Let’s Get Rural!

Managing Regulatory and Reimbursement Challenges

June 13, 2024

Introductions

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MIPS 101: A Refresher
HCRR #71 | Presented May 22, 2024

Spring 2024 Weather Report: It's Raining Rules!
HCRR #70 | Presented May 8, 2024

Hospital Price Transparency – Are You Ready for July 1?
HCRR #69 | Presented April 24, 2024

Managing Medicare Advantage
HCRR #68 | Presented April 10, 2024

2024 GCPG – Updates, Key Insights, & Recommendations
HCRR #67 | Presented March 20, 2024

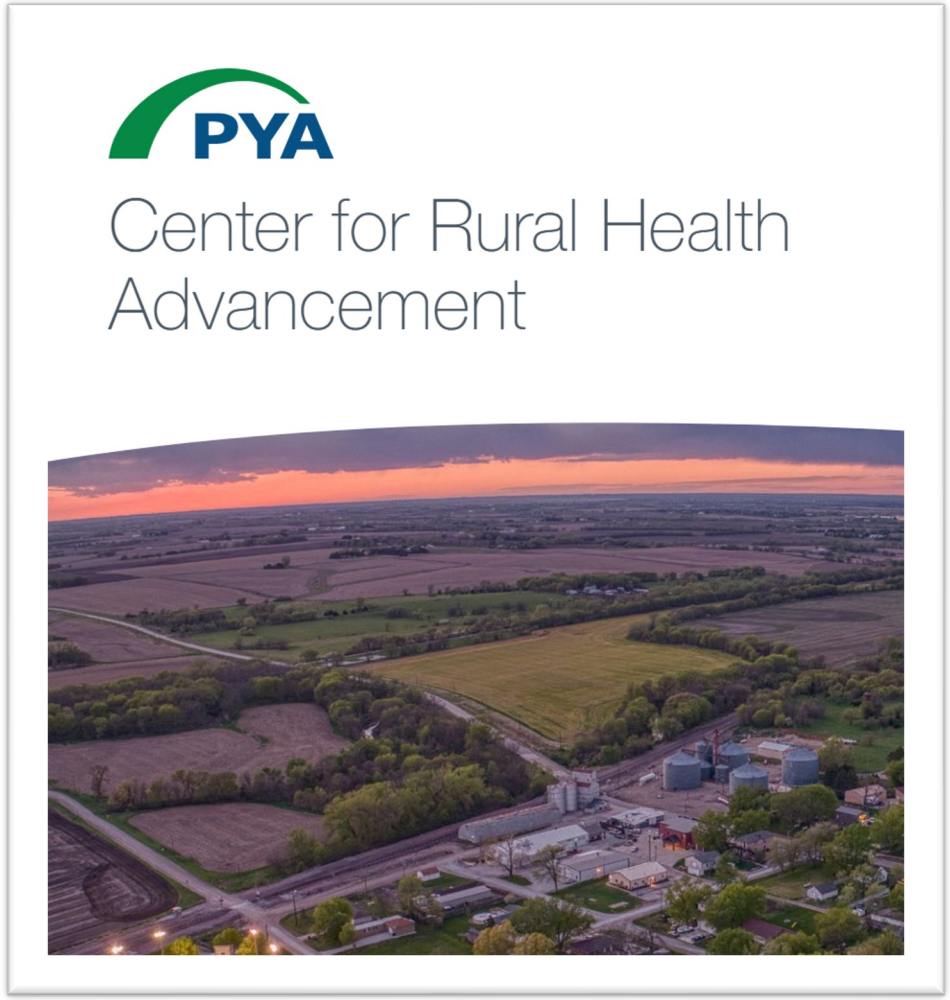
Navigating the Changing Cybersecurity Landscape
HCRR #66 | Presented March 6, 2024

Rural Health Clinic Opportunities
HCRR #65 | Presented February 21, 2024

Billing Medicare for G2211: What You Need to Know Now
HCRR #64 | Presented February 7, 2024

Coming to a Statehouse Near You
HCRR #63 | Presented January 24, 2024

2024 Physician Fee Schedule: MIPS, MSSP, and SDOH
HCRR #62 | Presented January 10, 2024



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

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

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

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

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

Today's Top Ten

1. Price Transparency
2. Section 1557 Non-Discrimination Rules
3. 340B Administrative Dispute Resolution (ADR) Process
4. Critical Access Hospital (CAH) Conditions of Participation (CoPs)
5. CAH Cost Reporting
6. Rural Emergency Hospital (REH) Program
7. Medicare Telehealth Coverage
8. Rural Health Clinics (RHC)
9. Long-Term Care Facilities (LTC)
10. Medicare Advantage (MA)

BONUS: What's Happening in DC

1. Price Transparency

Original Requirements – Effective 1/1/2021

- Executive Order (6/24/2019); 45 CFR Part 180 (11/17/2019)
  - Charge data must be posted in single machine-readable file (MRF)
    - Five types of "standard charges," i.e., regular rate established by hospital for item or service provided to specific group of paying patients
      - Gross charge
      - Payer-specific negotiated charge
      - De-identified minimum negotiated charge
      - De-identified maximum negotiated charge
      - Discounted cash price
  - Post consumer-friendly list of standard charges for limited set of shoppable services
    - Alternatively, may maintain and update annually internet-based price estimator tool
  - Both files must be updated at least annually and display date of last update

New/Revised Requirements – Effective 1/1/2024

- Hospitals must –
  - Make good faith effort to ensure information encoded in MRF is truly accurate and complete as of date indicated in MRF
  - Establish and maintain txt file as specified
    - Maintain link in footer on hospital's website (*including but not limited* to homepage) labeled "Price Transparency"
    - A TXT file must be located at root of public website that hosts MRF
      - www.yourhospital.com/cms-hpt.txt

New/Revised Requirements – Effective 7/1/2024

Encoding of Required Data Elements

- Hospital name(s), license number, and location name(s) and address(es)
- All standard charge information corresponding to each required data element in the MRF
  - CMS templates allow for comma-separated values (CSV) “wide” format, a CSV “tall” format, or JSON schema
- The type of method used to establish the standard charge
  - Location/setting (inpatient/outpatient/both)
  - Codes used for billing such as modifiers and code type (HCPCS, CPT, NDC, DRG, etc.)
  - Payer and plan (separate data elements)
    - Plans may be shown as categories (such as ‘‘all PPO plans’’) when the established payer-specific negotiated charges are applicable to each plan in the indicated category
  - Identify whether the standard charge is a dollar amount, or if the standard charge is based on a case rate, fee schedule, per diem, percentage or algorithm
    - If the standard charge is based on a percentage or algorithm, the MRF must also describe the percentage or algorithm that determines the dollar amount for the item or service

Data Validation

CMS V2.0 Online Validator https://cmsgov.github.io/hpt-tool/online-validator/

- Review uploaded MRF against required CMS template layout and data specifications
- If MRF does not conform to form and manner requirements, Online Validator will generate output consisting of “errors” and “warnings”

Certify MRF Completeness and Accuracy

Compliance Statement

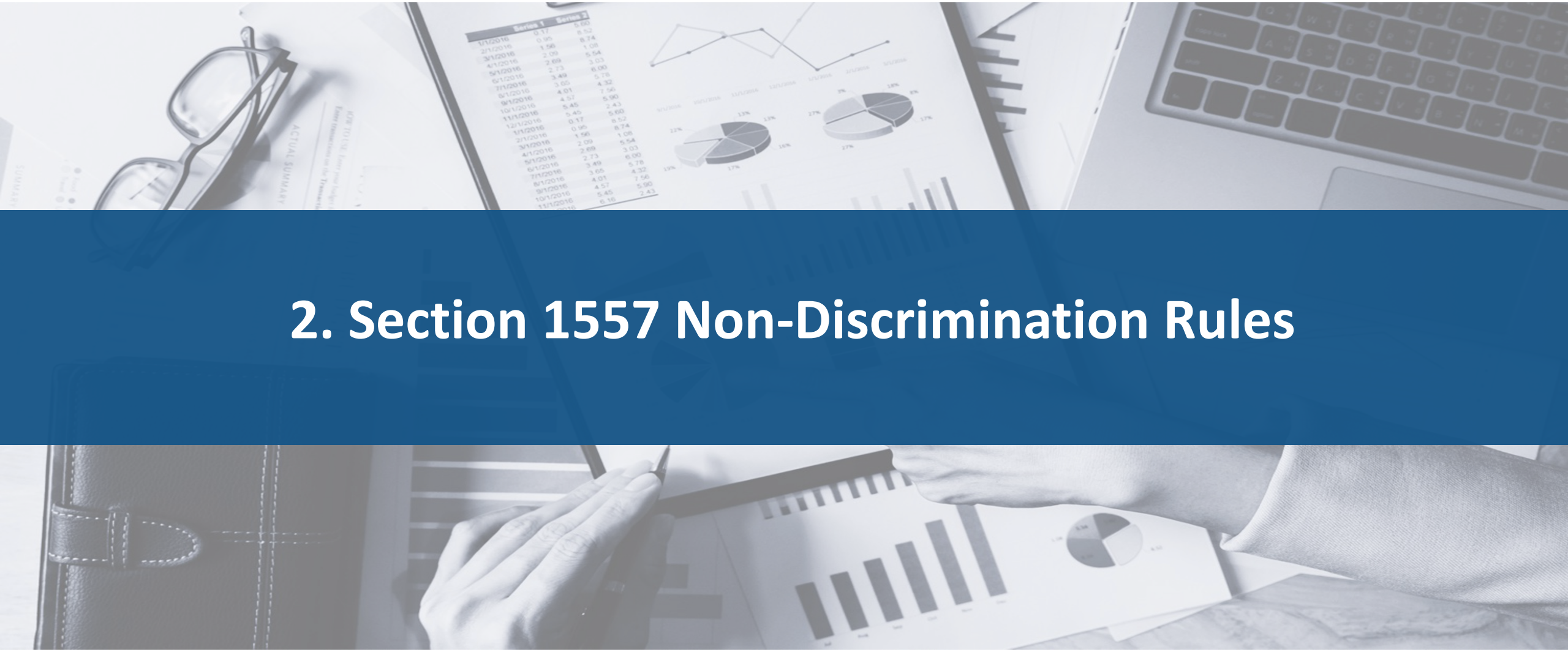
To the best of its knowledge and belief, this hospital has included all applicable standard charge information in accordance with the requirements of 45 C.F.R. §180.50 and the information encoded in this machine-readable file is true, accurate and complete as of the date indicated in this file.

Effective 7/1/2024

Hospital enters value of “true” or “false”

Additional MRF Data Elements – Effective 1/1/2025

- Report “estimated allowed amount” when negotiated rate based on algorithm/ percentage
  - Estimated allowed amount = average reimbursement in dollars previously received from payer for given item or service
- Drug unit and type of measurement
- Modifiers impacting “standard” charge, including description and impact on standard charge



2. Section 1557 Non-Discrimination Rules

Section 1557 Final Rule

- ACA Section 1557 prohibits discrimination based on race, color, national origin, sex, age, or disability in health programs/activities receiving Federal financial assistance
- Implementing regulations published in 2016 superseded by 2020 final rule which is now superseded by 2024 final rule
  - Proposed rule published in July 2022; OCR received over 85,000 comments
  - New rule effective on July 5
- Applies to Medicare/Medicaid participating providers, Medicare Advantage plans, Medicare Part D plans, state Medicaid agencies, Medicaid managed care plans, qualified health plans (non-exclusive list)

Key Provisions

- Defines discrimination based on sex to include sex assigned at birth, gender identity, recorded gender, and pregnancy or pregnancy-related conditions
- Providers may rely on applicable Federal protections for religious freedom and conscience regarding specific contexts, procedures, or health care services
  - Formal process to obtain assurances of such protections
  - Replaces blanket abortion and religious freedom exemptions for health care providers

Key Provisions – Action Items

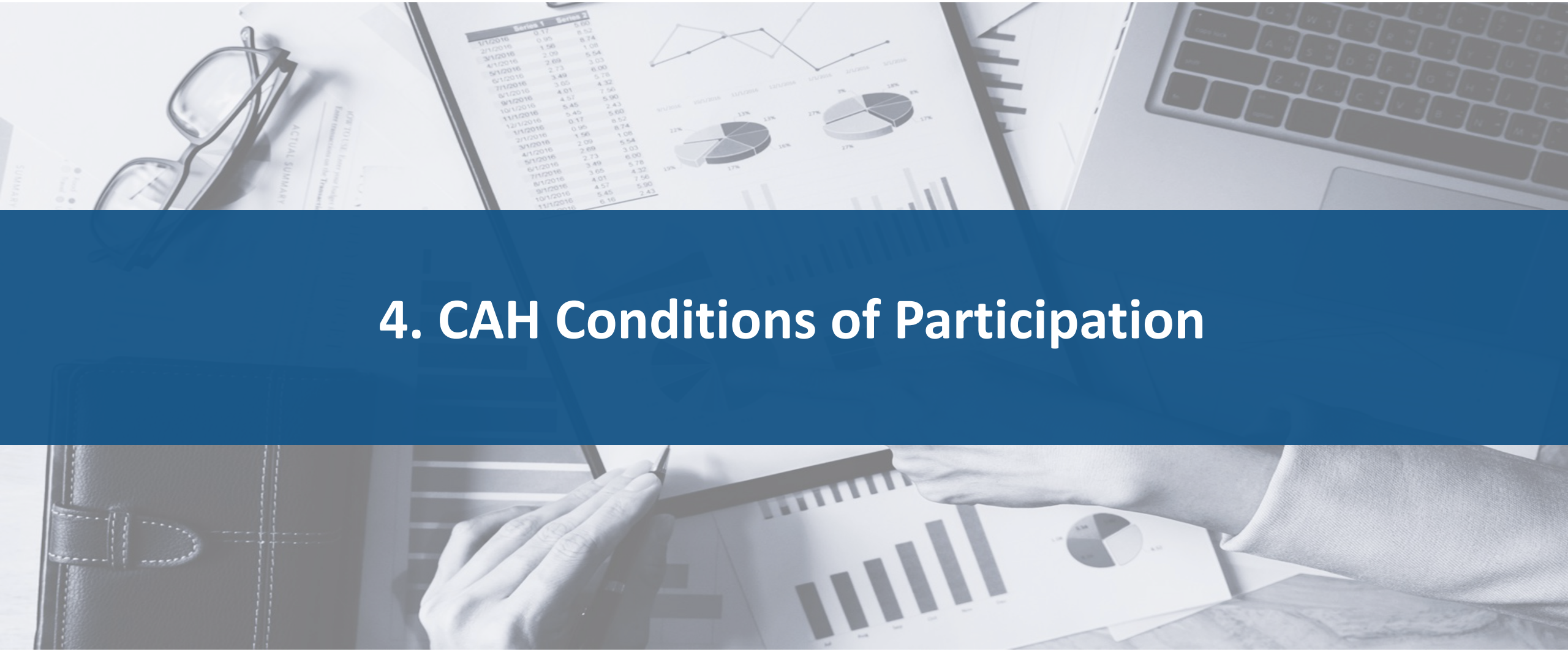
- By November 2, 2024
  - Designate Section 1557 Coordinator (if 15 or more employees)
  - Post Notice of Non-Discrimination on website and at physical locations; provide to individuals upon request
- By May 1, 2025
  - Implement and provide employee training on specified policies and procedures
  - Evaluate use of decision support tools (including AI) to identify and mitigate discrimination based on race, color, national origin, sex, age, or disability
- By July 5, 2025
  - Provide Notice of Availability of Services including language assistance and auxiliary aids
  - Likely will require modification of other notices and forms furnished to patients

Notice resources: https://www.hhs.gov/civil-rights/for-individuals/section-1557/translated-resources/index.html

3. 340B Administrative Dispute Resolution Process

Overhaul of 340B ADR Process

- Replaces trial-like process created by 2020 final rule with 340B ADR Panel to act on claims filed by covered entities and manufacturers
  - Covered entity claims that manufacturer overcharged for covered outpatient drug or limited covered entity's ability to purchase drugs at or below 340B ceiling price
  - Manufacturer claims that covered entity violated prohibition on duplicate discounts or resale/transfer of drugs to non-patient
- Specifies procedures for filing and responding to claim, submitting supporting evidence
  - HRSA Office of Pharmacy Affairs to provide additional guidance prior to June 18, 2024, effective date - https://www.hrsa.gov/opa/340b-administrative-dispute-resolution
- Details 304B ADR Panel decision and reconsideration processes



4. CAH Conditions of Participation

Recent Changes to CAH CoPs

- CMS *still* has not published Interpretive Guidelines for 2019 changes to CAH CoPs
  - Infection Prevention and Control/Antibiotic Stewardship (effective 03/30/2020)
  - Quality Assessment and Performance Improvement (effective 03/30/2021)
  - Interpretive Guidelines for similar changes to hospital CoPs published in March 2023
- 2023 change to distance requirement CoP
  - 35-mile drive from nearest hospital or 15-mile drive in area with only secondary roads available
  - Define 'primary road' as "numbered Federal highway, including interstates, intrastates, expressways, or any other numbered Federal highway; or numbered State highway with 2 or more lanes each way;" everything else = secondary road

Respiratory Illness Reporting Requirements

- COVID-19 and acute respiratory illness reporting requirements expired 04/20/2024
- FY 2025 IPPS Proposed Rule includes new reporting requirements as part of hospital & CAH infection prevention and control/antibiotic stewardship CoP
  - Effective 10/1/2024
  - Covers acute respiratory illnesses, including influenza, SARS-CoV02/COVID-19, and RSV
  - Reports to be made in standardized format and frequency specified by CMS (weekly)
  - Data elements
    - Confirmed infections among newly admitted and hospitalized patients
    - Total bed census and capacity, including for critical hospital units and age groups
    - Limited patient demographic information, including but not limited to age
    - During PHE, also report supply inventory and staffing shortages; relevant medical countermeasures and therapeutic inventories, or both; facility structure and operating status (including diversion status)

Request for Information on OB Services CoP

- FY 2025 IPPS Proposed Rule includes RFI on baseline requirements for OB services to address maternal mortality, morbidity, and access
- Key questions
  - To what types of facilities/care settings should such CoP apply (all hospitals, hospitals with/without OB units, hospitals with/without emergency services, CAHs, REHs, outpatient settings)?
  - Similar to other optional services CoPs requiring services be well organized and provided in accordance with nationally recognized standards of care and evidence-based best practices?

5. CAH Cost Reporting

Practical Considerations

- Appropriate placement of Medicare Advantage days
  - Treated differently than traditional Medicare days
- Appropriate expense grouping
  - For example, where staff is providing services
- Annual review of allocation statistics
  - As opposed to ‘rolling forward’ prior year’s statistics
- Run Medicare PS&R ~1 month prior to filing
  - As opposed to 3 months in advance

Day 1 | Thursday, June 20, 2024

Session 1:	**“Medicare Reimbursement and Effective Cost Reporting”**
Time:	June 20, 11:00 a.m.-12:00 p.m. ET
Presenter:	Emily Wetsel, PYA Director of Reimbursement Services
CPE:	1 CPE credit in Specialized Knowledge

https://www.pyapc.com/insights/webinar-pya-announces-2024-virtual-summer-cpe-symposium-hot-topics-in-healthcare

6. Rural Emergency Hospital Program

Completed Conversions

Arkansas (4)
Eureka Springs Hospital (CAH)
SMC Regional Medical Center (CAH)
St. Bernards Five Rivers Medical Center (PPS)
Progressive Health of Helena (PPS)
Georgia (2)
Blue Ridge Medical Center (CAH)
Irwin County Hospital (PPS)
Kansas(2)
Mercy Hospital (PPS)
South Central Kansas Medical Center (PPS)
Kentucky (1)
Crittenden Community Hospital (PPS)
Louisiana (1)
Assumption Community Hospital (CAH)
Michigan (1)
Sturgis Hospital (PPS)
Minnesota (1)
Mahnomen Health Center (CAH)
Nebraska (1)
Friend Community Healthcare System (CAH)

Mississippi (5)
Green County Hospital (CAH)
Jefferson County Hospital (PPS)
Panola Medical Center (PPS)
Perry County General Hospital (CAH)
Sharkey Issaquena Community Hospital (CAH)
New Mexico (1)
Guadalupe County Hospital (PPS)
Oklahoma (3)
Stillwater Medical – Blackwell (PPS)
Stillwater Medical - Perry (PPS)
Harper County Community Hospital (CAH)
Tennessee (1)
Tristar Ashland City Medical Center (CAH)
Texas (4)
Anson General Hospital (PPS)
Crosbyton Clinic Hospital (CAH)
Falls Community Hospital and Clinic (PPS)
St. Luke's Health - Memorial Hospital (PPS)

- Predictive modeling identified 68 hospitals that could potentially convert
  - Discontinuation of LVH, MDH?
- 27 REHs as of 05/01/2024
  - 12 CAHs
  - 14 PPS
- One REH has closed (Texas)
- One facility had its status revoked
  - Not located in rural area (Mississippi)
- 8 rural hospitals closed in 2023
  - 4 not eligible for REH conversion
- Per National Conference of State Legislatures, 17 states have enacted REH-authorizing legislation

https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-emergency-hospitals/

REH Implementing Regulations

- 2023 OPPS Final Rule – REH Conditions of Participation
  - January 2034 CMS guidance on enrollment and conversion
- 2024 OPPS Final Rule – REH Quality Reporting Program
  - While statute mandates REHQRP, no incentives or penalties associated with reporting
  - Four measures
    - Abdomen Computed Tomography - Use of Contrast Material (claims)
    - Median Time from Emergency Department (ED) Arrival to ED Departure for Discharged ED Patients (chart abstracted)
    - Facility Seven Day Risk-Standardized Hospital Visit Rate after Outpatient Colonoscopy (claims)
    - Risk-Standardized Hospital Visits Within Seven Days After Hospital Outpatient Surgery (claims)
  - Final Rule also established reporting processes, etc.
- 2025 OPPS Proposed Rule
  - Respiratory illness reporting (similar to 2025 IPPS Proposed Rule for PPS hospitals & CAHs)
  - Others?

https://www.cms.gov/files/document/qso-23-07-reh.pdf

Program Challenges

- Statutory limitations
  - Unavailable if hospital closed prior to 2021
  - Loss of swing beds (SNF distinct part unit)
  - Loss of 340B participation
- Reimbursement
  - Medicare Advantage?
    - In network vs. out-of-network emergency services
  - State Medicaid programs?
  - Commercial payers?
- Practical issues
  - Observation bed capacity
  - Transportation to/from inpatient facility
  - Expense reduction/staffing

7. Medicare Telehealth Coverage

Current Telehealth Policy

- Maintain expanded telehealth coverage through 2024
  - Waiver of geographic and location requirements
  - Delay in-person requirement for tele-behavioral health services
  - Add marriage and family therapists and mental health counselors as telehealth practitioners
  - Coverage of audio-only services
  - Payment outpatient therapy services (PT, OT, SLP), diabetes self-management training, and medical nutrition therapy services furnished via telehealth by institutional staff
  - FQHC and RHC reimbursement for medical telehealth services (more on this subject later)
- Continue “virtual” direct supervision through 2024
- Telehealth Services List - replace Categories 1, 2, and 3 with permanent and provisional categories
  - All services (not just Category 3 services) added to list during PHE moved to provisional category
  - Provisional codes not be removed so long as “evidence generation remains in process” unless patient safety issue identified

Current Telehealth Policy

- Beginning 1/1/2024, use POS 02 (telehealth provided other than in patient's home) or POS 10 (telehealth provided in patient's home) for services billed on MPFS
  - Discontinue use of 95 modifier + POS if service had been furnished in person
  - POS 10 paid at non-facility rate; POS 02 paid at lower facility rate
- Suspend frequency limits for subsequent inpatient visits, subsequent nursing facility visits, and critical care consultations thru 2024
- Continue to permit teaching physician to have virtual presence when service furnished via telehealth (three-way telehealth visits) thru 2024
- Continue to permit Opioid Treatment Programs to furnish periodic assessments via audio-only telecommunications thru 2024
- Permanently eliminate in-person requirement for injection training for Diabetes Self-Management Training; expands list of eligible DSMT distant site providers

8. Rural Health Clinics

Reimbursement

National standardized AIR increased from $126 to $139 on January 1, 2024

Beginning	Ending	Rate
1/1/2021	3/31/2021	$87.52
4/1/2021	12/31/2021	$100.00
1/1/2022	12/31/2022	$113.00
1/1/2023	**12/31/2023**	**$126.00**
1/1/2024	12/31/2024	$139.00
1/1/2025	12/31/2025	$152.00
1/1/2026	12/31/2026	$165.00
1/1/2027	12/31/2027	$178.00
1/1/2028	12/31/2028	$190.00
1/1/2029	12/31/2029	$190.00 + MEI

Telehealth – Behavioral Health Services

- New coverage created under Consolidated Appropriations Act, 2021
- Qualifies as RHC visit (and thus pays AIR) if –
  - Use audio/visual connection (audio only if patient cannot/does not want to connect visually)
  - Effective 01/01/2025 -
    - In-person mental health service furnished within 6 months prior to furnishing telehealth services (unless those services initiated during PHE)
    - In-person, non-telehealth visit furnished at least every 12 months
      - May be waived; reason documented in medical record
- Bill revenue code 0900 with appropriate HCPCS code and modifier CG
  - Use modifier 95 for audio/visual connection; modifier FQ for audio only

Telehealth – Medical Services

- Coverage through 12/31/24 created under Consolidated Appropriations Act, 2023
- Service must be included on CMS approved list of telehealth services
  - Available at https://www.cms.gov/medicare/medicare-general-information/telehealth/telehealth-codes
  - Includes CPT 99441 - At least 5 minutes of telephone E/M service by physician or APP provided to established patient; cannot be billed if originate from related E/M service within previous 7 days or lead to E/M service or procedure within next 24 hours/soonest available appointment
- Billed under G2025 (revenue code 0521); 2024 payment = $95.27
- May also bill telehealth originating site fee under Q3014 (revenue code 078x) – reimbursed at $29.92 (2024 rate)
  - Patient receiving telehealth from distant site provider physically present at RHC facility

RHC Care Management Services

- G0511 - General Care Management
  - Transitional care management
  - Chronic care management
  - Principal care management
  - General behavioral health integration
  - Chronic pain management
  - Community Health Integration Services (HCPCS G0019)*
  - Principal Illness Navigation Services (HCPCS G0023)*
  - Remote Physiological Monitoring (CPT 99454, 99457)*
  - Remote Therapeutic Monitoring (CPT 98976-77, 98980)*
- G0511 rate = average of national non-facility payment rate for these services
  - For 2024, ~$73.00 (revenue code 0521)
- May bill G0511 multiple times in calendar month, provided all requirements are met and resource costs are not counted more than once

9. Long-Term Care Facilities

Enhanced Facility Assessment Requirements

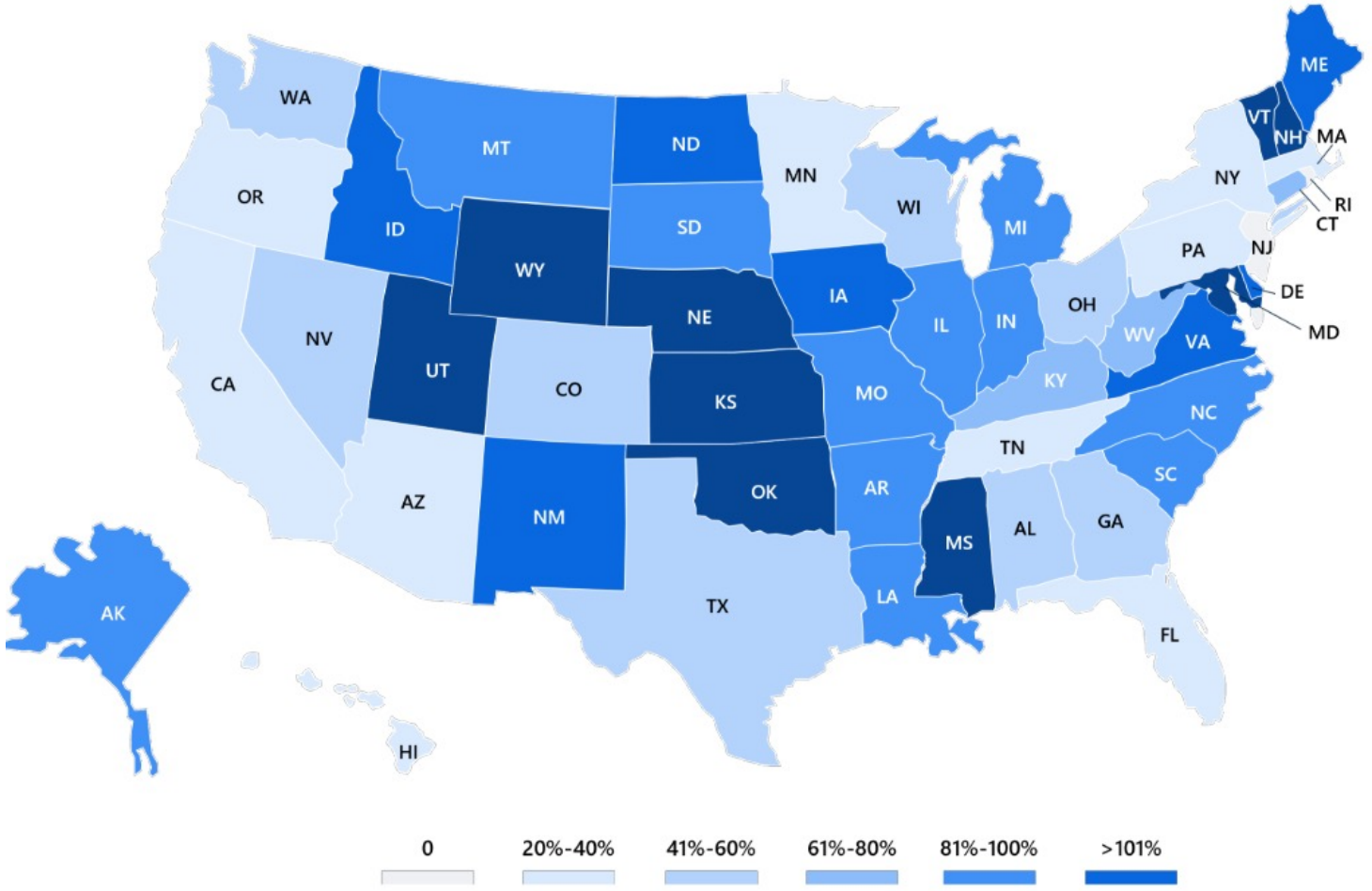
- LTCs presently required to conduct and review annually facility-wide assessment to determine resources needed to care for residents during regular operations and emergencies
- Additional requirements effective August 8, 2024:
  - Use evidence-based methods when care planning for residents, including those with behavioral health needs
  - Use facility assessment to assess each resident's specific needs and adjust as necessary based on any significant changes in resident population;
  - Include member of governing body + medical director as active participants in assessment process
  - Include input from leadership, management, nursing staff, other staff
  - Include input from residents and family members
  - Develop staffing plan to maximize staff recruitment and retention

Minimum Staffing Requirements

- RN physically present + available to provide direct patient care 24/7
  - 05/10/2026 for urban facilities, ***05/10/2027 for rural facilities***
- Minimum # of hours of nursing care per resident day (HPRD)
  - 3.48 HPRD irrespective of staff type
    - Compliance by 05/10/2026 for urban facilities, ***05/10/2027 for rural facilities***
  - 0.55 HPRD from RN, 2.45 HPRD from nurse aide (LPN, LVN, CNA)
    - Compliance by 05/10/2027 for urban facilities, ***05/10/2029 for rural facilities***
  - Hardship exemption
    - May apply if located in workforce unavailability area (≥20% below nat'l average provider-to-population ratio for nursing workforce or ≥20 miles from another LTC facility) + demonstrate financial commitment to staffing (total annual amount spent on direct care staff) and good faith efforts to hire
    - Not eligible if (1) failed to submit required Payroll Based Journal data, (2) designated as special focus facility, or (3) cited for widespread insufficient staffing with resident harm or immediate jeopardy with respect to insufficient staffing
    - If granted, facility must provide specified notice to residents and general public

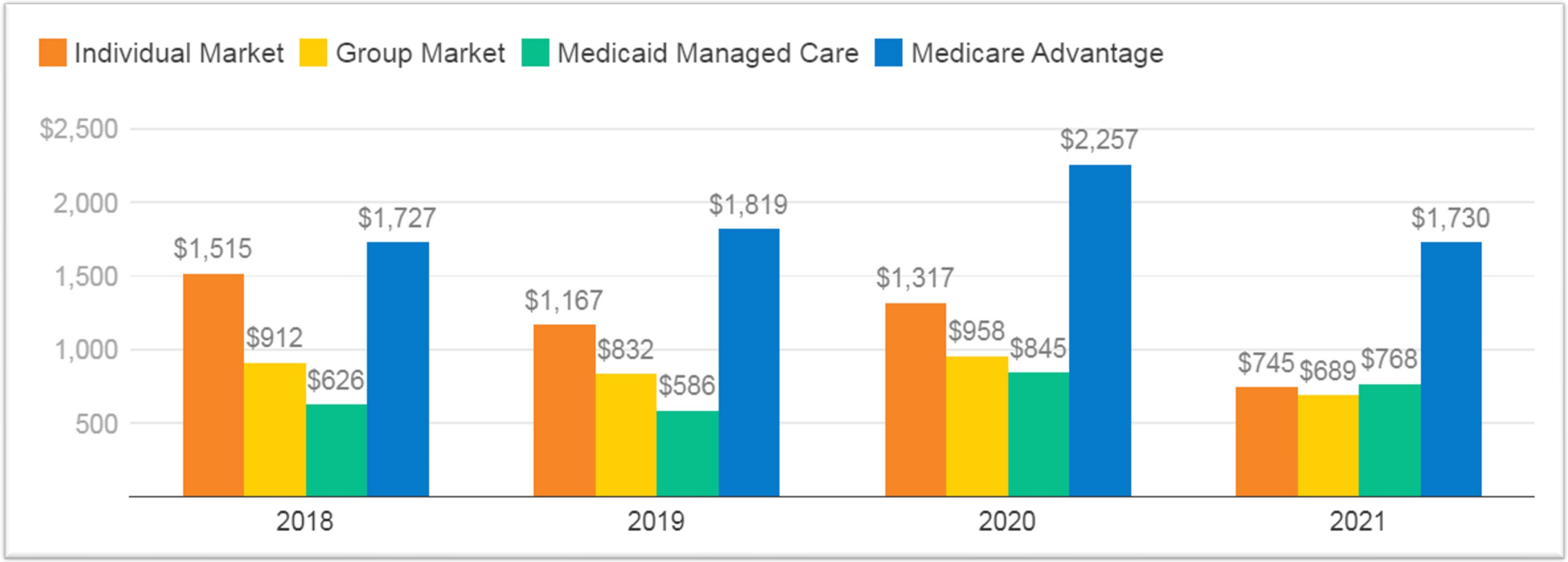
10. Medicare Advantage

MA Growth in Rural Communities, 2019 to 2023



https://www.chartis.com/sites/default/files/documents/chartis_rural_study_pressure_pushes_rural_safety_net_crisis_into_uncharted_territory_feb_15_2024_fnl.pdf

Payer Gross Margins Per Enrollee, 2018-2021



Source: https://www.kff.org/medicare/issue-brief/health-insurer-financial-performance/

Three-Headed Monster

- Payment rates
- Prior authorization and denials
- Beneficiary recruitment

Medicare Payments to Sustain Rural Hospitals

- ~95% of rural hospitals receive at least one of five types of special payments
  - Higher IPPS rates
    - Sole Community Hospital, Medicare Dependent Hospital, and Low-Volume Hospital programs
  - CAH cost-based reimbursement
  - REH fixed monthly payments + 105% OPPS
- Question: Do MA plans (as well as Medicaid MCOs and other payers) provide similar support for rural providers?

Medicare Payments to Sustain Rural Primary Care

- FFS Medicare enhanced payments
  - CAH Method II billing – 15% add-on
  - HPSA bonus – 10% quarterly bonus
  - GPCI floors – impact varies
- Separate payment systems to maintain primary care in rural/underserved areas
  - FQHCs
  - Provider-based and independent RHCs
- Question: Do MA plans (as well Medicaid MCOs and other payers) provide similar support for rural primary care?

MedPAC Analysis

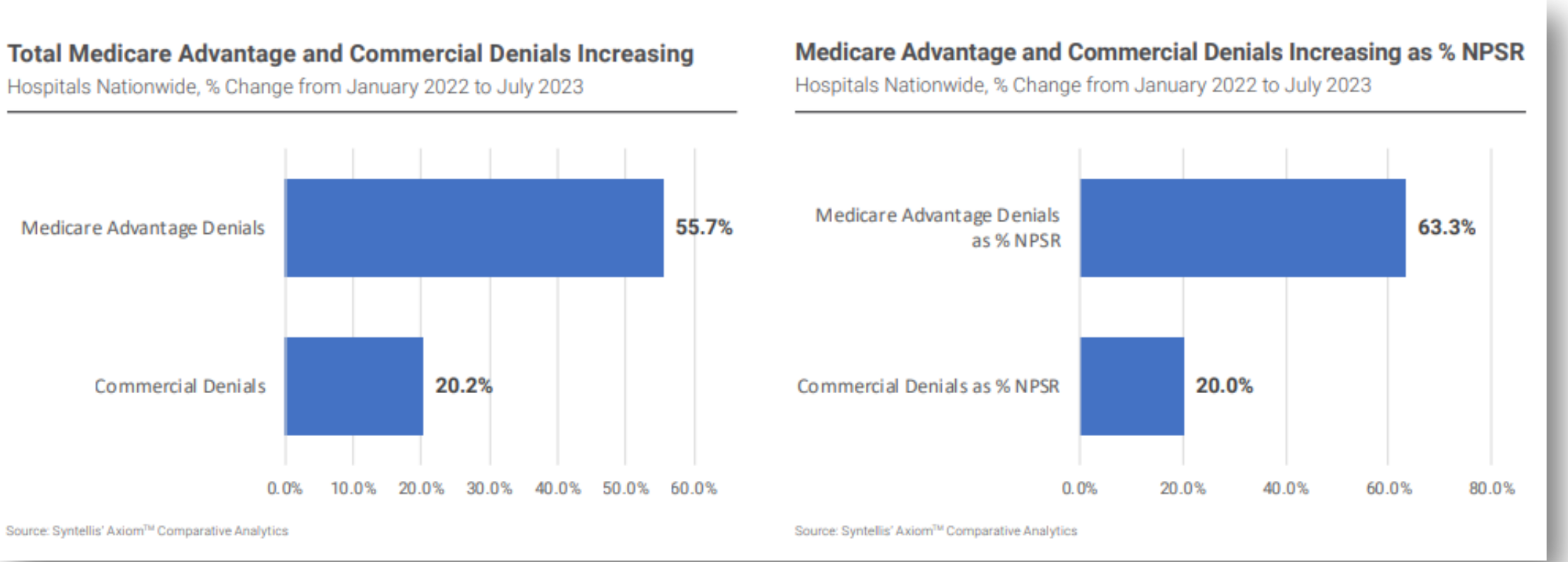
Hospital type	FFS Medicare margins, 2022 (excluding provider relief funds)		
	25th percentile	Median	75th percentile
Rural IPPS hospitals	−24.0%	−7.8%	3.1%
Urban IPPS hospitals	−21.5	−10.4	0.7
Critical access hospitals	≈0	≈0	≈0

Hospital type	All-payer operating margins, 2022 (excluding provider relief funds)		
	25th percentile	Median	75th percentile
Rural IPPS hospitals	−10.0%	−1.8%	5.2%
Urban IPPS hospitals	−6.5	0.9	9.8
Critical access hospitals	−5.7	0.9	7.6

MedPAC, Rural Hospital and Clinician Payment Policy: A Work Plan for 2024-2025 (March 7, 2024), available at https://www.medpac.gov/wp-content/uploads/2023/10/Rural-work-plan-FINAL.pdf (based on 2022 hospital cost report data)

Hospital Vitals: Financial and Operational Trends

Syntellis & American Hospital Association



https://www.syntellis.com/sites/default/files/2023-11/aha_q2_2023_v2.pdf

2024 MA & Part D Final Rule (effective 01/01/2024)

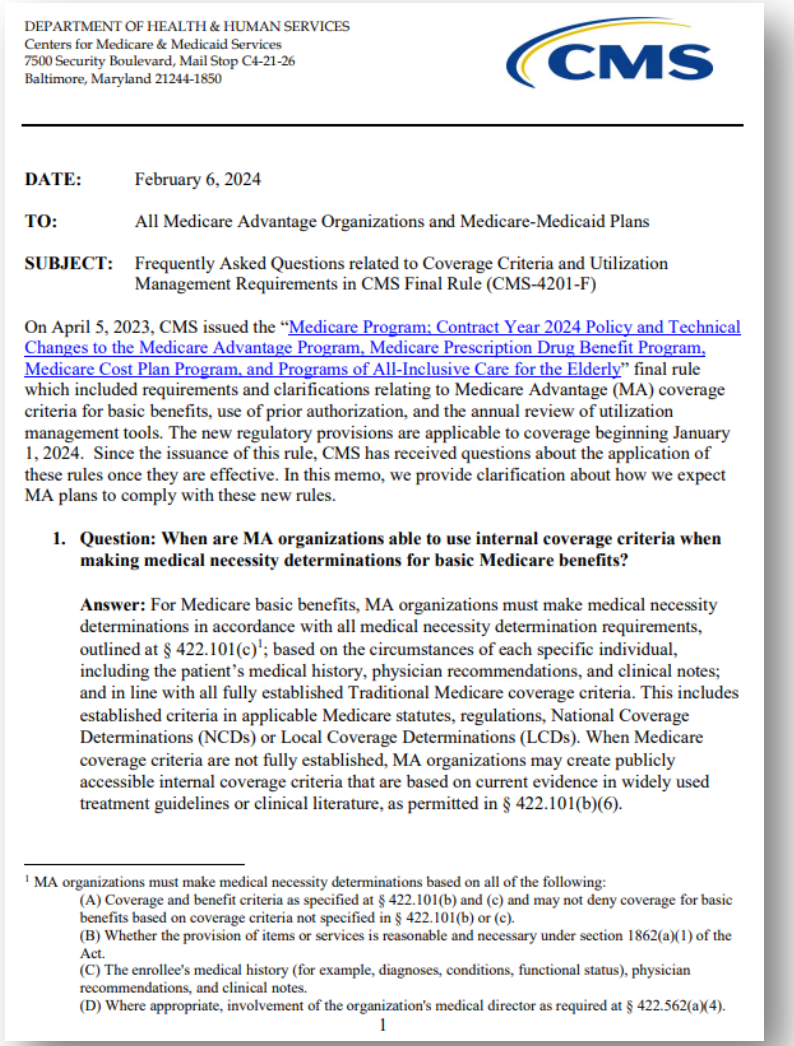
1. MA plan must comply with traditional Medicare NCDs, LCDs, and general coverage and benefit conditions
   - Including coverage criteria for inpatient, IRF, and SNF admissions and HHA services
   - Specifically, admissions for surgeries on inpatient only list and admissions meeting two midnight benchmark (but not the two-midnight presumption applied for medical review purposes)
2. If (and only if) coverage criteria not fully defined by above, may establish internal coverage criteria
   - Must be based on current evidence in widely used treatment guidelines or clinical literature
   - Must be publicly accessible (including summary of evidence)
   - Plan must demonstrate additional criteria provide clinical benefits highly likely to outweigh any harm (including delayed/decreased access to care)

2024 MA & Part D Final Rule

3. Must establish Utilization Management Committee led by Medical Director to review PA policies annually
    - 2025 MA & Part D Final Rule added new requirements
        - At least one committee member must have expertise in health equity
        - Committee must conduct annual plan-level health equity analysis of PA policies
4. PA approval must remain valid for as long as medically necessary to avoid disruptions in care; must provide minimum 90-day transition period when enrollee undergoing treatment changes coverage

Additional Clarification

FAQs issued February 6, 2024, clarify new regulations



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C4-21-26
Baltimore, Maryland 21244-1850

CMS

DATE: February 6, 2024

TO: All Medicare Advantage Organizations and Medicare-Medicaid Plans

SUBJECT: Frequently Asked Questions related to Coverage Criteria and Utilization Management Requirements in CMS Final Rule (CMS-4201-F)

On April 5, 2023, CMS issued the "Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly" final rule which included requirements and clarifications relating to Medicare Advantage (MA) coverage criteria for basic benefits, use of prior authorization, and the annual review of utilization management tools. The new regulatory provisions are applicable to coverage beginning January 1, 2024. Since the issuance of this rule, CMS has received questions about the application of these rules once they are effective. In this memo, we provide clarification about how we expect MA plans to comply with these new rules.

1. **Question: When are MA organizations able to use internal coverage criteria when making medical necessity determinations for basic Medicare benefits?**

   Answer: For Medicare basic benefits, MA organizations must make medical necessity determinations in accordance with all medical necessity determination requirements, outlined at § 422.101(c)[1]; based on the circumstances of each specific individual, including the patient's medical history, physician recommendations, and clinical notes; and in line with all fully established Traditional Medicare coverage criteria. This includes established criteria in applicable Medicare statutes, regulations, National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). When Medicare coverage criteria are not fully established, MA organizations may create publicly accessible internal coverage criteria that are based on current evidence in widely used treatment guidelines or clinical literature, as permitted in § 422.101(b)(6).

[1] MA organizations must make medical necessity determinations based on all of the following:
(A) Coverage and benefit criteria as specified at § 422.101(b) and (c) and may not deny coverage for basic benefits based on coverage criteria not specified in § 422.101(b) or (c).
(B) Whether the provision of items or services is reasonable and necessary under section 1862(a)(1) of the Act.
(C) The enrollee's medical history (for example, diagnoses, conditions, functional status), physician recommendations, and clinical notes.
(D) Where appropriate, involvement of the organization's medical director as required at § 422.562(a)(4).

1

https://www.aha.org/system/files/media/file/2024/02/faqs-related-to-coverage-criteria-and-utilization-management-requirements-in-cms-final-rule-cms-4201-f.pdf

Two Midnights – Benchmark vs. Presumption

- MA plans must follow two midnights benchmark (42 CFR 412.3(d)(1))
  - Admitting physician expects patient to require hospital care that crosses two-midnights
- MA plans not required to follow two midnights presumption (CMS medical review instruction)
  - Any claim that crosses two midnights following inpatient admission order are presumed appropriate for payment
- MA plan may evaluate whether admitting physician's expectation was *reasonable* based on complex medical factors documented in medical record

Prior Authorization Final Rule (MA & Medicaid MCOs)

- By 1/1/2026, plans must send PA decisions within 72 hours for urgent requests and 7 calendar days for standard requests
- By 1/1/2026, plans must furnish provider with written explanation for PA decision
- By 3/31/2026, plans must post on their websites specified PA metrics
  - Percent of PA requests approved, denied, approved after appeal
  - Average time between submission and decision
- By 1/1/2027, plans must implement APIs to facilitate electronic PA process
  - Identify items or services requiring PA, excluding drugs
  - Specify documentation requirements for items and services requiring PA

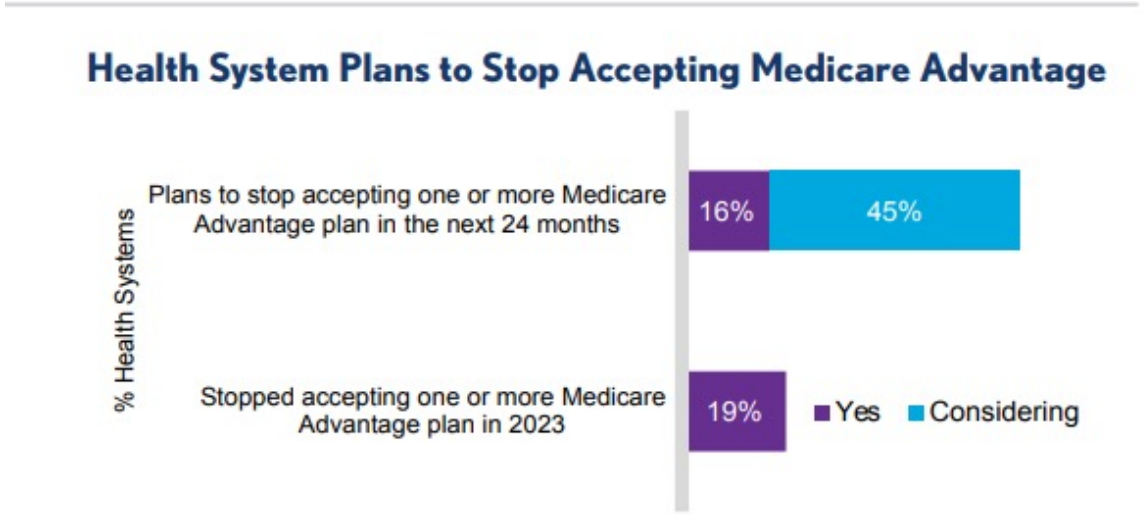
MA Plan Year 2024 Final Rule – Marketing

- 22 new restrictions on marketing activities based on CMS' review of recorded telephone calls and consumer complaints
  - Cannot mention widely available benefits (e.g., dental, vision, hearing, premium reduction, cost savings) in plan marketing unless materials filed/approved by CMS
  - Cannot use superlatives to describe plans unless also providing factual data that supports their usage and meets CMS requirements
  - Cannot tell potential enrollees how much they could save by comparing costs to those who don't have insurance or who have not paid their medical bills
  - Cannot use of Medicare name, CMS logo, and products and information issued by federal government in misleading way

MA Plan Year 2025 Final Rule – Marketing

1. Broker compensation
   - Broadens definition of ‘compensation’ to prevent add-on payments
   - Replaces compensation limits with flat rate
     - For 2025, $726 for each new enrollee, $313 for each renewal (estimates)
2. Limits on Third Party Marketing Organizations’ sharing personal beneficiary data
   - TPMO may share with another TPMO only with beneficiary’s express written consent to share data and be contacted for enrollment/marketing purposes
3. Mid-year enrollee notification of available supplemental benefits
   - Personalized notice to all enrollees each July with list of benefits not accessed + scope of benefit, costing-sharing, instructions for accessing, and customer service number for add’l help

HFMA Health System CFO Pain Points 2024



- **Between onerous authorization requirements and high denial rates, health systems are frustrated with Medicare Advantage.**
- **19% of health systems have stopped accepting a Medicare Advantage Plan 61% are planning to or are considering.**

Based on feedback from 135 health system CFOs. Summary available at https://www.hfma.org/wp-content/uploads/2024/03/Overview-2024-CFO-Pain-Points-Study.pdf

Impact on Beneficiaries

- Forced to change providers if maintain MA plan (except emergency services)
- Moving from MA to traditional Medicare
  - Higher cost or unavailability of Medigap plan (guaranteed issue vs. medical underwriting)
    - Limited federal guaranteed issue rights
    - Only 4 states prohibit medical underwriting by Medigap plans
  - Loss of supplemental benefits
  - Potential for higher out-of-pocket costs

Bonus: What's Happening in DC

OIG Swing Bed Report

Swing-Bed Services at Nationwide Critical Access Hospitals

In 2015, the Office of Inspector General reported that swing-bed usage at Critical Access Hospitals (CAHs) significantly increased from CY 2005 through CY 2010. Medicare spending for swing-bed services at CAHs steadily increased to, on average, almost four times the cost of similar services at alternative facilities. We estimated that Medicare could have saved $4.1 billion over the CY 2005 through CY 2010 period if payments for swing-bed services at CAHs had been made using Skilled Nursing Facility Prospective Payment System rates. We will review swing-bed data for CY 2015 through CY 2019 to determine whether: (1) any actions were taken to reduce swing-bed usage at CAHs; (2) Medicare payment amounts were updated for swing-bed services to CAHs; and (3) alternative care was available to Medicare beneficiaries at a potentially lower rate.

Announced or Revised	Agency	Title	Component	Report Number(s)	Expected Issue Date (FY)
Revised	Centers for Medicare and Medicaid Services	Swing-Bed Services at Nationwide Critical Access Hospitals	Office of Audit Services	W-00-20-35853	2024

https://oig.hhs.gov/reports-and-publications/workplan/summary/wp-summary-0000511.asp

House Ways and Means Committee

- Preserving Telehealth, Hospital, and Ambulance Access Act
  - Two-year Medicare telehealth extensions
  - Maintain Medicare Dependent Hospital and Low Volume Hospital programs through FY 2025
- Preserving Emergency Access in Key Sites (PEAKS) Act of 2024
  - Updates fee schedule for CAH-provided ambulance services
- Rural Hospital Stabilization Act,
  - $20 million/year between FY 2026 and 2029 for grants and technical assistance to rural hospitals
- Rural Physician Workforce Preservation Act
  - Ensures residency slots for rural training programs
- Second Chances for Rural Hospitals Act
  - Allows rural hospitals that closed after 01/01/2014 to re-open as REHs

Other Legislation

- Rural Hospital Closure Relief Act - re-open CAH necessary provider status
- Rural Hospital Support Act – payment adjustments for rural PPS hospitals
- Rural Health Innovation Act – grant funding for enhancing emergency services
- Save America's Rural Hospital Act – reforms to numerous rural health programs