4,000 treatment threshold, where many worried that maintaining the single threshold would incentivize facilities to restrict their patient caseload in order to remain eligible for the LVPA. Last year, we issued a request for information in which we discussed potential modifications to the LVPA. After careful consideration of comments and analysis of ESRD cost report data, our team formulated a two-tier alternative structure for the LVPA, which we proposed within the calendar year 2025 ESRD PPS proposed rule published on July 5.

The proposed two-tier structure includes one tier for facilities furnishing less than 3,000 treatments and a second tier for facilities furnishing between 3,000 and 3,999 treatments, which

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would receive 28.4% and 18.1% payment adjustments, respectively. The proposed two-tier approach provides the highest payment to the facilities, furnishing the lowest treatment counts, which we hope will prove beneficial to rural providers. We believe the two-tiered approach strikes a balance between simplicity for ESRD facilities, sufficiently large tiers to allow for treatment volume variation from one year to the next, and payment for current low-volume facilities, particularly those with the lowest volume.

Alongside the proposed two-tier structure and in an effort to address the payment cliffs that would still exist under two-tier structure, we also proposed to determine ESRD facilities' LVPA tier based on the median treatment count volume of the last three cost reporting years rather than using a single-year treatment count. We believe this methodology would increase stability and predictability in payments to low-volume facilities, especially for facilities whose treatment counts are on the margins of a tier. And we are extremely excited about this potential change. We hope that this proposed methodology will allow small facilities to grow without fear of losing the financial support that they're dependent on and help avoid closures in rural areas by providing a grace period for facilities that are on track to outgrow the LVPA criteria. That concludes the updates to the LVPA. I'd now like to pass the microphone to Lisa Rees.

**Lisa Rees:** Thank you, Leone. I'm presenting today [inaudible] in ESRD facilities. In 2018, we began paying for the treatment of acute kidney injury (AKI) within the dialysis facility. In this rule for 2025, we're proposing to pay for home dialysis for those patients who have acute kidney injury and choose to dialyze in the home setting. We believe this will be beneficial to the rural community because home care will be less labor intensive for the facilities and could lessen their staff, decrease in their travel time. Dialysis in the home setting is typically more gentle, and patients can perform dialysis on a more frequent basis. This may preserve some of their kidney function, and hopefully, their recovery will be quicker, and they will progress to ESRD. So, for all these reasons, we're very excited to propose that AKI patients can receive payment for dialyzing. And I'm going to pass it back to Abby.

**Abby Ryan:** Thanks to everyone—Russell, Leone, and Lisa—for that. These are our key proposals, the most effective rural facilities. Our comment period will end on August the 26<sup>th</sup>, and we encourage everyone to write in with your comments. We read every one of them and carefully evaluate all of them, and I appreciate your attention. And with that, I'll send it back to...who am I going to send back, to Heather?

**Heather Grimsley:** Yes, thanks, Abby. And thank you to all of the presenters today. As Abby mentioned, we encourage you to review the full proposed rules and submit comments on these proposals. I'd also like to highlight that the calendar year 2025 Outpatient Prospective Payment System proposed rule will be discussed on the upcoming Hospital Open Door forum on July 25.

It's now time...we can take any questions and have some answers for our participants today. So, if you have any questions related to today's agenda item, please use the raised hand feature at the [This transcript was current at the time it was published or uploaded onto the web; CMS policy changes frequently so links to the source documents have been provided within the document for your reference; This transcript was prepared as a service to the public and is not intended to grant rights or impose obligations; This transcript document may contain references or links to statutes, regulations, or other policy materials; The information provided is only intended to be a general summary; It is not intended to take the place of either the written law or regulations; We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents;](#)

bottom of the screen and we will call on you. When the moderator says your name, please unmute yourself on your end to ask your question and one follow-up question. Please introduce yourself and what organization or business you are calling from. I think we have a couple of questions. I'm going to turn it over to you.

**Marvelyn Davis:** Barbara, your line is unmuted. Barbara, your line is unmuted. Barbara Pettis, P-E-T-T-I-S. Your line is unmuted.

**Heather Grimsley:** OK, we'll skip to the next one and go back to her.

**Marvelyn Davis:** Fine. Nathan, your line is unmuted.

**Nathan Baugh:** Hello. Thank you, guys, for doing this. My name's Nathan Baugh with the National Association of Rural Health Clinics. My question was, in regard to the care management services changes proposed, are you anticipating that Rural Health Clinics and FQHCs would still be billed on the UB-04 for those care management services, or?

**Sarah Shirey-Losso:** Yes.

**Nathan Baugh:** OK.

**Sarah Shirey-Losso:** Yes, that's correct.

**Nathan Baugh:** Perfect. Thank you, Sarah. That's my only question. I have more, but that's my only question for now. Thank you.

**Marvelyn Davis:** Mary, your line is muted. Mary Ellen N-O-D-R, your line is unmuted.

**Mary Ellen Nodr:** Yes. Can you hear me?

**Marvelyn Davis:** Yes.

**Mary Ellen Nodr:** OK. I'm with Legal Aid of Central and Southeast Ohio. I just had a question regarding the assessments. In the criteria, do you have examples of the different types of assessments that are used for assigning the hours? I'm assuming that's what you were talking about for the home health. And if not, are there proposed assessments to be used?

**Kelly Vontran:** Are you talking about the OASIS-D to E crosswalk?

**Mary Ellen Nodr:** I think you said that you wanted comprehensive assessments that would be like, used to improve it further. I'm assuming that the assessment is the type of assessment—and

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I could be wrong—that is used to determine the hours of service for home health care. Is that not, correct? If it's not, I'm sorry.

**Kelly Vontran:** No, the OASIS is the assessment tool that's already required to be used by home health agencies when they assess a patient. When claims are submitted, that's usually when the units of time are included on the claim. But the OASIS itself is not used in terms of the amount of time.

**Mary Ellen Nodr:** In the assessment?

**Kelly Vontran:** Yes. I mean, there might, in all honesty, I know the OASIS is oftentimes incorporated into the bigger body of a home health agency assessment, which could include...the health agencies could include the time in and out. But in terms of for the purposes of reporting to Medicare, the time in, especially for the calculation of outlier payments, is done going on the clinic.

**Mary Ellen Nodr:** OK, thank you.

**Heather Grimsley:** Are there any other questions for today? We'll give it a couple of minutes, apparently a couple of seconds. Oh, there we go.

**Marvelyn Davis:** Bonnie, your line is unmuted.

**Bonnie Quinonez:** Can you hear me?

**Marvelyn Davis:** Yes.

**Bonnie Quinonez:** Perfect. The discussion about allowing home health services in the home for acute kidney injury in the rural setting, my experience—and I'm sorry, I'm from CommonSpirit in California—my experience has been home health services in the outlying rural areas are very difficult to contract to go all the way out. I guess my question is, is there any consideration given to rates that would maybe encourage home health services to go a little further out of their normal route, if that makes sense?

**Lisa Rees:** Yes. This is for payment for the dialysis facility to provide home dialysis, not for home health agencies.

**Bonnie Quinonez:** OK. So, then the dialysis agencies would actually go to these very remote places to deliver the dialysis or at least provide the home health units and those types of things and educate. So, they would be responsible for that?

**Lisa Rees:** Correct.

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**Bonnie Quinonez:** Gotcha. OK. Thank you.

**Marvelyn Davis:** Mary, your line is unmuted. Currently, there are no more raised hands.

**Heather Grimsley:** OK, great. Thank you. Well, I want to thank everybody for participating in today's webinar. We like to present information in this forum that is helpful to you. So please remember to send topics for future webinars to [ruralhealthodf@cms.hhs.gov](mailto:ruralhealthodf@cms.hhs.gov). Thank you, and have a great rest of your day.

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