PYA Healthcare Regulatory Roundup #107: Happy New Year: New Proposed Rules, New Payment Models, New Guidance

Presented January 21, 2026 by PYA's Martie Ross and Kathy Reep | Part of the Healthcare Regulatory Roundup Webinar Series

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WEBINAR SUMMARY

This episode of PYA's Healthcare Regulatory Roundup provides an overview of regulatory, legislative, and payment changes healthcare organizations face entering 2026. The presenters explain updates related to Medicare telehealth, Medicaid work requirements, healthcare extenders and provisions, and Medicare Advantage oversight. The webinar also covers new 340B drug program developments, price transparency rules, interoperability and health IT initiatives, and CMS payment models.

Key topics include:

- New proposed rules and payment models
- Consolidated Appropriations Act 2026
- Medicaid disproportionate share hospital (DSH) cuts
- Medicare telehealth program
- Medicare Advantage (MA) plans and complaints tracking module
- MedPAC Report
- Transparency and coverage regulations
- Healthcare extenders
- CMS Innovation Center's new proposed alternative payment models (APMs)
- Interoperability and information technology (IT) in healthcare
- ASTP/ONC Deregulatory Actions to Unleash Prosperity (HTI-5)
- Medicaid work requirements and Medicaid Ratio
- Wasteful and Inappropriate Service Reduction (WISeR) model
- 340B drug survey
- Medicare OPPS Drug Acquisition Cost Survey
- Rural Health Transformation Program (RHTP)
- Medicare Condition of Participation (COP) on Sex Change Procedures proposed rule
- Advancing Chronic Care with Effective Scalable Solutions (ACCESS)
- Long-Term Enhanced ACO Design (LEAD ACO)

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WEBINAR HIGHLIGHTS AND FREQUENTLY ASKED QUESTIONS

What healthcare regulatory issues were prioritized at the start of 2026?

- Key issues included telehealth policy, Medicaid eligibility changes, Medicare Advantage oversight, and payment model updates.

How do Medicaid work requirements affect healthcare providers?

- Work requirements may change Medicaid eligibility patterns, impacting hospital reimbursement and compliance planning.

What changes to Medicare telehealth were discussed?

- The session reviewed ongoing extensions and uncertainty around future telehealth coverage rules.

Why is Medicare Advantage oversight a concern for providers?

- Oversight influences payment accuracy, appeals, and accountability for managed Medicare plans.

What role does price transparency play in compliance planning?

- Hospitals must meet reporting requirements that support patient access to pricing information.

How are new CMS alternative payment models evolving?

- CMS continues testing models that emphasize value, care coordination, and outcome-based reimbursement.

ACTION ITEMS

1. **Track CAA 26 (Consolidated Appropriations Act 2026) progress**
    - Monitor whether CAA 26 actually passes House, Senate, and President.
    - Refresh shutdown contingency plans for HHS-dependent programs in case it stalls.
2. **Review and adjust your telehealth and hospital-at-home strategy**
    - Plan investments and staffing knowing:
        - Medicare telehealth flexibilities extend through Dec 2027.
        - Hospital at Home extends through Sept 2030.
    - Update contracts and business plans to these dates.
3. **Model the risk for rural and special hospital programs**
    - Quantify the impact if LVH, MDH, work GPCI floor, ambulance add-ons end after this FY.
    - Build “with/without extender” scenarios into your budget and bond discussions.
4. **Engage on the Medicare Advantage technical rule**
    - Decide if your organization will submit comments opposing/reshaping the removal of complaints, appeals, timeliness, Maximus concurrence, plan-finder accuracy, and member experience from Star Ratings.
    - Coordinate provider stories/data to illustrate why these measures matter.

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5. **Start using the new MA complaints portal**
    - Stand up a process so staff:
        - Escalate serious MA access/denial behaviors.
        - Routinely submit these to the CMS MA complaints tracking module.
    - Use complaint data to support contract negotiations and policy comments.
6. **Prepare for ACCESS and LEAD model opportunities**
    - ACCESS model: Evaluate whether you should apply as an ACCESS entity or partner with one (chronic care management, outcome-tied payments, waived cost-sharing).
    - LEAD model (post-ACO REACH):
        - Watch for the RFA and assess 2027 readiness, particularly if you're a safety-net / add-on payment provider.
7. **Check exposure to TEAM and the Ambulatory Specialty Model**
    - Confirm whether your CBSA is selected for:
        - TEAM (inpatient episodic model; financial accountability 30 days post-procedure).
        - Ambulatory Specialty Model (CHF and low back pain from 2027).
    - If selected, organize cardiology and related specialties for "MIPS on steroids" performance.
8. **Align your health IT roadmap with HTI-5 (FHIR and info-blocking)**
    - With HTI-2 elements withdrawn, pivot fully to HTI-5:
        - Confirm your EHR vendor's path to FHIR APIs for patient access, prior auth, and public health.
        - Assess effort and timelines, especially for rural/small sites.
    - Consider submitting comments, focusing on realistic compliance timelines.
9. **Protect DSH and 340B: tighten Medicaid eligibility and data**
    - Improve registration and eligibility work to:
        - Run Medicaid checks as late as feasible before cost report filing.
        - Capture out-of-state and prior-state Medicaid when patients move.
    - Identify hospitals sitting close to the 11.75% (or 8%) 340B DSH threshold and track trends.
10. **Treat the ODACS Drug Cost Survey as high-risk and high-priority**
    - If you're an OPPS hospital, confirm:
        - You are on the required list and properly registered (POC + submitter).
        - You can report NDC-level units and net acquisition costs (340B and non-340B, all discounts/rebates included).
    - Assume non-response can hurt your 2027 drug payments (bundling, rate cuts) and resource ODACS accordingly.

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WEBINAR OUTLINE

Introduction and Overview of New Changes and Impacts for Healthcare in 2026

- PYA Moderator introduces the webinar and the topic: Happy New Year, New Proposed Rules, New Payment Models, New Guidance.
- Martie Ross thanks the audience and introduces Valerie Rock, who will cover telehealth changes, global payment reforms, and skin substitutes, while Martie will discuss care management and wellness.

Legislation and Government Shutdowns

- Martie Ross discusses the legislative history leading up to the Consolidated Appropriations Act 2026 (CAA 26).
- Martie explains the legislation includes funding for Health and Human Services (HHS), Labor, Homeland Security, and Education.
- She notes the overall funding for HHS is $116.8 billion, a slight increase from the previous year but more than the President's budget request.
- Martie highlights that CAA 26 restricts the Secretary's ability to restructure the agency and prohibits unilateral cuts or defunding of major programs.

Healthcare Extenders and Provisions

- Kathy Reep discusses the healthcare extenders included in CAA 26, such as Medicaid disproportionate share cuts and Medicare telehealth program extensions.
- She explains the Medicare telehealth program is extended until December 2027, and hospital at home is extended until September 2030.
- Kathy details how low volume hospitals and Medicare dependent hospitals face funding uncertainties.
- The presenters discuss the Gypsy floor for Medicare Physician Fee Schedule, which is extended through 2028.

Medicare Advantage and Transparency in Coverage

- Kathy Reep highlights the proposed rule for Medicare Advantage plans, including changes to star ratings and quality measures.
- She explains the rule proposes to remove administrative measures and focus on outcomes.
- Kathy details how the Transparency in Coverage rule aims to improve the usability of data and requires plans to report by provider network and maintain change logs.
- She notes the rule also mandates that plans provide negotiated rates by phone and in print.

Medicare Advantage Complaints and MedPAC Report

- Kathy Reep discusses the new Medicare Advantage complaints tracking module and the importance of submitting comments on the proposed rule.
- Martie Ross mentions the MedPAC report comparing federal spending on traditional Medicare and Medicare Advantage, highlighting the $76 billion difference.
- The presenters explain the report suggests the need for reforms in Medicare Advantage.
- Martie and Kathy note that health insurance executives are scheduled to testify on Capitol Hill about the cost of health insurance in America.

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CMS Innovation Center and Alternative Payment Models

- Martie Ross introduces the CMS Innovation Center's new proposed alternative payment models, including the WISeR model for reducing drug costs and the ACCESS model for care management services.
- The Access model allows Part B providers to provide care management services for beneficiaries with chronic conditions and receive payment based on outcomes.
- The ACO REACH program is being replaced by the Lead model, which aims to address issues in benchmark calculations for providers receiving add-on payments.
- The Team Model and Ambulatory Specialty Model are also discussed, focusing on episodic payment and quality measures for specific conditions.

Interoperability and Health IT

- Kathy Reep discusses the proposed rule and withdrawal notice related to health data technology and interoperability.
- She notes the withdrawal notice removes provisions that have not been implemented due to cost and complexity.
- Kathy highlights the new rule, HTI 5, which focuses on patient access, electronic prior authorization, and public health reporting.
- She advises that the Health IT Advisory Committee is scheduled to meet in mid-February to discuss the rule's implementation.

Medicaid Work Requirements and Community Engagement

- Martie Ross discusses the initial guidance on Medicaid work requirements and community engagement requirements.
- She details how the requirements apply to the expansion population and include working a certain number of hours or engaging in community activities.
- Martie specifies the states are responsible for verifying compliance and exceptions, such as for medically frail individuals.
- She notes that CMS will issue an interim final rule by June and additional guidance to states.

Medicaid Eligibility and 340B Program

- Martie Ross explains the impact of Medicaid work requirements on hospitals' Medicaid disproportionate share (DSH) percentage and 340B eligibility.
- She advises that hospitals should run Medicaid eligibility checks as late as possible and consider programs with high Medicaid percentages.
- Martie explains the outpatient drug survey (ODACS) is required for all hospitals paid under the Outpatient Prospective Payment System to establish acquisition costs for separately payable drugs.
- She notes that non-responders to the survey may face future payment rate reductions.

Conclusion and Next Steps

- Martie Ross and Kathy Reep both thank the attendees and remind them to reach out with any additional questions.
- PYA Moderator provides contact information for further questions and mentions that slides and recordings of the webinar are available at pyapc.com.

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