

Centers for Medicare & Medicaid Services
Rural Health Open Door Forum
Thursday, November 21, 2024
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Webinar recording:

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Jill Darling: All right, well thanks, everyone, for joining us again. Thank you for your patience. Good morning and good afternoon, everyone. I'm Jill Darling in the CMS Office of Communications, and welcome to today's Rural Health Open Door Forum (ODF). Before we begin our agenda, I have a few announcements. For those who need closed captioning, a link was provided in the chat function of the webinar, and I will provide it again for you. This webinar is being recorded. The recording and transcript will be available on the CMS Open Door Forum transcript web page, and that link goes on the agenda that was sent out, and I will, again, I will share it for you in the chat. If you are a member of the press, please refrain from asking questions during the webinar. If you do have any questions, please email press@cms.hhs.gov. All participants are muted upon entry. And for today's webinar, I have the agenda slide displayed for you, so this will be up during the whole duration of the, I'm sorry, the presentations today.

We will be taking questions at the end of the agenda. We note that we will be presenting and answering questions on the topics listed on the agenda. We ask that any live questions relate to the topics presented during today's call. If you have any questions unrelated to these agenda items, you may not have the appropriate person on the call to answer your question. 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 ODF resource mailbox that I will provide for you, and we'll 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 Q&A. Please introduce yourself with your organization or business you're calling from. And when the moderator says your name, please unmute yourself on your end to ask your question and one follow-up question. And we will do our best to get to all of your questions today. And now I will turn the call over to our Co-Chair, Heather Grimsley.

Heather Grimsley: Thanks, Jill. Thank you everyone for joining today's Rural Health Open Door Forum, and happy National Rural Health Day. We have a very robust agenda today with presentations on several of the recently published final rules. But first, it is my distinct pleasure to introduce Jonathan Blum for some opening remarks. Jon serves as the Principal Deputy Administrator and Chief Operating Officer at CMS. In this dual role, Jon oversees CMS' program policy planning and implementation and also day-to-day operations for the entire agency. Jon has more than 25 years of public and private sector experience working in health care policy and administration. In addition to serving many roles at CMS, he has also worked as a strategy and management consultant and Executive Vice President of Medical Affairs at CareFirst BlueCross BlueShield, professional staff on the Senate Finance Committee, and also a

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program analyst at the Office of Budget and Management. So welcome, Jon, and thank you so much for taking the time to talk with us today.

Jonathan Blum: Well, thank you, Heather, and thank you to the whole CMS team who have worked diligently during the past year to ensure that our policies not only best serve Medicare—Medicare—beneficiaries, but also serve rural health care parts of our country so much better. I also want to take the time to thank John Hammarlund and his team. John has really pushed the agency hard to ensure that we're traveling more, we're getting out into the field to really understand what's happening throughout the country. And John has coined the phrase that CMS needs to spend more time with the underheard, the underserved. And John, really want to thank you for your leadership to really push the agency hard. And I also want to thank the stakeholders that have joined us today, that you are critical to our work, and to this day that we're celebrating today, National Rural Health Day. Just want to take the time to honor those that have joined us and just help—just help—make CMS policies, programs so much better.

We have put out new papers and to really illustrate that CMS now is—now is—taking more time to listen, to think, and to really think about what policies for the future that—that—we can think about together to ensure that our programs better serve those that are covered by Medicare, covered by Medicaid. And so, I asked the CMS team to ensure those links—links—go into the chat because there is some phenomenal work that our team has done. And one of the things that we did this year for the first time is to travel to the country in three different areas to really change the conversation. And for these three meetings, one took place in—in—Billings, Montana, one took place in Dallas, Texas, one took place in—and Wilson, North Carolina, but I had the privilege to attend as well. And each of those meetings, we asked different questions. And so, we asked the stakeholders that joined us to tell us—tell CMS—what is the policy problem that we're trying to solve for? More important, what is the policy solutions that—that—CMS could follow to help respond to that policy problem? And this is work that we've cataloged. This is work that our team now is considering. And one of the key insights that came out during the conversations that I joined in—in—North Carolina this summer was that by far the stakeholders that participated didn't seek more money from CMS. They didn't seek new things that we should cover, for example, but they really sought from CMS ways that we can help support communities to come together to share resources, share data, share information, so that those who are serving those covered by Medicare, those covered by Medicaid, could just do their jobs better. And I think this is going to be the core challenge that CMS has to think about more and the core challenge that all of us need to think about together. Yes, we need to make sure that our—our—various payment systems continue to respond to the challenges that you're facing. But I think even more important, that our programs, policies need to better support community, need to support folks coming together and sharing resources, sharing data, sharing information, so those—those—dollars, those resources can be applied thus to those covered by our programs.

So again, really want to thank the CMS team here. They have worked super hard to ensure that our policies are far more responsive than they have been in the past. Want to thank our teams for pushing all of us to travel more, to get out more, and really want to thank all of the stakeholders here, but also throughout the country, that are giving us far better ideas, far better thoughts for

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how we can think about our policies. And for that, we'll celebrate today, and I'll turn it back to Heather, and can't thank you enough for your leadership. So, with that, thank you.

Heather Grimsley: Thank you very much, and great. With that, we'll get right to our agenda. The first presenter today is Dan Tsoi, and he's going to present updates from the calendar year 2025 Home Health Prospective Payment System (PPS) final rule.

Dan Tsoi: Thank you. The final rule for calendar year 2025 Home Health Prospective Payment System updated the Medicare payment policies and rates for home health agencies (HHAs). This rule also updated the IVIG (intravenous immune globulin) items and services payment rate for 2025 for DME (Durable Medical Equipment) suppliers. The rule finalized a permanent prospective adjustment of -1.975% to the calendar year 2025 home health payment rate to account for the impact of implementing PDGM (Patient-Driven Groupings Model). For calendar year 2025 Home Health Prospective Payment System final rule using calendar year 2023 claims, and the methodology finalized in calendar year 2023 final rule, CMS determined that Medicare is still paying more under the new system than it would have under the old system. We determined a total permanent behavior adjustment of -3.95% is needed to be applied to the 30-day base payment rate to account for overpayments in calendar year 2023, as well as the remaining adjustment of 2.89% that CMS delayed finalizing in calendar year 2024.

However, in response to commenter concerns that this would impose too large—too large—of a reduction in a single year, we are finalizing only half of the adjustment, which is 1.975% to the calendar year 2025 payment rate. This adjustment will continue to satisfy the statutory requirements of section 1895(b)(3)(D) of the Social Security Act to offset any increases or decreases resulting from the impact of differences between the assumed and actual behavior changes on estimated aggregate expenditures. The application of a permanent behavior adjustment will reduce the need for any future large permanent behavior adjustments and help slow the accrual of the temporary payment adjustment amount. The final permanent behavior adjustment is also anticipated to lessen any potential temporary adjustments in future years. While we did not propose to implement a temporary behavioral adjustment in calendar year 2025, the final rule provided the calculated temporary behavioral adjustment dollar amount, which is approximately \$971 million based on analysis of calendar year 2023 claims.

The law provides CMS the discretion to make any future permanent or temporary behavioral adjustments in a time and manner determined appropriate through analysis of estimated aggregate expenditures through calendar year 2026. In addition, we finalized crosswalk for mapping responses on the current OASIS-E (Outcome and Assessment Information Set-E) to the prior OASIS-D responses for use in the methodology to analyze the differences between assumed and actual behavior changes and estimated aggregate expenditures. Therefore, to continue with the methodology, CMS will need to impute responses for three items from OASIS-D that have changed in the OASIS-E. Additionally, 13 items in the OASIS-E are no longer required to be asked at a follow-up visit. For these items, we use the most recent Start of Care or Resumption of Care assessment (SOC/ROC) to determine a response which would not require

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imputation. We finalized a crosswalk to address this issue by mapping the OASIS-E items back to the OASIS-D in this final rule.

We also finalized recalibrated PDGM case-mix weights, updated LUPA (low-utilization payment adjustment) thresholds, the functional impairment levels, and the comorbidity adjustment subgroups. We finalized and adopted the most recent OMB (Office of Management and Budget) CBSA (Core-Based Statistical Area) delineations for the home health wage index. We also finalized an occupational therapy LUPA add-on factor and updated physical therapy, speech pathology, and skilled nursing LUPA add-on factors. The updated fixed dollar loss for calendar year 2025 final rule is an estimated 0.4% decrease. We estimate that Medicare payments to HHAs in 2025 would increase in aggregate by 0.5%, or approximately \$85 million, compared to calendar year 2024. The finalized calendar year 2025 national standardized 30-day period payment rate for home health agency is \$2,057.35. For HHAs that do not submit quality data, the payment rate is \$2,017.28. The finalized calendar year 2025 home IVIG items and services payment rate is \$431.83. The final home IVIG items and services will be posted in the billing and rate section of the CMS Home Infusion Therapy (HIT) web page and will be updated using the Home Health Prospective Payment System rate update change request or technical direction letter and posted on the CMS HIT home IVIG services web page. That concludes my section, and I'll be passing it now to Mary.

Mary Rossi-Coajou: Thank you, Dan. So, CMS finalized updates to the home health Conditions of Participation, which are our health and safety standards, to reduce avoidable care delays by helping ensure that referring entities and prospective patients can select the most appropriate HHA based on their care needs. We finalized a new standard that requires home health agencies to develop, implement, and maintain through an annual review, a patient acceptance-to-service policy that is applied consistently to each prospective patient referred for home health care. In the finalized requirement, this policy must address at a minimum, specific criteria. This criteria includes anticipated needs of the referred prospective patient, the HHA's caseload and case mix, the HHA's staffing levels, and the skills and competencies of the HHA staff. This final rule does not prevent home health agencies from maintaining an existing or their existing acceptance-to-service policy, but rather is intended to complement them. And then lastly, CMS finalized a requirement that HHAs must make available to the public, accurate information regarding the services offered by the home health agency and any service limitations related to types of specialty services, service duration, or service frequency. The home health agencies must review this information as frequently as services are changed, but no less often than annually. And I will pass this over to Kim Roche for long-term care updates.

Kim Roche: Thank you, Mary. This final rule contains information on long-term care facility acute respiratory illness reporting. This new rule requires long-term care facilities to report COVID-19, influenza, and RSV (respiratory syncytial virus) data for resident vaccination status, confirmed resident cases, overall and by vaccination status, hospitalized residents with confirmed cases of COVID, influenza, and/or RSV, and that's by overall and by vaccination status. So, I'm going to talk about two different categories, ongoing reporting and public health emergency (PHE) reporting. For ongoing reporting, beginning January 1, the new date of reporting standard addresses a broader range of acute respiratory illnesses. So again, beginning

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on January 1, long-term care facilities are required to electronically report information about COVID-19, influenza, and RSV in a standardized format and frequency specified by the Secretary. This new standard will replace the current COVID-19 reporting standard at 48380G for long-term care facilities. The new data elements for which will be—for which reporting will be required include facility census, resident vaccination status for COVID, influenza, and RSV, confirmed resident cases of COVID-19, influenza, and RSV, and that's overall and by vaccination status, and hospitalized residents with confirmed cases of COVID, influenza, and/or RSV, overall and by vaccination status.

CMS continues to believe that sustained data collection and reporting of respiratory illnesses outside of emergencies will help long-term care facilities gain important insights related to their evolving infection control needs. The effective date for reporting the broader range of acute respiratory illnesses is January 1, but in the meantime, until November 31, nursing homes should continue reporting COVID-19 cases, hospitalizations, and vaccination data weekly for residents, and COVID-19 vaccination data weekly for staff into CDC's (Centers for Disease Control and Prevention) NHSN, the National Healthcare Safety Network.

Now I'm going to move on to public health reporting. So, CMS has also finalized that during a declared national, state, or local public health emergency for an acute respiratory illness, the Secretary may require reporting of data elements that include relevant confirmed infections for staff, supply inventory shortages, staffing shortages and relevant medical countermeasures and therapeutic inventories, usage or both. I'd like to also mention that CDC's NHSN trainings for the long-term care community have occurred, and another one is planned for December 11. So now I'd like to send the microphone over to Cara, and Cara will talk about 2025 Physician Fee Schedule (PFS), the final rule. Thank you.

Cara Meyer: Thank you, Kim. Hi, everyone. My name is Cara, and today I'll provide an overview of the changes made to the rural health clinic (RHC) Conditions for Certification, or CFCs, which are included in this year's Physician Fee Schedule final rule. These changes aim to improve the access to services for patients in rural areas, increase flexibility and the services RHCs may provide, and decreasing provider burden. In this rule, we essentially made two changes within the provision of services CFC that directly impact RHCs. The first change in this rule is under the basic requirements, where we are finalizing a new standard that requires RHCs to provide primary care services. We were made aware by interested parties, challenges RHCs were experiencing with providing sufficient amount of outpatient specialty care services to meet the needs of their communities because of a longstanding policy in the subregulatory guidance that requires RHCs to primarily provide primary care services.

By adding this new standard, it removes the limit on the volume, especially outpatient services, RHCs may provide as they would only be required to provide primary care services at some level as opposed to being primarily engaged. As a result, RHCs will have the autonomy to tailor their services to better meet the unique needs of their patients. We are also finalizing the removal of “hemoglobin and hematocrit” as well as the “examination of stool specimens for occult blood” from the list of laboratory services RHCs are required to provide onsite. This is because RHCs report that they're not ordering these labs or doing so infrequently as they're typically outsourced

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to other labs. Additionally, CMS is finalizing a revision to the primary—primary—culturing lab requirement to reflect modern lab techniques. This requirement will now read as collection of patient specimens for transmittal to a certified laboratory for culturing rather than the RHCs performing the primary culturing on site. And so by finalizing these changes, CMS anticipates RHCs will see a decrease in the burden associated with purchasing and maintaining the laboratory equipment and having qualified staff needed to process these tests. Alleviating these burdens will allow RHCs to focus their resources on other services that they provide, thereby improving overall efficiency and patient care. And now I'll be passing it off to Michele and CM (Center for Medicare) to go over payment.

Michele Franklin: Thank you, Cara. Hi, everyone. Again, I'm Michele Franklin and my colleague, Lisa Parker, and I will be going over additional policies impacting RHCs and FQHCs (Federally Qualified Health Centers) under the Physician Fee Schedule CY 2025 final rule. Namely, we will be going over care—care—coordination services, which were formerly known as care management services, including Advanced Primary Care Management (APCM) services, intensive outpatient program services, productivity standards, and dental services. For care coordination services, we finalized several changes to the furnishing of care coordination services and RHCs and FQHCs. We finalized reporting of individual CPT (Current Procedural Terminology) HCPCS (Healthcare Common Procedure Coding System) base codes, and—and—add-on codes for each of the care coordination services, which will now replace HCPCS G0511. These services will be paid at the national non-facility payment rate when the service is furnished either alone or with other payable services. We also finalized to allow additional time for those RHCs and FQHCs that need to update their billing systems, that they may continue to bill G0511 until July 1, 2025. For those that are ready, they should bill individual HCPCS codes beginning January 1, 2025. In addition, we finalized to align with the PFS and adopt the coding and policies for Advanced Primary Care Management services. Payment for care coordination services will be updated annually based on the PFS amounts for these codes, which is how these updates are made currently. I will now turn it over to my colleague, Lisa Parker.

Lisa Parker: Thank you, Michele. My name is Lisa Parker, and I will be addressing IOP (Intensive Outpatient Program) services, productivity standards, and RHCs and dental services. In last year's rule, we finalized adding a payment rate for up to three Intensive Outpatient Program, or IOP, services per day. This year, we finalized adding a payment rate for four or more IOP services per day. We also finalized the removal of productivity standards for RHCs for cost reporting periods ending after December 31, 2024. We also clarified that when RHCs and FQHCs furnish dental services that align with the policies in the physician setting, we would consider those services to be a qualifying visit. I will now turn it over to my colleague, Rachel Radzyner.

Rachel Radzyner: Thank you. So, I'll be talking about several proposals related to vaccines and other preventive services in RHCs and FQHCs. First for CY 2025, we finalized the policy to allow RHCs and FQHCs to bill and be paid for Part B preventive vaccines and their administration at the time of service. Payments for these claims will be made according to the Part B preventive vaccine payment rates in other settings to be annually reconciled with the facility's actual vaccine costs on their cost reports. Due to the operational systems changes

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needed to implement this policy, RHCs and FQHCs can begin billing for preventive vaccines in their administration at the time of service for dates of service beginning on or after July 1, 2025. We also finalized a policy to allow payment for hepatitis B vaccines and their administration to be made at a 100% of reasonable costs in RHCs and FQHCs in order to streamline payment for all Part B vaccines in those settings.

Second, for this coming year, we're proposing a fee schedule for Drugs Covered as Additional Preventive Services, or DCAPS drugs for short. CMS had not paid for any drugs under this benefit—benefit—category of additional preventive services until CMS recently released the final NCD (national coverage determination) regarding Part B coverage for PrEP (Pre-Exposure Prophylaxis) for HIV (Human Immunodeficiency Virus) drugs on September 30, 2024. So, in the PFS final rule, we finalized our proposal to determine a payment limit for these drugs, DCAPS drugs, according to the ASP (Average Sales Price) methodology set forth section 1847A of the Act, and that's when ASP data is available for those drugs. And in cases where ASP data is not available, we finalized alternative payment mechanisms or calculated payment limits for DCAPS drugs. And we also finalized payment limits for supplying and administration fees of DCAPS drugs, which are similar to those paid for other Part B drugs. And in terms of RHCs and FQHCs, we proposed and finalized that we'll use the same fee schedule for DCAPS drugs and any administration or supplying fee. And when the RHCs and FQHCs provide these drugs, the administration and supplying fees will be paid at 100% of the Medicare payment amount and will be paid on a claim-by-claim basis separate from the FQHC PPS and the RHC AIRs (All-Inclusive Rates), separate from those. And that's it for me. And I'll pass it to Emily Yoder.

Emily Yoder: Thanks so much. So, I will be covering, first, some updates for the Medicare telehealth policy for physicians and other practitioners as well as some updates for telehealth specifically for RHCs and FQHCs. So, we are finalizing our proposal to add caregiver training services to the Medicare telehealth services list provisionally. And we are also permanently adding coding describing HIV PrEP counseling and coding describing safety planning interventions to the telehealth list as well. We are finalizing to continue the suspension of frequency limitations for certain services for 2025. We are finalizing that an interactive telecommunication system may include two-way, real-time, audio-only communication technology for any Medicare telehealth service furnished to a beneficiary in their home if the distance site practitioner is technically capable of using but the patient does not—is not capable of or does not consent to the use of video technology. We are also finalizing that for a certain subset of services that are required to be furnished under the direct supervision of a physician or other practitioner, to permanently adopt a definition of “direct supervision” that allows the virtual presence of the supervising practitioner through real-time audio and video.

For all other services requiring direct supervision, we are finalizing to continue to permit direct supervision to be provided through real-time audio/video only through December 31, 2025. And lastly, we are also finalizing a policy to continue 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 service is furnished virtually through December 31, 2025. And onto the specific updates for telehealth and RHCs and FQHCs, we are finalizing a policy clarification to allow direct supervision via interactive audio and video telecommunications and

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to extend the definition of “immediate availability” as including real-time audio and video interactive telecommunications technology, excluding audio-only, through December 1, 2025. We are also finalizing a policy to allow payments on a temporary basis for non-behavioral health visits furnished via telecommunication technology under the methodology that has been in place for these services during and after the COVID-19 PHE through December 31, 2024.

Specifically, under our finalized policy, RHCs and FQHCs can continue to bill for RHC and FQHC services furnished using telecommunications technology by reporting HCPCS code G2025 on the claim, including services furnished using audio-only communications technology through December 31, 2025. For payments for non-behavioral health visits furnished via telecommunications technology in 2025, we will calculate the payment amount based on the average amount for all PFS telehealth services on the Medicare telehealth services list weighted by volume for those services reported under the PFS. And finally, we are finalizing a continued policy to delay the in-person visit requirements for mental health services furnished via communication technology by RHCs and FQHCs to beneficiaries in their homes until January 1, 2026. And with that, I will pass it off to the OPPTS (Outpatient Prospective Payment System) team.

Molly Anderson: Thank you. Today, I'll be discussing the health and safety standards for obstetrical services in hospitals and CAHs, or critical access hospitals, or CAHs, that we finalized in the OPPTS finalized rule. These requirements, which were informed by public input built on CMS' comprehensive Maternity Care Action Plan, drive improvements in access and aim to make pregnancy childbirth and postpartum care safer. These new standards ensure that all Medicare and Medicaid participating hospitals and CAHs offering these services are held to a consistent standard of high-quality maternity care that protects the health and safety of pregnant, birthing, and postpartum women. As part of this final rule, we have established new requirements for maternal Quality Assessment and Performance Improvement, or QAPI, baseline standards for organization staffing and delivery of obstetrical care and staff training on evidence-based maternal health practices. For the organization staffing and delivery of services, hospitals and CAHs that provide obstetrical services outside the emergency department will be required to provide such services in a well-organized manner in accordance with nationally recognized acceptable standards of practice.

The hospitals and CAHs will be required to make specified equipment readily available for treating obstetrical cases in accordance with the scope, volume, and complexity of services offered. For staff training, hospitals and CAHs will be required to develop policies and procedures to ensure that relevant staff, as identified by the governing body, are trained biannually on evidence-based best practices aimed at improving the delivery of maternal health care services within the facility. Staff identified by the governing body will also be required to complete an initial training, and new staff will be required to complete an initial training. The staff will be required to complete subsequent training every two years. For QAPI, hospitals or CAHs with obstetrical services must use their QAPI programs to assess and improve health outcomes and disparities among obstetrical patients on an ongoing basis, analyze data and quality indicators for obstetrical patients by diverse subpopulations, measure, analyze, and track quality indicators on patient outcomes and disparities in processes of care, services, and

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operations and outcomes among obstetrical patients, develop and implement actions to address these disparities and monitor subsequent results, and conduct at least one performance improvement project focused on reducing maternal health disparities annually. Obstetrical leadership must be engaged in the facility's QAPI program as well. If a Maternal Mortality Review Committee, or MMRC, is available at the state, local, or Tribal level, the facility must have a process for incorporating the MMRC data and recommendations into the facility's QAPI program.

Additionally, we have established emergency services readiness and transfer protocol requirements for all patients, which will better prepare hospitals and CAHs to respond to obstetric emergencies. For emergency services readiness, hospitals and CAHs will be required to have adequate provisions and protocols to meet the emergency needs of patients. Under this requirement, hospitals—hospitals—specifically must have equipment, supplies, and medication used in treating emergency cases that must be kept at the hospital and are readily available for treating emergency cases. For transfer protocols, the hospitals must have written policies and procedures for transferring patients under their care, which would be inclusive of hospital inpatients to the appropriate level of care as needed to meet the hospital—to meet the patient's needs. The staff must also be trained on transfer protocols annually.

Lastly, we have also finalized a phased-in implementation to balance the need for improved maternal health outcomes while also reducing potential burden and mitigating against any unintended consequences. The implementation will be conducted in three phases, with each phase starting from the effective date of this final rule. So, phase one will begin in six months and include emergency services readiness for hospitals and CAHs and transfer protocols for hospitals. Phase two will begin in one year and include organization, staffing, and delivery of services for hospitals and CAHs. And then lastly, phase three will begin in two years and include obstetrical services, staff training, and QAPI requirements for both hospitals and CAHs. Thank you.

Jill Darling: OK, thank you, Molly. And thank you to all of our speakers. We will begin our Q&A. So, at the bottom of your screen, please click on the raise hand feature and we will wait for some hands raised.

Moderator: Kira, your line is unmuted. Kira, your line is unmuted. Sharon McKinney, your line is unmuted.

Sharon McKinney: Yes, I'm sorry, I couldn't find the unmute button on my end. Thank you so much. I'm not sure if this question is appropriate here, but I'm going to take a chance on asking it because I've been on a wild goose chase to get an answer. Can somebody advise me regarding the billing of an E/M (evaluation and management) code in conjunction with a preventive maintenance code in rural health? I'm new to rural health, and I'll be doing billing and coding, and I cannot get a definitive answer to that question. Thank you.

John Hammarlund: Sharon, this is John Hammarlund, Co-Chair. I don't think we have anybody on this call to be able to answer that particular question today, and I'm sorry, but we do want to

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be able to get you an answer. So, at the end of this call, we'll give an email address if you can send that in—in—writing to us and we'll make sure we address it.

Sharon McKinney: Could I put it in the chat?

John Hammarlund: Sorry, we don't have the right person on to answer it today.

Sharon McKinney: OK.

John Hammarlund: We'll attend to it.

Sharon McKinney: I'll put that in chat. Thank you.

John Hammarlund: Oh, OK. Great. Thank you.

Jill Darling: I just sent the Rural Health ODF email to everyone. So, you should see it in the chat.

John Hammarlund: Right.

Jill Darling: OK, let's give it one more moment if we have any questions.

Sharon McKinney: I'm sorry, but my chat is disabled.

Jill Darling: Yes. I just sent the Rural Health ODF email into the chat for everyone to grab. I'll do it again for you.

Sharon McKinney: Thank you.

Jill Darling: OK. OK. I do not see more raised hands, so I will hand it back to John for closing remarks.

John Hammarlund: Thank you, Jill. Yeah, so I'm really delighted that so many could join us on this call today. Thank you so much for being part of it. I think Heather introduced this as a robust agenda. I hope we lived up to that billing. I thought it was chock-full of important information. And I want to remind you, though, that you, all of you, have an opportunity to help us build the agendas for these Open Door Forum calls. So, we invite you to suggest agenda items for future calls. The email box that Jill just put into the chat is the—is the—way to do that, and we would help you—we would appreciate your assistance in building future robust agendas.

I also want to, speaking of Jill, she put some other things in the chat that I want to bring to your attention before we close today's call. On Monday, we released a report. It's a year in review, fiscal year 2024 year in review report, on advancing health care in rural, Tribal, and geographically isolated communities. This report details our commitment to improving health equity and addressing the unique needs of rural and Tribal and geographically isolated

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communities. So, I commend that report to your viewing. We also released a report last week entitled “Rural Urban Disparities in Health Care and Medicare.” And there's a description of that report as well along with the link to that report. So, we encourage you to take a look at that. And then finally, we published a white paper last week called “Re-Imagining Rural Health: Themes, Concepts, and Next Steps from the Center for Medicare and Medicaid Innovation Hackathon Series.” Now, the hackathon series is what Jon Blum was mentioning at the outset of this call where he mentioned that we had some dynamic listening and problem solving sessions in three different parts of the country. This white paper is what sort of summarizes what came out of those. And again, you have the link here below it, and I really encourage you to take a look at that. We're very proud of the work that our colleagues in the Innovation Center did to facilitate those sessions, and we learned a lot from them. So, we hope you'll take a look at that as well. So, thank you, Jill, for putting all of that information into the chat and the links as well. So, on behalf of Heather and myself, again, thank you so much for joining today's call. We are—we are honored as public service to serve those of you who serve the rural geographically isolated, Tribal communities in our nation. You—you—do fantastic work, and our agency wants to do all we can to support you in that. So, I'll close by simply saying we wish you all and thank you all for a National Rural Health Day 2024. Thanks again, everybody, for joining today's call. I'll let Jill close it out with any final comments. Thank you.

Jill Darling: Great. Thank you, John. That does conclude today's call. Again, the Rural Health Open Door Forum email I sent out, ruralhealthodf@cms.hhs.gov. And this will, I believe, conclude for the year. So, we will speak with everyone next year, and if I misspeak, then you will receive an agenda from me for December. But thank you, everyone. That will conclude today's call.

Mary Ellen Nose: I don't know if you can hear me but thank you. I didn't review the different ones that you sent, so it was great. Thanks.

John Hammarlund: Thank you, Mary Ellen. Appreciate that.

Mary Ellen Nose: Yeah, it was really helpful.

John Hammarlund: Bye, everybody. Thank you for joining today.