Healthcare Regulatory Roundup #97

Washington Updates: One Big Beautiful Bill, Lots of Proposed Rules

July 16, 2025

Housekeeping

- Slides, handouts, and forms available in **Resources Panel**
- Enter questions in **Q&A Panel**
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Introductions

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Today's Agenda

1. OBBBA: Medicaid and ACA Premium Tax Credits
2. OBBBA: Rural Health Transformation Program
3. OBBBA: Other Healthcare-Related Provisions
4. What's Next for Congress?
5. CY 2026 Hospital Outpatient Prospective Payment System Proposed Rule
6. CY 2026 Home Health Prospective Payment System Proposed Rule
7. CY 2026 End-Stage Renal Disease Prospective Payment System Proposed Rule
8. CMS Innovation Center WISeR Model

1. OBBBA: Medicaid and ACA Premium Tax Credits

Work Requirements

- Effective 12/31/2026, states required to condition 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 required to 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 in 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, eliminate eligibility for refugees, asylees, and humanitarian parolees
  - Now limited to lawful permanent residents, certain Cuban/Haitian entrants, and citizens of Freely Associated States
  - 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)
  - Expansion states must reduce existing provider taxes to comply with decreasing thresholds, and cannot impose new taxes or expand existing 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
  - Non-expansion states may maintain those CMS-approved provider taxes enacted and imposed as of 07/04/2025, but cannot impose new taxes or expand existing taxes
- Close loophole in formula used to determine if provider tax is generally redistributive (substantially similar to May 14 proposed rule)
- CBO: $191 billion reduction in federal spending on Medicaid over 10 years
  - Based on 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 (SDPs)

- No future SDPs exceeding 100% of Medicare rates (110% for non-expansion states)
  - Prohibition does not extend to requests for new SDPs submitted to CMS by 05/01/2025 (or 07/04/2025 for SDPs targeting rural hospitals)
  - If no Medicare rate for specific service, cannot exceed Medicaid rate specified in state plan
- For any existing SDP exceeding applicable rate, state must reduce rate by 10% each year beginning with rating period on or after 01/01/2028 until reach applicable rate
  - Applies equally to expansion and non-expansion states (likely impacts 30 states)
  - No exception for SDPs for nursing facilities or intermediate care facilities
- CBO: $149 billion reduction in federal spending on Medicaid over 10 years
  - Based 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 SDP provision in bill passed by House on May 22

Other Medicaid Provisions

- Retroactive coverage: Effective 01/01/2027, retroactive coverage reduced from 90 days prior to application to 1 month for expansion population and 2 months 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)
- Moratorium on enforcement of nursing facility minimum staffing rule through 2034
- Elimination of special FMAP for emergency services furnished to aliens effective 10/01/2026
- Expanded access to home- and community-based services to those not requiring nursing home care effective 07/01/2028
- Budget neutrality rules for Section 1115 waivers
- Prohibition on payment of Medicaid funds to Planned Parenthood for one year
- **WHAT'S MISSING:** Delay in mandated Medicaid DSH reductions ($8B/year for 4 years) beyond 9/30/2025
  - Had been included in House-passed version of bill
  - Absent Congressional action, first $8 billion reduction will occur in FY 2026

ACA Marketplace Premium Tax Credits (PTCs)

- Effective PY2027, limit eligibility for PTCs to same classes of aliens now eligible for Medicaid
  - CBO: Reduces federal expenditures by $120 billion over 10 years
- Effective PY2028, verification of specific insurance application information required to qualify for PTCs
  - CBO: Reduces federal expenditures by $37 billion over 10 years
- Effective PYF2028, PTCs no longer available during income-based special enrollment periods
  - CBO: Reduces federal expenditures by $39 billion over 10 years
- **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
  - CBO: June 2025 ACA Marketplace Integrity and Affordability Final Rule will increase number of uninsured by another 900,000

2. OBBBA: Rural Health Transformation Program

$50 Billion Over 5 Years, Starting in 2026

- Created in response to concerns about impact of Medicaid cuts on rural hospitals
  - But award of funds not tied 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 ≥ 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 (vs. annual MEI-based adjustments in House bill)
- 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. What's Next for Congress?

What We're Watching

- FY 2026 appropriations process (President's proposed budget)
- Sequestration
- Currently expiring 09/30/2025:
  - Medicare Dependent Hospital program
  - Low Volume Hospital program
  - Medicare telehealth coverage expansion
  - Waiver of ACA Medicaid DSH cuts
- Changes to Medicare Physician Fee Schedule conversion factor calculation
- Regulation of Medicare Advantage plans
- Expansion of site neutral payments (more to come on this subject….)
- Expansion of price transparency requirements (more on this as well….)
- Second reconciliation bill including additional Medicaid cuts (e.g., discontinue 90% FMAP for expansion population)

5. CY 2026 Hospital Outpatient Prospective Payment System Proposed Rule

Comments due September 13

CY 2026 Payment Changes

- Proposed 2.4% increase to conversion factor
  - Hospital inpatient market basket increase of 3.2 percent less productivity adjustment of 0.8 percent
  - Statutory 2.0 percentage point reduction for hospitals that do not meet HOQR requirements
- Outlier threshold reduced from $7,175 to $6,450

Start: CY 2025 Final OPPS Conversion Factor = **$89.169**
Step 1a: Adjust the conversion factor to temporarily account for additional drug and device pass-through spending and outlier spending in CY 2025. This action causes an increase in the conversion factor. So, the amount of both drug and device pass-through spending (0.0037) and the percentage of outlier spending (0.01) as a share of total OPPS outpatient hospital spending is subtracted from 1.0000, which represents total OPPS outpatient hospital spending for CY 2025.
➢ 1.0000 – (0.0037 + 0.01) = 0.9863

Conversion Factor Calculation

Step 1b: Divide $89.169 by 0.9863

- $89.169/0.9863 = **$90.408**

Step 2: Adjust the conversion factor by the required wage index budget neutrality adjustment of approximately 1.0116. This adjustment increases the amount of OPPS outpatient hospital spending and is multiplied with $90.408.

- $90.408* 1.0116 = **$91.456**

Step 3: Adjust the conversion factor by the 5 percent annual cap for individual hospital wage index reductions adjustment of approximately 0.9955. This adjustment reduces the amount of OPPS outpatient hospital spending and is multiplied with $91.456.

- $91.456* 0.9955 = **$91.045**

Step 4: Adjust the conversion factor by the cancer hospital payment adjustment of 1.0000. Because the PCR for cancer hospitals is the same between CY 2025 and CY 2026, there would be no change to the OPPS conversion factor.

- $91.045*1.0000 = **$91.045**

Step 5: Adjust the conversion factor by rural SCH adjustment policy of 1.0000. Since we propose to maintain our current policy, there is no impact on the conversion factor by this policy.

- $91.045*1.0000 = **$91.045**

Step 6a: Adjust the conversion factor by the OPD fee schedule increase factor of 0.024 for CY 2025. The OPD fee schedule increase factor increases outpatient hospital spending in CY 2026 over CY 2025 and is added to 1.0000 which represents total outpatient hospital OPPS spending in CY 2024.

- 1.0000+0.024 = 1.0240

Step 6b: Multiply $91.045 by 1.0240.

- $91.045*1.0240 = **$93.230**

Step 7a: Adjust the conversion factor to remove additional drug and device pass-through spending and outlier spending for CY 2026. This action causes a decrease in the conversion factor. So, the amount of both drug and device pass-through spending (0.0059) and the percentage of outlier spending (0.01) as a share of total OPPS outpatient hospital spending is subtracted from 1.0000, which represents total OPPS outpatient hospital spending for CY 2026.

- 1.0000 – (0.0059+0.01) = 0.9841

Step 7b: Multiply $93.230 by 0.9841 to get the CY 2026 final OPPS conversion factor.

$93.230*0.9841 = **$91.747**

Finish: **CY 2026 OPPS Conversion Factor = $91.747**

OPPS 340B "Remedy"

- Revises the reduction OPPS conversion factor from 0.5 to 2%; reduces 'pay-back period from 16 to 6 years
  - Not applicable to hospitals enrolled in Medicare after 01/01/2018 (will receive full payment update)
- Impact on 2026 conversion factor:

> * *Reduction for Providers Subject to the 340B Remedy Offset*
>
> *Step 8:* Multiply $91.747 by 0.9805 to get the CY 2026 proposed OPPS conversion factor for the providers subject to the 340B remedy offset.
>
> $91.747*0.9805 = **$89.958**

It's not a 2.4% increase – it's a 0.877% increase over current conversion factor!
(except for hospitals enrolled in Medicare after 01/01/2018)

Déjà Vu All Over Again – Inpatient Only List (IPO)

- Phase out IPO over 3 years starting in CY 2026
- Remove 285 mostly musculoskeletal services for CY 2026
  - Includes 16 non-musculoskeletal services recommended by 2020 HOP Panel (cardiovascular, lymphatic, digestive, gynecological, endovascular procedures)
- Continue policy exempting procedures removed from IPO from two-midnight policy review until claims data shows procedures more commonly billed in outpatient setting
- Corresponding changes to ASC Covered Procedures List (CPL)
  - Move 276 procedures to CPL based on traditional criteria plus additional 271 procedures proposed for removal from IPO (assuming finalized)

Medicare OPPS Drug Acquisition Cost Survey

- April 15 Executive Order "Lowering Drug Prices by Once Again Putting Americans First"
  - "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."
- CMS to survey acquisition costs for each separately payable drug acquired by all hospitals and paid under OPPS
  - Submission window opening early CY 2026

Market-Based MS-DRG Relative Weight Data Collection

- Require hospitals to report payer-specific Medicare Advantage payment rates by DRG on cost report
  - Effective for cost reporting periods ending on or after 01/01/2026
  - Required to report median of payer-specific negotiated “charges” that hospital has disclosed for all MAOs on most recent MRF
  - Would be used to calculate MS-DRG relative weights to reflect relative market-based pricing
    - Goal is to use new methodology beginning in FY 2029

Price Transparency

- New requirements effective January 2026 (CMS estimates one-time burden of $478.08 per hospital)
  - Reporting of actual payment amounts when standard “charges” are based on percentages or algorithms
    - Removes requirement for hospitals to encode estimated allowed amount
    - Requires disclosure of 10th percentile, median, and 90th percentile allowed amounts in MRF
    - Also requires count of allowed amounts used to calculate encoded amounts
    - Defines look-back period as no longer than 12 months prior to posting MRF
  - Requires encoding of name of CEO, president, or senior hospital official designated to oversee reporting of true, accurate, and complete data
  - Requires encoding of organizational (Type 2) National Provider Identifier
  - Proposes to allow hospitals opportunity to reduce CMP by 35% by waiving right to ALJ hearing

Revised Attestation Statement – Effective January 2026

"The hospital has included all applicable standard charge information in accordance with the requirements of § 180.5, and the information encoded is true, accurate, and complete as of the date in the file. The hospital has included all payer-specific negotiated charges in dollars that can be expressed as a dollar amount. For payer-specific negotiated charges that cannot be expressed as a dollar amount in the machine-readable file or not knowable in advance, the hospital attests that the payer-specific negotiated charge is based on a contractual algorithm, percentage or formula that precludes the provision of a dollar amount and has provided all necessary information available to the hospital for the public to be able to derive the dollar amount, including, but not limited to, the specific fee schedule or components referenced in such percentage, algorithm or formula."

Site Neutral Payment Reform – Drug Administration

- General rule: payment rates for services performed in on-campus and excepted off-campus HOPDs are higher than rates for same service performed in physician clinic due to different cost structures
  - Excepted off-campus HOPD = operating prior to 11/02/2015
- 2019: apply MPFS equivalent payment rate for clinics visits (HCPCS G0463) performed in excepted off-campus HOPD
  - Phased in over 2 years in non-budget neutral manner; exemption for rural sole community hospitals
  - MPFS equivalent rate = 40% of HOPD rate
- 2026: apply MPFS equivalent payment rate for 61 HCPCS codes assigned to drug administration APCs (5691-94) performed in exempt off-campus HOPD
  - Implement in non-budget neutral manner; exemption for rural sole community hospitals
  - Estimated $280 million in savings in 2026 ($70 million in reduced beneficiary coinsurance)
- RFI on additional site neutral payment reforms (excepted off-campus and on-campus HOPDs)

https://www.pyapc.com/insights/hcrr-90-webinar-tightening-your-belt-prepare-for-site-neutral-payment-reforms/

Outpatient Quality Reporting Program

- Adopt Emergency Care Access & Timeliness electronic clinical quality measure (eCQM) beginning with voluntary reporting for CY 2027 reporting period followed by mandatory reporting beginning with the CY 2028 reporting period/CY 2030 payment determination
  - Remove Median Time from ED Arrival to ED Departure for Discharged ED Patients and Left Without Being Seen measures beginning with the CY 2028 reporting period/CY 2030 payment determination
- Remove following measures:
  - COVID–19 Vaccination Coverage Among Healthcare Personnel measure beginning with the CY 2024 reporting period/CY 2026 payment determination;
  - Hospital Commitment to Health Equity measure beginning with CY 2025 reporting period/CY 2027 payment determination;
  - Screening for Social Drivers of Health measure beginning with the CY 2025 reporting period; and
  - Screen Positive Rate for SDOH measure beginning with the CY 2025 reporting period.

Star Rating Methodology Changes

- 2026-only: 4-star cap for hospitals in lowest quartile of Safety of Care measure group performance
- 2027+: blanket 1-Star reduction for hospitals in lowest quartile of Safety of Care measure group performance
  - Exemption for 1-Star hospitals
- Hospitals with fewer than 3 Safety of Care measures exempt from star rating adjustments

Other Items of Note

- Permanent virtual supervision of pulmonary rehab, coronary rehab, intensive coronary rehab and diagnostic services
  - Provider required supervision via audio-visual real-time communications technology
  - Excludes diagnostic services with global period indicator of 010 or 090
- RFI on software as a services (SaaS), e.g., AI to support clinical-decision making
  - To determine whether specific payment adjustments are needed to more accurately pay for these products across settings of care
- Separate payment for certain skin substitute products as incident-to-supplies in both the non-facility and hospital outpatient settings
  - Under OPPS, would unpackage the skin substitute from payment for administration and payment both separately
- Considering 7 complete applications for device pass-through payments

RFI on Deregulation

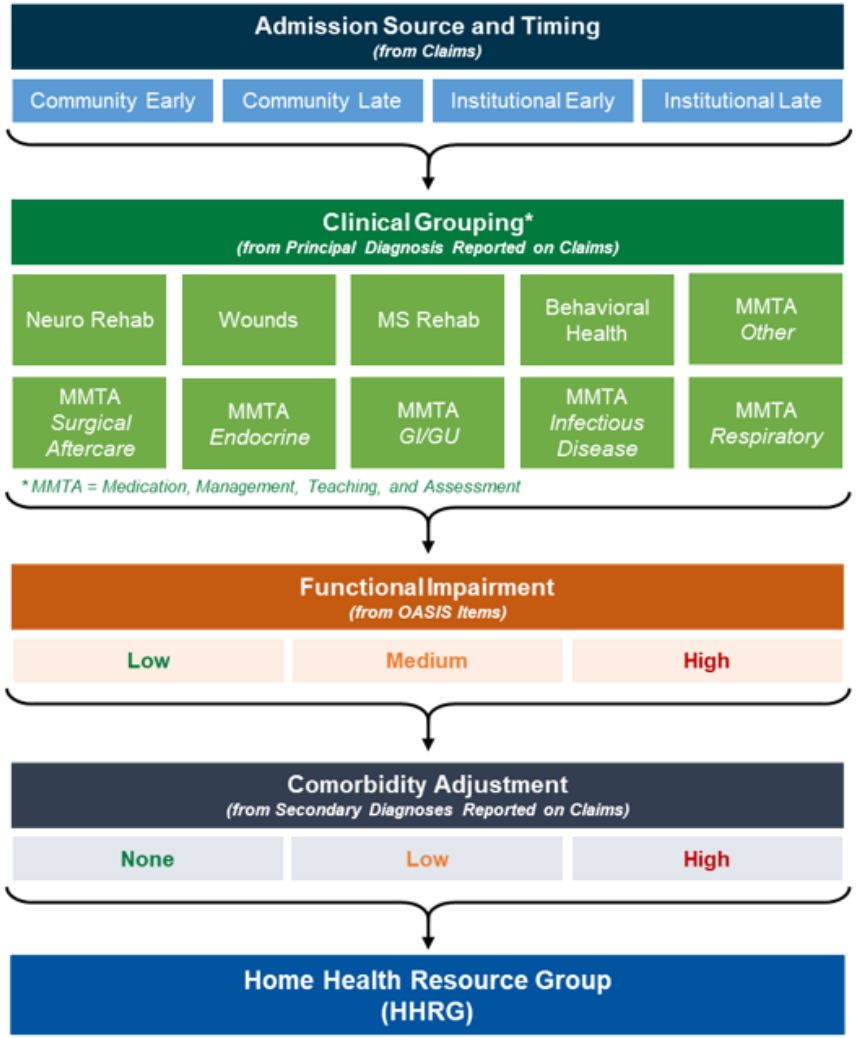
- Follows EO issued January 31, 2025, related to reducing private expenditures required to comply with federal regulations
- Solicits input on opportunities to streamline regulations and reduce administrative burden on providers, suppliers, beneficiaries and other interested parties
- **Submit comments:** https://www/cms.gov/medicare-regulatory-relief-rfi

6. CY 2026 Home Health Prospective Payment System Proposed Rule

Comments due August 29

Patient-Driven Groupings Model (PDGM)

- National, standardized 30-day period payment rate (previously 60-day episode)
- Agency-specific adjustments
  - Wage Index
  - Quality Reporting Program
  - Value-Based Purchasing Model
- Case-specific adjustments
  - Each 30-day period assigned to one of 432 Home Health Resource Groups based on beneficiary's health conditions and care needs
  - Additional adjustments for low-utilization and partial periods, outliers, rural add-on payment



Base Rate and Weights

- 6.4% reduction to current payments (**$1.4 billion decrease from 2025**)
  - 3.2% market basket increase, less 0.8% productivity adjustment = 2.4% ($425 million increase)
  - Less 3.7% prospective, permanent behavior assumption adjustment ($655 million decrease)
  - Less 4.6% temporary adjustment to recoup past overpayments ($815 million decrease)
  - Less 0.5% decrease due to proposed update to fixed-dollar loss ratio for outliers ($90 million decrease)
- Behavior assumption adjustment
  - Accounts for differences between assumed behavior changes and actual behavior changes on estimated aggregate expenditures due to implementation of PDGM and 30-day unit of payment (budget neutrality)
  - Previous permanent adjustments were determined insufficient based on more recent claims data
    - Final adjustments represented only half of calculated permanent adjustments needed
  - Temporary adjustments not previously used to achieve budget neutrality
    - Intended to recoup $786 million of $5.3 billion in estimated overpayments from CYs 2020-2024
    - Could propose additional temporary adjustments in future rulemaking

30-Day Period Payment Rates

TABLE 26: CY 2026 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT

CY 2025 National Standardized 30-Day Period Payment	Permanent Adjustment Factor	CY 2026 Case-Mix Weights Recalibration Neutrality Factor	CY 2026 Wage Index Budget Neutrality Factor	CY 2026 HH Payment Update Factor	CY 2026 National, Standardized 30-Day Period Payment (Without Temporary Adjustment)	Temporary Adjustment Factor	CY 2026 National, Standardized 30-Day Period Payment (With Temporary Adjustment)
$2,057.35	0.95941	1.0051	1.0019	1.024	$2,035.38	0.95000	$1,933.61

The CY 2026 national standardized 30-day period payment rate for an HHA that does not submit the required quality data would be updated by 0.4 percent (the proposed CY 2026 home health payment update percentage of 2.4 percent minus 2 percentage points) and is shown in table 27.

TABLE 27: CY 2026 NATIONAL, STANDARDIZED 30-DAY PERIOD PAYMENT AMOUNT FOR HHAS THAT DO NOT SUBMIT THE QUALITY DATA

CY 2025 National Standardized 30-Day Period Payment	Permanent Adjustment Factor	CY 2026 Case-Mix Weights Recalibration Neutrality Factor	CY 2026 Wage Index Budget Neutrality Factor	CY 2026 HH Payment Update Factor Minus 2 Percentage Points	CY 2026 National, Standardized 30-Day Period Payment (Without Temporary Adjustment)	Temporary Adjustment Factor	CY 2026 National, Standardized 30-Day Period Payment (With Temporary Adjustment)
$2,057.35	0.95941	1.0051	1.0019	1.004	$1,995.63	0.95000	$1,895.85

Other Payment-Related Changes

- Recalibrates 432 HH resource group case-mix weights using CY 2024 data
- Updates low utilization payment adjustment thresholds, functional impairment levels, and comorbidity adjustment subgroups
- Updates fixed-dollar loss threshold for outlier payments

Home Health Quality Reporting Program

- Removal of five measures beginning with CY 2026 HH QRP (April 1, 2026)
  - COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date
    - Also removes corresponding OASIS data element
  - Living Situation (R0310)
  - Food (R0320A and R0320B)
  - Utilities (R0330)
- Permit provider to submit request for reconsideration of initial determination of noncompliance if provider can demonstrate full compliance
- RFI related to future quality measures relating to interoperability, cognitive function, nutrition, and patient well-being
- RFI related to data submission deadline for HH QRP data
  - Change to the final data submission deadline period from 4.5 months to 45 days

Home Health Value-Based Purchasing

- Four new measures under HH VBP model
  - Medicare Spending per Beneficiary
  - Three measures related to patient functional improvement in dressing and bathing
- Would result in changes to weights of individual measures and measure categories

Home Health CAHPS

- Addition of three new questions
  - Whether care provided helped patient take care of their health
  - Whether patient's family/friends were given sufficient information and instructions
  - Whether patient felt the staff cared about them "as a person"
- Removal of four questions
  - Whether someone asked to see all prescription and over-the-counter medicines patient was taking
  - Whether patient is taking any new prescription medicines or whether patient's medicines have changed
  - Whether home health providers talked to patient about purpose for taking new or changed prescription medicines
  - Whether home health providers talked to patient about when to take medicines

DMEPOS Competitive Bidding Program

- Rule includes “improvements” to DMEPOS Competitive Bidding Program (CBP), however…
  - No announcement as to product categories
    - Clarifies that ostomy, tracheostomy, and urological supplies are medical equipment mandated for inclusion under CBP
  - No announcement on timeframe for the next competition
  - Currently, there is “temporary” gap in the program
- Payment for Class II continuous glucose monitors and insulin infusion pumps
  - Proposes reclassification to “frequent and substantial servicing” payment category under CBP to ensure access to latest technology
    - Bundled monthly rental payment (including necessary supplies and accessories)
  - Proposes same payment methodology for CGMs and pumps outside CBP (e.g., Class III CGMs)

Face-to-Face Encounter Policy

- Current policy
  - Non-physician practitioners can perform required face-to-face encounter regardless of whether they care for patient in hospital or post-acute setting; does not need to be certifying practitioner
  - Physicians required to be certifying practitioner or to have previously cared for patient

- Proposed policy
  - Physician may provide face-to-face encounter even if not certifying practitioner or did not previously care for patient

7. CY 2026 End-Stage Renal Disease Prospective Payment System Proposed Rule

Comments due August 29

Payment Changes

- Increase base rate to $281.06
  - ~1.9% increase over current rate of $273.82
- Update outlier services fixed dollar loss (FDL) and Medicare allowable payment (MAP) amounts using more current data
  - Pediatric beneficiaries: FDL decrease from $234.26 to $148.34; MAP decrease from $59.60 to $44.10
  - Adult beneficiaries: FDL decrease from $45.41 to $12.77; MAP decrease from $31.02 to $22.09

ESRD Quality Incentive Program (QIP)

- Changes for PY 2027
  - Remove three measures finalized in CY 2024 final rule
    - Facility Commitment to Equity
    - Screening for Social Drivers of Health
    - Screen Positive Rate for Social Drivers of Health
  - Update the ICH CAHPS clinical measure to 39 questions (currently 62 questions)

8. CMS Innovation Center WISeR Model

Wasteful and Inappropriate Service Reduction Model

- New CMS Innovation Center model announced June 27 imposing new prior authorization requirements in traditional Medicare
- Center now soliciting applications from companies to handle providers' PA requests using AI tools
  - Companies will receive share of money CMS saves by avoiding improper payments, similar to RAC auditors
- New PA requirements apply to providers in Arizona, Ohio, Oklahoma, New Jersey, Texas, and Washington beginning 01/01/2026
  - List of services included in Request for Applications available at https://www.cms.gov/files/document/wiser-model-rfa.pdf

Our Next Healthcare Regulatory Roundup Webinars

July 30, 2025; 11 am – 12 pm ET

Healthcare Regulatory Roundup #98:
CY 2026 Medicare Physician Fee Schedule Proposed Rule, Part 1

August 13, 2025; 11 am – 12 pm ET

Healthcare Regulatory Roundup #99:
CY 2026 Medicare Physician Fee Schedule Proposed Rule, Part 2

Please leave a comment regarding topics for future HCRR webinars!

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