Let's Get Rural #2 Webinar Transcript

2025 Regulatory Update and Final Rules

Presented December 5, 2024

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SPEAKERS

Martie Ross, Kathy Reep, Colton Hager, PYA Moderator

SUMMARY KEYWORDS

2025 Final Rules, Medicaid cuts, regulatory update, telehealth waiver expiration, telehealth, telebehavioral health, maternal health conditions of participation, MPFS provisions, rural emergency hospital, REH, vaccination billing, USDA Community Facilities Program, disproportionate share, critical access hospitals, pay go reduction, price transparency, site neutrality payments, physician fix, off-campus providers, Medicare Advantage, 340B, safety from violence, rural health, facility financing, 1557 anti-discrimination, HIPAA, privacy rule, TEAM, Loper Bright, G2025, EMTALA sign

WEBINAR SUMMARY

The webinar covered regulatory updates and 2025 Final Rules for rural healthcare providers. Key points included the expiration of telehealth waivers on December 31, 2024, unless extended by Congress, and the continuation of telebehavioral health services with new requirements. Changes to RHC telehealth billing and care management services were discussed, including the transition to CPT codes and the impact on reimbursement rates. The new maternal health conditions of participation were highlighted, with compliance deadlines in 2025 and 2027. The USDA Community Facilities Program was presented as a funding solution for rural hospital capital projects, with a case study of DeSoto Regional Health System's $50 million renovation. Kathy Reep and Martie Ross discussed the potential financial impacts on hospitals due to Medicaid disproportionate share hospital cuts, which could result in a $32 billion reduction over several years. If not addressed, hospitals might face a 6% sequestration, on top of the current 2% sequestration. They also touched on the implications of lame-duck legislative actions, including price transparency and site neutrality payments. Concerns were raised about the potential use of hospital payments to fund physician fixes and the elimination of grandfathering for off-campus providers. The conversation concluded with a reminder to complete a survey for CPE credit and a reminder to stay on the line for additional information and questions.

The webinar covered 2025 updates and Final Rules, specifically for rural healthcare providers, focusing on 11 key topics:

- Provisions in 2025 Medicare Physician Fee Schedule Final Rule impacting rural health clinics
- Telehealth update
- Rural Emergency Hospital program update

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- Respiratory disease reporting requirements
- Maternal health Conditions of Participation
- New anti-discrimination regulations
- Impact of new TEAM Payment Model on rural providers
- Changes to HIPAA Privacy Rule
- Price transparency update
- Medicare co-insurance for critical access hospitals
- Impact of Supreme Court's *Loper Bright* decision

ACTION ITEMS

- □ Review and update policies and procedures related to the new 1557 anti-discrimination regulations by July 5, 2025.
- □ Train staff on the new 1557 anti-discrimination regulations by May 1, 2025.
- □ Reach out to legislators to address the potential impact of the TEAM model on critical access hospitals with swing beds.
- □ File complaints with CMS regarding issues with Medicare Advantage plan denials and adherence to coverage policies.
- □ Engage with USDA regional offices to explore capital financing options for hospital replacement or renovation projects.

TRANSCRIPT

PYA Moderator **00:05**

Thank you for joining us. The webinar will begin shortly.

Good afternoon, everyone. Welcome to the second episode of the Let's Get Rural Webinar Series. Today's topic is Regulatory Update and 2025 Final Rules. PYA is happy to present today's webinar on this important topic in conjunction with our affiliate company, Realty Trust Group.

Before we get started with the webinar, I would like to go over a few housekeeping items. As this event is for 1.5 CPE credit hours, there are some additional steps that we'll take in order to comply with NASA's requests. Attendees will be provided five polling questions throughout today's webinar. The responses are documented electronically. Attendees must respond to these polling questions within the allotted time to receive CPE credit for this course. A post event survey will also be provided for attendees to submit regarding their webinar experience. The polling questions and post event survey must be submitted for proof of participation today.

You may submit questions during the webinar by typing a message into the questions pane of the control panel. Also immediately following the end of the webinar, you'll be asked to complete a short survey and submit any additional questions. We will respond to questions posed after the webinar via email.

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We've posted in the handouts pane of the control panel a PDF copy of the slides for your reference. Also, you'll receive an email later today with a copy of the slides and a recording of the webinar.

With that, I would like to introduce our presenters, Martie Ross and Kathy Reep of PYA, and Colton Hager of Realty Trust Group.

Martie Ross **02:19**

Great. Thank you, Jennifer, and thank you for joining us for the next 90 minutes to talk about the impact of federal rules and regulations on rural providers. I am Martie Ross. I'm with PYA in our Kansas City office, although today I'm actually joining you from beautiful western Kansas. I'm joined today by Kathy Reep, based in Orlando; and Colton Hager, who is with RTG, based in Dallas. So, let's get rural. Where did this come from? Kathy and I may look familiar to some of you, because every month about, well, twice each month, PYA presents the Healthcare Regulatory Roundup webinar series, and it's often Kathy and me, but also many of our colleagues here at PYA often serve as presenters. But we appreciated that that webinar series really doesn't allow us the opportunity to take a deeper dive into issues that impact world survivors. So, twice each year, generally in June and now in December, we will focus in on rural-specific issues.

But for your reference, if there are topics of particular interest to you, we maintain on our website recordings of all the webinars, plus the slides, and then also they are available on Spotify and Apple podcast for those of you that want to listen while you work, shall we say. But we generally cover in healthcare regulatory Roundup, all of the proposed and Final Rules as well. Take a deeper dive into certain regulatory schemes, like this year, we did 340 B in detail. We took a deep dive into MIPS. So, hopefully we're providing some content that's helpful, we are always open to suggestions. So, if there's topics you'd like us to take a deeper look at, we'd be very pleased to do so. PYA is commitment to supporting rural providers is reflected in our Center for Rural Health Advancement. That's our vehicle to bring together our experts at PYA, be that reimbursement or strategy or compliance or clinical performance improvement, and we look at issues through a rural lens and how we can right size services, right size solutions for rural providers. And that's why we're really excited to have Colton join us today with RTG and take a deeper dive into facilities critical access hospitals in particular, that are considering building replacement facilities and some of the options that are available to those facilities. But that's your reward for making that through what's proven to be a very lengthy agenda.

In the spirit of the holiday season, we have put way too much on our plate, and we probably won't get through all. But we'll try our best. As Jennifer noted, you've got a copy of the slides that are in the handout section. We email the slides to you after the webinar presentation along with the recording. So, the slides are dense. I'll admit that. I'll be the very first to admit that they're going to be dense today, but they're really intended to help be a helpful reference tool for you after the fact.

So, with no further delay, let's jump into our first topic today, which is, everyone guessed it, telehealth. What's going on in telehealth today? A lot of uncertainty, I think, is what's going on in telehealth today. We're going to talk specifically about Medicare coverage for telehealth services. So, the statutory provision that defines when Medicare covers a service delivered via telehealth is Section 1830-4M of the Social Security Act, and it poses five specific requirements that must be satisfied for Medicare to cover telehealth services. And the two that are most significant are referred to as the geographic restriction and

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the originating site restriction, meaning that only if the individual resides in a rural area geographic and is physically present at a facility at the time the services are being delivered, the originating site recover requirement, that is when Medicare will provide telehealth services. Well, if you remember, like we all do, March 17, 2020, CMS announced, pursuant to congressional authorization, that it would be waiving the geographic and original site requirements during the pandemic. And those waivers, through congressional action have been extended, but now are set to expire on December 31 2024 absent some congressional action during the lame duck session.

So, what does that mean? Specifically with respect to medical telehealth services, that means coverage is now going to be limited to beneficiaries that are residing in rural areas, that are physically present at a specified facility at the time the service is provided. So, a critical access hospital, rural health clinic, and FQHC, a skilled nursing facility, but not in the home, the coverage for telehealth services furnished in the patient's home will be discontinued. What will continue, however, is coverage for telebehavioral health services. Back in the Consolidated Appropriations Act 2021 Congress permanently waived the geographic and originating site restrictions with respect to telebehavioral health services, and so they will continue to be covered. Note, however, the beginning in 2026 again, absent any congressional action, there will be a prerequisite for coverage for telebehavioral health services that there must be an in-person visit within six months of the initiation of the telebehavioral health services with the provider. Again, that the that was actually a provision in the Consolidated Appropriations Act, but we've kicked that can down the road. And so that will only become that will become effective on January 1 of 2025 again, absent any congressional action. I think I may have misspoken there, because I think I said 26 and 25 in fact, the service, the in-person visit requirement, will be in effect for patients new to telebehavioral health services on or after January 1, 2025. So if you're providing the telebehavioral health services now there's no retrospective requirement to do an in-person visit.

There is some good news that from the Final Rule that CMS published the telehealth provisions typically are in the Medicare Physician Fee Schedule Final Rule. The first is that medic that CMS is maintaining its expanded list of telehealth services back to 1830 4m only services that have been identified by CMS can be considered for coverage when delivered via telehealth. We started with about 100 services at the beginning of the pandemic, expanded out to about 250 and CMS has now decided to maintain that entire list of telehealth services. Some are deemed permanent, some are deemed provisional. It doesn't matter for purposes of coverage right now, provisional just means that CMS is still going through the process validating the evidence to support delivering the service via telehealth. Change in the rule with regard to audio only visits again during the pandemic and this subsequent period, following the end of the public health emergency, there have been specific EDM codes that we've utilized to provide services audio only, and there have been certain services that CMS has designated as being covered. If they're furnished audio only. Our issue here is that the statute says that to be covered, service must be delivered via audio visual connection.

So, CMS in the final in the final position fee schedule rule this year came up with an interesting solution. It's now in the implementing regulations for 18304M CMS now says that a service can be covered as telehealth, when furnished audio only if three things are true. The first is that the patient is actually receiving the services at home, so they give your telebehavioral health services. Secondly, the provider, in fact, has audio visual capabilities. So, they can do audio visual, meaning, basically they have one of these right. And then third, the patient either lacks that video access, so challenge, internet challenges, for example, or the beneficiary expresses a preference for audio only.

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So, now, if those three conditions are present, we will have coverage for telehealth services delivered audio only, without regard to the specific service involved. For billing purposes, you're going to include modifier 93 when the service has been, is, delivered in such a manner. And again, this applies to medical services as well as telebehavioral health services. Also in the Final Rule, CMS gave us a one-year extension of virtual direct supervision. As you know, direct supervision typically requires physical presence the billing practitioner at the time that the auxiliary staff is furnishing the service. But since the beginning of the PHE we've allowed that supervision to be done virtually, meaning the auxiliary staff could can immediately speak with the position on the phone. The position is on the phone at the time, but they are available via smartphone for connection. CMS is extending for one more year that virtual supervision exception, it has indicated that it is seriously considering a permanent change to the rule, but we're not there yet. We are, in part, however, because they have made permanent virtual supervision, but only for a narrow class of services. It's when a serve the auxiliary staff is actually an employee of the billing practitioner, and it's certain diagnostic services that are provided that will now have a permanent virtual drug supervision allowance.

Finally, and this isn't CMS, this is actually our friends at the Drug Enforcement Agency. They in couple weeks ago, sometimes in November, they finally published a rule stating that they would continue for one more year, the waiver of the in-person requirement for prescribing controlled substances, meaning that practitioners may continue prescribing controlled substances based only on telehealth services. There is no face-to-face requirement, and we'll see where that goes, but we at least are in one more year of that requirement not being that gets us to polling question number one. Jennifer, back to you.

PYA Moderator **13:16**

All right, the first question is: I predict that Congress will not extend telehealth flexibilities; Congress will extend telehealth flexibilities for one year; Congress will extend telehealth flexibilities for two years; or Congress will permanently extend healthcare. Excuse me, telehealth flexibilities. Remember, you must fill out the polling questions in order to receive CPE credit, and you will have approximately 30 seconds to answer you.

PYA Moderator **14:13**

Thank you for participating in our poll. Now I'll hand it back over to Martie.

Martie Ross **14:20**

Well, a few of you are not feeling particularly optimistic, about 20% of you are not. Have little faith in Congress to extend the telehealth flexibilities. The issue we're dealing with is that it costs money. The Congressional Budget Office says there's a $4 billion price tag associated with extending telehealth coverage for a period of two years, and Congress, because of pay go requirements, has to find the money to pay for that. So, something will happen, we hope during the lame duck session. I don't think I want to watch because it's sort of like sausage making, right, Kathy? But we'll certainly stay tuned on that. You. There. We all back it together. Yes, okay, sorry about that. It's whenever I come out of the polling question, I've got to make sure I once again reconnected to the slide advancer. Sorry, way too much detail.

Topic number two. Let's talk about RHCs and what happened in the final position fee schedule rule this year. Several things. This was a banner year for RHC regulation within the position fee schedule. We'll

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start with you. There we go, telehealth services. So, the rules regarding when RHC provides telehealth services, when those are covered, are different than the rules we just discussed at the top of the webinar. So, for an RHC when they provide telebehavioral health services. This is now considered a covered RHC service, and it is reimbursed as an RHC visit, meaning that you're going to be paid at your air for that service. The requirements here are that the service you are providing, the telebehavioral health service you are providing is one of the services that had been identified by CMS as a covered telehealth service, and again, the use of audio-visual connection.

Again, remember the rule we just talked about, the change in the implementing regulations in 18304M don't apply to RHCs. So, this is separate regulatory provision, which now says that that views an audio-visual connection, unless the patient does not want to or cannot connect visually. And then this is the additional requirement would be that face-to-face requirement, have you seen the patient within the last six months? Now, for everybody else, that requirement is going to go into effect on January 1 2025 for RHCs, it's not going to go into effect until January 1 of 2026, so we have more time to establish those internal processes with an RHC so the patient's actually being has a visit with the clinic before the initiation of the telebehavioral health services.

Or I am having a heck of a time with the advancers here. There we go. Medical, oops. Went too far. Sorry about that, high-end technology for me. Let's talk about RHC, telehealth services for medical services. There's a separate reimbursement methodology that CMS created during the pandemic, which allowed an RHC to provide a service via telehealth. But rather than being paid at their air they are instead reimbursed under G2025, and that code reimburses at about $95 regardless of the services being provided via telehealth. It's all going to be evened out at that $95 rate. Again, it's lower than your typical air. Also, keep in mind that RHCs can continue to build the originating site fee the Q 3014 that's reimbursed just at about $30 this is when a patient comes to your facility, and they receive telehealth services from a distance site. So, the specialist in the urban area is providing services to your patient who's physically present in the RHC. In those circumstances, you'll be able to continue to Bill 3014 second significant change for RHCs as well as FQHCs.

In addition to those telehealth changes, are how you bill for care management services. So, today, in 2024 when you provide those non-face-to-face services, they are billed under G0511, which is the general care management code, and the service you provide meets the requirements of one of these listed care management services you can build G0511, if you provide more than one of these services, say you do both chronic care management and remote patient monitoring. In those circumstances, you'd build two units of G0511, the reimbursement rate for G0511 is based on an average reimbursement for the services that are covered listed above 2024 it's just shy of $73 separately.

CMS also reimburses RHCs and FQHCs that provide psychiatric collaborative care model that's billed under 50A0512, it reimburses right at $147 and that again, can be billed once a month for 2025. CMS is discontinuing the use of 0511, and now RHCs and FQHCs will bill using the CPT code for the service they are providing. And again, there you see on the screen the complete list of services for which an RHC or FQHC can bill. But now they're going to be billing that not under OG511, but on the applicable CPT code for the service that's delivered. The reimbursement then will be at the non for those non-face-to-face services will be at the National non-facility payment rate. The question, I think that's still outstanding to be announced, is, will the copayment owed for those services be based on charges, as is typically the case for RHCs, or will instead be based on this Medicare allowable?

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So, stay tuned. I don't think that was addressed in the Final Rule, appreciating that all RHCs and FQHCs may not be prepared for this change. CMS is allowing a six-month transition period, meaning that you can continue to bill for these services under G0511, through the end of June; however, important to note that this is not a clever way to keep the higher rate of reimbursement, because CMS, CMS for 2025 has reduced the reimbursement on G0511 to just shy of $55. So, it goes from $73 down to $55 if you bill it, if you elect to continue to build G0511 it's an all or nothing proposition. So, the first time you bill, the first time you build a CPT code instead of the G0511 you're done with G0511 separate and apart. However, the psychiatric collaborative care bottle will continue to be billed under G0512.

As you can see at the example on the screen that generally this change to the CPT code, if any instances, is going to result in a reduction in reimbursement. The one issue where there is an opportunity for increased reimbursement is if you are billing more, if you're providing more than 20 minutes of chronic care management services or RTM treatment, treatment management services, because you now can bill those add on units. So, it's 994, 90 plus 994, 39 and you'll see that that would result in higher reimbursement than you would have received under previously, having just billed the single Geo, 511, just because it's concerning to me, there's a discussion I want to make highlight a discussion in the Final Rule, in response to comments that were Raised by RHCs concerned about this change, that they're going to be seeing lower reimbursement for many care management services. And CMS response to that was, well, they're going to get the national non facility payment rate, and we set those based on costs, so it should be adequate, disregarding the fact that we created the RHC program because the costs in those clinics is higher than it would be in regular physician practices. So, some concern about the attitude here that CMS is showing and making this change on care management.

Next up are the changes to vaccinations, again in 2024 today, when you do flu, pneumonia, and COVID, 19 vaccines, you're paid at 100% of reasonable costs, and that's accomplished through the cost report. And if you provide the hep B vaccine in RHC, it first requires a physician order, and also, generally, you're reimbursed, not separately on the cost report, but it's generally included in your air or PPS reimbursement. We're going to see a significant change in 2025 not until June 30. I mean, well, effective July one. Put it that way, you now will bill for these Part B, vaccines, including hep B, as well as vaccine administration at the time of service. You can also, then also bill for the additional code for in-home administration now, because there's a statute that requires that RHCs be reimbursed at 100% of costs for vaccine, and a vaccine administration will still do the true up on the cost report, but rather than you having to wait for that cost report reconciliation to get paid for vaccines, you'll now get that regular reimbursement as you submit claims.

CMS promises that will be issuing additional guidance, specifically cost report instructions in early 2025 well in advance of the March, effective July 1 deadline for this new service. Also note some change. For the conditions of certification or coverage for rural health clinics, eliminating the more than 50% requirement of services that are focused on primary care, thus allowing broader latitude, and performing specialty care services within RHC. Finally eliminating the RHC productivity standard, because it's effectively been null and void, given the matter of reimbursement we've had, but they're officially taking it off the books. And there's also some changes to the requirements with regard to clinical lab services report performing RHCs.

That gets us to Topic number three, the rural emergency hospital program update. So, where are we with conversions over to this new category of rural emergency hospital, the hospital without inpatient services

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that's reimbursed on the OPPS plus 5% the predictive modeling prior to the effective date of the program, January 1 2024 predicted around 68 hospitals That would convert to REH. Where we stand today is at 31 hospitals that are REHs. Interestingly, there was a conversion in Mississippi that got reversed when the regional office realized that the facility was actually located in a metropolitan statistical area and thus didn't qualify as rural. So, they went all the way down that road and then found out, oops, that they would have to convert back to their prior status. But there are 31 RHS as of today.

Kathy Reep **26:25**

Interestingly, 32 because a Texas hospital converted this week.

Martie Ross **26:30**

This week. Oh, well, there you go. Excellent. Back to 32 I guess that's the right number.

Kathy Reep **26:36**

I'm sorry, Tennessee, Tennessee.

Martie Ross **26:38**

Okay, sorry, Texas. Can't get credit for that one. As you can see, Texas, and Texas has been the most aggressive in terms of the number of conversions, but interestingly, more PPS hospitals than car hospitals, and we'll talk about this more when we talk about the lame duck session.

We are also on the brink of losing the low volume hospital adjustment as well as the Medicare dependent hospital program, because those both need to be renewed prior to January 1 2025 if Congress doesn't act, are we going to see even more PPS hospitals having to elect for REH status, given their financial woes. It's interesting to note that in 2023 we had eight hospitals closed. Of those eight hospitals, four were not eligible to convert to REH, so the solution that was promised to be the, you know, the solution for hospital closures and communities no longer being served is only working 50% of the time.

The other challenge we have is that we have a lot of hospitals that have not yet passed authorizing legislation that one of the requirements for REH conversion is that your state law has to recognize the REH as a hospital. And according to the National Conference of State Legislatures, only 18 states have done that thus far. So, if you are in a state that has not yet implemented that legislation, and that there are hospitals eligible and considering REH, it's important that, as we now start legislative sessions the beginning of the year, that that somehow get on their radar screen. I won't go into detail. These are familiar the problems with the REH program. There's, you know, you can't this isn't an option. If the hospital closed prior to 2021 you lose your swing beds, you lose your 340 B. There's all sorts of open questions regarding, who How are you going to get reimbursed by commercial payers or by state Medicaid programs? There's just the practical issues of, how do you reduce costs after you close inpatient beds to meet the gap? All of these are questions to be addressed. A lot of folks are predicting that the new Trump administration is committed to expanding the REH program. So, hopefully we will see some solutions in the form of new legislation working its way through Congress quickly, hoping it's hope it's going to be in the lame duck session, but we'll see what happens there.

So, that gets us to polling question number two, Jennifer.

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PYA Moderator **28:59**

All right, the second question is, my organization has converted to REH is considering conversion to REH has ruled out conversion to REH, or is not eligible for conversion to REH, remember, you must fill out the polling questions in order to receive CPE credit, you will have approximately 30 seconds to answer.

Thank you for participating in our poll. Now back to Martie Ross.

Martie Ross **30:00**

Right? We've got some 6% of you are REH currently at REH is we're glad to have you joining us today. But as you see, kind of a mixed bag in terms of where we are with this program, which isn't necessarily surprising, those. Kathy, there you go.

Kathy Reep **30:24**

I'm going to move forward with price transparency and a few other short topics, but couple of things on the price transparency. Next slide, that I just wanted to remind folks of, and that is the requirement for a compliance attestation. They attestation essentially indicates that, to the best of its knowledge and belief, the hospitals included all applicable standard charge information in accordance with the requirements of 45 CFR one, 80.50 and the information include encoded in this machine-readable file is true, accurate and complete as of the date indicated on this file. Please. This is being certified to as a part of the encoded document that you have posted on your website. You've indicated true because it won't be accepted if you have said false. But I urge individuals within the organization to take a look at the information that has been posted, not rely solely on an outside firm to have posted your data and have checked off that it is true. Make sure that that is this is spot checked in terms of the actual accuracy of your charge information that all of your payers and plans are properly identified. It is very easy to have a simple typo that makes thing makes things totally unreliable as far as your data goes, whether this be an exorbitant charge for a particular service because of lack of a decimal place, or improper coding of revenue. Codes for services are provided. Someone does need to spot check this information because it is being reviewed by other entities.

On the next slide, you see that there were some requirements that we are facing as of January 1, 2025 coming very quickly. This is the requirement to include an estimated allowed amount for any payment contracts or payment arrangements that are based upon an algorithm or any type of a formula. And this is actually going in and looking at your historical reimbursement for that particular service from that particular payer. It is not, CMS has not said, use this as your source for that, but they have indicated that using the electronic transaction standard 835 would be an appropriate way to go back and get historical information. If it is a new contract and you don't have historical data, then CMS has said, fill it with nine nines, and that would until you actually have correct information. They have also required as of January, for any pharmaceutical items, drugs that you have included in in your standard charge file, that you include the unit of measurement and the type of measurement for those particular for those drugs, whether it be grams or whatever the dosage might be that be clearly indicated. And finally, if a modifier is going to impact the actual standard charge of a service, think about the modified modifier for a bilateral service, then you're also going to need to include those modifiers and the impact that those modifiers have on your payment rates.

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If we look very quickly on the next slide at compliance. This is from Turquoise Health, and this was run as of November 8. Hospitals were at 48.1% compliance, meaning both having posted their machine-readable files, their txt file adoption. This is that image where you have your domain name with a txt file and the version 2.0 schema, either a JSON schema or a CSV format. 48.1% met the requirements. As of today, it is 49.7 so we're plugging along. However, I want you to know that our friends at patientsrightsadvocate.org have just released a report as well. They are indicating that overall compliance is at 21.1%, down from 34.5 In February with the old rules, but hospitals are 21.1 and they have also come out with a new measure. It is called a pricing data sufficiency measure, which we're scoring at about if you look at pricing data sufficiency plus the requirements to post in the new format, we're at about 6.7% compliance. PRA essentially said that for many hospitals, the way they have posted the data, they have up, they have obfuscated prices behind estimates, averages, and algorithms. I thought that was what we were told to do, is to show an estimate, historical average, etc. So, who knows?

Martie Ross **35:55**

Kathy, one thing before you go on, but you say hospital in this context here, including critical access hospitals….

Kathy Reep 35:59
Talking all hospitals, yes. Polling question number three, I think, is coming up.

PYA Moderator 36:07
It is. Our third question is…My organization: Is compliant with the new price transparency requirements. Is not compliant with the new price transparency requirements. May be compliant with the price transparency requirements. I'm unsure, or, is not subject to current price transparency requirements. Remember, you must fill out the polling questions in order to receive CPE credit, you will have 30 seconds to answer.

Thank you for participating in our poll. Now it's back to Kathy.

Kathy Reep **37:04**

Okay, I like that. 46% you're more in alignment with what turquoise has said, and definitely not in line with what PRA patient rights advocate has said.

The next slide just really gets into a review of those requirements for January 1, but we did touch on those already. So, let's talk about EMTALA. We want to keep, or maybe someone wants to keep, the sign makers in business. So, we do have, as of August of this year, updated language for the EMTALA signs that you have posted within your hospital in those areas where patients are waiting to be examined or treated for a perceived medical emergency/medical condition. Remember, this is prudent layperson definition. So, if those patients are waiting for care because of concern with an emergency, you need to be looking at posting this new sign. The main thing that this sign does, is it release it. It provides information to the patient about, if they have a complaint about their rights having been violated, how they should take action in terms of addressing, getting someone to address their complaint for not having received the appropriate level of care. The current it's the law this goes away, and now we need to start looking at the new model signage.

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Martie Ross **38:38**

Kathy, I was in an ER with a family member earlier this week, and as I am want to do, I was checking and they only had the, it's the law notice. I felt compelled…you know, I didn't…but I felt compelled that they need to get the if you have an emergency sign. But okay.

Kathy Reep 38:53
And I want you to know that Martie also has the story of finding a sign behind the vending machine, so please look for your signs. Update them.

Martie Ross **39:03**

It's good, good for the compliance officer always to walk around the hospital and check for you.

Kathy Reep **39:07**

Absolutely, absolutely. There was a notice that came out from the state survey agencies on November 20. And just a very quick, essentially page and a half document, but it's intended to really clarify some issues for critical access hospitals who have space sharing arrangements, and you have to really separate those two arrangements into either a timeshare or leased space.

So, under the timeshare arrangements, you are sharing space with another healthcare provider who is not a hospital or a critical access hospital, and that particular provider provides outpatient services at the critical access hospital using your space, your supplies, your staff, etc., and it could be CA patients or non-CA patients. And what the survey letter clarifies is that the critical access hospital is responsible for maintaining and demonstrating compliance with the conditions of participation at all times. So, if it is a timeshare arrangement, the COPs apply. However, if we are looking at leased space in which another healthcare provider who is not a hospital or a critical access hospital leases space and they don't use the supplies or the staff of the critical access hospital, then the car is not responsible for COP compliance.

So, you really need to make sure you understand the arrangement that you have with this entity, because in certain instances, you could be looking at making sure that there is compliance with the COPs and others you are not and it also at the end of this particular document, it does include a reminder that all arrangements must comply with app fraud and abuse laws. So, if you have not seen this state survey letter, I urge you to get a copy of it and make sure that those who are making the arrangements within your organization are following it.

Martie Ross **41:24**

These state survey agency letters, those directions from CMS to the state surveyors of how to apply the regulations when doing COP compliance surveys, they just pop up. There's just a little wording, and they're not they're not specifically circulated to every hospital. But it's almost, I mean, hospital, state hospital associations are great about posting these for their membership, and so just a good reminder for folks to pay attention to that those emails circulated by your state hospital associations because they really are a lifeline about knowing when these happens.

We're going to talk about another instance of that when we get to Medicare Advantage later, aren't we, Kathy?

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Kathy Reep **42:05**

Absolutely. Okay. So, last but not least for now, for me, is respiratory disease reporting requirements. And this is a new requirement for both hospitals and critical access hospitals. This was contained in the 2025 Inpatient Prospective Payment System Final Rule, and it does require weekly electronic reporting to the CDC on respiratory infections such as COVID 19, influenza, and RSV. If there were to be another public health emergency, then there would be increased requirements coming out at that time. But the information that you are going to be required, or you are required to report, is any confirmed infection amongst your patients, bed census and capacity, and certain patient demographics.

We have given you the link to the reporting guidance, but recognize that this was effective November one. So, we want to make sure that you are dealing with this, particularly as we move into this season. On the weekly reporting requirements, you are required to submit your value, your daily values, by 11:59pm Pacific Time on each Tuesday; and you would include the data for the previous week, Sunday through Saturday. You report your weekly totals for new admissions and RSV by age group. And finally, you report as a one day a week, snapshot, your bed capacity and occupancy, your prevalence of any hospitalizations and your patients in ICU with a respiratory illness.

So, this is something that you are to be doing now, and we hope you have moved forward with it.

Martie Ross **44:03**

Yeah, there's been confusion around this, because we had the reporting requirements through the PHA those finally sunset at…it was April or May, Kathy, I can't remember which…. And folks, you know, CMS said, "Well, we think you'll voluntarily report, and only about 30% of hospitals continue reporting after that deadline." So, CMS came back around and said, "If you don't volunteer, we'll volunteer you and make it mean you've been volunteer. You've been volunteered." Exactly. And since it's so obvious, you know, if you don't submit, you don't submit, I expect we're going to see some pretty rapid-fire enforcement action around this, similar to what we saw during the PhD, when hospitals….

Kathy Reep **44:41**

Right, it is a condition of participation.

Martie Ross **44:44**

Good idea. Was it speaking of conditions of participation. Thank you, Kathy. Let's talk about the new maternal health conditions of participation.

So, November 1 was a banner day for publications in the Federal Register. It was when they released the Medicare physician fees data for 2025, they also released the Outpatient Prospective Payment System rule. And in addition to talking about how we're going to pay hospitals for outpatient services, they finalized what had previously been proposed as a set of new conditions of participation, or revisions to existing conditions participation all around the maternal health crisis in the United States; and importantly, in this Final Rule, they gave us the timeframe for compliance. And while CMS may have thought it was generous in providing sort of a phased in compliance approach, there are some pretty significant

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requirements that are effective July 1 of 2025 which are going to require some immediate action by healthcare providers.

So, we actually got a set, we got one brand new condition of participation, which is an obstetrical service condition of participation. So, these are considered optional services. You don't have to provide the service to be a hospital that participates in Medicare or a call that participates in Medicare, but if you do provide the service, like emergency services, surgical services, and the like, if you do provide OB services outside the emergency department, then you are required to comply with the standards that are created for obstetrical care services. Note that this new COP would not apply to hospitals or critical access hospitals that do not provide OB services outside of the emergency department.

Second change was to the Quality Assurance and Performance Improvement COP, or the QAPI COP, as we like to say, adding new requirements relating to OB services and how you review OB services as part of quality assurance. Again, these requirements are only going to be applicable to those hospitals and critical access hospitals that provide OB services outside the emergency department. And again, I would be remiss not to say, once again, we're still waiting CMS for the interpretive guidelines for the quappy cops. There's a fun one to say four times fast! But we've had the QAPI COPs in effect since 2021 we're still waiting for the IGs to provide us that specific guidance on how to operate those programs, as well as, in fact, as well as the antibiotic stewardship programs within our critical access hospital. So, you were waiting for those. They still haven't showed up. Just to give you some reassurance, back to what we're talking about, that's maternal health.

The third change to the COPs was specifically to the hospital discharge planning COP, so this does not apply to critical access hospitals. CMS notes that cause already have the requirement to have a transfer agreement in place. So, it's not necessary to amend the COP but instead, this now requires hospitals, as part of their discharge planning process to have certain transfer protocols in place.

And fourth is the update to the emergency service COPs to address protocols, provisions, and training. It is that last change in COPs that applies to all hospitals and all critical access hospitals. So, let's talk about how CMS is phasing this in. Because I noted July 1, 2025 those emergency services COPs go into effect. In addition, the hospital transfer protocol requirements must be satisfied by that date as well, January 1 2026, so a year out, would be establishing those baseline standards for OB services, with the exception of the requirements regarding staff training. And then on January 1, 2027, two years out, that's when we have to meet the OB staff training requirements, as well as add those quality assurance program elements that address OB services. By that date, we're going to focus now in more detail on those changes to the emergency services COPs, because this is six months to and we are a dead sprint for compliance with these, there are three main requirements. And again, all hospitals, all critical access hospitals that offer emergency services are going to be subject to these requirements.

First, you must maintain protocols that are consistent with the complexity of the scope of services offered in your facility and that are consistent with nationally recognized evidence-based guidelines on caring for patients with emergency conditions. This includes, but not necessarily as limited, to OB emergencies, complications, and immediate post-delivery care. The focus here, obviously, is on OB, but the language of this COP revision is broad and talks about how you deliver all emergency services. What's critically important here is the language that requires a facility as part of its development of the. Protocols to articulate those standards and the sources for those standards that demonstrate the evidence-based nature

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of the protocols you adopt. So, this isn't just sit around the table and write a protocol. This is being able to look at the American College of OB GYN and the recommendation, recommendations they make for handling OB emergencies and incorporating those into your protocols, so that you can demonstrate that, yes, what we're doing is consistent with nationally-recognized sources. So, again, work has to be done short order getting those protocols in place.

Second requirement are the adequate provisions readily available to treat emergencies within your facility. That means you need to identify, what do we have available to our staff at the ED in terms of equipment, supplies, drugs, blood and blood products, and biologics? What do you need that are commonly used in lifesaving emergency. So, it's that maintaining the inventory and compliance with that inventory within your facility the one very specific requirement, the only thing you gotta have, they say, is a call-in system for each patient that are in emergency services treatment areas, and CMS promises that they're going to issue some sub-regulatory guidance, hopefully very, very soon, on exactly what they mean and what satisfies this requirement for a call in system.

Third requirement in this COP is the training requirement that your applicable staff are retrained, are trained annually on these protocols and provisions that you recognize. And again, this isn't necessarily "check the box" training. First requirement under training is that the governing body, your governing body, is responsible for identifying who is going to be trained and documenting that. So, yes, the survey is going to be looking for the minutes of the board meeting where the Board approved the positions that are subject to the training on emergency services, yeah. How often does your board meet? And how soon you're going to have to get this done in place to ensure completion of training by the end of June? Secondly, you need to have your training informed by copy program findings. This is sort of an odd provision to reconcile, since those QAPI requirements don't go into effect until 2027 but to the extent you have done copy work around OB around emergency services, that your training reflects the findings of those activities. Third is that you must document successful completion of training in staff personnel records, and interestingly, a requirement now that you have to be able to demonstrate your staff actually learned something from the training. That they're not just all sitting in front of screens, you know, clicking through the pages; that there must be some vehicle you utilize to show that, in fact, yes, our staff obtain knowledge with that skill demonstration. That that's post training testing, whatever vehicle you determine, but your ability to demonstrate to a surveyor that you, in fact, have your team has gained knowledge as a result of participating in this training.

Kathy Reep **53:12**

The next six months….

Martie Ross **53:13**

And doing this all the next six months. So, this is clearly works up. It's on your works up on your priority list for 2025.

Briefly, let's just review the other changes to the conditions of participation the discharge planning COP specifically, again, to hospitals. How are you going to transfer patients to an appropriate level of care to meet their needs? This is not just trans, this includes transfer from the ED to an inpatient admission, from one unit of the hospital to another unit of the hospital, and from your hospital to a hospital that provides a higher level of care. All that, how you accomplish that, who approves it, how the communication is

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documented? That all needs to be part and parcel now of your discharge planning procedures. You also need to be providing annual training to relevant staff regarding these P&Ps as well. So, that's also hooking on to this July 1 requirement. Although not specifically required, CMS also encourages hospitals to develop policies on how they're going to accept transfers of patients as well.

Next up are the new COPs and obstetrical services. They specifically go to organization and staffing. That's going to be the requirement applicable January of 2026, the delivery of services. Again, this provisions and protocols and how to handle OB emergencies. Those need to be in place as well. Again, that's the 2026 requirements. The 27 requirements is the completion of training, and you'll see the requirements for that training of OB staff are similar to those requirements for ER staff in terms of designation by the board, documentation of the personnel records, ability to demonstrate that they actually learned something.

And last but not least the changes to the QAPI COPs. Again, these are effective 2027 hopefully we'll have Caja interpretive guidelines on QAPI by then. I'm not holding my breath, but you see how, in fact, you'll need to be analyzing OB emergencies as well as engaging in at least one OB-focused performance improvement initiative on an annual basis. It can be the same performance improvement initiative over several years, but at least one active pi related to OB on an ongoing basis. And again, CMS promising some sub regulatory guidance in this area. So, it was quick. CMS put these the proposed language in the proposed COP changes in the 2025 proposed OPPS rule. We thought we'd have a breathing room, but they actually finalized them in November, and now we have these very quick compliance dates. So, what they deem a maternal health crisis, they are ready to jump on and address what they can with hospitals. There was a lot of commentary received from providers regarding these COPs saying, well, this isn't enough to solve the crisis. You know, this is a broader issue. It's just not the hospital problem. And CMS said, You darn right, absolutely. This is a multifaceted issue. It requires a multifaceted response, but this is something we can do now this we think is going to be helpful, and we intend to move forward with it.

So, let's switch gears from COPs and talks briefly here about anti-discrimination regulations. Just to be sure, this is on your radar screen. These are rules that are applicable to all providers, not specific to rural providers, but certainly important requirements that have been finalized here in 2024 there are these. Are a set of rules around 1557, to the Affordable Care Act, which prohibits discrimination in federal healthcare programs; as well as section 504, of the Rehab Act, which is the precursor to the Americans with Disability Act, that concerns the treatment and care of individuals with disabilities. The key provision of 1557 includes a broadening of the definition of sex discrimination to include discrimination, discrimination based on sex characteristics, intersex traits, pregnancy or pregnancy-related conditions, sexual orientation, and gender identity. The rule also changes the blanket abortion and religious freedom exemption from discrimination to instead require, instead to propose an opportunity for filing a notice of objection to protect the provider, and then also extends nondiscrimination to telehealth as well as artificial intelligence. The use of artificial intelligence, those of you that have been tracking AI, you know one of the concerns we have to deal with is AI is blind, and AI tends to incorporate discriminatory standards as part of their algorithms. And if you are using AI, are you taking appropriate measures to ensure that that does not then seep into some discrimination in the manner in which you provide services? There are also a number of administrative requirements that are now in effect around 1557 including the appointment of a 1557 coordinator, the implementation of policies and procedures, the completion of training, as well as compliance with notification requirements.

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Just to note, I thought this was on the slides, Kathy, but I got Kathy and Colvin, I guess I didn't mention this, there has been litigation around the inclusion of gender identity in the definition of sex discrimination. There is, at present, a nationwide preliminary injunction that prohibits HHS from enforcing the 1557 requirements with regards to discrimination based on gender identity. So, we'll see how that moves forward. Now in the Trump administration, the 1557 rule has been sort of watching a ping pong game, because there were the Obama administration rules, and there were the Trump administration rules, and there were the Biden administration rules. I suspect we're going to have a second one of the Trump administration rules. But as it stands now, these regulations are on the book, and they require compliance.

Kathy Reep **59:27**

Martie, go back one slide.

Martie Ross **59:29**

Yep, I'll try Yep.

Kathy Reep **59:32**

We must implement policies and procedures by July 5, but we must train on the policies…is that May 1 2024, 2025…

Martie Ross **59:43**

That would be 2025, Kathy.

Kathy Reep **59:46**

Thank you for pointing out, I've got to train on something that I haven't implemented yet.

Martie Ross **59:51**

Yep, that's how the reg reads. I don't have a solution for that, but that's how the regulations….

Kathy Reep **59:55**

Just wanted to clarify that that should be May 1, 2025 but it is. Still before you've implemented the policies and procedures.

Martie Ross **1:00:02**

Yeah, I know we've gone through this quickly. I just want to highlight that make sure the appropriate folks in your organization are aware of these requirements, are working towards compliance with these requirements. The new notice of nondiscrimination requirements went into effect on November 2. So, it's yet another posting in your facility of a notice. Since delivery of a notice to individuals, we also have to make sure those processes are in place. The other rule, which has got lost less attention than 1557 is the 504 Final Rule, again, 504 dates back to 1972. They haven't updated the regulation since 20 years ago. And finally, we came back in the office for civil rights within HHS, and was addressing, you know, how you provide treatment to individuals should not be impacted by their disability unless it has a direct bearing on the matter in which you deliver care. And there's a in the Final Rule, CMS went, Excuse me. OCR

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went through the comments. They talk about some of the egregious circumstances in which they were aware, where they cited providers, altering the manner in which they provided care, altering what care was available to individuals with disabilities with which and when, in fact, they did not impact the care provided. You need to make sure, if you're using self-service kiosks, that you've afforded an opportunity for individuals who may be vision impaired, that they are not in any way discriminated against, and thus because they can't use a registration kiosk, for example. And importantly, though, it's a long-term issue, providers will now be required to ensure that their web content, as well as mobile apps, comply with the Web Content Accessibility Guidelines though WCAG, 2.1, AAS. There's some specific exemptions for certain content, but that compliance is going to be required by May of 2026. The reason to pay attention to this now is, if you are doing a website update, make sure with your vendor that they are aware of this requirement in terms of Web Content Accessibility, because this isn't something you can decide to work on May 10, 2026 and expect to be compliant. And again, this is public facing web content, very easy for OCR to monitor compliance going forward with this.

The other and last piece of 504, we want to talk about is the MDE requirement, medical diagnostic equipment. So, MDE is defined as stuff like medical exam tables, weight scales, dental chairs, radiology equipment, mammography of machines and the like. So, it's equipment you use for the purposes of making a patient diagnosis. 504 requires now that as of July 8, 2024 the MD you have a facility in your facility must meet certain accessibility standards. They're referred to as the MDE standards, up to the point that your scoping requirements are satisfied. The scoping requirement says at least 10% of the equipment you have in your facility, of a certain type of equipment, like a weight scale, has to meet the MDE accessibility, excuse me, the MDE standards. And if you don't have 10 of something for 10%, at least one unit needs to meet the accessibility requirements.

If you're a rehab facility that goes up to 20% the key here is, as you acquire new equipment, appreciating that you've got a process in place to ensure that you are meeting the scoping requirements, and at least 10% of your exam tables or weight scales are all meeting these standards. And of course, you start talking about diagnostic equipment that radio radiological diagnostic equipment that's becoming even more significant. You probably don't have 10 mammography machines, but you're if you were to replace the machine, you have to ensure that it meets these MDE standards with regard to exam tables and weight scales. If you and you haven't replaced anything in the time period, you will have to have at least one that complies with the scoping requirements by 2026; and if you are a facility, a large facility, and you've got weight scales all over the place, you can't hide all of the MDE-compliant weight scales in one room. They should be distributed across the organization. In addition, to ensure you have the equipment you need to make sure your staff knows how to use the equipment appropriately. In addition to these very specific requirements on securing appropriate MDE, accessible, accessible MDE, you are still under a more general obligation that if you have a patient who is disabled and you cannot be, you cannot diagnose the patient because you can't put them on a weight scale. Get them up on an exam table, you are still then required to provide a reasonable accommodation, such as providing treatment for the individual in their home or at some other locations that that broad accessibility requirement still applies. In addition to these very specific requirements around MDE accessibility,

Kathy Reep **1:05:21**

Let's go TEAM.

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TEAM is on the next slide, the transforming episode accountability model. Going to give a very brief overview of this. It does not apply to reflect hospitals, but it would apply to certain rural PPS hospitals.

TEAM is a mandatory five-year episodic payment model that will begin on January of 2026, so based upon when the rule came out, we essentially had about 15 months or so to get prepared for it. Time is getting quicker. Now we're closer to 12 months in terms of be preparing for TEAM, but the individual hospital that initiates an episode, either an admission or an outpatient encounter for certain services, will be held financially accountable for the total cost of the episode of care for traditional Medicare beneficiaries. This is not Medicare Advantage, but only traditional Medicare patients.

So, got a PPS hospital or that were selected based upon Core Based Statistical Areas, CBSA, by CMS. There are a few hospitals that can volunteer to be in this program. But essentially, we're going to be looking at the anchor event, which is the actual hospital encounter, inpatient or outpatient plus 30 days post-discharge or post-procedure. We're going to be looking at all spend for Medicare Part A and Part B, and comparing that to a target price, a regional target price, to determine whether or not the individual provider should be receiving increased reimbursement based upon having come in lower than the target. Or do they actually owe money because they spent more than the target? On the next slide, you can see the services that are impacted by this. Coronary artery bypass grafts, bowel procedures, and surgical hip and femur factors are inpatient only the lower extremity, joint replacements and spinal fusions are both inpatient and outpatient. Granted, I said that certain rural PPS hospitals could be subject to this program. But I also wanted to stress on the next slide the impact of this on critical access hospitals with swing beds.

CMS, said in the Final Rule, essentially that there were comments that were submitted saying how this could impact critical access hospitals who were used to receiving a patient back into their community, after they had gone and had a sad joint replacement, they came back to their local community into a swing bed.

CMS says, since cost, swing beds are exempt from SNF; PPS, they are reimbursed at a higher rate. TEAM participants have historically used utilized swing beds, and therefore they would be in a position to earn significant savings if they used a traditional sniff rather than a swing bed. I want you to really think about this. If you are a critical access hospital with swing beds, who has been receiving patients back into a community, into your community, with any of those conditions that were mentioned, and think about reaching out. This isn't effective until January 2026 reach out to your legislators and address the fact that this is, in many instances, the lifeblood of a critical access hospital. If they lose these patients in their swing beds, their communities might lose the critical access hospitals.

This needs to be addressed. It needs to be modified. So, I urge you to reach out on that one.

Martie Ross **1:09:30**

Yeah, not just your legislatures, but near referring hospitals. So, the tertiary care facility down the road, either your swing bed referrals are going to dry up. They need to appreciate shorter length of stay, quality, lower readmissions, lower part B costs associated with swing bed stays. There's definitely an economic case to be made for swing beds beyond just the important revenue it generates for the care but the critical service it provides to the community at a very efficient. Shouldn't matter. So, listen the comment about

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Kathy Reep **1:10:05**

Congress involved in this one too. Absolutely, exactly.

Martie Ross **1:10:08**

It's just, it's, it's so dismissive the language they've used. It's the equivalent of the language in the care management section for rural health clinics. Like, oh, they don't have to worry, their costs are fine when they correct. We've created these programs for the purpose of ensuring care in these local communities.

Okay, in the interest of time, very briefly on the changes to the HIPAA Privacy Rule. If you'll recall, we had expected an omnibus legislation, omnibus regulation that would significantly revise the HIPAA Privacy Rule. Instead, what we got was a limited Final Rule published in April that focused specifically on reproductive health care. The rule went into effect in June. But what I want to highlight here is the compliance date is December 23, and that's during the Biden administration, before the change in administration. So, this is something that does necessitate your attention in short degree. And sure, we have delved into this in prior webinars and the requirements, but now it is an issue of if you receive a request for production of information that would include reproductive healthcare information. If the purpose of that request is for healthcare oversight, judicial administrative proceedings, law enforcement purposes, or disclosures to coroners, it you will require these folks now to sign an attestation that their request for the information is not for a prohibited purpose, i.e. pursuing some sort of enforcement action against an individual who, in fact, received lawful reproductive health services.

So, just again, keep it on your radar that we have an effective date just a few days away at this point with that. And also note that in addition to again, change in administration that may have a longer-term impact on this regulation, there has, in fact, been a lawsuit filed down in Texas at this point. There's no preliminary injunction in place, but we'll see again how that will play out before the December 23 deadline. So, I guess pay attention. There may be more to the story coming down the pipe.

Kathy Reep **1:12:10**

The Medicare payment Advisory Commission med pack has in their 2024-2025, year, begun looking at cost sharing for outpatient services at critical access hospitals. One of the things, what they raised at a recent meeting, I believe this was their October meeting, was that call coinsurance is set at 20% of charges, and in many instances, current coinsurance is for critical access hospitals is in excess of 50% of the total payment that the critical access hospitals receive receives. There's no cap on the coinsurance that the individual is responsible for paying.

So, the questions that were addressed by the commission were essentially they asked, Should outpatient coinsurance continue to be set based upon charges in a critical access hospital? If not, should it be set at 20% of payment rate? Or should it be, should there be a cap on coinsurance, such as the one that is in place under the Outpatient Prospective Payment System? One of the issues that was raised is setting coinsurance based upon 20% of what that service would have paid in a PPS, setting the issue on this is what they were struggling to do, is to decrease the amount of money that the patient is going to pay, or their supplemental insurance is going to pay. We recognize that perhaps the payment rate, the cost of the insurance premium for the coinsurance, would either stay where it is or go down.

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But I want to make the critical access hospitals on the call realize that Medpac is not saying you should get less. They are saying that the reduction in your payment for coinsurance should be offset by an increase in the actual payments that are coming through the Medicare program. So, it is a way to help the beneficiary but not harm the critical access hospital. So, that is the approach that they're taking and what they're looking at moving on to Medicare Advantage.

A couple of things. Well, we do have a polling question before I go into my spiel on Medicare Advantage.

PYA Moderator **1:14:38**

All right, the fourth polling question is compared to last year, my organization has experienced significantly more MA plan denials this year, slightly more MA plan denials this year, about the same number of MA plan denials this year. I'm not familiar with my organization's MA denial rates. Or my organization doesn't provide services to MA beneficiaries. Remember, you must fill out the polling questions in order to receive credit, you will have 30 seconds to answer.

Thank you for participating in our poll. Now back to Kathy.

Kathy Reep **1:15:39**

All right, significantly more denials and/or you're not familiar. So, let's talk a little bit about MA and what's gone on in the last year.

The first thing that I wanted to touch base on we talked about this in previous calls, was that as of January of 2024, there were new requirements on the Medicare Advantage plans to follow fee for service Medicare coverage policies. This relates to the inpatient only list, to the two-midnight benchmark, things like that. And then, if there was not a Medicare coverage policy, the individual plan could create its own criteria, but it had to be based upon treatment guidelines and clinical literature. They had to cite the source for the for the criteria they were developing. That information had to be publicly accessible by you, me, and the patient, and that criteria had to be clinically beneficial to the individual. In many instances, the plans have not paid attention to the rules that were published effective in January of this year. CMS, in February, published an FAQ in response to some plans' questions. A simple question was, what do you mean by a local coverage determination, or an LCD can you know, I take care of patients in Florida? Can I use a Kansas policy? Is that local enough? And CMS response responded, No.

So, we've given you the source for this particular document, and we urge you to print a copy, keep it on your computer when you have a problem with a plan, look at this. Cite it in a letter to them. Recognize that they have been told by CMS very clearly what they are required to do.

Skipping a slide. And let's look at the compliance. This is as an example two-midnights. We have the policy that essentially says that a patient who has an expectation of a two-midnight stay, and it is documented by the physician that there is an expectation and why should be covered as an outpatient, observe as an inpatient. However, this information came from Kodiak that essentially looks at the average length of stay in observation for a Medicare Advantage enrollee compared to traditional Medicare. 14.9 days versus 3.7. So if the physician expected two-midnights, the patient should have been an inpatient.

Skipping on over to the issue of complaints. We really want to stress this.

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CMS has released information that is and tracking this down is very hard to do, but they have essentially said that if you have a complaint against a Medicare Advantage plan, you need to file that complaint with CMS. You must first go to – and this is only going to be in the case of a payment dispute, not a where they failed to – this is going to be a payment dispute where you have then gone to the plan and you have argued the appropriateness of payment, or when they have not followed the normal appeals processes, things like that. In an appeal complaint, you need to document who you talk to. You need to clearly go through recognizing what that you have done, outreach to the plan. If they have not worked with you, or you're not satisfied, then you have the opportunity to complete a cover sheet, appeal, claim, just payment dispute. Cover Sheet is available at the link we've given you. You're going to file it both with the two email addresses on the slide. CMS will not accept this if you have not had previous dialog with the plan. You actually need to be identifying who you talk to at the plan and what happened. You're not providing patient you know too much patient information, but the plan that Medicare is then going to step in and help to facilitate communication between the payer and the provider. But more importantly, the number of complaints that are filed are going to come in as a part of the plans star rating measure. This is one of the areas upon which their payment rate is based, and they they're going to look at the number of entries into the complaint tracking module per 1000 members. So, if you are having issues, we urge you to follow up with these particular complaint process and get that loaded into the tracking module.

On the next slide, we have given you some information related to a no going to skip this one. Martie again, looking at time, we have a proposed rule for 2026 for Medicare Advantage. What they have done, essentially, here is taken a lot of the information that they expected that they had said in 2024 would be effective in 2025, and five or no in 2026, and they are restating a lot of it; saying, we really mean this, you can't refuse payment for an inpatient admission that you prior authorized. I mean, yes, if there's fraud involved, but internal coverage criteria, they're looking at further streamlining and tightening the controls on the plans, writing their own criteria, notification of appeal rights.

Martie and I are going to do a webinar on this particular issue, on the don't do that to me, on the proposed rule, along with what happens this month in December in DC, so that will be in early January. So, rather than spending a lot of time on these provisions, recognize that CMS is still telling the plans what to do.

Colton?

Colton Hager **1:22:17**

Thank you, Kathy Appreciate it.

We're going to change gears a little bit here and talk about capital project financing. Go to the next slide, Martie. We'll be looking at these slides into perspective really like an independent rural hospital that's in need of new facilities, either full renovations or hospital replacement. Some of the challenges that you might have familiar with rural hospital, existing facilities today, aging facility. Facilities that have increased maintenance and utility costs; not up to current building code; not up to modern standards of patient care; or, more importantly, your design of facilities simply don't align with the current business model of the hospital, business strategy of your health system. And of course, any major requirement requires major capital dollars, 10s of millions of dollars, usually to replace a hospital or renovate, do major

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innovations. And so, finding the funds and finding the fundings, the jobs available, is what we'll hit on the next slide.

Again. These are some solutions we've seen from rural hospitals, of capital solutions to fund these major capital projects. I won't hit on all these today, for the sake of time, we're going to highlight the bottom bullet here, the USDA community facilities program. It's a nationwide program for rural hospitals. In terms of eligibility, most healthcare projects fall under could be eligible under USDA includes hospitals, healthcare, clinics, but then they have a broad brush of other community-based initiatives. This program isn't limited to just healthcare. There are other community assets they also help fund. So, most rural healthcare projects would be qualified. Public bodies and community-based nonprofits or federally recognized tribes are eligible, and the community must be less than 20,000 residents.

I will know there's a priority system, given that USDA, if you are, if your community is less than 5500 or you'll be a low-income community. USDA gets a lot of applications, and so having your loan request, move with a priority is important in terms of the products they offer. This is what's really enticing about the program. Is the first one being a low interest direct loan program. Now, this excludes an interim or construction loan for a major project. This is just the permanent debt that would go on the building after it's complete. But it's a fixed rate loan, the life of the loan. And the current 2020, 24 market rates is 3.875% the great rate in today's world last year is 3.5% and then that number updates annually on January 1. And the good news is you that late that rate gets obligated to you at loan obligation, but you get the lower of the market rates, either a loan obligation or permanent funding. So, let's say you have, and you go and get your loan approved in 2026, and you get obligated at certain rates, but your billing isn't completed two years later. We need the lower of those two rates available to pick from loan terms go up to 40 years and there's no prepayment.

Fauci so this is all what's very attractive about the USDA products, and what causes applicants to pursue it. They also have a loan guarantee program. So, this allows a guarantee from USDA to commercial lending products. So, if you're thinking about a construction loan or interim loan to fund you during construction, USDA will help guarantee that loan for your lender. So, if a lender, a lender might normally not been able to or had less interest in funding a construction loan for your project, and rule setting. Well, that USDA guarantee allows them to have interest in the project. They also have various grants, but those, those depend on various eligibility requirements as well. We'll note the process to go through these loans are, it's quite intensive. It's really runs the USDA state and regional offices. So, my recommendation, if you are interested in going this route, first reach out to your state on regional office. You'll be working with them closely if you go this route. Ultimately, though, all approval processes run up to the federal level. USDA doesn't mean approval is required for all steps of the process, your contracts, your general contact, your selection, selection, your budgets, design schedule, and then you continue to monitor the project through construction. We'll note, if you've done a USDA project in the past, it's actually only gotten more review and have more underwriting than it has as a 2020, mostly when it comes to around collateral and appraisal requirements. So, you'll need to make sure you're working with a lender that's familiar with updated USDA underwriting standards. And again, it's a heavy administrative process. It could take three years or more to start from your initial application from USDA, ultimately through the through to loan closing. There’re hundreds of documents that go back and forth between your organization and USDA. So, really recommend you identify consultants or project managers of USDA experience to really support your hospital leadership. Or at minimum, have a very organized file sharing system and follow checklist diligently, because you'll need them generally the process is about three steps, with the

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third step being the longest one. But I really like this graphic here to the right. It really shows all the different parties involved in getting the approval processes needed for USDA, hospital, architect, general contractor, your consultants, your lender, all have to work together to really get this loan closed.

The first step of is a pre-application process, and they require, USDA requires, three denial letters for similar sized loans from lending institutions. So, you have to actually request a similar sized loan, either to local lenders or regional lenders and have them, you know, provide you some letter to show to USDA that this really is a loan of last resort for you to really justify USDA providing you the loan. From then on, you could go through application process which requires various documents, like a CPA, a feasibility study for from a CPA for a preliminary architecture report, which begins to outline the shape and budget of the project and timeline. Then, after your through application, USDA will review your contracts with your architect, will review all the plans and specs, your contract with the general contractor, how you went through the selection process for the general contractor, verify that you have construction financing and in various other forms that they'll track through that process.

I'll end here on a case study. This is DeSoto Regional Health System. It's in Mansfield, Louisiana, about 45 minutes south of Shreveport, currently under construction as of September of this year. There's a private, not for profit, PPS, formerly 34-bed acute care hospital with facilities that dated back from the 1950s and 1970s, really desperately in need of a full hospital renovation and expansion. Then an updated care model, which is reflected in their new project, is being built right now. The whole project, including, you know, construction costs, architect costs, consultants, attorneys, came into $50,000,000. 32 million of that after completion, is funded by USDA, three and a half percent a 35-year loan term, 4 million of that, a private bank will provide a loan to the hospital that's guaranteed by USDA, and the hospital provided $14 million equity.

With that, I will pass over the moderator for the last polling question. Thank you, Colton.

PYA Moderator **1:29:42**

All right, our final and fifth question is, which is the greatest challenge with your existing hospital facilities? Aging facilities with increased maintenance and utility costs Substandard patient experience. Facility design doesn't align with business and strategy care models. Multiple challenges. Or none or unsure. Remember, you must fill out the polling questions in order to receive CPE credit, you'll have approximately 30 seconds.

Thank you for participating in our poll. Now back to our presenters.

Martie Ross **1:30:40**

Multiple challenges.

Kathy Reep **1:30:43**

Y'all say that exactly Martie and I wanted to talk about very quickly, was lame duck priorities we're looking at this month, and essentially what Congress might do.

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We do recognize that we have a deadline of December 20 in order for the federal government to be continued funding. We'll see what happens. Do we get a short term do we get something broader? I think it'll be short term. Martie mentioned earlier that we've got to get some fixes in for telehealth and for those expiring provisions related to low-volume hospitals and Medicare-dependent hospitals. We need to have those programs continued and telehealth continuing, at least the way it is now, the docs definitely…we need to be looking at a physician fix because of the current Final Rule with a reduction in reimbursement for the physicians, that needs to be funded some way or other. Concerning in terms of how they will fund fixing that.

We recognize that under the Medicaid side, we're looking at $8 billion in Disproportionate Share. Should be DSH, rather than, sorry about that, but DSH cuts, disproportionate share hospital cuts. So, recognize that if we don't get a fix here, it's been pushed, I believe, four times now, down the road in terms of this projected $32 billion cut over a number of years. We'll see what happens and very significant for all hospitals, but predominantly critical access hospitals as well. Prior to the end of the year, if we don't get something done, or if they don't push it down the road again, we're looking at a 4% pay go reduction, which would be on top of the 2% sequestration that we currently have, it would be a 6% sequestration number.

Martie Ross **1:32:45**

So, 99% down to 95%.

Kathy Reep **1:32:51**

Right? Wow. Think about that. So, also when we look at lame duck possibilities, if not lame duck early next year extension or expansion of price transparency. Remember, all that we're dealing with now essentially came about during the as an executive order during the prior Trump administration. Martie knows that Kathy has this fear that they're going to use hospital site neutrality payments as a way to pay for physician fix. Are they going to eliminate the grandfathering for off-campus providers, or are they going to address drug administration and outpatient areas? Will Congress finally step in on Medicare Advantage prior authorizations? They keep talking about it, but have they done it? REH, Martie mentioned we've got things like 340 B that need to be addressed, and the Safety from Violence for Health Care Employees Act again. What's going to be happening over the next month?

Martie Ross **1:33:53**

As I say, never a dull moment, and especially when it comes to rural health. So, thank you all for joining us today. Colton, thanks for providing some insights on facility financing. We will be back in June with another version of Let's Get Rural, and we'll see what happens between now and then. From PYA, thank you, everyone, and Happy Holidays.

PYA Moderator **1:34:18**

Thanks to our presenters, Martie, Kathy, and Colton. Please remember to stay on the line once the webinar disconnects to complete a short survey for CPE credit. Later today, you'll also receive an email with our presenters' contact information and a recording of the webinar.

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Please remember to stay on the line once the webinar disconnects, to complete a short survey and post any additional questions you may have. On behalf of PYA and RTG, thank you for joining us. Have a great rest of your day!

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