RURAL HEALTH WORKSHOP

Welcome Back!

WELL-AHEAD

LOUISIANA RURAL HEALTH ASSOCIATION

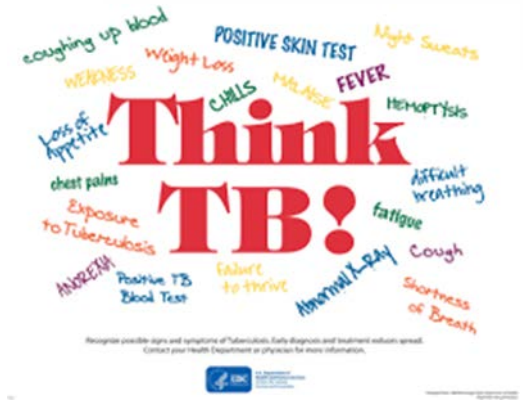
Day Two!

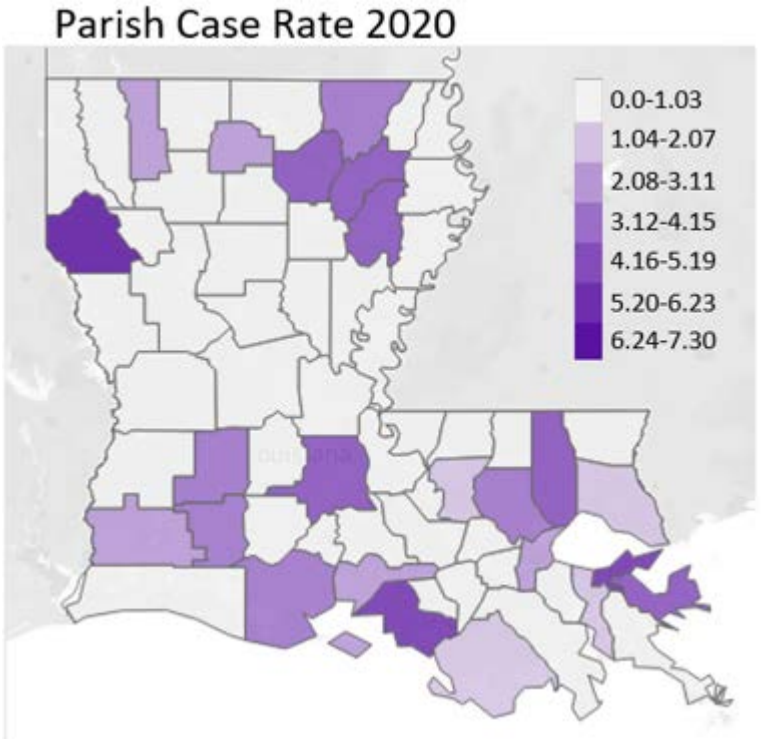
- Break with Exhibitors: Take the Exhibitor Challenge!
  - 11 am – 12 pm
- Concurrent Sessions
  - 1:30 – 2:30 pm
- Break with Exhibitors: Take the Exhibitor Challenge!
  - 2:30 – 3 pm
- Concurrent Sessions
  - 3 – 4 pm

Speakers

- Michael Lacassagne
  - Louisiana Department of Health, Office of Public Health, Tuberculosis Control Program

Office of Public Health Tuberculosis Control Program





- 99 Cases in 2021
- 2.1 cases per 100,000

- Signs and Symptoms
  - Prolonged Cough (3 Weeks or More)
  - Loss of Appetite
  - Unintentional Weigh Loss
  - Fever
  - Chills
  - Night Sweats

- 9 Regional TB Control Programs
- TB Services available in Public Health Units across the state

- For More Information:
- https://ldh.la.gov/page/1005
- (504) 568-5015

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Speaker

- Patrick Gillies
  - Executive Director, Medicaid
  - Louisiana Department of Health

Questions?

Speaker

- Libby Gonzales, RN, BSN
  - Medical Certification Program Manager
  - Louisiana Department of Health, Health Standards

Louisiana Department of Health & Hospitals

Health Standards Section

Rural Health Clinics

December 7, 2021

Libby Gonzales, RN, BSN

Medical Certification Program Manager

LOUISIANA DEPARTMENT OF HEALTH

RHC Surveys/Regulations

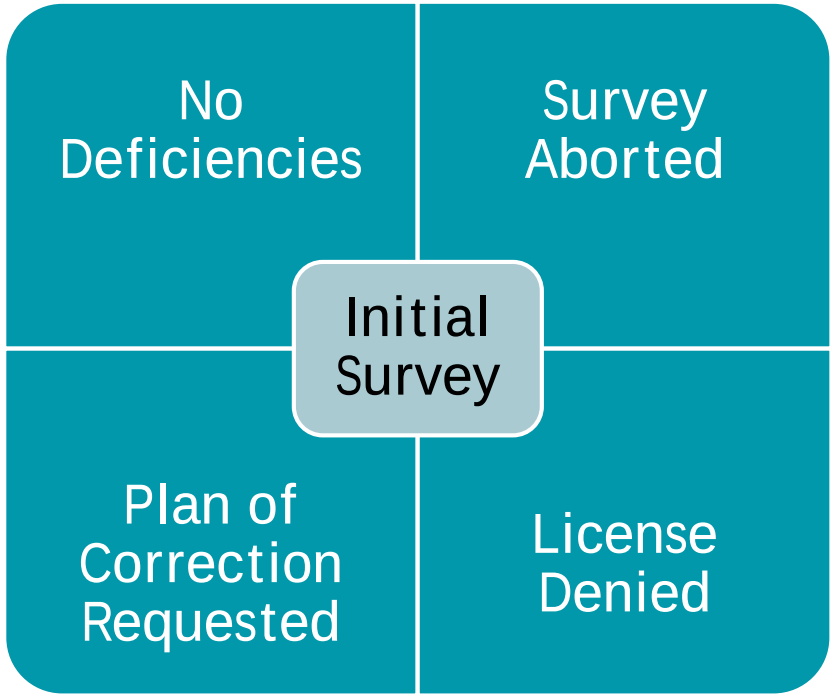
Type of Survey	Licensing Regulations	Federal Regulations
Initial Licensing Survey	RHC Licensing Standards	
Relicensing Survey	RHC Licensing Standards	
Initial Certification Survey		RHC Conditions for Coverage & AO Standards
Recertification Survey		RHC Conditions for Coverage & AO Standards (if accredited)
Complaint Survey	RHC Licensing Standards	RHC Conditions for Coverage

Initial Licensing Survey

Initial Licensing Survey

- This is an announced survey coordinated between the provider & Field Office
- RHCs must be operational and have seen at least 5 patients prior to the survey
- All State Licensing Standards must be met

Results of Initial Licensing Survey

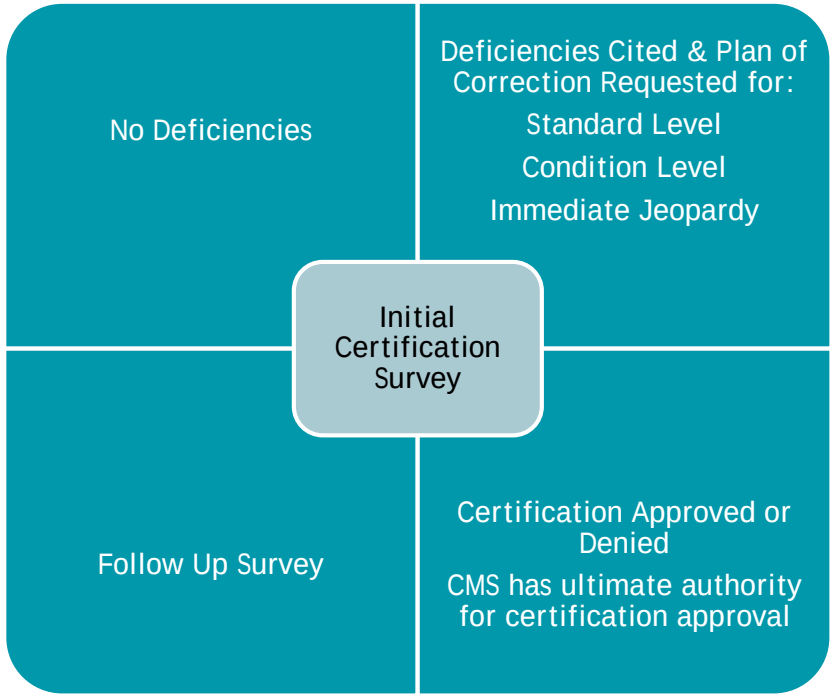


Initial Certification Survey

Initial Certification Survey

- Resources for **Initial Certification** Surveys are highly constrained due to the current budget for Survey & Certification.
- CMS longstanding policy makes complaint investigations, re-certifications, and other core work for existing Medicare providers a higher priority compared with certification of new Medicare providers.
- Providers have the option of attaining accreditation that conveys deemed Medicare status conducted by a CMS-approved accreditation organization (in lieu of Medicare surveys by CMS or States). Providers are advised that such deemed accreditation is likely to be the fastest route to certification.
- This Certification process can only take place **after** the provider has been issued a license by the State.

Results of Initial Certification Survey



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Re-Certification Survey

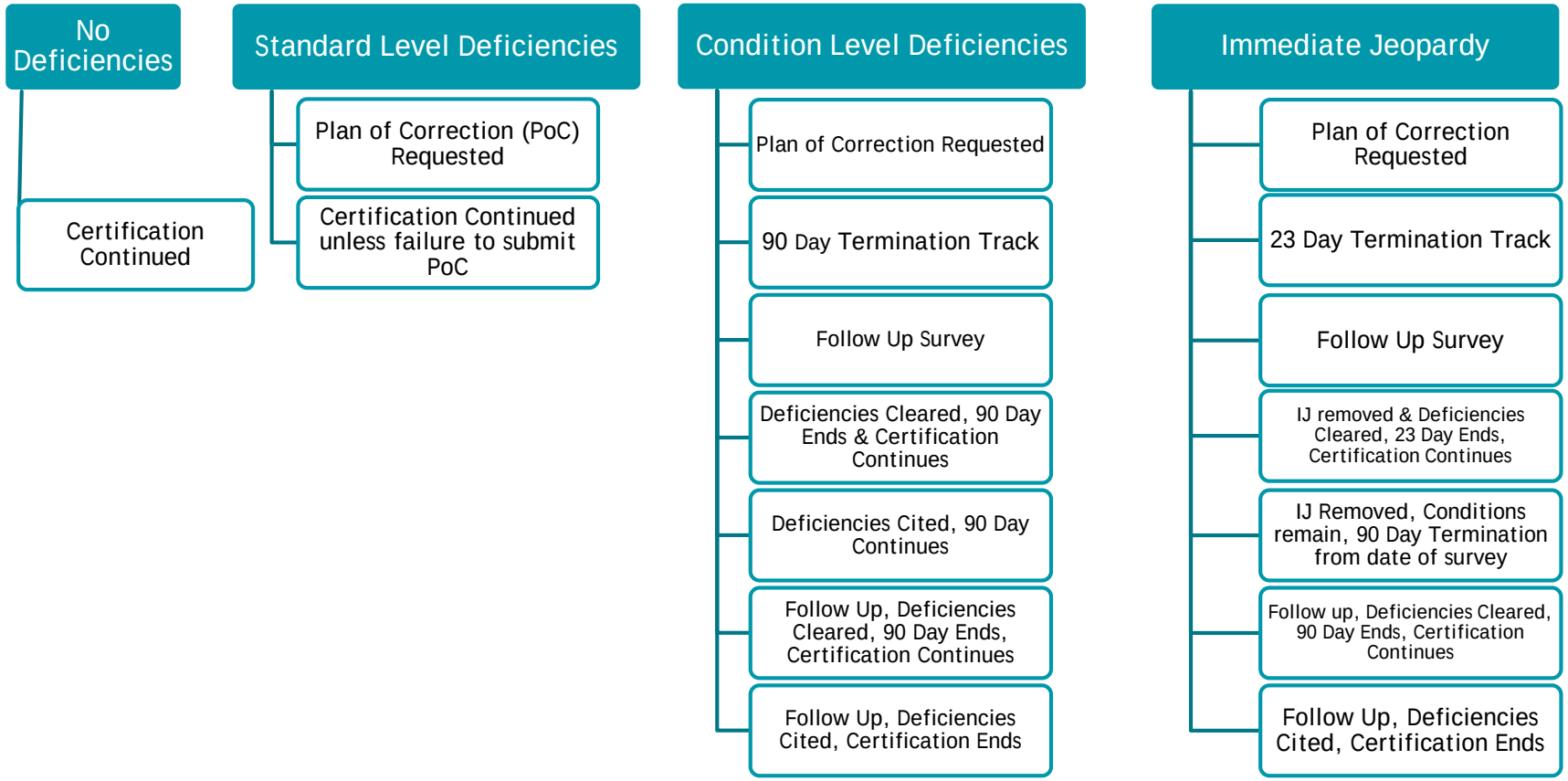
Accredited RHCs

- Accreditation is granted for 3 years
- The Accrediting Organization will conduct an unannounced reaccreditation survey prior to the expiration of the current accreditation survey.
- All AO standards are reviewed.

Non-Accredited RHCs

- Once a year CMS issues a priority schedule to Health Standards outlining the types of federal surveys to be conducted.
- RHC are selected for unannounced recertification surveys based on the priority document
- All Conditions for Coverage & Life Safety Codes are reviewed
- Re-licensing & recertification surveys are usually conducted concurrently except for Hospital Offsite RHCs which may be on a different schedule.

Re-Certification Survey



Conditions of Coverage

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Most frequently cited tags

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Complaint Survey

- Rebecca Havard, RN handles complaint intakes

State and/or Federal Regulations

- Surveyors will review the corresponding licensing regulations and federal Conditions of Participation/Coverage relative to the complaint.

You have a Deficiency-What is next?

- Standard Level Deficiency
  - The surveyor will email the statement of deficiencies to the administrator
  - The RHC will submit a plan of correction within 10 calendar days from the date of receipt

- Condition Level Deficiency
  - The RHC is placed on a 90 day termination track
  - State Office will email the statement of deficiencies to the administrator along with a 90 day termination letter.
  - VERY TIME SENSITIVE

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What to do now?

- First-Get started fixing the problem as soon as it is brought to your attention. DO NOT WAIT to receive the statement of deficiencies.
- Reach out for help-especially if you have condition level deficiencies.
  - State Office is not allowed to consult….but that does not apply to all agencies
    - Denae Hebert's group with the State Office of Rural Health can be a very valuable resource

Standard Deficiencies Only

- Statement of deficiencies sent to the provider.
- Provider has:
  - **10 calendar** days from the date of receipt to complete plan of correction and send to RHC C&S desk.
  - Must send all documentation created or changed to address the cited deficiencies.(i.e., updated or changed policies and procedures, audit sheets created, staff in-service sign in sheets).
  - Plan needs to be signed dated and titled by CEO or authorized signature.

Conditions of Coverage

Please note that if a deemed RHC is found to be not in compliance with one or more CfCs:

- CMS removes the “deemed status’ and the RHC is notified by letter.

Timeline for 90 day Terminations

- **Fifteenth Working Day-** State Agency sends the statement of deficiencies and a letter to the supplier indicating there is a determination of noncompliance and placing facility on 90 termination track. Supplier has 10 calendar days to complete plan of correction.
- **Thirty-Fifth Calendar Day-** If supplier submits acceptable plan of correction, the State Agency conducts a revisit survey to determine compliance. Only 2 revisits permitted
- **Fifty-Fifth Calendar Day-** If compliance has not been achieved, the State Agency certifies noncompliance. Supporting documentation sent to Regional Office.
- **Sixty-Fifth Calendar Day-** Regional Office determines whether survey findings continue to support a determination of noncompliance
- **Seventieth Calendar Day-** Regional Office sends an official termination notice to the supplier.
- **Ninetieth Calendar Day-** termination takes effect if compliance is not achieved
- ***Please ensure the CEO/Administrator's e-mail is accurate***

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April 3, 2014

Administrator
ABC Hospital
123 Dark Street
Happy Town, LA XXXXX

90 day termination letter

Medicare Provider # XXXXX

E-MAIL – READ RECEIPT REQUESTED

Dear Administrator:

On the basis of the deficiencies found to exist in your facility on 01/15/2014, it no longer appears that ABC Hospital qualifies as a provider of services in the Medicare program. To participate in Medicare, a provider must meet the statutory requirements established under Title XVIII of the Social Security Act and must also meet health and safety requirements prescribed by the Secretary of the U. S. Department of Health and Human Services. The results of the **01/15/2014** survey confirmed that **ABC Hospital** is out of compliance with the following Medicare Conditions of Participation:

42 CFR 482.13 Patient Rights

The CMS form 2567 Statement of Deficiencies is enclosed for your response and is to be returned to this office signed and dated by the administrator or other authorized official as indicated. The plan of correction must be entered on the original statement of deficiency report and must be specific, realistic and state how the deficient practice will be prevented from recurring. Refer to the enclosed "Required Components for a Plan of Correction" for guidance in developing your Plan of Correction. The Plan of Correction must be completed and returned to this agency within **10 days after receipt** of this letter or action to terminate your agreement will proceed as scheduled. Proposed Plan of Correction completion dates for the Conditions of Participation and related deficiencies **cannot exceed April 19, 2014 (35th day).** Compliance with all Conditions of Participation must be achieved at the time of this revisit if further action is to be avoided.

If the deficiencies have not been satisfactorily corrected at the time of this revisit, a certification of non-compliance will be forwarded to the Centers for Medicare and Medicaid Services (CMS) with the recommendation that your Medicare provider agreement be **terminated effective April 15, 2014.** In that event, you can expect to receive a letter from CMS advising you of the exact date of termination and your appeal rights. During that period, CMS will give public notice of the date of termination and the reasons for termination. Once terminated, you can anticipate being out of the Medicare program for at least 60 days.

Plan of Correction

THE REQUIRED COMPONENTS FOR A PLAN OF CORRECTION MUST CONTAIN THE FOLLOWING 5 COMPONENTS:

1. Address how corrective actions were accomplished for those residents/clients/patients found to have been affected by the deficient practice; (refer to the survey identifier list; if applicable)

2. Describe how other residents/clients/patients that have the potential to be affected by the deficient practice will be identified; and what will be done for them.

3. The measures that will be put in place or the system changes that will be made to ensure that the deficient practice will not recur.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. Indicate how the corrective measures will be monitored. What quality assurance program will be put into place? Monitoring must include who (what discipline), how (chart audits, direct observations, specific procedures), how often (daily, weekly, twice a month), and what will be done if problems are discovered.

5. Include dates when corrective action will be completed.

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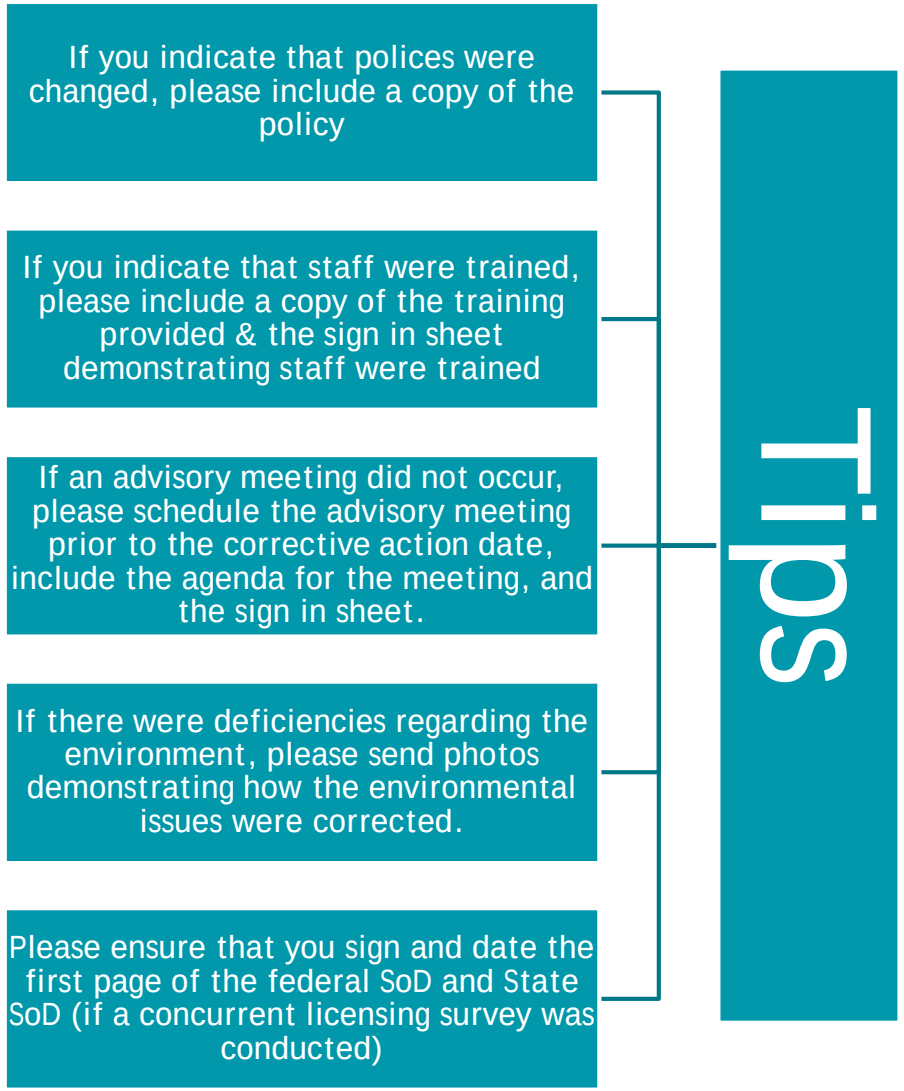
Plans of Correction



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Please remember:

Keep CEO/Administrator information with us

CURRENT –This database is also used by CMS

PoC's are sent via e-mail to HSSNLTCSurveyPackets@la.gov

or

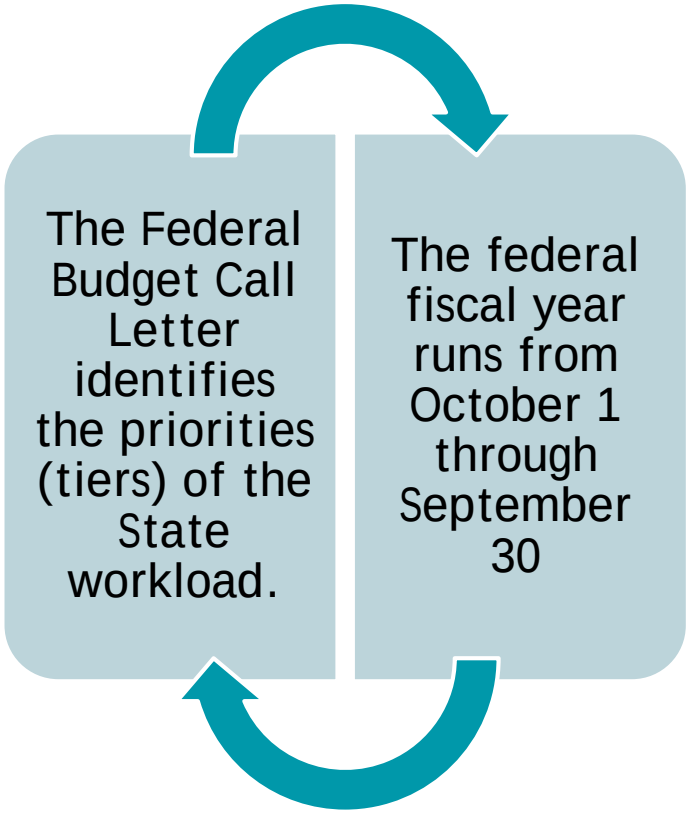
Mailed to Health Standards Section, P.O. Box 3767, Baton Rouge, LA 70821

Both a hard copy and e-mail are not needed!

Budget & Workload

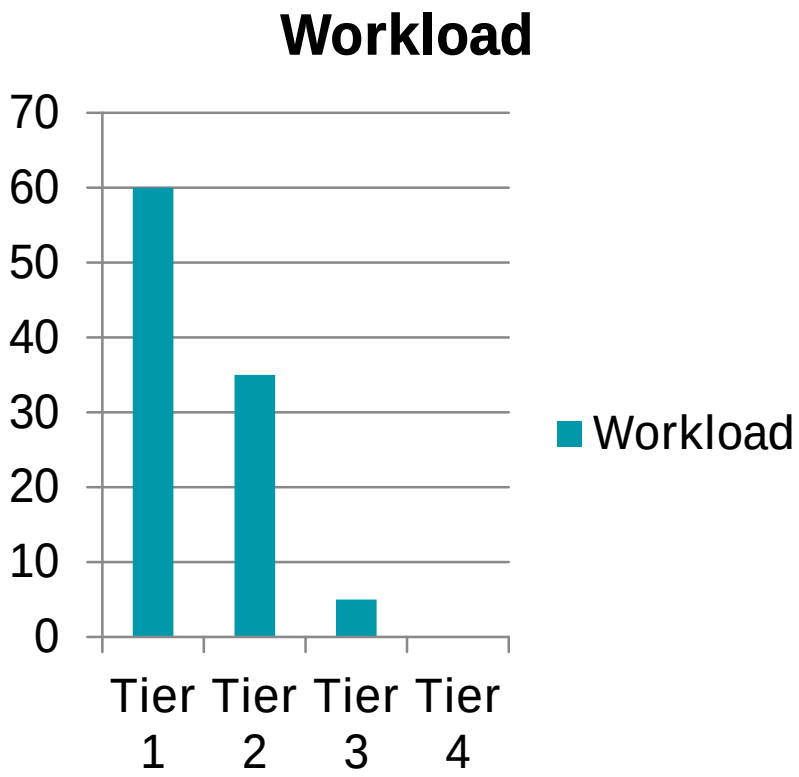
A Real Balancing Act

Budget & Workload



Priority Tiers

- Tiers reflect statutory mandates and program emphasis.
- States must assure that Tiers 1 and 2 will be completed as a pre-requisite to planning for subsequent Tiers.



Tier Workload

Tier 1
Complaint surveys prioritized as potential Immediate Jeopardy complaints.
Full surveys following complaint investigations in which a Condition of Coverage (CoC) was found to be out of compliance.
Tier 2
Complaint Surveys prioritized as non-Immediate Jeopardy High complaints.
Recertification Surveys of at least 5% of the non-deemed RHCs.
Relocations of any provider displaced during a public health emergency declared by the Governor.

Tier Workload

Tier 3
Complaint Surveys prioritized as non-Immediate Jeopardy Medium complaints.
Recertification Surveys on RHCs to ensure no more than 7 years elapses between surveys.
Tier 4
Additional Recertification Surveys of non-accredited RHCs to ensure a 6 year average.
Initial Certification Surveys of all RHCs since RHCs have the option to achieve deemed Medicare status through an approved AO.
Relocations of deemed providers.

Why is an AO doing my initial certification survey?

- Because of the CMS Tier Level Workload

Approved AOs for RHCs

American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) http://www.aaaasf.org/	The Compliance Team http://www.thecompliancetea m.org/
5101 Washington St., Suite 2F P.O. Box 9500 Gurnee, IL 60031 1-888-545-5222	905 Sheble Lane, Suite 102 P.O. Box 160 Springhouse, PA 19477 Kate Hill: 1-215-654-9110 khill@TheComplianceTeam. org
	

Licensing

- All Rural Health Clinic's, regardless of type, are licensed as RHC or an offsite/department of the hospital
- License must be displayed in an obvious place in the RHC at all times
- 2 License Types:
  - Full License: In substantial compliance with the rules, standards and law. These are issued for 12 months and renewed annually.
  - Provisional License: Not in substantial compliance with the rules, standards and law. These can be issued for up to 6 months if there is no immediate and serious threat to the health & safety of patients.

License

- Not assignable or transferable
- Issued to a specific owner and to a specific geographic location.
- Immediately voided if Rural Health Clinic ceases to operate or if its ownership changes.
- Voided if the hospital (or off-site campus) relocates.
- The rural health clinic must notify HSS at least fifteen days prior to any operational changes.
- RHC must be open and operational prior to the licensing survey.

3 Types of Rural Health Clinic's

1. Independent RHC – licensed and certified as a stand alone facility.
2. Provider–Based RHC- licensed and certified independently but CCN number is linked to the hospital CCN number (should meet the provider based criteria).
3. Hospital Department or Offsite- licensed to the hospital and certified independently as a RHC (should meet the provider based criteria).

Only 1 License

A Rural Health Clinic can only be licensed as one type. The RHC can't have 2 or more licenses, i.e. it can't be licensed as a free standing RHC and a Hospital Outpatient Department simultaneously.

Changes in Ownership

- Changes in ownership structure can be processed in one of two ways:
  - Change in Information (CHOI)
  - Change in Ownership (CHOW)

- Regardless of which way it is processed you will need to submit a change of ownership structure packet to Health Standards.

Changes in Ownership

Licensing Standards & Federal 42 CFR 489.18

- A change in ownership (CHOW) is the sale or transfer (whether by purchase, lease, gift or otherwise) of a RHC by a person/corporation of controlling interest that results in:
  - a change of ownership or control of 30% or greater of either the voting rights or assets or
  - the acquiring person/corporation holding a 50% or greater interest in the ownership.

Changes in Ownership

Notice to HSS

- No later than 15 days after the effective date of the CHOW, the prospective owner shall submit to the department a completed application for the CHOW. A license is not transferable from one entity or owner to another.

- Please note that as soon as the CHOW occurs (effective date) the current license is no longer valid. Upon submission of a CHOW packet 15 days following the CHOW, the RHC may be granted up to 90 days to obtain the CMS 855A on a case-by-case basis.

- No other licensing actions will be processed until the CHOW is completed because the license is no longer valid.

Notice to CMS

- A provider who is contemplating or negotiating a change of ownership must notify CMS.

Changes in Ownership

Provider Agreement

- CMS automatically assigns the provider agreement to the new owners.
- The new owners may formally notify CMS that they plan to reject “assignment” of the provider agreement.
- When the new owner does not accept assignment of the previous owner’s provider agreement, the provider agreement is voluntarily terminated. If the new owner wishes to participate in Medicare/Medicaid, it is treated as a new applicant.

Changes in Ownership

Effects of **Accepting** Assignment of the Provider Agreement

- New owners retain the Medicare and Medicaid provider agreements.
- New owners are responsible for all known and **unknown** Medicare and Medicaid liabilities of previous owners
- No break in Medicare or Medicaid payments
- No survey of CoPs required.
- Retains all applicable payment statuses, including rural designation

Changes in Ownership

Effects of **Rejecting** Assignment of the Provider Agreement

- A rejection of the provider agreement is a voluntary termination of the agreement and means the provider no longer exists.
- When the Medicare provider agreement terminates so does the Medicaid provider agreement.
- If the new owner wishes to continue to participate it must reapply as an initial applicant (855, OCR, full survey after the new owners begin providing services).
- An initial certification survey must be conducted by the Accrediting Organization
- Loss of any special statuses (i.e. rural designation, provider-based status, etc.)

Changes in Ownership

Effects of **Rejecting** Assignment of the Provider Agreement

- Effective date is not the same as the date of the CHOW. New effective date is after the RHC meets all Federal requirements which can mean an unknown interval of time with no Medicare/Medicaid payment.

CHOWs and CHOIs

- Health Standards has changed the way we handle these actions
- The RHC program desk no longer handles the initial portion of CHOWs and CHOIs.
- Those applications should be sent to: HSSOwnerships@la.gov.
- Please copy the RHC program desk on those submissions
- Check our website under “Change of Ownership Information”
  - There is a Change of Ownership application accessible on the website. The RH-01 is no longer used
- Once all documents (including the 855A) are received and reviewed by the CHOW/CHOI program manager, they will forward the paperwork to the RHC program desk.
- At this point, the license will be issued and any other actions that occurred as part of the CHOW/CHOI will be processed (DBA name changes, etc.).

HEALTH STANDARDS

Louisiana.gov > LDH > Health Standards Section

- PROGRAMS
- PROVIDER DIRECTORIES
- DATA REQUEST PROCEDURE
- PUBLIC RECORDS REQUEST PROCEDURE
- RULEMAKING

Directory

Select Another Division

Change of Ownership Information

Providers must complete this document when they have a change in their ownership structure. This document would be used for both a change of ownership (CHOW) as defined by state and/or federal regulations, or a change of ownership information (CHOI) that does not meet the state and/or federal regulations CHOW definition.

For Health Standards to make a CHOW/CHOI determination, all providers must submit the following documents:

1. Letter of Intent (including d/b/a (doing business as) and entity name of the previous and the new owner, the effective date of change of ownership, address and phone number).
2. A diagram showing the ownership structure "before" and "after" the change
3. Copy of the executed legal transaction documents (Bill of Sale, lease, etc.)
4. CHOW/CHOI License Application
5. Change of Ownership Application
6. 855A/B approval letter for the following Medicare Certified providers: Home Health, hospice, hospitals, RHCs, ASCs, ESRDs, portable x-ray, community mental health, CORF, Nursing Facilities, and OPT.

Note: If this action is a CHOI, the documents above are the only documents you need to submit. There is no fee for a CHOI.

If this action is a CHOW, the following are also needed:

1. Does your facility have a CLIA Certificate? If yes, you may also be required to complete a CHOW for CLIA.
2. Licensing Fee: Click here for the link for the Health Standards Fee Schedule

Note: The fee for a CHOW is usually the same as a license renewal unless the facility is making additional changes. For providers completing an acquisition/merger, please contact the program desk for assistance.

Please select the appropriate provider type below and see the corresponding section indicated for additional documents that are required.

Adult Brain Injury	Home Health
ADHC	Hospice
ARCP	ICF DD
ASC	Nursing Homes
Behavioral Health Service	Outpatient Rehab
CMHC	Pain Management
CRC Level III	PDHC
CORF	Portable X-Ray
EMTS	PRTF
ESRD	RHC
FSTRA	Support Coordination
HCBS	TGH
Hospital	

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License Renewals

- License Renewals are all done via email now
  - Will be sent to administrator's email
  - Imperative that the administrator's email is up to date
- Can be returned to the same email address the renewal came from
- License renewals will come from:

HSS-RHC-Licensing@la.gov

Licensing Actions

- All licensing action packets are accepted via email
- Submission via email is encouraged
- They may be submitted directly to the RHC program desk or to HSS-RHC-Licensing@la.gov
- Once received, the action will be logged and placed into the que for review
- At this time providers should receive an email notifying them of their log number
- Please include the log number in the subject line of all email communication for the action going forward.
- If you have emailed your packet to us, please do NOT mail us hard copy to us

Expedited Licensing Process

- Memo dated December 20, 2018
- Final rule published in the Louisiana Register December 20, 2018.
- Fee for RHC expedited survey is $6000 + licensing fee
- Expedited survey shall be conducted within 10 working days
  - The licensing packet must be complete to start the 10 working days timeline.
  - To be considered complete, the expedited fee and licensing fee must be received by State Office and have cleared the bank.

Is this right for you?

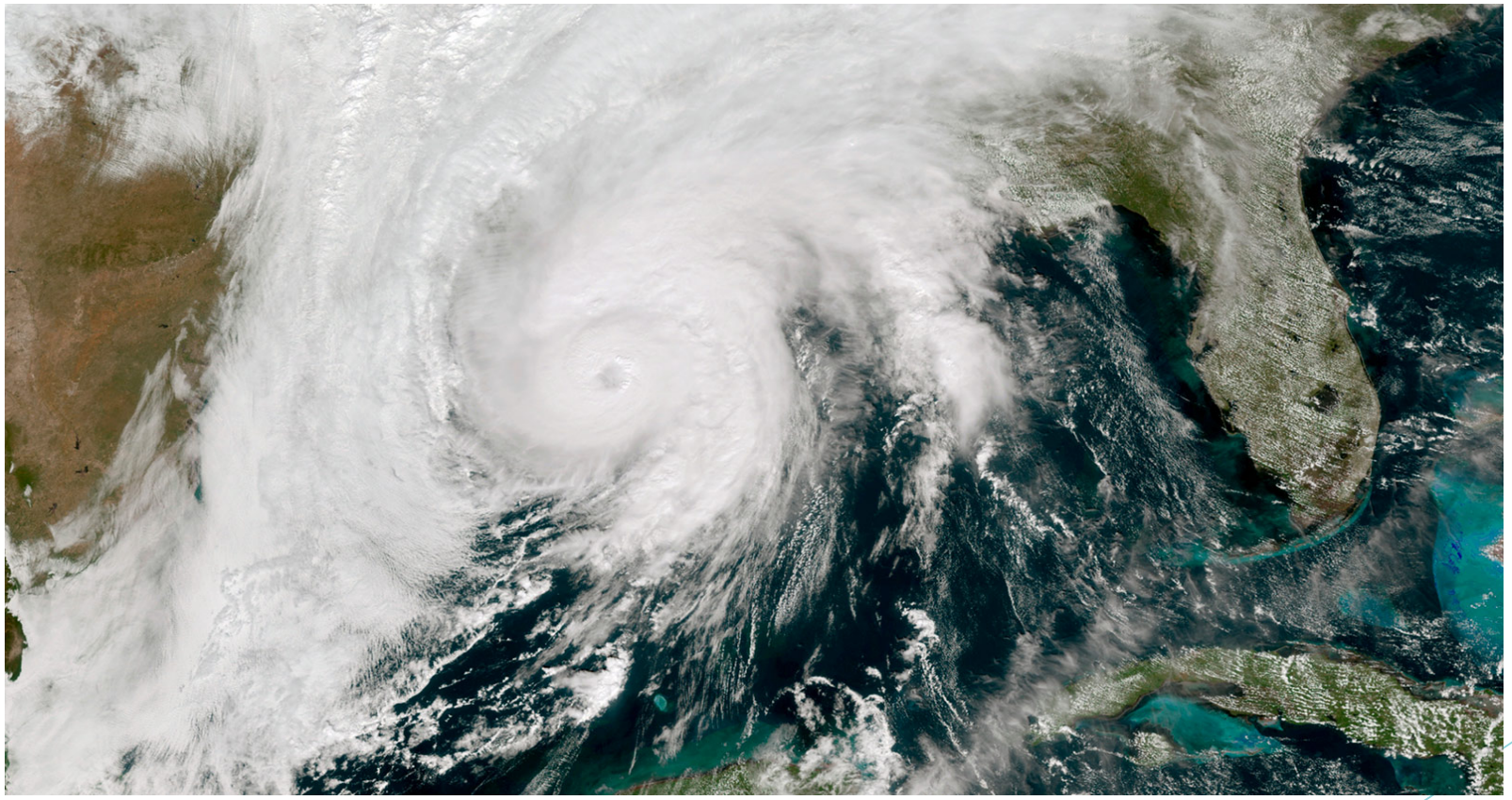
Mobile Units

- Currently, we do not license mobile units. We license the RHC to one geographical address, and do not currently have the licensing capability for mobile units.
- We are exploring allowing the provision of mobile RHC services under the license of a currently licensed RHC.
- With this option, a separate license would not be issued for the mobile unit.
- When the details of this option are finalized we will notify current RHC providers via email and post information on our RHC web page.

Can a RHC have an offsite location?

- No-this is a federal regulation.
- If ever reversed, we have the ability to license a RHC with multiple offsite locations.

Here we go again….



Post Disaster Status Update

As soon as it is possible, Providers should:

- Notify the RHC program desk via email of the RHC's status
  - If you had no effects from the storm, let us know that your are open and conducting business as usual
  - If your facility sustained damages, tell us about them, for example: flooding and/or structural damage
  - Did your facility lose power? If so, do you have a generator?
  - Did your facility lose water?
  - Is your area under a boil advisory?

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Post Disaster Re-Entry

- Who needs to submit the Re-entry request form:
  - If you were closed longer than planned for the storm
  - If you lost power for longer than 48 hours
  - If you had damages to the facility including flooding, structural damage, roof leaks, etc.
- Who needs to get the form?
  - OPH
  - RHC program desk

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HSS Home Page:

https://ldh.la.gov/subhome/32

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Health Standards Section
Licensing & Certification Processes

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Questions?

Speaker

- Carmen Irwin
  - Health Insurance Specialist
  - Centers for Medicare & Medicaid Services Dallas Office – Local Engagement and Administration

CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES
OFFICE OF PROGRAM OPERATIONS
AND LOCAL ENGAGEMENT

CMS Updates

2021 Virtual Rural Health Workshop

Carmen Irwin, Rural Health Coordinator
CMS Dallas Office
Local Engagement & Administration

December 7, 2021

Purpose & Agenda

- Executive Summary of Policy Changes CY 2022 PFS
- FY 2022 Hospital OPPS and ASC Payment System 2022
- CMS Enrollment Updates
- Questions & Answers

Telehealth Services Under the PFS

- Finalizes that certain services added to the Medicare telehealth services list will remain on the list through December 31, 2023, allowing additional time for us to evaluate whether the services should be permanently added to the Medicare telehealth services list.

- Extends inclusion of certain cardiac and intensive cardiac rehabilitation codes through the end of CY 2023 to allow additional time for data collection and review.

- Permanently adopts coding and payment for HCPCS code G2252 as described in the CY 2021 PFS final rule to describe a “virtual check-in” that involves 11-20 minutes of medical discussion to determine whether an in-person visit is necessary.

Expanded Access to Mental Health Services Furnished Through Telehealth

- Section 123 of the Consolidated Appropriations Act (CAA) removed the geographic restrictions and added the home of the beneficiary as a permissible originating site for telehealth services when used for the purposes of diagnosis, evaluation, or treatment of a **mental health disorder**,

- Section 123 requires for these services that there must be an in-person, non-telehealth service with the physician or practitioner within six months prior to the initial telehealth service

- Finalizes that an in-person, non-telehealth visit must be furnished at least every 12 months for these services. Exceptions to the in-person visit requirement may be made based on beneficiary circumstances (with the reason documented in the patient's medical record), and that more frequent visits are also allowed under our policy, as driven by clinical needs on a case-by-case basis.

Expanded Access to Mental Health Services Furnished Through Telehealth – Audio-Only Communication

- Amends the current definition for interactive telecommunications system for telehealth services to include audio-only communication technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes under certain circumstances.

- Limits the use of an audio-only interactive telecommunications system to mental health services furnished by practitioners who have the capability to furnish two-way, audio/video communications, but where the beneficiary is not capable of using, or does not consent to, the use of two-way, audio/video technology.

- Requires use of a new modifier for services furnished using audio-only communications, which would serve to certify that the practitioner had the capability to provide two-way, audio/video technology, but instead, used audio-only technology due to beneficiary choice or limitations.

Mental Health Services Furnished via Telehealth for RHCs and FQHCs

- Allows Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to report and receive payment for mental health visits furnished via telehealth in the same way they currently do when visits take place in-person, including audio-only visits when the beneficiary is not capable of or does not consent to the use of video technology.

- An in-person, non-telehealth visit must be furnished at least every 12 months for these services. Exceptions to the in-person visit requirement may be made based on beneficiary circumstances (with the reason documented in the patient's medical record), and that more frequent visits are also allowed under our policy, as driven by clinical needs on a case-by-case basis.

Opioid Treatment Program (OTP) Payment Policy

- Finalizes proposal to allow OTPs to furnish counseling and therapy services via audio-only interaction (such as telephone calls) after the conclusion of the COVID-19 PHE in cases where audio/video communication is not available to the beneficiary, including circumstances in which the beneficiary is not capable of or does not consent to the use of devices that permit a two-way audio/video interaction, provided all other applicable requirements are met.

- Requires that OTPs use a service-level modifier for audio-only services billed using the counseling and therapy add-on code, as well as document in the medical record the rationale for a service being furnished using audio-only services in order to facilitate program integrity activities.

Evaluation and Management (E/M) Visits

Split (or Shared) Visits

In the CY 2022 PFS rule, we are establishing the following:

- Definition of split (or shared) visits as E/M visits provided in the facility setting by a physician and an NPP in the same group. (The visit is billed by the physician or practitioner who provides the substantive portion of the visit.)
- By 2023, the substantive portion of the visit will be defined as more than half of the total time spent. For 2022, the substantive portion can be history, physical exam, medical decision-making, or more than half of the total time (except for critical care, which can only be more than half of the total time).
- Documentation in the medical record must identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record.

Implementation of Additional CAA Requirements

Coinsurance for Colorectal Cancer Screening

- Finalizes implementation of Section 122 of the CAA, which amended the statute by providing a special coinsurance rule for procedures that are planned as colorectal cancer screening tests but become diagnostic tests when the practitioner identifies the need for additional services (e.g., removal of polyps).
    - Beginning January 1, 2022, the amount of coinsurance patients will pay for such additional services would be reduced over time, so that by January 1, 2030, it would be down to zero.

Physician Assistant (PA) Services

- Implements section 403 of the CAA which authorizes Medicare to make direct payment to PAs for professional services they furnish under Part B. Beginning January 1, 2022, PAs may bill Medicare directly for their professional services, reassign payment for their professional services, and incorporate with other PAs and bill Medicare for PA services.

Therapy Services

- Completes implementation of section 53107 of the Bipartisan Budget Act of 2018, which requires CMS, through the use of new modifiers (CQ and CO), to identify and make payment at 85 percent of the otherwise applicable Part B payment amount for physical therapy and occupational therapy services furnished in whole or in part by physical therapist assistants (PTAs) and occupational therapy assistants (OTAs) — when they are appropriately supervised by a physical therapist (PT) or occupational therapist (OT), respectively — for dates of service on and after January 1, 2022.

Vaccine Administration Services

- Increases Medicare Part B payment rates for influenza, pneumococcal, and hepatitis B vaccine administration from roughly $17 to $30.
- Maintains the current payment rate of $40 per dose for the administration of the COVID-19 vaccines through the end of the calendar year in which the ongoing PHE ends.
- Continues the additional payment of $35.50 for COVID-19 vaccine administration in the home under certain circumstances through the end of the calendar year in which the PHE ends.
- Sets the payment rate for COVID-19 vaccine administration at a rate to align with the payment rate for the administration of other Part B preventive vaccines (effective January 1 of the year following the year in which the PHE ends)

COVID-19 Monoclonal Antibody Products

- CMS will continue to pay for COVID-19 monoclonal antibodies under the Medicare Part B vaccine benefit through the end of the calendar year in which the PHE ends.

- During this interim time, we will maintain the $450 payment rate for administering a COVID-19 monoclonal antibody in a health care setting, as well as the payment rate of $750 for administering a COVID-19 monoclonal antibody therapy in the home.

- Effective January 1 of the year following the year in which the PHE ends, CMS will pay physicians and other suppliers for COVID-19 monoclonal antibody products as biological products paid under section 1847A of the Act; health care providers and practitioners will be paid under the applicable payment system, and using the appropriate coding and payment rates, for administering COVID-19 monoclonal antibodies similar to the way they are paid for administering other complex biological products.

Medicare Diabetes Prevention Program Expanded Model Policy Changes

- Waives the provider enrollment Medicare application fee for all organizations that submit an application to enroll in Medicare as an MDPP supplier on or after January 1, 2022.

- Shortens the MDPP services period to one year by removing the Ongoing Maintenance sessions phase (months 13-24) of the MDPP set of services for beneficiaries starting MDPP on or after January 1, 2022.

- Redistributes all of the Ongoing Maintenance sessions phase performance payments to certain Core and Core Maintenance Session performance payments.

Calendar Year (CY) 2022 Medicare Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Final Rule

FY 2022 Hospital OPPS and ASC Payment System

On November 2, 2021, the Centers for Medicare and Medicaid Services (CMS) finalized Medicare payment rates for hospital outpatient and ASC services. In addition to updating the payment rates, this final rule includes policies that align with several key goals of the Administration, including:

- Addressing the health equity gap
- Fighting the COVID-19 Public Health Emergency (PHE)
- Encouraging transparency in the health system, and
- Promoting safe, Effective, and patient-centered care.

This rule furthers the agency's commitment to strengthening Medicare and uses lessons learned from the COVID-19 PHE, focusing on changes that will help close the equity gap.

Major Policy Changes for CY 2022

- Comment Solicitation for Temporary Policies for the PHE for COVID-19
- Changes to Beneficiary Coinsurance for Colorectal Cancer Screening Test
- Price Transparency of Hospital Standard charges
- Updates to OPPS and ASC payment rates
- Use of CY 2019 Claims Data for CY 2022 OPPS and ASC Payment System Resetting due to the PHE
- Changes to the Inpatient Only List (IOL)
- Two-Midnight Rule Medical Review Activities Exemptions
- Changes to the ASC Covered Procedure List
- OPPS Payments for Drugs Acquired Through the 340 B Program
- Device Pass-Through Payment Applications
- Payment for Non-Opioid Pain Management Drugs and Biologicals Under Section 6082 of the SUPPORT Act
- Partial Hospitalization Program
- Radiation Oncology Model (RO Model)
- Hospital Outpatient/ASC Quality Reporting Program
- Hospital Inpatient Quality Reporting (IQR) Program and Medicare Promoting Interoperability

Comment Solicitation for Temporary Policies for the PHE for COVID-19

In response to the COVID-19 pandemic, CMS undertook emergency rulemaking to implement a number of flexibilities to address the pandemic such as preventing spread of the infection and supporting diagnosis of COVID-19. While many of these flexibilities will expire at the conclusion of the PHE, we sought comment on whether there are certain policies that should be made permanent. Specifically:

- we sought comment on services furnished by hospital staff to beneficiaries in their homes through use of communication technology,
- direct supervision when the supervising practitioner is available through two-way, audio/video communication technology,
- and code and payment for COVID-19 specimen collection.

We will consider comments received for future rulemaking.

Changes to Beneficiary Coinsurance for Colorectal Cancer Screening Test

Section 122 of the Consolidated Appropriations Act (CAA) of 2021 amends section 1833(a) of the Act to offer a special coinsurance rule for screening flexible sigmoidoscopies and screening colonoscopies regardless of the code that is billed for the establishment of a diagnosis as a result of the test, or for the removal of tissue or other matter or other procedure, that is furnished in connection with, as a result of, and in the same clinical encounter as the colorectal cancer screening test.

We are finalizing our proposal that all surgical services furnished on the same date as a planned screening colonoscopy or planned flexible sigmoidoscopy could be viewed as being furnished in connection with, as a result of, and in the same clinical encounter as the screening test for purposes of determining the coinsurance required of Medicare beneficiaries for planned colorectal cancer screening tests that result in additional procedures furnished in the same clinical encounter.

Price Transparency of Hospital Standard Charges

Hospital Price Transparency (HPT)

CMS is committed to ensuring consumers have the information they need to make fully informed decisions regarding their health care. Hospital transparency helps people know what a hospital charges for items and services it provides. CMS expects hospitals to comply with these requirements, and is enforcing these rules to ensure people know what a hospital charges for items and services

In this final rule, CMS is making modifications to the hospital price transparency regulation designed to increase compliance.

Hospital Price Transparency (HPT) continued…

Increase in Civil Monetary Penalties (CMP)

Increasing the Civil Monetary Penalty (CMP) Amounts Using a Scaling Factor amount based on a hospital's number of beds

- For non compliant hospitals with a bed count of 30 or fewer set a minimum CMP of $300/day
- A maximum daily dollar CMP amount calculated as number of beds times $10 for non compliant hospitals with at least 31 beds up to and including 550 beds
- A maximum daily dollar CMP amount of $5,500 for non complaint hospitals with a number of beds greater than 550

HPT Civil Monetary Penalties (CMP) Chart

TABLE 63: Application of CMP Daily Amounts for Hospital Noncompliance for CMPs Assessed in CY 2022 and Subsequent Years.

Number of Beds	Penalty Applied Per Day	Total Penalty Amount for full Calendar Year of Noncompliance
30 or less	$300 per hospital	$109,500 per hospital
31 up to 550	$310 - $5,500 per hospital (number of beds times $10)	$113,150 - $2,007,500 per hospital
>550	$5,500 per hospital	$2,007,500 per hospital

HPT continued…

CMS will determine the number of beds for a Medicare-enrolled hospital using the most recently available, finalized Medicare hospital cost report.

If the number of beds cannot be determined using Medicare hospital cost report data:

- CMS will specify the conditions for receipt of documentation from the hospital to determine its number of beds, and

If the hospital does not provide CMS with such documentation (in the prescribed form and manner, and by the specified deadline), CMS will impose a CMP on the hospital at the highest, maximum daily dollar amount ($5,500 per day).

Deeming of Certain State Forensic Hospitals as Having Met Requirements:

CMS is modifying the hospital price transparency regulation's deeming policy to include state forensic hospitals as having met the requirements, so long as such facilities provide treatment exclusively to individuals who are in the custody of penal authorities and do not offer services to the general public.

HPT continued…

HPT- New Prohibited Specific Barriers to Accessing the Machine-Readable File

CMS is updating the regulation's prohibition of certain activities that present barriers to access to the machine-readable file, specifically requiring that the machine-readable file be:

- accessible to automated searches and
- direct downloads

Clarify the expected output of hospital online price estimator tools when hospitals choose to use an online price estimator tool in lieu of posting standard charges for the required shoppable services in a consumer-friendly format

CY 2022 Medicare Enrollment Updates

AN IMPORTANT MESSAGE FROM MEDICARE

COMPARING PLANS CAN SAVE YOU MONEY

REVIEW YOUR 2022 PLAN OPTIONS NOW AT MEDICARE.GOV.

Medicare Open Enrollment is here

Now is the time to compare your current coverage to all your choices for 2022, and select the plan that best fits your health care needs. Medicare's Open Enrollment period gives everyone with Medicare the opportunity to make changes to their health plans or prescription drug plans for coverage beginning January 1, 2022. But don't delay, the Open Enrollment period ends on December 7.

Why compare plans for next year?

Medicare plans change from year-to-year, even your current plan may be changing. Not all plans have the same benefits and out-of-pocket costs. By comparing all your options, you could save money, find better coverage, or both. Review your current plan, costs, and health needs, then go to **Medicare.gov/plan-compare**.

The Plan Finder at Medicare.gov makes comparing plans easier

With this useful tool you can do a side-by-side comparison of plan coverage, costs, and quality ratings to help you more easily see the differences between plans and feel confident in your choice. If you choose a new plan for 2022, you can enroll right there. Current coverage still meets your needs best? Then, you don't have to do anything.

MEDICARE OPEN ENROLLMENT OCT. 15–DEC. 7

Prefer to talk it over?

Call 1-800-MEDICARE (1-800-633-4227)
TTY Users: 1-877-486-2048

We're here to help 24 hours a day during Open Enrollment, including weekends. Or, find free, personalized health insurance counseling from your State Health Insurance Assistance Program (SHIP). Visit **shiptacenter.org** for locations near you. Many SHIPs offer virtual counseling.

Medicare Savings Program

Need help with Medicare costs? You may qualify for help from your state to pay for Medicare premiums and other costs. If your income for 2021 is below $18,000, it might be worth contacting your state's Medicaid program about Medicare Savings Programs that could be available for you. To find out more, contact **1-800-MEDICARE**.

October 2021

Medicare Part B Income-Related Monthly Adjustment Amounts

Since 2007, a beneficiary's Part B monthly premium is based on his or her income. These income-related monthly adjustment amounts affect roughly 7 percent of people with Medicare Part B. The 2022 Part B total premiums for high-income beneficiaries are shown in the following table:

Beneficiaries who file individual tax returns with modified adjusted gross income:	Beneficiaries who file joint tax returns with modified adjusted gross income:	Income-related monthly adjustment amount	Total monthly premium amount
Less than or equal to $91,000	Less than or equal to $182,000	$0.00	$170.10
Greater than $91,000 and less than or equal to $114,000	Greater than $182,000 and less than or equal to $228,000	68.00	238.10
Greater than $114,000 and less than or equal to $142,000	Greater than $228,000 and less than or equal to $284,000	170.10	340.20
Greater than $142,000 and less than or equal to $170,000	Greater than $284,000 and less than or equal to $340,000	272.20	442.30
Greater than $170,000 and less than $500,000	Greater than $340,000 and less than $750,000	374.20	544.30
Greater than or equal to $500,000	Greater than or equal to $750,000	408.20	578.30

Medicare Part A Premium and Deductible

The Medicare Part A inpatient hospital deductible that beneficiaries pay if admitted to the hospital will be $1,556 in 2022, an increase of $72 from $1,484 in 2021.

Part A Deductible and Coinsurance Amounts for Calendar Years 2021 and 2022 by Type of Cost Sharing

	2021	2022
Inpatient hospital deductible	$1,484	$1,556
Daily coinsurance for 61st-90th Day	$371	$389
Daily coinsurance for lifetime reserve days	$742	$778
Skilled Nursing Facility coinsurance	$185.50	$194.50

Marketplace Open Enrollment

The Marketplace Open Enrollment Period on HealthCare.gov runs from November 1, 2021 to January 15, 2022. Consumers who enroll by midnight December 15 can get full year coverage that starts January 1.

This year, the Centers for Medicare & Medicaid Services (CMS) is focusing on increasing access to assistance for Marketplace consumers, ensuring robust outreach and education efforts to reach consumers about the opportunity to enroll or re-enroll in Marketplace coverage. CMS has also committed to raising awareness around low-cost plans for 2022, as a result of the American Rescue Plan Act (ARP).

https://www.healthcare.gov/

Questions?

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214-767-3532

Questions?

RURAL HEALTH WORKSHOP

Thank you for joining us!

WELL-AHEAD

LOUISIANA RURAL HEALTH ASSOCIATION