HEALING COMMUNITIES
Transforming Rural Healthcare

Hot Topics in Rural Hospital Regulations

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2025 IHA SMALL & RURAL HOSPITALS ANNUAL MEETING

Illinois Health and Hospital Association

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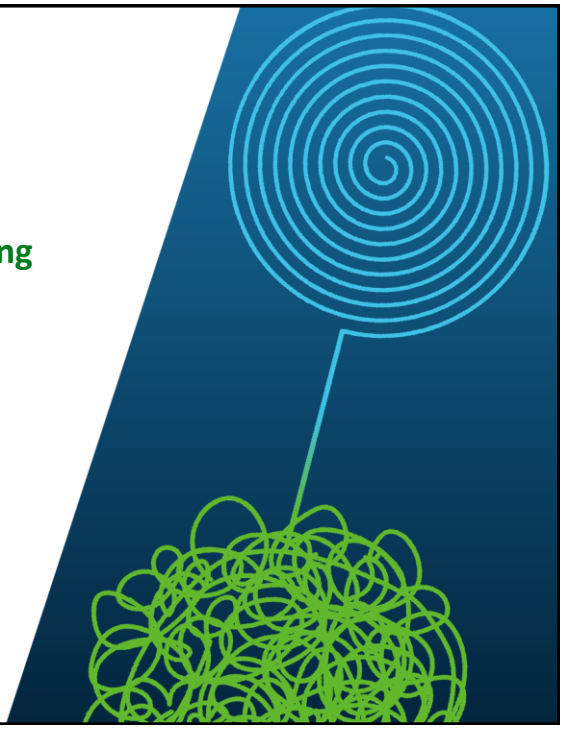
Illinois Health and Hospital Association
Small and Rural Hospitals Annual Meeting

Federal Legislative and Regulatory Update

June 12, 2025



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Introductions

Martie Ross, JD
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Following a successful two-decade career as a healthcare transactional and regulatory attorney, Martie now serves as a trusted advisor to providers navigating the ever-expanding maze of healthcare regulations. Her deep and wide understanding of new payment and delivery systems and public payer initiatives is an invaluable resource for providers seeking to strategically position their organizations for the future.

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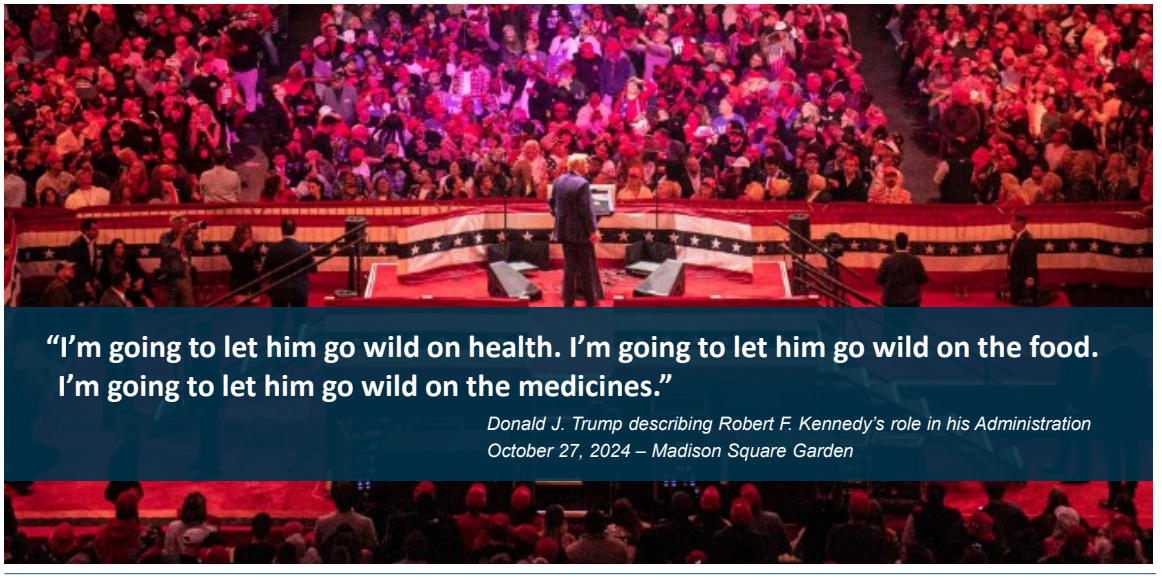
Day 143



"I'm going to let him go wild on health. I'm going to let him go wild on the food. I'm going to let him go wild on the medicines."

Donald J. Trump describing Robert F. Kennedy's role in his Administration
October 27, 2024 – Madison Square Garden

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What's It All Mean?

How will changes impact hospital operations?

What issues should CEOs be discussing with their boards?

What are the immediate priorities for hospital leaders, both near-term and longer-term?

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Today's Agenda

1. Full-Year Continuing Appropriations and Extensions Act, 2025
2. OBBBA
3. President's FY 2026 Proposed Budget
4. Price Transparency
5. Government Enforcement Activity
6. Re-Defining Discrimination
7. Rights of Conscience and Requests for Religious Accommodations
8. Swing Beds
9. Rural Health Clinics
10. FFY 2026 Hospital Inpatient Prospective Payment System Proposed Rule
11. Medicare Conditions of Participation

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1. Full-Year Continuing Appropriations and Extensions Act, 2025

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CAEA, 2025

- Maintains discretionary spending at FFY2024 levels, except increases defense spending by ~$6B and reduces domestic spending by ~$13B (including $890M in HRSA grants for healthcare facilities and equipment)
- What's in: 6-month extensions (through 9/30/2025)
  - Temporary changes to low volume hospital payment adjustment
  - Medicare Dependent Hospital program
  - Add-on payments for ambulance services
  - Work geographic practice cost index (GPCI) floor (calculation of MPFS payments)
  - Acute hospital care at home waivers
  - $8B reduction in Medicaid disproportionate share payments
- What's out
  - Reversal of 2.83% cut in MPFS conversion factor
    - Includes hospital services reimbursed under MPFS, e.g., mammography, therapies
  - Advanced APM incentive payments for 2025

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Medicare Telehealth Coverage

- Since 2021, Medicare covers *tele-behavioral health services* furnished to beneficiary at home on permanent basis
  - May be billed by physicians, practitioners, and RHCs/FQHCs (billed as RHC/FQHC visit)
  - Effective 10/1/2025 (1/1/2026 for RHCs/FQHCs) -
    - For new patients, must have face-to-face visit within 6 months of initiating telehealth services, and
    - Must have face-to-face visit once every 12 months following initiation of tele-behavioral health services (with certain exceptions)
- Effective 10/1/2025, *medical telehealth services* covered only if beneficiary physically present at a facility in rural area at time of service
- Effective 10/1/2025, PTs, OTs, and speech language pathologists can no longer bill Medicare for telehealth services

Medicare Telehealth Coverage

- Through 12/31/2025, RHCs/FQHCs can be distant site providers for medical telehealth services, billing under HCPCS G2025 (~$97)
- Through 9/30/2025, those medical telehealth services CMS previously identified as covered when using audio-only platform will be covered (except CPT 99441-99443)
- On a permanent basis, any telehealth service will be covered when furnished audio-only if:
  - Beneficiary is at home when service provided, **and**
  - Practitioner is capable of audio-video connection, **and**
  - Beneficiary cannot or does not want to connect by video

2. One Big Beautiful Bill Act (OBBBA) (Passed House on May 22)

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OBBBA at 30,000 Feet (vs. 1,118 pages)

- **Tax cuts and credits = $3.819T**
  - Extend and expand TCJA individual provisions ($3.8T)
  - Revive TCJA business provisions ($278B)
  - Adopt new tax cuts/credits ($663B)
    - No tax on tips, overtime, vehicle loan interest; higher senior standard deduction (all expire in 2028)
    - Health savings account expansions
    - Trump accounts for newborns
    - Other individual and business tax cuts and credits
  - Repeal/restrict eligibility for tax credits, impose new taxes ($980B offset)
- **New spending = $321.1B**
  - Judiciary ($110B)
  - Armed Services ($144B)
  - Homeland Security ($67.1B)
- **Offsets (spending reductions) = $1.57T**
  - Medicaid ($625B)
    - ~7.6M will lose Medicaid coverage
  - SNAP ($290B)
    - Committee also approved $60B in new aid to farmers
  - Student loans and grant programs ($349.1B)
- **Increases debt by $3.3T by 2034**

Data compiled by Committee for Responsible Federal Budget From Congressional Budget Office and Joint Committee on Taxation publications, available at https://www.crfb.org/blogs/adding-house-reconciliation-bill

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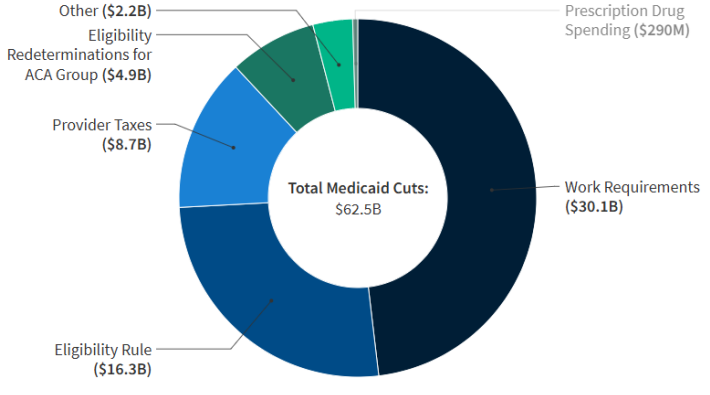
OBBBA – Key Medicaid Provisions

- **Work requirements:** Effective 12/31/2026, states must condition Medicaid eligibility for non-disabled individuals ages 19-64 on working or participating in qualifying activities for ≥ 80 hours/month, with specific exceptions
  - States must verify applicant meets requirement for ≥ 1 month prior to application and complete re-verifications every 6 months
- **Eligibility and Enrollment Final Rule:** Delays implementation until 2035
- **Redeterminations for expansion population:** Effective 10/1/2027, states must conduct eligibility redeterminations at least every 6 months for expansion population
- **Provider taxes:** States prohibited from establishing any new provider taxes or increasing rates of existing taxes.
  - Illinois has pending request with CMS that should be grandfathered
- **State-directed payments:** Expansion states (including Illinois) prohibited from adopting new SDPs for hospitals and nursing facilities that exceed published Medicare rates; non-expansion states cannot exceed 110% of those rates

Medicaid Cuts

CBO Estimates of Potential Federal Medicaid Cuts in the House Energy and Commerce Reconciliation Bill

1-year average estimate of federal spending cuts, by policy



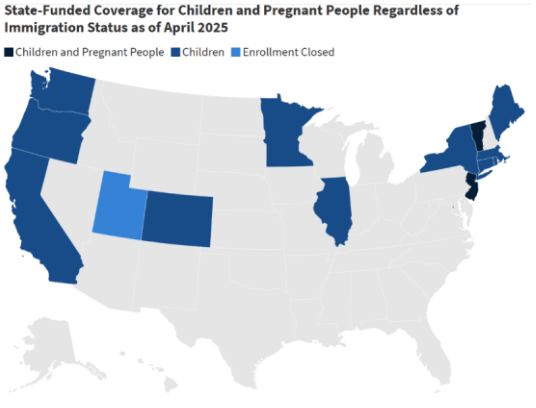
https://www.kff.org/medicaid/issue-brief/state-level-context-for-federal-medicaid-cuts-of-625-billion-and-enrollment-declines-of-10-3-million/ (based on CBO estimates)

OBBBA – Other Medicaid Provisions

- **Retroactive coverage:** Effective 10/1/2026, states must provide Medicaid coverage for qualified medical expenses incurred for up to 30 days (vs. current 90 days) prior to date of application
- **Cost sharing:** Effective 10/1/2028, states must impose up to $35 cost-sharing on expansion adults with incomes 100-138% FPL; maintains exemptions for specific services and population and 5% of family income cap on out-of-pocket expenses
- **Enrollee contact information:** States must verify data to prevent multiple-state enrollments, payments to deceased individuals
- **Provider screening requirements:** Effective 10/1/2028, states must conduct monthly exclusion checks and quarterly Death Master File checks
- **Erroneous Medicaid payments:** Beginning in FY 2030, states subject to FMAP reductions for payment errors (payments to ineligible individuals + overpayments to eligible individuals)
- **Changes to immigrant coverage rules**
- **Rules for calculating Section 1115 waiver budget neutrality**
- **Prohibition on payment of Medicaid funds to Planned Parenthood**
- **Prohibition on use of federal matching funds for gender transition procedures**

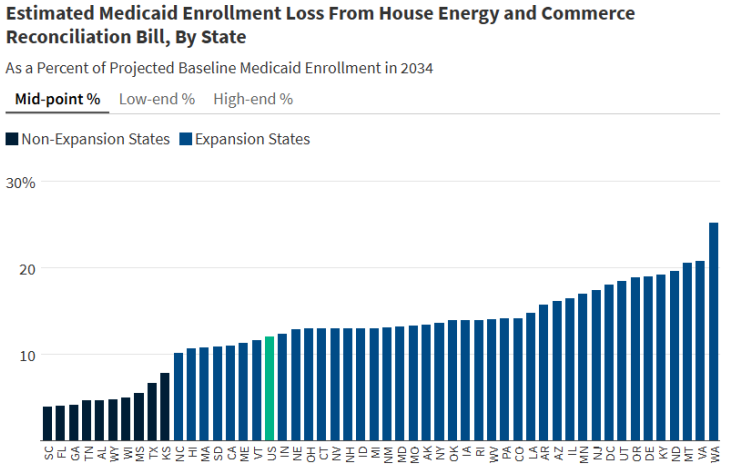
Coverage for Undocumented Children and Pregnant Women

- 14 states + DC have state-funded coverage for undocumented children + pregnant women
- Under OBBBA, penalty for states providing such coverage = reduction of federal Medicaid matching rate for ACA Medicaid expansion population from 90% to 80%
  - Due to Illinois' trigger law, provision could result in federal funding and coverage losses for the entire ACA Medicaid expansion population



https://www.kff.org/racial-equity-and-health-policy/issue-brief/state-health-coverage-for-immigrants-and-implications-for-health-coverage-and-care/

State-Level Impacts – Enrollment



https://www.kff.org/medicaid/issue-brief/state-level-context-for-federal-medicaid-cuts-of-625-billion-and-enrollment-declines-of-10-3-million/ (based on 2024 Medicaid spending and enrollment data, census data, NASBO reports, CBO estimates)

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OBBBA – Other Medicaid Provisions (Good News)

- Delays Medicare DHS reductions ($8B/year for 4 years) through 9/30/2028
- Prohibits HHS from enforcing nursing home minimum staffing rules
- Requires states to establish streamlined enrollment processes for out-of-state pediatric providers by 2029
- New prescription drug pricing rules for pharmacy benefit managers (PBMs)
  - Requires pharmacies to complete NADAC survey on drug acquisition costs
  - Requires publication of NADAC survey data
  - Requires PBM reforms

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Medicare Physician Fee Schedule (MPFS) Changes

- **Current law (MACRA)**
  - Payment rate for specific service = conversion factor x assigned RVU
    - Conversion factor = how MPFS "pie" is divided based on projected total RVUs
  - For 2025, base adjustment to conversion factor was 0, but reduced by 2.9% to satisfy budget neutrality requirements (expanded coverage + changes in assigned RVUs = higher total RVUs)
  - On annual basis beginning in 2026, conversion factor will increase by 0.75% for advanced APM participants, 0.25% for everyone else
    - Still subject to budget neutrality adjustments
- **OBBBA**
  - For 2026, increase in conversion factor equal to 75% of Secretary's estimate of the percentage increase in Medicare Economic Index (MEI) for the year
    - Estimated 2.25% increase over 2025 current conversion factor
  - Thereafter, annual increase in conversion factor equal to 10% of Secretary's estimate of the percentage increase in MEI for the year
    - E.g., assume estimated 3.5% increase in MEI in 2027 = 0.35% increase in conversion factor
  - Still subject to budget neutrality adjustments

Rural Emergency Hospital (REH) Program

- Permit CAH or PPS hospital with <50 beds that closed between 2014 and 2020 to "re-open" as REH
  - "New" REH must be at least 10 miles from nearest hospital to receive monthly facility payment and 35 miles from nearest hospital to receive enhanced OPPS reimbursement
  - Implementing regulations to address ownership, licensure, location, etc.
- No 340B eligibility, no swing bed reimbursement

Other Healthcare Related Provisions

- Medicare Eligibility
  - No longer available for those with temporary protected status, refugees, and asylees
- ACA Marketplace (included in tax offsets)
  - Does NOT extend expanded premium tax credits expiring in 2025
  - Institutes eligibility and income verification for enrollees
  - Rolls back income-based special enrollment periods
  - Limits definition of "lawfully present" to qualify for premium tax credits
- Artificial Intelligence (AI)
  - Appropriates $25 million for HHS to contract with AI vendors and data scientists to identify and recoup improper Medicare payments; requires HHS to report to Congress on progress in reducing improper payments using AI
- Tax Advantaged Accounts
  - Codifies regulations from President Trump's first term that allow Individual Coverage Health Reimbursement Arrangements to be used for purchasing qualified health insurance on the individual market; greater flexibility for employers/employees using these arrangements
  - Expands Health Saving Account eligibility, allowing more individuals to contribute and broadening list of services covered.

Sequestration

- On May 21, CBO released analysis of potential Statutory Pay-As-You-Go (PAYGO) effects of OBBBA
  - ***Medicare payments to providers, MA plans, and prescription drug plans would be reduced by 4% beginning in 2026*** and continuing through 2034 under PAYGO's automatic deficit reduction provisions.
- Congress could avoid with enactment of subsequent legislation to offset deficit increase, waive recordation of OBBBA's effects on PAYGO scorecard, or otherwise mitigate or eliminate statutory requirement
  - E.g., Tax Cuts and Jobs Act of 2017, American Rescue Act of 2021
  - Would require 60 votes in Senate (vs. 50 votes required for reconciliation bill)

Next Up – The Senate

- Only requires 50 votes (vs. 60 usually required to end debate), ***but….***
  - Medicaid, SNAP, and student loan cuts
  - SALT deduction
  - Clean energy tax credits
  - Medicare provider payment cuts (e.g., site neutral payments)
- Byrd Bath
  - Compliance with Senate budget reconciliation rules, including requirement each provision have non-incidental budgetary impact

3. President's FY 2026 Budget Proposal (Discretionary Spending)

Proposed FY 2026 HHS Budget Released May 30

- Consistent with documents leaked earlier this spring
- FY 2026 HHS discretionary budget of $95 billion; 25% less than FY 2025 funding
  - Reduces workforce to 90% of pre-COVID levels, with 70% of reductions attributed to centralizing administrative functions
  - Terminates, descopes, or non-renews over 5,000 contracts
- Consolidates 28 operating divisions to 15 and shuts down five regional offices
- Creates new Administration for a Healthy America
  - Specific focus on prevention of chronic disease, including broadband technology integration, nutrition services, physical activity venue access, and reducing medication dependency

Proposed Funding Reductions for Current Agencies

- Health Resources and Services Administration
  - 18% cut ($9.5B to $7.8B); cuts to maternal/child health programs ($274M million), workforce programs ($1B), family planning programs ($286M), education & training ($74M) (including FLEX grants)
- Centers for Disease Control and Prevention
  - 43% cut ($8.4B to $4.8B); refocus agency's mission on core activities on emerging and infectious disease surveillance and maintaining public health infrastructure
- National Institute of Health
  - 40% cut ($45.4B to $27.5B); consolidate programs into 5 focus areas: National Institutes on Body Systems Research, Neuroscience and Brain Research, General Medical Sciences, Disability Related Research, and Behavioral Health
- Substance Abuse and Mental Health Services Administration
  - 14% cut ($7.4B to $6.3B)
- Centers for Medicare & Medicaid Services
  - 16% cut ($4.1B to $3.5B); administrative expenditures only, does not impact provider payments
- Administration for Strategic Preparedness and Response
  - Eliminate funding for Hospital Preparedness Program ($240 million)
- Agency for Healthcare Research and Quality
  - 34% cut ($374B to $245B)

4. Price Transparency

February 25 Executive Order

- "Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information"
- Directs Secretaries of Treasury, Labor, and HHS to take action within 90 days to:
  - Require disclosure of actual prices, not estimates, for all items and services
  - Issue updated guidance/proposed regulations to ensure pricing information is standardized and comparable across hospitals and insurers, including prescription drug prices
  - Issue guidance/proposed regulations updating enforcement policies intended to ensure compliance with requirements to make prices transparent

Price Transparency

LOWERING COSTS FOR AMERICAN FAMILIES: When healthcare prices are hidden, large corporate entities like hospitals and insurance companies benefit at the expense of American patients. Price transparency will lower healthcare prices and help patients and employers get the best deal on healthcare.

DELIVERING ON PROMISES TO PUT AMERICAN PATIENTS FIRST: President Trump is delivering on his promise to once again put American patients first by holding the healthcare industrial complex accountable for delivering transparent prices.

https://www.whitehouse.gov/fact-sheets/2025/02/fact-sheet-president-donald-j-trump-announces-actions-to-make-healthcare-prices-transparent/

May 22 Updated Guidance

- Regulations require hospitals to encode standard charge dollar amount in machine-readable file (MRF) if it can be calculated
  - Includes negotiated rate for item or service, base rate negotiated for service package, and dollar amount if standard charge based on % known fee schedule
- Hospitals should discontinue encoding 999999999 (nine 9s) in estimated allowed amount data element within MRF, instead encoding actual dollar amount
  - Had anticipated nine 9s would be infrequent, but found frequent usage upon review

5. Government Enforcement Activity

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A New Sheriff in Town?

- HHS announced on April 30 "DOGE and CMS are working on a number of program integrity rules, process improvements, and audit tools that have the potential to save over $40 billion per year."
  - Achieving such savings would require significant increase in enforcement activity, as federal agencies reported ~$10 billion in such savings in 2024
- To that end, CMS announced on April 28 via social media launch of new Fraud Detection Operation Center
  - FDOC leverages current fraud prevention system that uses artificial intelligence and machine learning models to flag potentially fraudulent behavior by providers
  - Spend money to save money: HHS-OIG reports every $1 invested in 'fraud fighting' results in $10 returned to federal healthcare programs

https://www.hhs.gov/hhs-big-wins-maha/index.html

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Going After "High Impact" White Collar Crime

- On May 12, DOJ Criminal Division published memo addressing prosecution of white collar crimes
  - Many hoped new Administration would put the breaks on such prosecution
- Will focus on 10 "high impact" areas, including healthcare fraud and abuse
- Announces changes to Criminal Division's Corporate Enforcement and Voluntary Self-Disclosure Policy
  - Streamline self-disclosure incentives
  - Provide clear path to declination
- Makes revisions to Criminal Division's monitorship policies
  - Strongly disfavored; will review all monitorships regularly to control costs, prevent scope creep

https://www.justice.gov/opa/media/1400141/dl?inline

6. Re-Defining Discrimination

Stopping Unlawful DEI-Related Workplace Discrimination

- **January 21**
  - Executive Order 14173, "Ending Illegal Discrimination and Restoring Merit-Based Opportunities"
    - Instructs federal agencies to terminate discriminatory policies and programs and requires federal contractors and grant recipients to certify they do not operate DEI programs that violate anti-discrimination law
      - Certification = basis for False Claims Act liability
      - Department of Labor Office of Federal Contract Compliance Programs (OFCCP) previously advised that Medicare participating providers not considered covered federal contracts for purposes of OFCCP jurisdiction and compliance
    - On March 14, 4th Circuit stayed nationwide preliminary injunction on EO's certification, termination, and enforcement provisions pending appeal
- **February 5**
  - Attorney General memo directing Office of Civil Rights to investigate, eliminate, and penalize illegal DEI activities in private sector
    - Does not prohibit educational, cultural, or historical observances that promote awareness without engaging in exclusion/discrimination
  - Office of Personnel Management memo requiring agencies to end diversity requirements for hiring panels and candidate pools and discriminatory employee resource groups

March 19 EEOC/DOJ Technical Assistance Guides

- "Under Title VII, DEI initiatives, policies, programs, or practices may be unlawful if they involve an employer…taking an employment action motivated – in whole or in part – by an employee's or applicant's race, sex, or another protected characteristic"
- Disparate treatment
  - Hiring, firing, promotions, demotions
  - Compensation and fringe benefits
  - Access to or exclusion from training (including leadership development programs)
    - Cannot separate employees into protected groups when administering training
  - Access to mentoring, sponsorship, workplace networks/networking, and internships
  - Participation in employee resource groups
  - Job duties and/or work assignments

https://www.eeoc.gov/wysk/what-you-should-know-about-dei-related-discrimination-work

March 19 EEOC/DOJ Technical Assistance Guides

- "Employment decisions based on the discriminatory preferences of clients, customers, or co-workers are just as unlawful as decisions based on an employer's own discriminatory preferences"
- "Depending on the facts, an employee may be able to plausibly allege or prove that a diversity or other DEI-related training created a hostile work environment by pleading or showing that the training was discriminatory in content, application, or context."
- "No general business interests in diversity and equity (including perceived operational benefits or customer/client preference) have ever been found by the Supreme Court or the EEOC to be sufficient to allow race-motivated actions"
  - Research showing diverse workforce improves patient outcomes?

7. Rights of Conscience and Requests for Religious Accommodations

Rights of Conscience Refusals

- Recent OCR investigations
  - Technician facing potential termination for refusing to conduct ultrasounds for abortion procedures
  - Nurse allegedly terminated for requesting religious accommodation to avoid administering puberty blockers/hormones to minors seeking gender-affirming care
- Executive Order 14291 established Religious Liberty Commission to promote and safeguard religious freedom, including conscience protections in healthcare and vaccine mandates
- Adopt/update formal policy regarding conscience refusal
  - Employee right to refuse participation based on sincerely-held religious/moral beliefs; accommodation request and review; non-retaliation; maintaining patient access to care; internal education and monitoring

8. Swing Beds

Site Neutral Payments – Swing Beds

December 2024 | A-05-21-00018

Medicare Could Save Billions With Comparable Access for Enrollees if Critical Access Hospital Payments for Swing-Bed Services Were Similar to Those of the Fee-for-Service Prospective Payment System

What OIG Found

- Swing-bed utilization for skilled nursing services at CAHs increased by 2.8 percent from CY 2015 through 2020; meanwhile, the average daily reimbursement amount increased by 16.6 percent over the same period.
- Based on our sample results, we found that 87 of 100 sampled CAHs were within a 35-mile driving distance of an alternative facility that had skilled nursing care available and estimate that 1,128 of the 1,297 CAHs in our sampling frame had an alternative facility within 35 miles that could have provided care during CY 2020.
- Based on our sample results and mathematical calculation, we estimate that Medicare could have saved up to $7.7 billion over a 6-year period if payments made at CAHs were reimbursed using SNF PPS rates.

What OIG Recommends

We recommend that CMS seek a legislative change that will allow it to reimburse CAHs at rates that align with those paid to alternative facilities when it determines that similar care is available at alternative facilities.

CMS did not concur with our recommendation.

https://oig.hhs.gov/documents/audit/10151/A-05-21-00018.pdf

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TEAM and Swing Beds

"Since CAH swing beds are exempt from [SNF PPS], they are reimbursed at a higher rate….TEAM participants that have historically utilized CAH swing beds will be in a position to earn significant savings by establishing relationships with traditional SNFs and discharging patients they would otherwise move to CAH swing beds to traditional SNFs."

- 2025 Medicare Inpatient Prospective Payment System Final Rule

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Truth About Swing Beds

- Swing bed length of stay significantly lower than SNF LOS
- Swing bed patients significantly less likely to have readmissions
- Total cost of care for post-discharge period for swing bed patients is higher than for SNF patients, but not double the cost
- Comparison of swing bed to SNF payments must accurately account for impact on CAH cost allocation

**See Appendix for detailed analysis*

9. Rural Health Clinics
2025 Medicare Physician Fee Schedule Final Rule

RHC Telehealth – Behavioral Health Services

- New coverage created under Consolidated Appropriations Act, 2021
- Qualifies as RHC visit (and thus pays AIR) if –
  - Service included on CMS approved list of telehealth services
    - Available at https://www.cms.gov/medicare/medicare-general-information/telehealth/telehealth-code
  - Use audio/visual connection (audio only if patient cannot/does not want to connect visually)
  - Effective **01/01/2026** -
    - In-person mental health service furnished within 6 months prior to furnishing telehealth services (unless services initiated prior to 01/01/2026)
    - In-person, non-telehealth visit furnished at least every 12 months (may be waived; reason documented in medical record)

RHC Telehealth – Medical Services

- Continue current reimbursement methodology through 12/31/25 while evaluating alternatives
  - Service must be included on CMS approved list of telehealth services
  - Not reimbursed AIR; instead, billed under G2025 – reimbursed at $94.96 (regardless of service provided via telehealth)
  - NOTE: If Congress does not extend telehealth flexibilities, telehealth services furnished to patients in their homes will not be reimbursable
- May also bill telehealth originating site fee under Q3014 – reimbursed at $29.96 (2024 rate)
  - Patient physically present at RHC facility receiving telehealth from distant site provider

RHC Care Management Services – 2024

- Non-face-to-face services billed under G0511 - General Care Management
  - Transitional care management
  - Chronic care management
  - Principal care management
  - General behavioral health integration
  - Chronic pain management
  - Community Health Integration
  - Principal Illness Navigation
  - Principal Illness Navigation – Peer Support
  - Remote Physiological Monitoring
  - Remote Therapeutic Monitoring
- G0511 rate = average of national non-facility payment rate for these services
  - For 2024, $72.90
- Psychiatric Collaborative Care Model (CoCM) billed under G0512 - $146.73 (no more than once/month) (revenue code 0521)

RHC Care Management Services - 2025

- Discontinue use of G0511; bill under assigned CPT code
  - Transitional Care Management
  - Chronic Care Management
  - Complex Chronic Care Management
  - Principal Care Management
  - Advanced Primary Care Management
  - Psychiatric Collaborative Care Model
  - General Behavioral Health Integration
  - Chronic Pain Management
  - Community Health Integration
  - Principal Illness Navigation
  - Principal Illness Navigation – Peer Support
  - Remote Physiological Monitoring
  - Remote Therapeutic Monitoring
- Cannot bill for new Advanced Primary Care Management codes

FQHC/RHC Care Management Services - 2025

- Non-face-to-face services reimbursed at MPFS non-facility national payment rate
  - Co-payment based on Medicare allowable, not charges
- 6-month transition period; may continue to bill G0511 through 6/30/2025
  - 2025 reimbursement for G0511 reduced from $72.90 to $54.67
  - All-or-nothing; can't pick and choose when to bill G0511

Code	2025 Payment Rate
HCPCS G0511	$54.67
CPT 99490 (CCM, 1st 20 min)	$60.55
CPT 99439 (CCM, each add'l 20 min)	$45.93
CPT 99454 (RPM monthly monitoring)	$47.27

Vaccinations - 2024

- Influenza, Pneumococcal, and COVID-19 Vaccines
  - Vaccines and their administration paid at 100% of reasonable cost through cost report
  - Report charges on cost report Worksheet M-4 (provider-based) or B-1 (independent)
  - Do not report on UB-04
  - Coinsurance waived
- Hepatitis B Vaccine
  - Requires physician order; reimbursement included in AIR

Vaccinations – After June 30, 2025

- Bill for Part B vaccines (including Hepatitis B) and vaccine administration at time of service
  - Includes expanded coverage for hepatitis b – doctor's order no longer required
  - Also bill M0201 for in-home administration
- Due to statutory requirement that RHCs be reimbursed 100% of costs for vaccines and vaccine administration, will reconcile annually as part of cost report
- Additional guidance (including updated cost report instructions) were to be released in early 2025

RHC Conditions of Certification/Coverage

- Eliminate requirement that require >50% of RHC's total hours of operation must involve primary care services
  - Still must provide primary care services, but not at specified level
  - Still cannot be rehabilitation agency or facility primarily for treatment of 'mental diseases'
  - May provide outpatient specialty services within practitioner's scope of practice to meet community needs
- Eliminate RHC productivity standards (specified # of visits per FTE)
- Revise list of required clinical lab services
  - Remove hemoglobin and hematocrit from list of services RHC must provide directly
  - Change "primary culturing for transmittal to certified laboratory" to "collection of patient specimens for transmittal to a certified lab for culturing"

10. FFY2026 Hospital Inpatient Prospective Payment System Proposed Rule

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Request for Information – Unleashing Prosperity Through Deregulation of the Medicare Program

- Included in all four proposed FY2026 payment rules in response to Executive Order 14219; responses were due June 10
- CMS sought "public input on approaches and opportunities to streamline regulations and reduce administrative burdens on…stakeholders participating in the Medicare program"
  - Streamline regulatory requirements
  - Opportunities to reduce administrative burden of reporting and documentation
  - Identification of duplicative requirements
  - Additional recommendations
- See also –
  - Executive Order 14192, *Unleashing Prosperity Through Deregulation* (repeal 10 for each new regulation)
  - April 19 Presidential Memorandum directing agencies "to effectuate the repeal of any regulation, or the portion of any regulation, that clearly exceeds the agency's statutory authority or is otherwise unlawful"

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IPPS Payment Update

- Rebase and revise IPPS operating and capital market basket to reflect 2023 base year
  - 2.4% increase in base rate, based on market basket increase of 3.2% less 0.8 percentage point productivity adjustment (vs. 2.9% increase for FFY 2025)
- Apply national labor-related share of 66% (i.e., portion subject to wage index adjustment) for hospitals with wage index >1.0 (currently 67.6%)
  - Remains at 62% for hospitals with wage index of ≤1.0
- Increase capital payment rate to $528.95 (currently $510.51)
- Decrease IPPS outlier threshold to $44,305 (currently $46,152)
- Increases Medicare uncompensated care pool for DSH hospitals by $1.4B (total pool $7.140B compared to 2025 pool of $5.705B)
- Increase of $234M for new technology payments

IPPS Payment Rates

TABLE 1A. NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS; LABOR/NONLABOR (66.0 PERCENT LABOR SHARE/34.0 PERCENT NONLABOR SHARE IF WAGE INDEX GREATER THAN 1)

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.4 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.0 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.6 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.8 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$4,511.41	$2,324.06	$4,405.67	$2,269.59	$4,476.16	$2,305.90	$4,370.43	$2,251.43

TABLE 1B. NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1)

Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.4 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.0 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.6 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.8 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$4,237.99	$2,597.48	$4,138.66	$2,536.60	$4,204.88	$2,577.18	$4,105.55	$2,516.31

IQR, Promoting Interoperability, Value-Based Purchasing

- See Appendix for detailed explanation of proposed changes for FY2026

11. Medicare Maternal Health Conditions of Participation

Medicare Conditions of Participation (CoPs)

- *Process-oriented* requirements organized by categories of services
  - Protect patient safety, ensure quality of care
- Compliance monitoring
  - State surveyors following CMS Interpretive Guidelines (IGs)
    - Appendices to State Operations Manual (SOM)
    - Appendix A - Hospitals
    - Appendix G - RHCs
    - Appendix W - CAHs
    - Appendix V - EMTALA
  - CMS-approved private accrediting agencies with standards that meet/exceed Medicare CoPs + survey procedures comparable to applicable IGs
- Plan of Correction, *then* termination of participation in federal healthcare programs

Recent CoP Changes

- Infection Prevention and Antibiotic Stewardship Program (ASP)
  - New requirements for CAHs and hospitals effective March 2020
  - Hospital IGs published in 2022; still waiting for CAH IGs
- Quality Assessment and Performance Improvement (QAPI) Program
  - New requirements for CAHs effective March 2021
  - Still waiting for IGs

New Hospital and CAH CoPs

- For *all* hospitals/CAHs that provide emergency services
  - New sub-section in emergency services CoP requiring 'emergency services readiness' requirements (protocols, provisions, and training)
- For hospitals/CAHs providing OB services outside emergency department (i.e., holds itself out to public as caring for obstetrical medical conditions)
  - New CoPs establishing baseline standards for obstetrical services
    - Similar to CoPs for other optional services
    - New CoPs "do not dictate standards of care or otherwise require hospitals [or CAHs] to offer any specific type of care to patients"
  - Update to QAPI CoPs to include OB-related activities
  - Update to hospital discharge planning CoP to include transfer protocols

Phased-In Effective Dates

- **July 1, 2025**
  - Emergency services readiness
  - Hospital transfer protocols
- January 1, 2026
  - Baseline standards for OB services (except OB staff training requirements)
- January 1, 2027
  - OB staff training requirements
  - QAPI program for OB services

Update to Emergency Services CoPs - Protocols

- Maintain protocols consistent with (1) complexity and scope of services offered, and (2) nationally recognized evidence-based guidelines for care of patients with emergency conditions
  - Including, but not limited to, OB emergencies, complications, immediate post-delivery care
  - Facility must "be able to articulate their standards and source(s) and to demonstrate that their standards are based on evidence and nationally recognized sources"
- CMS "offers hospitals and CAHs flexibility in determining what other protocols are needed to meet the needs of their specific emergency services patient populations."
  - Injuries and poisonings
  - Respiratory conditions
  - Cardiovascular conditions
  - Gastrointestinal conditions
  - Neurological conditions
  - Behavioral health conditions

Update to Emergency Services CoPs - Provisions

- Maintain adequate provisions readily available to treat emergencies
  - 'Adequate provisions' = equipment, supplies, drugs, blood & blood products, and biologicals commonly used in life-saving procedures
    - Consistent with evidence-based protocols
  - 'Readily available' = on unit or in close proximity and easily accessible to unit personnel
  - Call-in system for each patient in each emergency services treatment area
    - CMS delayed implementation of this requirement, promising clarifications in future sub-regulatory guidance

Update to Emergency Services CoPs - Training

- Train applicable staff annually on protocols and provisions (each and every one?)
  - Governing body must identify and document staff to be trained
  - Must be informed by QAPI program findings
  - Must document successful completion of training in staff personnel records
  - Must be able to demonstrate staff knowledge on training topics

Update to Hospital Discharge Planning CoP

- No changes to CAH CoP on agreements with network hospitals
- Maintain written P&Ps for transferring patients (not just OB patients) to appropriate level of care promptly and without delay to meet specific patient's needs
  - Including transfers from ED to inpatient admission, transfers between inpatient units within hospital, and inpatient transfers to different hospital
- Provide annual training to relevant staff regarding P&Ps for patient transfers
- CMS encourages hospitals to –
  - Develop P&Ps on acceptance of transfers
  - Develop collaborative relationships to facilitate regional continuum of care
  - Foster relationships with birthing facilities

Appendix

Hospital Inpatient Quality Reporting Program

- Modify 4 existing measures:
  - For two measures, include MA patient cohort data and shorten performance period from 3 years to 2 years
    - Risk-Standardized Complication Rate Following Elective Primary THA/TKA beginning with FY 2027 payment determination (4/1/2023 – 3/31/2025 reporting period(?))
    - 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke Hospitalization beginning with FY 2027 payment determination (7/1/2023 – 6/30/2025 reporting period(?))
  - For two measures, modifications to reporting requirements
    - Hybrid Hospital-Wide Readmission Rate for FY 2028 payment determination (7/1/2025 – 6/30/2026 reporting period)
    - Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Rate for FY 2028 payment determination (7/1/2025 – 6/30/2026 reporting period)

Hospital Inpatient Quality Reporting Program

- Remove COVID-19 diagnosed patients measure denominator exclusions beginning with FY 2027 program year
- Remove 4 existing measures for FY 2026 payment determination
  - Hospital Commitment to Health Equity
  - Screening for Social Drivers of Health
  - Screen Positive Rate for Social Drivers of Health
  - COVID–19 Vaccination Coverage among Healthcare Personnel
- Update and codify Extraordinary Circumstances Exception (ECE) policy to clarify that CMS may extend time for data submission in response to ECE request

Promoting Interoperability Program (PPS and CAHs)

- Amend regulatory definition of 'EHR reporting period for a payment adjustment year' as minimum of any continuous 180-day period within calendar year
  - Codifying change from 90-day period in CY 2024
- Modify Security Risk Analysis measure to require hospitals/CAHs to attest "yes" to having conducted security risk management (in addition to attesting "yes" to having conducted security risk analysis)
  - Required implementation specification for risk analysis and risk management under HIPAA Security Rule
- Modify SAFER Guides measure by requiring hospitals/CAHs to attest "yes" to completing annual self-assessment using 8 SAFER Guides published in January 2025
- Add optional bonus measure to Public Health and Clinical Data Exchange objective for submission of health information to public health agency using Trusted Exchange Framework and Common Agreement (TEFCA)

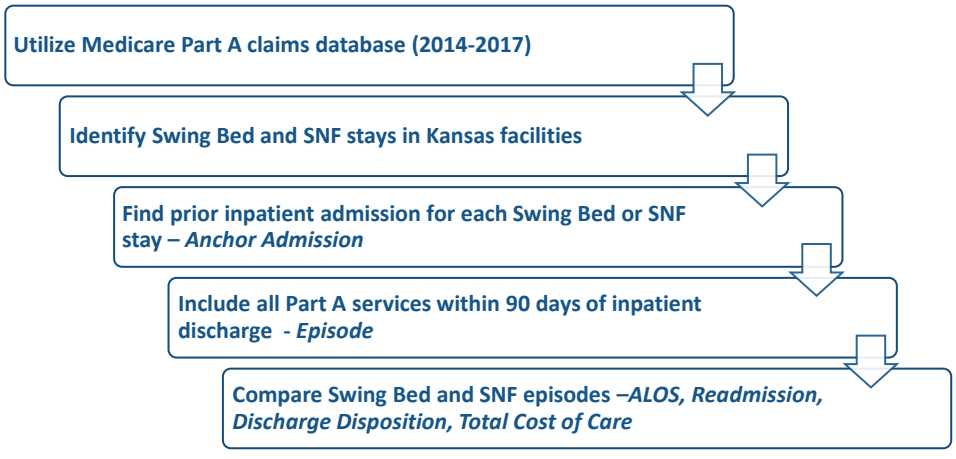
Hospital Readmission Reduction Program

- Hospital with higher-than-expected 30-day readmission rates penalized up to 3% of hospital's base Medicare inpatient payments
- Proposed changes
  1. Refine all six readmission measures to add MA patient cohort data beginning with FY 2027 program year
     - Modify formula for calculating aggregate payments for excess readmissions (numerator in formula to calculate percentage reduction in hospital's base Medicare inpatient payments) to include MA payments
  2. Reduce the applicable period from 3 years to 2 years
     - E.g., for the FY 2027 program determination, claims/encounter data with admission dates beginning from 7/1/2023 through 6/30/2025 would be used (vs. 7/1/2022 through 6/30/2025)
  3. Remove COVID-19 diagnosed patients measure denominator exclusion from all six readmission measures beginning in FY 2027 program year
  4. Update ECE policy to give CMS discretion to grant extension of deadlines for data submission

Hospital Value-Based Purchasing Program

- Across-the-board 2% withhold of Medicare payments (~$1.7B) redistributed to top performers on 14 measures across 4 domains
  - Person and community engagement, safety, clinical outcomes, cost savings and efficiency
- **Proposed changes:**
  1. Modify THA/TKA Complications measure beginning in FY 2033 program year
     - Include MA patient cohort data; change performance period from 3 years to 2 years (4/1/2029 to 3/31/2031)
  2. Remove COVID-19 exclusion from clinical outcomes domain measures beginning in FY 2027 program year
  3. Technical update to 4 CDC NHSN HAI measures in safety domain beginning in FY 2028 program year
  4. Remove Health Equity Adjustment for hospitals serving higher percentage of dual eligibles
     - "[s]implifying the…scoring methodology by removing the HEA will improve hospitals' understanding of the program and provide clearer incentives to hospitals as they seek to improve the quality of care for all patients"
  5. Provide previously and newly established performance standards for the FY 2028 – FY 2031 program years
  6. Update ECE policy to give CMS discretion to grant extension for data submission

Cost of Swing Beds - Methodology



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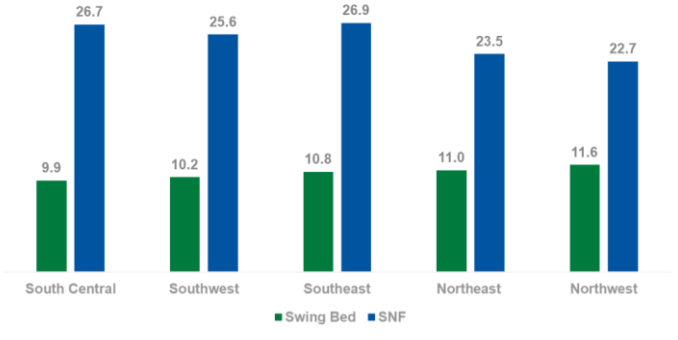
Kansas - ALOS Per Discharge



On average, swing beds stays are *~14 days less* than SNF stays

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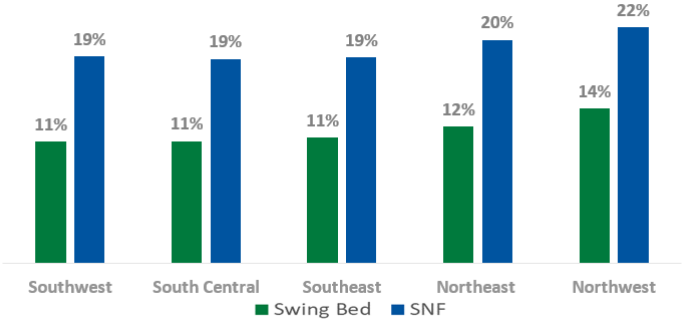
Kansas – Readmission Rate



On average, swing beds have *~7% lower readmission rates* than their SNF peers

Kansas - Total Cost of Care by Admitting Diagnosis

		Average						
IP Admitting DRG	IP Admitting DRG Description	Total Episodes	IP Anchor LOS	Readmission LOS	Swing Bed LOS	Other PAC LOS	Swing Bed Total Cost of Care	SNF Total Cost of Care
470	MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC	1,723	3.7	0.7	14.9	10.15	$37,030	$25,303
194	SIMPLE PNEUMONIA & PLEURISY W CC	1,597	3.9	2.0	15.9	10.24	$27,689	$21,220
195	SIMPLE PNEUMONIA & PLEURISY W/O CC/MCC	946	3.8	1.5	14.7	11.15	$25,771	$18,901
690	KIDNEY & URINARY TRACT INFECTIONS W/O MCC	898	3.7	1.7	19.5	11.90	$29,132	$22,230
603	CELLULITIS W/O MCC	599	3.7	1.9	18.3	13.78	$31,532	$22,448
481	HIP & FEMUR PROCEDURES EXCEPT MAJOR JOINT W CC	579	4.9	1.0	34.8	15.61	$63,374	$33,142
641	MISC DISORDERS OF NUTRITION,METABOLISM,FLUIDS/ELECTROLYTES W/O MCC	540	3.7	2.1	19.1	12.58	$31,699	$20,634
292	HEART FAILURE & SHOCK W CC	517	4.1	2.2	17.0	12.69	$31,892	$23,471
552	MEDICAL BACK PROBLEMS W/O MCC	444	3.9	2.0	22.6	11.89	$37,285	$25,061
948	SIGNS & SYMPTOMS W/O MCC	437	3.8	2.1	24.3	14.14	$33,020	$24,066

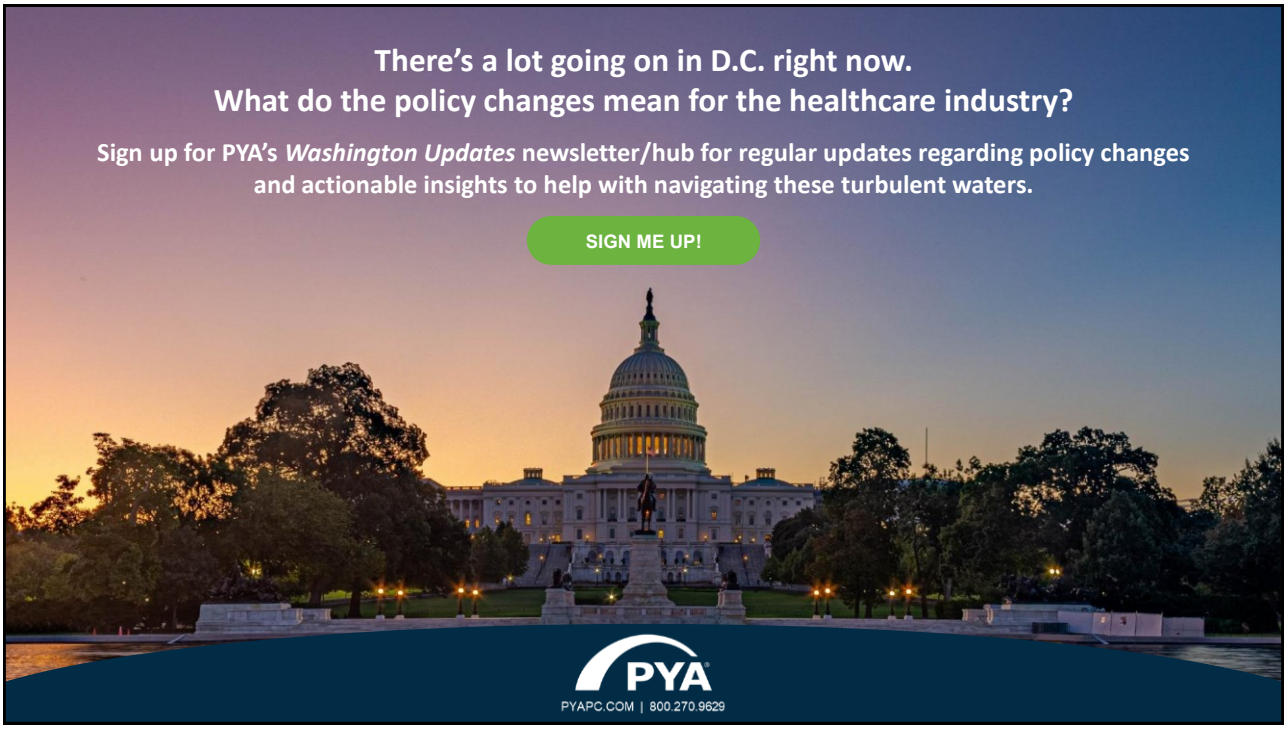
Most significant difference (medical back problems w/o MCC) is less than 50% higher than SNF total cost of care

Additional Costs - Part B Services During SNF Stay

- Patient with severe headache requires CT scan
  - SNF: Excluded service under the SNF PPS consolidated billing requirements = additional Part B expense (not part of $400/day)
  - CAH Swing Bed: Must include on swing bed claim, regardless of reason for service, findings, or if additional services were required (included in $1400/day)

Medicare Post-Acute Care Transfer Policy

- For ~ 270 DRGs, hospital receives per-diem rate (vs. full MS-DRG rate) when patient with LOS < geometric mean is discharged to one of the following:
  - Skilled nursing facilities
  - Inpatient rehab facilities and units
  - Long term care hospitals
  - Psychiatric hospitals and units
  - Children's and cancer hospitals
  - Home with a home health plan of care that begins within 3 days
  - Hospice care
- Does NOT apply to swing bed transfers (Patient Status Discharge Code 61)



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