Let’s Get Rural!

Navigating New Rules, Risks, and Reforms in Rural Healthcare

July 10, 2025

Introductions

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Today's Agenda

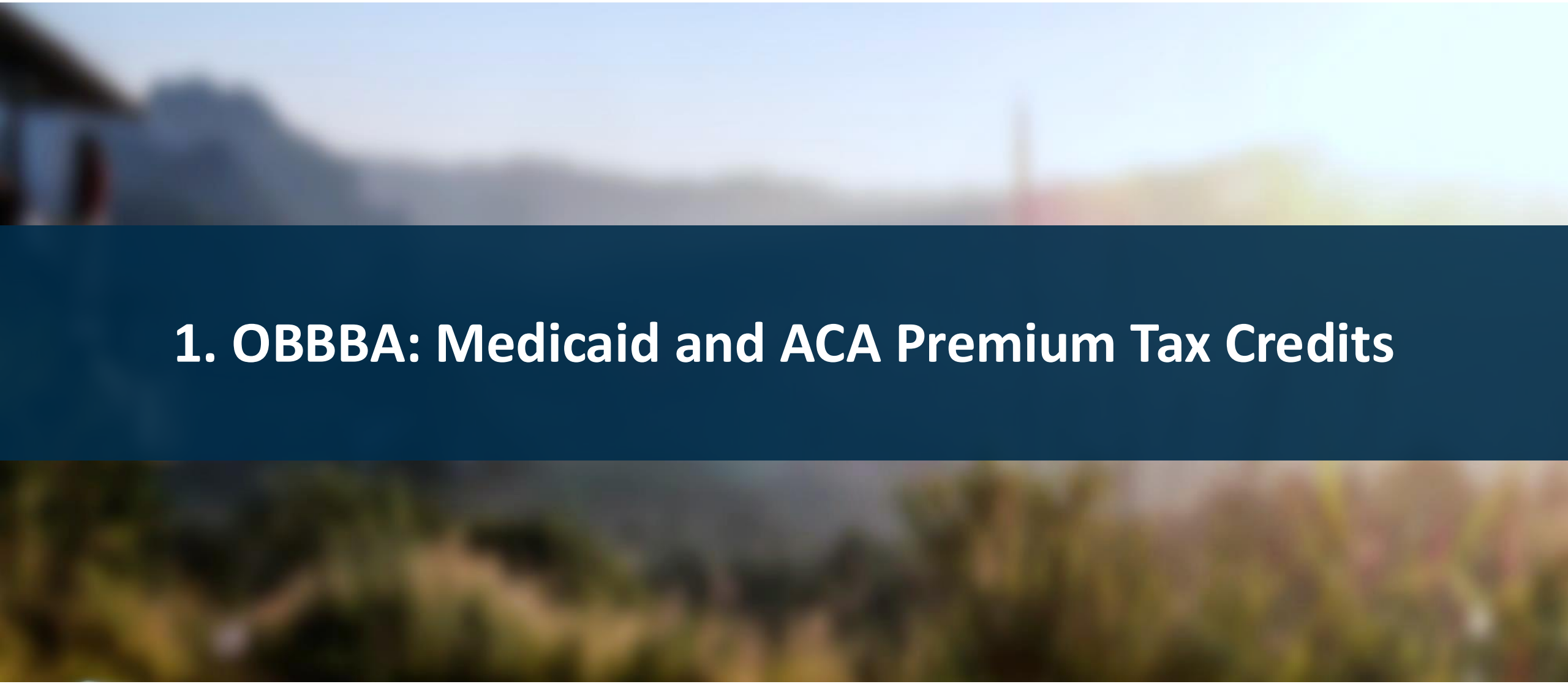
1. One Big, Beautiful Bill Act (OBBBA): Medicaid and ACA Premium Tax Credits
2. OBBBA: Rural Health Transformation Fund
3. OBBBA: Other Healthcare-Related Provisions
4. FY 2026 Appropriations Process
5. 2025 Medicare Trustee Report
6. 2026 Medicare Advantage Final Rules
7. HIPAA Privacy Rule – Reproductive Healthcare
8. Transforming Episodic Accountability Model
9. Recent CMS Directives and Guidance: Price Transparency, EMTALA, Medicare Advantage Audits
10. April 15 Executive Order - Lowering Drug Prices by Once Again Putting Americans First
11. MedPAC: Beneficiary Cost-Sharing for CAH Outpatient Services
12. Clinically Integrated Networks

https://thehill.com/homenews/5388842-russ-vought-trump-megabill-no-downside/

"It is a home run. There's like, no downside to this bill. This is not one where you have to say pros and cons. It's all good."

– Russell Vought

Director, Office of Management & Budget
July 7, 2025



1. OBBBA: Medicaid and ACA Premium Tax Credits

Work Requirements

- Effective 12/31/2026, states must condition Medicaid eligibility for non-disabled, non-excepted individuals ages 19-64 on working or participating in qualifying activities for ≥ 80 hours/month
  - States may request up to 2 additional years to fully implement work requirements and verification processes
  - HHS to issue interim final rule regarding implementation by 06/30/2026
  - $200 million appropriated in FY2026 to assist states with implementation
- State verification requirements
  - Must verify applicant meets requirement for at least 1 month prior to application (state may require up to 3 months)
  - At each regularly-scheduled redetermination, must verify beneficiary met requirement for at least 1 month since initial determination/latest redetermination
    - States may require additional months and/or more frequent verification of compliance
    - States may allow short-term hardship exception for qualifying hospitalization, ongoing medical treatment outside county of residence, Presidentially-declared disaster or emergency in county of residence, or high county unemployment rate
- CBO: $326 billion reduction in federal spending on Medicaid over 10 years

Other Eligibility Provisions

- Delay implementation of Eligibility and Enrollment Final Rules until 2035
  - CBO: $167 billion reduction in federal Medicaid spending over 10 years
- Effective 12/31/2026, states must conduct eligibility redeterminations at least every 6 months for expansion population
  - CMS to issue guidance (not regulations) within 180 days
  - CBO: $62 billion reduction in federal Medicaid spending over 10 years
- Starting 2027, states required to phase in additional screening and verification procedures to prevent improper enrollment
  - $30 million appropriated to CMS for system implementation; no monies appropriated to states for implementation
  - CBO: $18 billion reduction in federal Medicaid spending over 10 years
- Effective 10/1/2026, limit eligibility for aliens (no federal funds for services furnished to non-covered aliens
  - CBO: $6 billion reduction in federal Medicaid spending over 10 years

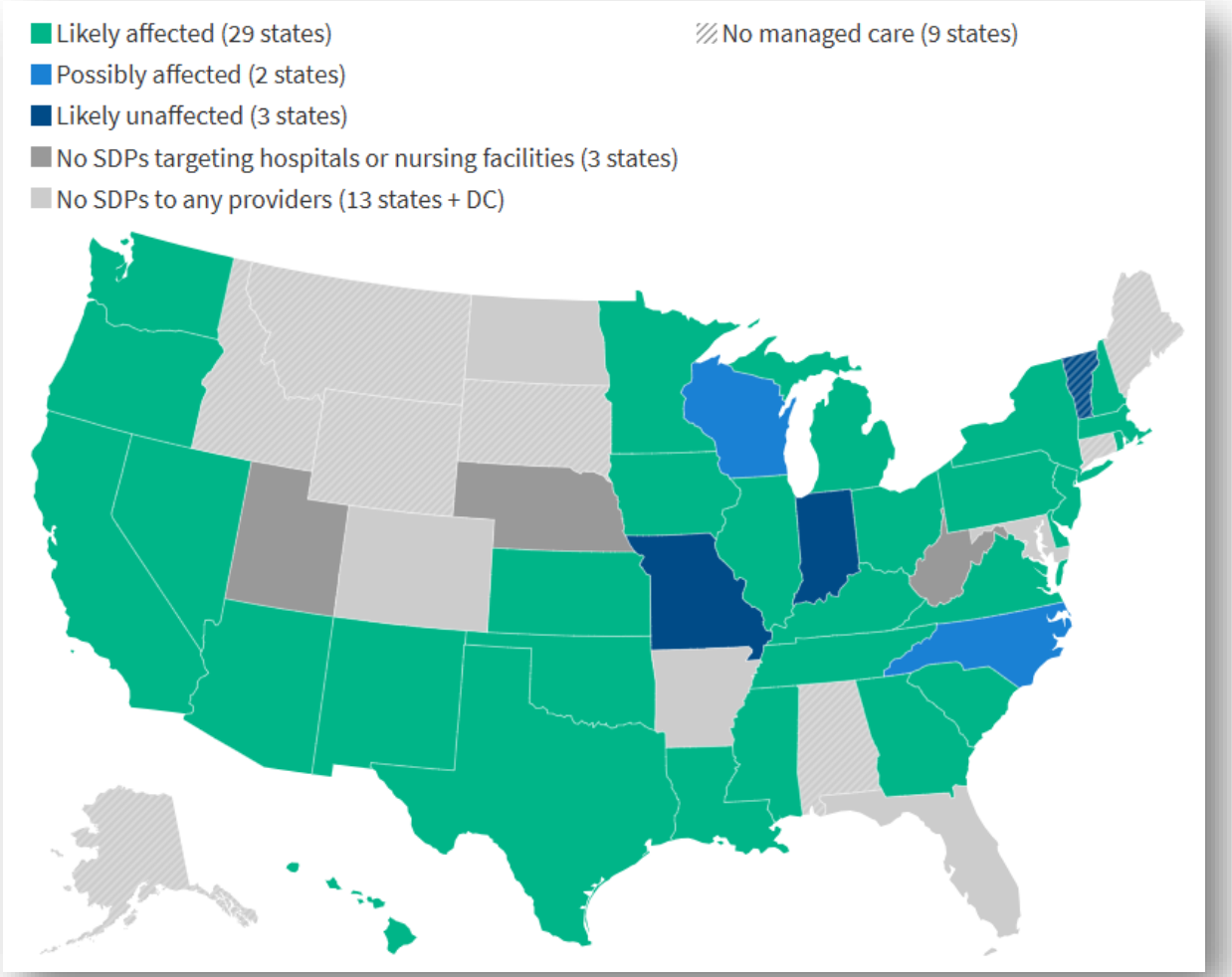
Provider Taxes

- Decrease in threshold for hold harmless provision (currently 6% net patient revenue)
  - Non-expansion states may maintain those provider taxes enacted and imposed as of 07/04/2025 that CMS has determined to be within current threshold, but cannot expand existing taxes or impose new taxes
    - Does not extend to requests for approval pending with CMS
  - Expansion states must reduce existing provider taxes to comply with decreasing thresholds, and cannot expand existing taxes or impose new taxes
    - Threshold decreases by 0.5% each year beginning in 2028 until reaches 3.5% in 2032
    - Existing provider taxes on nursing facilities and intermediate care facilities not subject to required reduction
- CBO: $191 billion reduction in federal spending on Medicaid over 10 years
  - Calculated with reductions beginning in 2027; was changed to 2028 during Senate floor debate
  - Compared to $89 billion for provider tax provision in bill passed by House on May 22

State-Directed Payments

- No future state-directed payments exceeding 100% of Medicare rates (110% for non-expansion states)
  - If no Medicare rate for specific service, cannot exceed Medicaid rate specified in state plan
- For any existing state-directed payment exceeding applicable rate, state must reduce rate by 10%each year beginning with the rating period on or after 01/01/2028 until reach applicable rate
  - Requests for new state-directed payments submitted to CMS by May 1, 2025 (or July 4, 2025, for payments to be made to rural hospitals) included in this grandfathering provision
  - No exception for nursing facilities or intermediate care facilities
- CBO: $149 billion reduction in federal spending on Medicaid over 10 years
  - Calculated on reductions beginning in 2027 and no extended grandfathering period for payments to rural hospitals (both changed during Senate floor debate)
  - Compared to $72 billion for state-directed payment provision in bill passed by House on May 22
- Additional provision closing loophole in formula used to determine if tax is generally redistributive (substantially similar to May 14 proposed rule)

Impact of SDP Rate Caps



https://www.kff.org/medicaid/issue-brief/reconciliation-language-could-lead-to-cuts-in-medicaid-state-directed-payments-to-hospitals-and-nursing-facilities/

https://www.politico.com/live-updates/2025/07/08/congress/ron-johnson-believes-he-will-get-second-bite-of-the-apple-on-medicaid-cuts-00443331

"That's where I gained a fair amount of confidence from the White House, the President, our leadership, that we will have a second bite of the apple."

– Sen. Ron Johnson (R-Wisconsin)

Referencing elimination of 90% FMAP for expansion population

July 8, 2025

Other Medicaid Provisions

- Retroactive coverage: Effective 01/01/2027, retroactive coverage reduced from 90 days prior to application to 30 days for expansion population and 60 days for non-expansion population
- 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
  - States may impose higher cost-sharing for non-emergency hospital services
- Erroneous Medicaid payments: Beginning in FY 2030, states subject to FMAP reductions for payment errors (payments to ineligible individuals (or individuals with insufficient evidence of eligibility) + overpayments to eligible individuals)
- Elimination of special FMAP for emergency medical treatment furnished to aliens
- Rules for calculating Section 1115 waiver budget neutrality
- Prohibition on payment of Medicaid funds to Planned Parenthood for one year
- Moratorium on enforcement of nursing facility minimum staffing rule through 2034
- WHAT'S MISSING: Delay in mandated Medicaid DSH reductions ($8B/year for 4 years) beyond 9/30/2028
  - Had been included in version of bill that passed House on May 11
  - Absent Congressional action, first $8 billion reduction will occur in FY 2026

ACA Marketplace Premium Tax Credits

- Limit eligibility for premium tax credits (PTCs) to narrow class of aliens
  - CBO: Reduces federal expenditures by $120 billion over 10 years
- Requires verification of specific insurance application information to qualify for PTCs
  - CBO: Reduces federal expenditures by $37 billion over 10 years
- Eliminates availability of PTCs during income-based special enrollment periods
  - CBO: Reduces federal expenditures by $39 billion over 10 years
- Limits definition of “lawfully present” to qualify for PTCs
- **What’s missing**: extension of enhanced PTCs set to expire at end of 2025
  - CBO: Expiration will increase number of uninsured by 4.2 million by 2034

ACA Marketplace Integrity and Affordability Final Rule

- Regulatory Impact Analysis: Total reduced annual enrollment between 725,000 and 1,800,000 individuals in PY 2026
  - CBO estimates 900,000 additional uninsured
- How?
  - Exclude DACA recipients from definition of “lawfully present” used to determine enrollment eligibility
  - Beginning in PY2027, shorten open enrollment period for federal marketplace to November 1 to December 15; state-based marketplace may select up to 9-week period between November 1 and December 31
  - Eliminate special enrollment period (SEP) for persons with annual household incomes below 150% FPL
  - Impose pre-enrollment verification procedures for SEPs (federal marketplace only)
  - Verify income using other trusted sources (rather than self-attestation) when no IRS data available
  - Deny eligibility for advance payments of premium tax credit (APTC) if tax filer fails to reconcile APTC for one year (vs. 2 consecutive years)
  - Permit issuer to require payment of both initial and past-due premiums to effectuate new coverage

Impact on Rural Providers

- Lower payment rates + increase in uncompensated care
  - ACA coverage expansion reduced uncompensated care by one-third
    - From $62.8 billion in 2011-2013 to $42.4 billion in 2015-2017
    - Number of individuals with uncompensated care costs went from 20.2 million to 13.1 million
  - 60% of uncompensated care furnished by hospitals (before and after ACA)
  - Delayed care = more expensive care
- Response?
  - Limited impact of DSH and bad debt payments to hospitals
  - Increase commercial payer rates
  - Increase local taxes
  - Reduce services
  - Alternative payment models

2. OBBBA: Rural Health Transformation Program

$50 Billion Over 5 Years Starting in 2026

- Program created in response to concerns about impact of Medicaid cuts on rural hospitals
  - However, nothing in statutory language ties award of Program funds in any way to amount of such lost revenues
- States to submit applications to CMS by no later than 12/31/2025
  - Detailed rural health transformation plan to accomplish following:
    - Improve access to hospitals, other health care providers, and health care items and services furnished to state's rural residents
    - Improve health care outcomes of rural residents
    - Prioritize use of new and emerging technologies that emphasize prevention and chronic disease management
    - Initiate, foster, and strengthen local and regional strategic partnerships between rural hospitals and other healthcare care providers
    - Enhance economic opportunity for, and the supply of, healthcare clinicians through enhanced recruitment and training
    - Prioritize data and technology driven solutions that help rural providers furnish high-quality health care services as close to patient's home as possible
  - Outline strategies to manage long-term financial solvency and operating models of rural hospitals
  - Identify specific causes driving accelerating rate of stand-alone rural hospitals becoming at risk of closure, conversion, or service reduction
- CMS Administrator must approve or deny each state application by no later than 12/31/2025

Allotments

- Each year, $5 billion allotted equally to each state with approved application
  - Presumably without regard to number or financial condition of state's rural health facilities
- Each year, $5 billion allotted by Administrator among not fewer than 25% of states with approved applications
  - Factors to be considered by Administrator
    - Percentage of State population located in rural census tract of an MSA
    - Proportion of rural health facilities in the state relative to number of rural health facilities nationwide
    - Situation of state's hospitals in the state which serve a disproportionate number of low-income patients with special needs
    - Any other factors that the Administrator determines appropriate
  - Unclear whether allotments made for entire 5-year period or adjusted annually
    - One-time application process for states
- Administrator's decisions not subject to administrative or judicial review under Social Security Act or otherwise

State Expenditures

- Administrator to specify terms and conditions, including requirement that state submit plan to use its allotment to carry out 3 or more of the following:
  - Promoting evidence-based, measurable interventions to improve prevention and chronic disease management
  - Providing payments for provision of health care items or services, as specified by the Administrator
  - Promoting consumer-facing, technology-driven solutions for prevention and management of chronic diseases
  - Providing training and technical assistance for adoption of technology-enabled solutions that improve care delivery in rural hospitals
  - Recruiting and retaining clinical workforce talent to rural areas, with commitments to serve rural communities for minimum of 5 years
  - Providing technical assistance, software, and hardware for significant IT advances to improve efficiency, enhance cybersecurity capability development, and improve patient health outcomes
  - Assisting rural communities to right size their health care delivery systems by identifying needed preventative, ambulatory, pre-hospital, emergency, acute inpatient care, outpatient care, and post-acute care service lines.
  - Supporting access to OUD treatment services, other SUD use disorder treatment services, and mental health services.
  - Developing projects that support innovative models of care that include alternative payment models, as appropriate.
  - Additional uses designed to promote sustainable access to high quality rural health care services, as determined by the Administrator
- Administrator can withhold or recoup funds if state does not adhere to program requirements

3. OBBBA: Other Healthcare-Related Provisions

Other Healthcare-Related Provisions

- Temporary payment increase under Medicare Physician Fee Schedule
  - 2.5% increase for 2026 (in place of 0.75/0.25% increase under MACRA)
- Telehealth
  - Permit high-deductible health plans to cover telehealth and other remote services before deductible
- Direct primary care
  - Treat monthly subscription fees as medical expense (vs. insurance fees), thus permitting use of HSA funds
- Workforce
  - New caps on student loans
    - Replaces unlimited Grad PLUS loans with $200,000 aggregate borrowing limit for doctoral, medical, or professional degrees
    - Caps Parent PLUS loans at $65,000 per student
  - Workforce Pell
    - Extends Pell grants to short-term (8 to 15 weeks) credential programs (including unaccredited programs)

4. FY 2026 Appropriations Process

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 (AHA)
  - Specific focus on prevention of chronic disease, including broadband technology integration, nutrition services, physical activity venue access, and reducing medication dependency
  - Consolidates:
    - Office of Assistant Secretary for Health (OASH)
    - Health Resources and Services Administration (HRSA)
    - Substance Abuse and Mental Health Services Administration (SAMHSA)
    - Agency for Toxic Substances and Disease Registry (ATSDR)
    - National Institute for Occupational Safety and Health (NIOSH)
    - Components of Centers for Disease Control and Prevention (CDC) relating to non-infectious diseases

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
  - 30% reduction in payments to MACs; budget "reflects efficiencies gained by descoping non-statutory workload and optimizing the level of effort"
- 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)

What We're Watching

- Extension of Medicare Dependent Hospital program
- Extension of higher thresholds for Low Volume Hospital program
- Change in base year for Sole Community Hospital program
- Extension of Medicare telehealth coverage expansion
- Expansion of Rural Emergency Hospital program
- Re-opening of necessary provider designation for new CAHs
- Changes to Medicare Physician Fee Schedule conversion factor calculation
- Expansion of site neutral payments
- Additional price transparency requirements
- *And another reconciliation bill?*

5. 2025 Medicare Trustee Report

Medicare Hospital Insurance Trust Fund Insolvent in 2033

- Three years sooner than 2024 HI report (2036)
- Reduced timeframe attributed to higher-than-expected 2024 expenditures and higher projected spending for inpatient hospital and hospice services
- After 2027, will likely have to draw from reserves to pay costs
- Insolvency results in spending cut of 11 percent, with cut growing to 14 percent by 2049
- To maintain solvency through 75-year projection period:
  - "The standard 2.90-percent payroll tax could be immediately increased by the amount of the actuarial deficit to 3.32 percent, or expenditures could be reduced immediately by 9 percent."

https://www.cms.gov/oact/tr/2025

6. PY 2026 Medicare Advantage Final Rules

What's In the Final Rule – Organizational Determinations

- Cannot deny coverage for lack of medical necessity if:
  - Gave prior authorization
  - Pre-service determination of coverage/payment
  - Concurrent determination during enrollee's receipt of inpatient/outpatient service absent good cause/reliable evidence of fraud
- Cannot use clinical information obtained after initial organizational determination to establish good cause for reopening approved inpatient hospital admission
- Must notify enrollee and provider seeking organizational determination of such determination
  - Provider may appeal failure to provide such notice

What's *Not* In the Final Rule

- Enhanced rules on internal coverage criteria
- Prohibiting MA plans from imposing in-network cost sharing for behavioral health services in excess of cost-sharing in traditional Medicare
- Changes to Star Ratings measures
  - Adding Initiation and Engagement of Substance Use Disorder Treatment
  - Updating Plan Makes Timely Decisions About Appeals and Reviewing Appeals Decisions
- Requiring agents/brokers to inform potential enrollees of:
  - Potential eligibility for Low-Income Subsidy and Medicare Savings Program
  - Potential impact of MA enrollment on future Medigap guaranteed issue rights

More That's *Not* In the Final Rule

- Requiring plans and third-party marketing organization to submit "generic" MA ads for review and approval before use
  - Since 2023, CMS has issued denials for over 1,500 TV ad submissions as being non-compliant and misleading to consumers
- Requiring plans to provide and regularly update provider directory data to CMS to populate Medicare Plan Finder
- Clarification of expenses excluded from inclusion in medical cost ratio

Still More **That's *Not* In the Final Rule – Health Equity**

- Did **not** finalize:
  - Guardrails on use of artificial intelligence in making organizational determinations
  - "acknowledge the broad interest in regulation of AI"
  - New reporting requirements as part of annual health equity assessment of utilization management policies
  - Changes to calculation of Health Equity Index Reward for Star Ratings (to be implemented in 2026)
- CMS now reviewing the following for consistency with Executive Order 14192, "Unleashing Prosperity Through Deregulation"
  - Excellent Health Outcomes for All (EHO4all) Reward (f/k/a Health Equity Index Reward) for Star Ratings
    - To be implemented beginning with 2027 Star Ratings
  - Annual health equity assessment of utilization management policies
  - Requirement for MA plans to provide culturally and linguistically appropriate services
  - Quality improvement and health risk assessments focused on equity and social determinants of health

Payers' Prior Authorization Pledge

- AHIP document released June 23 with specific promises and list of participating health plans
  - Implement standardized PA data and submission requirements (using FHIR® APIs) by 01/01/2027.
  - Demonstrated reductions in scope of claims subject to PA by 01/01/2026
  - Honor existing prior authorizations for benefit-equivalent in-network services as part of 90-day transition period when patient changes insurance companies during course of treatment by 01/01/2026
  - Provide clear explanations of PA determinations by 01/01/2026
  - By 2027, at least 80% of electronic PA approvals (with all needed clinical documentation) will be answered in real-time (tied to adoption of FHIR® APIs across all markets)
  - Re-statement of commitment that all non-approved requests based on clinical reasons will be reviewed by medical professionals
- RFK, Jr. – "We have deliverables. We have specificity on those deliverables. We're grateful to the insurance industry for stepping up, and for hospitals for stepping up."

https://ahiporg-production.s3.amazonaws.com/documents/202506_AHIP_Report_Prior_Authorization-final.pdf

2026 Rate Announcement

- Projects **5.06% increase** ($25B) in payments to MA plans for PY 2026
  - Advance Notice published in early January projected 2.23% increase
- Increase attributable to changes in effective growth rate between January and April
  - Up from 5.93% to 9.04%
  - Inclusion of additional data, including Q4 2024 utilization
- Continue to apply statutory minimum coding intensity adjustment of 5.9%
- Fully implement technical adjustment to effective growth rate calculation relating to indirect and direct medical education costs
  - Pausing implementation = $7B in additional payments to MA plans for 2026
- Fully implement 2024 CMS-HCC risk adjustment model
  - Pausing implementation = $3.4B in additional payments to MA plans in 2026

https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/announcements-and-documents/2026

7. HIPAA Privacy Rule – Reproductive Healthcare

2024 Changes To HIPAA Privacy Rule

- Prohibits use/disclosure of PHI relating to reproductive health for purpose of:
  - Conducting criminal, civil, or administrative investigation or imposing criminal, civil, or administrative liability for mere act of seeking, obtaining, providing, or facilitating reproductive healthcare where such care is lawful in circumstances in which provided
  - Identifying any person for purpose of conducting such investigation/imposing such liability
- "Reproductive healthcare" is defined as healthcare "that affects the health of an individual in all matters relating to the reproductive system and to its functions and processes"
- Covered entities and business associates must obtain signed attestation that certain requests for PHI potentially related to reproductive health are not for prohibited purposes:
  - Health oversight activities
  - Judicial and administrative proceedings
  - Law enforcement purposes
  - Disclosures to coroners/medical examiners regarding decedents

Legal Challenge

- On June 18, federal district court judge in Texas ruled in State of Texas' favor in lawsuit challenging new rule
  - Decision nullifies rule effective immediately on nationwide basis
- Unlikely Trump Administration will appeal decision
- District court previously denied third parties' motions to intervene, appeal now pending with 5th Circuit Court of Appeals
  - Those parties would appeal district court's decision if permitted to intervene
- ***For now, providers do not have to comply with the rule's requirements***, including securing attestations from parties requesting disclosures of reproductive health information

8. Transforming Episodic Accountability Model TEAM

TEAM Overview

- Mandatory 5-year episodic payment model beginning 01/01/2026 under which hospital financially accountable for total cost of defined episode of care for traditional Medicare beneficiaries
  - Hospital = Selected PPS hospitals* + voluntary participants
  - Episode of care = anchor event (specified inpatient stay/outpatient procedure) + 30 days post-discharge/post-procedure
  - Total cost = all non-exempt Part A & B payments (prorated if service staddles episode)
  - Accountable = owe money if total cost > target price, receive additional payment if total cost < target price

*List of selected PPS hospitals available at https://www.cms.gov/priorities/innovation/innovation-models/team-model

Selected Episodes – Focus on Surgical Care

Surgical Episode	Inpatient MS-DRGs	Outpatient HCPCS Codes
Coronary Artery Bypass Graft	231-236	
Lower Extremity Joint Replacement	469, 470, 521, 522	27447, 27130, 27702
Major Bowel Procedures	329-331	
Surgical Hip/Femur Fracture Treatment	480-482	
Spinal Fusion	402, 426-430, 447-448, 450-451, 471-473	22551, 22554, 22612, 22630, 22633

Potential Impact of TEAM on CAH 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."
  - Are any of the hospitals to which you refer patients part of TEAM?
  - Do those hospitals presently send patients back to your swing beds?
  - Have you quantified the potential impact of losing those swing bed admissions?
  - Have you discussed your concerns with TEAM-participating hospitals?
    - Are there other CAHs in the same position as you?
    - Can you demonstrate the value of your swing beds as compared to SNF admissions? (lower readmissions, shorter lengths of stay, patient satisfaction, avoided Part B expenses)

8. Recent CMS Guidance and Directives

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 act within 90 days:
  - 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 – 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

Price Transparency – May 22 Updated Guidance

- Instructs hospitals to use remittance advice to calculate rate if item/service was used one or more times within 12-month period prior to posting the file and to encode average of those "charges"
- If no history exists from last 12-month period, encode value in dollars and cents related to expectation of what "charge" would be for item/service
  - Include in "notes" data element that there were "zero instances of the item or service in the 12 months prior to posting the file"
- Posted by CMS June 16: *"The new HPT guidance issued by CMS on May 22, 2025, is effective immediately."*

EMTALA

- In July 2022, Biden Administration advised hospitals of EMTALA obligation to provide emergency abortions if *mother's health* is at risk
  - Federal law pre-empts state law prohibiting abortion except in cases in which *mother's life* is at risk
- One June 3, CMS rescinded July 2022 guidance, stating it is "work[ing] to rectify any perceived legal confusion and instability created by the former administration's actions."
  - "CMS will continue to enforce EMTALA, which protects all individuals who present to a hospital emergency department seeking examination or treatment, including for identified emergency medical conditions that place the health of a pregnant woman or her unborn child in serious jeopardy"
  - CMS did not go so far as to say state law trumps hospitals' EMTALA obligations

https://www.cms.gov/newsroom/press-releases/cms-statement-emergency-medical-treatment-and-labor-act-emtala

Medicare Advantage Audits

- Risk Adjustment Data Validation (RAD-V) audits
  - Verify diagnoses used to calculate MA risk scores are documented in enrollee medical records
    - If diagnoses not validated, plan may be required to repay CMS
  - CMS announcement May 21: Backlog from 2018 thru 2024 to be completed by early 2026
    - Enhanced Technology: use of advanced systems to efficiently review medical records and flag unsupported diagnoses
    - Workforce Expansion: Increase medical coders from 40 to ~2,000 by September 2025
    - Increased Audit Volume: Increase audits from ~60 MA plans a year to all eligible MA plans each year; increase from auditing 35 records per health plan per year to between 35 and 200 records per health plan per year
- Potential for provider claw-backs: check contracts' indemnification provisions

9. April 15 Executive Order
Lowering Drug Prices by Once Again Putting Americans First

Key Provisions for Providers

- “Within 180 days… the Secretary shall publish in the Federal Register a plan to conduct a survey…to determine the hospital acquisition cost for covered outpatient drugs at hospital outpatient departments.”
- “Within 90 days…the Secretary shall take action to ensure future grants available under section 330(e) of the Public Health Service Act…are conditioned upon health centers establishing practices to make insulin and injectable epinephrine available at or below the discounted price paid by the health center grantee or sub-grantee under the 340B Prescription Drug Program (plus a minimal administration fee) to individuals with low incomes….”
- “Within 180 days…the Secretary shall…propose regulations to ensure that payment within the Medicare program is not encouraging a shift in drug administration volume away from less costly physician office settings to more expensive hospital outpatient departments.”
- “Within 1 year…the Secretary shall take appropriate steps to develop and implement a rulemaking plan and select for testing…a payment model to improve the ability of the Medicare program to obtain better value for high-cost prescription drugs and biological products covered by Medicare….”

10. MedPAC: Beneficiary Cost-Sharing for CAH Outpatient Services

Proposal to Reduce Beneficiary Cost-Sharing

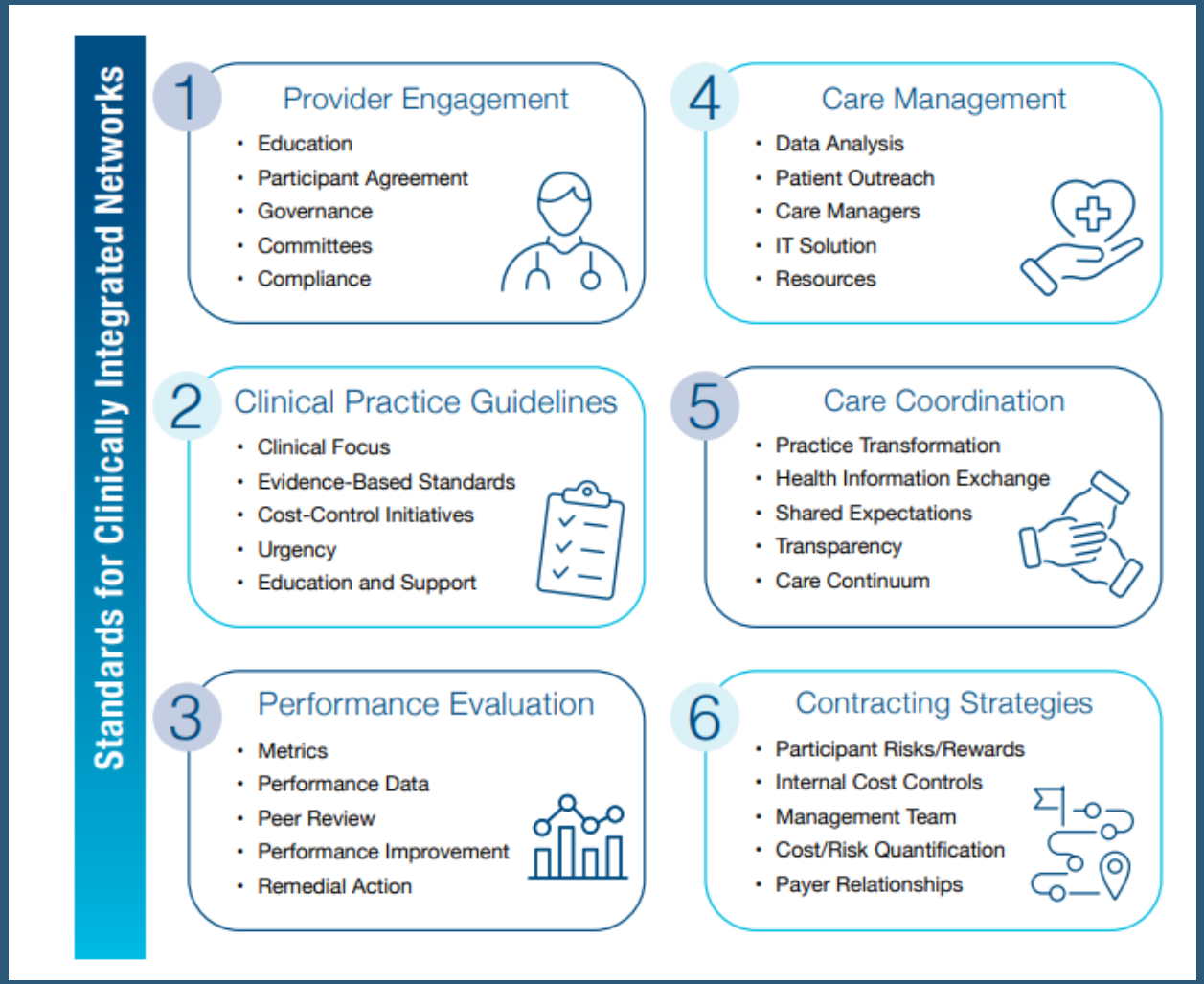
- Currently, CAH coinsurance for outpatient services set at 20% of charges, with no cap
  - PPS hospital coinsurance = 20% of payment rate, capped at Medicare inpatient deductible (currently $1,676)
- On average, CAH coinsurance equaled 52% of total outpatient payments
  - In 4% of cases, total bill was considered coinsurance
  - In 2022, average coinsurance billed to beneficiaries at CAHs = $1,750
- Proposal in June 2025 Report to Congress
  - Reduce cost sharing to 20% of payment amount with cap on per claim coinsurance equal to inpatient deductible
  - Reduction in beneficiary cost sharing results in increased payment from Medicare
- Expected impact:
  - Reduce cost-sharing liability for beneficiaries and resultant bad debts
    - Could impact site-of-service decisions by beneficiaries without supplemental coverage
  - Potential to reduce Medigap premiums for beneficiaries in states with CAHs
  - Likely increase Part B premiums for all beneficiaries

11. Clinically Integrated Networks

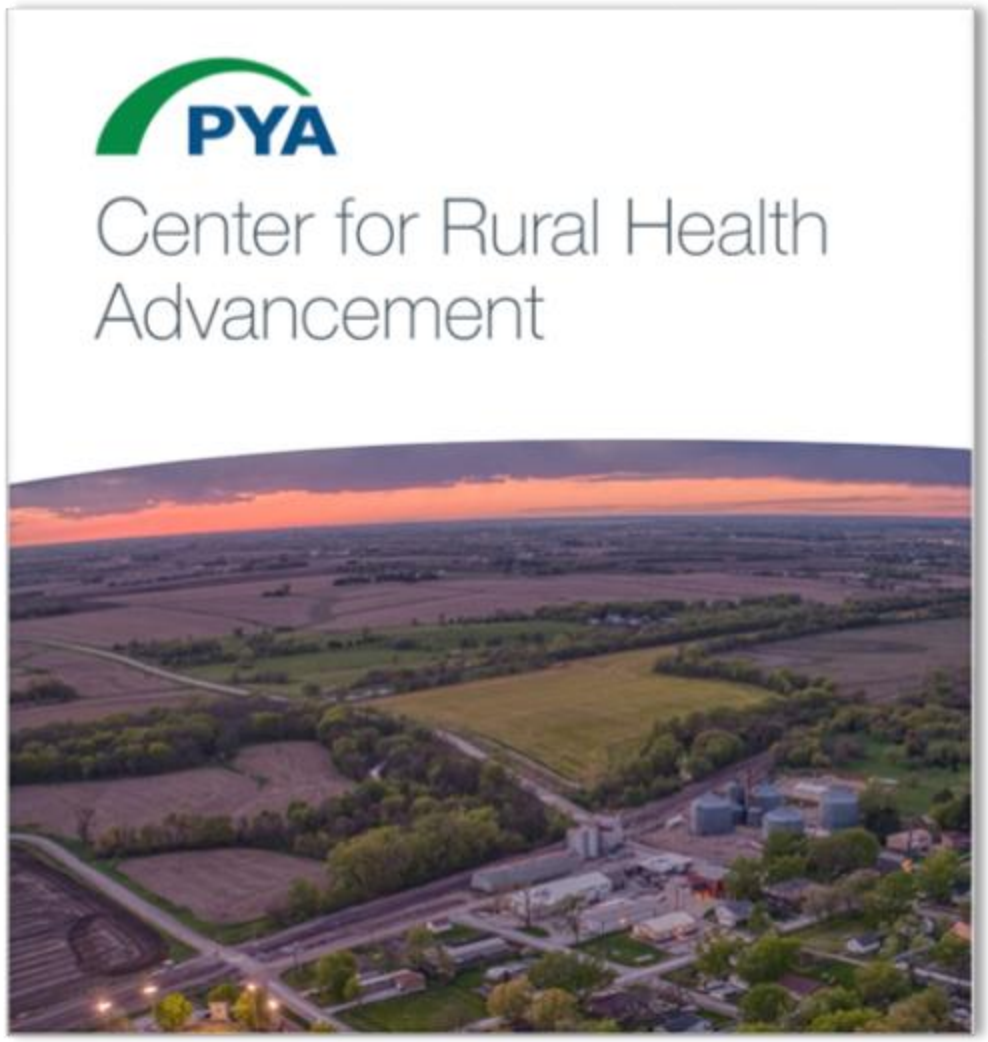
Independence Through Interdependence

- Antitrust laws make it per se illegal for competitors to engage in any form of joint price negotiations
  - Health system acquisition as means to access higher commercial rates
- Recognized exceptions for healthcare industry
  - Economic integration
    - Group of independent providers share substantial financial risk
    - Providers operate independently but accountable to each other for their performance
    - Joint price negotiations are vehicle to manage risk, with price playing secondary role
  - Clinical integration
    - Group of independent providers accountable to each other and communities they serve to deliver high-quality care efficiently
    - Joint price negotiations are vehicle to promote competition on quality and efficiency, with price playing secondary role
    - Federal antitrust agencies have articulated criteria by which to evaluate clinical integration
- Clinically integrated network (CIN) provide the infrastructure needed to meet these criteria
  - Providers create and interact within collaborative governance structure to develop, implement, and maintain evidence-based practices and related performance measures across CIN participants
  - Serves as vehicle to pursue and perform under value-based arrangements

CIN Evaluative Criteria



Learn more at https://www.pyapc.com/insights/building-a-clinically-integrated-network-to-support-joint-payer-negotiations/



The PYA Center for Rural Health Advancement helps rural providers transform their operations by delivering a full range of practical, rural-specific solutions focused on the four foundations of long-term sustainability.

Community Engagement – Understanding and prioritizing community needs, aligning with community organizations, building and maintaining trust with local residents, enhancing access to affordable primary care services, maintaining a strong governance and leadership team.

Clinical Excellence – Engaging in service line planning and execution, pursuing collaborative relationships and provider alignment, securing an adequate workforce.

Financial Stability – Gaining access to needed capital, optimizing revenue cycle operations, making purposeful IT investments, positioning for value-based contracting.

Regulatory Compliance – Understanding and implementing new regulatory requirements, ensuring IT security, preparing for and responding to survey findings.

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