GREAT CONNECTIONS
GREAT SUCCESS JULY 19-20
2023 FLEX PROGRAM REVERSE SITE VISIT

Rural Policy and Regulatory Updates

Flex Program Reverse Site Visit
July 20th , 2023

GREAT CONNECTIONS
GREAT SUCCESS JULY 19-20
2023 FLEX PROGRAM REVERSE SITE VISIT

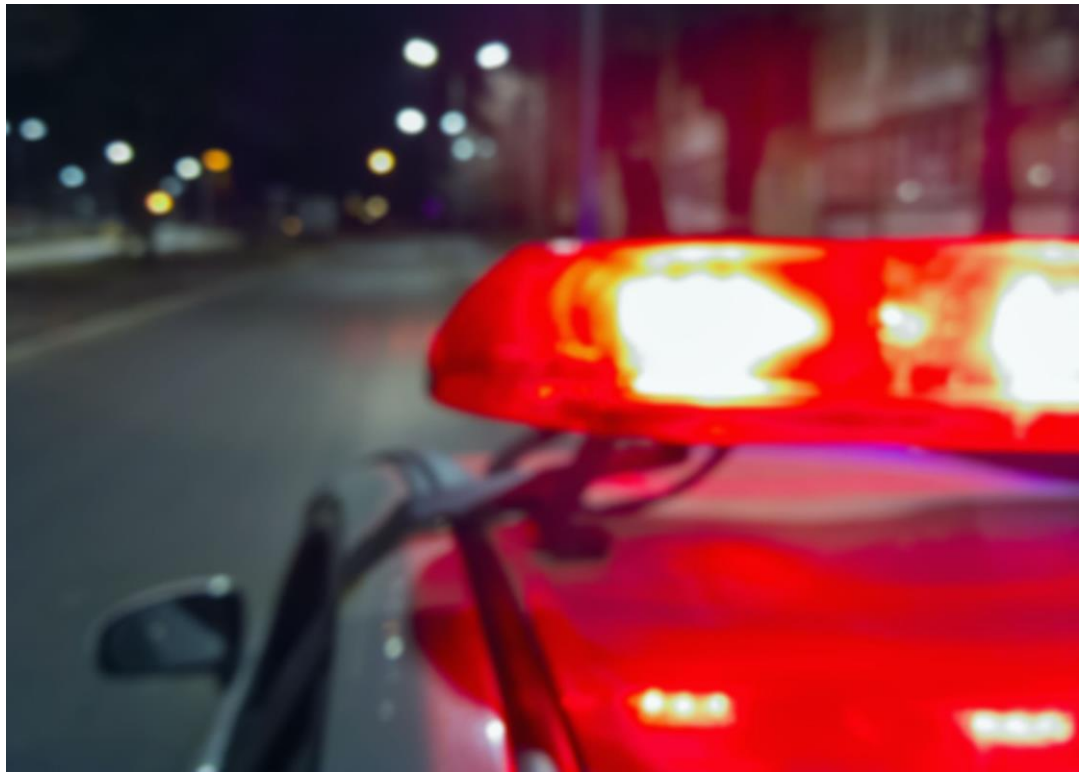
What are some of the regulatory issues that critical access hospitals face including upcoming proposed rules to be aware of and what are the operational and community priorities?

Medicare Hospital Policy

Inpatient Prospective System Final Rule for Fiscal Year 2023

- Graduate Medical Education (GME)
    - Rural Training Programs (RTPs)
- Inpatient Quality Reporting program
    - New Health Equity Measures
- Birthing-Friendly Hospital Quality Designation
- Wage Index Policies

Medicare Hospital Policy (cont.)



Outpatient Prospective System Final Rule for Calendar Year 2023

- CAH Mileage Policies
- Payment for 340B Acquired Drugs
- Tele-Behavioral Health in Hospital and CAH Outpatient Departments
- Rural Emergency Hospitals

Payment Rules

- **Inpatient PPS:** A net **2.8%** payment rate increase in FY 2024.
- Treat rural reclassified hospitals as geographically rural for the purposes of calculating the wage index.
- Allow hospitals to count residents training Rural Emergency Hospitals for purposes of GME and IME.
- Seek information on supporting safety-net providers.
- **Expect OPPS and PFS next week**
  - Site neutral, price transparency
  - telehealth

340B Program Updates

HHS Issues Proposed Remedy for 340B Payment Cuts

1. HHS would repay 340B hospitals
   A. a single-lump sum payment of $7.8 billion
   B. calculations of the amounts owed to the approximately 1,600 affected 340B covered entity hospitals
2. HHS proposes to recoup funds in a budget neutral approach
   A. by adjusting the outpatient prospective payment system (OPPS) conversion factor by minus 0.5% starting in calendar year (CY) 2025
   B. making this adjustment until the full amount is offset, which CMS estimates to be 16 years

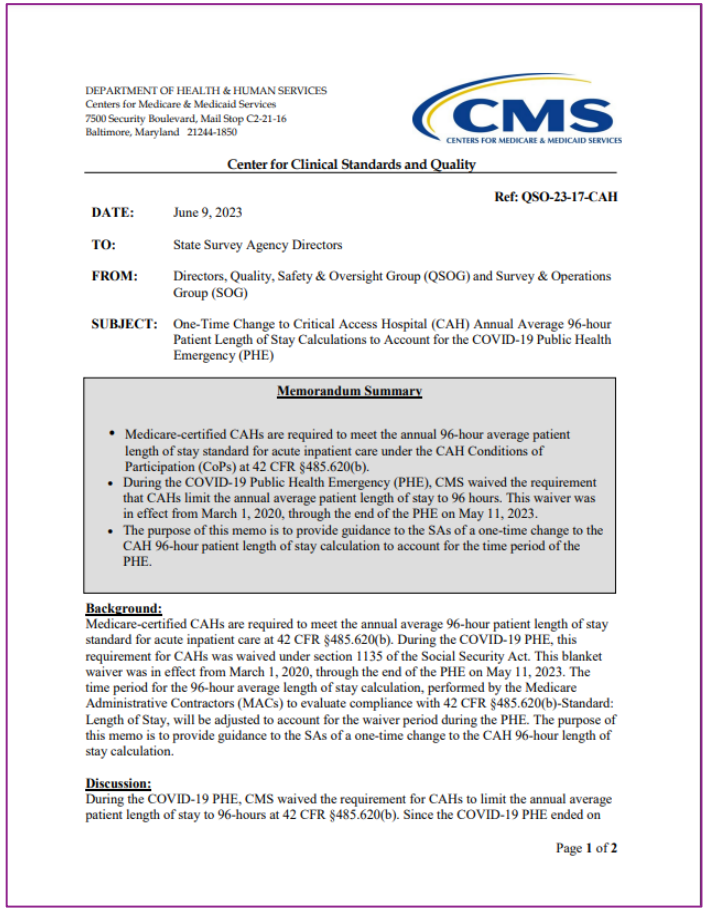
Feedback on 340B Drug Discount Program

Seeking information from stakeholders on bipartisan policy solutions that would ensure the program has stability and oversite to continue to achieve its original intention of serving eligible patients.

96-Hour Rule & Necessary Provider Provisions

Temporary Relief for CAHs

- 96-hour Rule Waiver expired with PHE
- AHA worked with CMS to express CAH concerns
- CMS issued one-time change: requirements to resume with first full cost reporting period ***after*** May 11
- Reopen necessary provider provision



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality

Ref: QSO-23-17-CAH

DATE: June 9, 2023

TO: State Survey Agency Directors

FROM: Directors, Quality, Safety & Oversight Group (QSOG) and Survey & Operations Group (SOG)

SUBJECT: One-Time Change to Critical Access Hospital (CAH) Annual Average 96-hour Patient Length of Stay Calculations to Account for the COVID-19 Public Health Emergency (PHE)

Memorandum Summary

- Medicare-certified CAHs are required to meet the annual 96-hour average patient length of stay standard for acute inpatient care under the CAH Conditions of Participation (CoPs) at 42 CFR §485.620(b).
- During the COVID-19 Public Health Emergency (PHE), CMS waived the requirement that CAHs limit the annual average patient length of stay to 96 hours. This waiver was in effect from March 1, 2020, through the end of the PHE on May 11, 2023.
- The purpose of this memo is to provide guidance to the SAs of a one-time change to the CAH 96-hour patient length of stay calculation to account for the time period of the PHE.

Background:
Medicare-certified CAHs are required to meet the annual average 96-hour patient length of stay standard for acute inpatient care at 42 CFR §485.620(b). During the COVID-19 PHE, this requirement for CAHs was waived under section 1135 of the Social Security Act. This blanket waiver was in effect from March 1, 2020, through the end of the PHE on May 11, 2023. The time period for the 96-hour average length of stay calculation, performed by the Medicare Administrative Contractors (MACs) to evaluate compliance with 42 CFR §485.620(b)-Standard: Length of Stay, will be adjusted to account for the waiver period during the PHE. The purpose of this memo is to provide guidance to the SAs of a one-time change to the CAH 96-hour length of stay calculation.

Discussion:
During the COVID-19 PHE, CMS waived the requirement for CAHs to limit the annual average patient length of stay to 96-hours at 42 CFR §485.620(b). Since the COVID-19 PHE ended on

Page **1** of **2**

Source: CMS

Rural Emergency Hospital

Six REH Conversions as of June 2023

- 4 TX, 1 GA, 1 MS
- 1 CAH, remaining are small PPS hospitals
- Barriers for conversion:
  - 340b
  - Swing bed
  - State licensure

Medicaid Activities

- **Fee-for-Service**
  - Replace state access monitoring review plans with new payment rate transparency standards including benchmarking a subset of rates to Medicare rates.
- **Managed Care**
  - Network Adequacy
  - State Directed Payments (SDPs) - Set upper payment limit for SDPs at ACR, comply with certain non-federal share financing requirements in addition to other safeguards
- **Mitigating Coverage Loss during Re-determination Process**

GREAT CONNECTIONS
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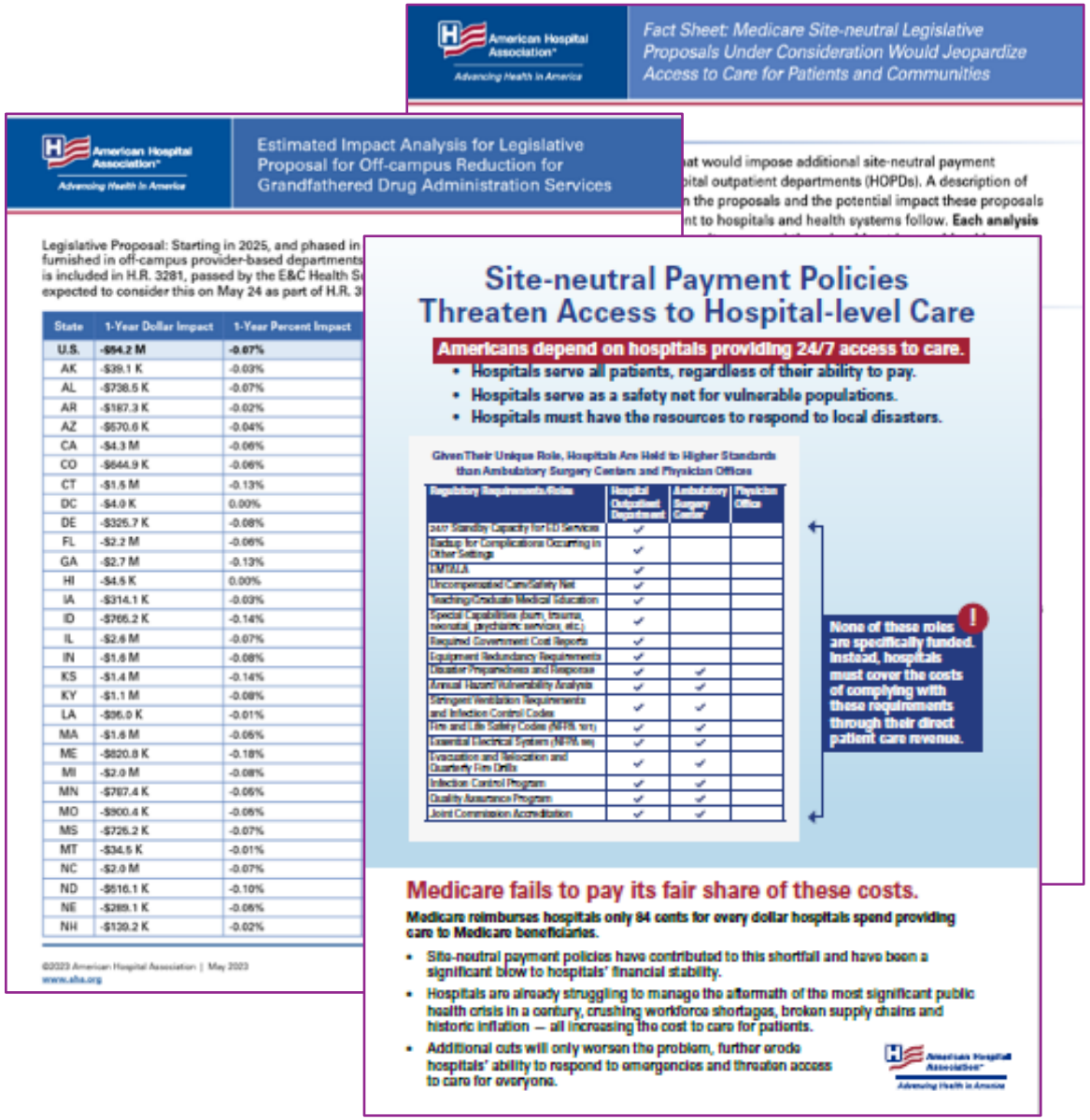
What are the top 3 legislative issues your organization is pursuing to support hospitals and clinics?

Threat: Site-Neutral Payments



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Fact Sheet: Medicare Site-neutral Legislative Proposals Under Consideration Would Jeopardize Access to Care for Patients and Communities

...at would impose additional site-neutral payment ...pital outpatient departments (HOPDs). A description of ...the proposals and the potential impact these proposals ...nt to hospitals and health systems follow. **Each analysis**

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Estimated Impact Analysis for Legislative Proposal for Off-campus Reduction for Grandfathered Drug Administration Services

Legislative Proposal: Starting in 2025, and phased in ... furnished in off-campus provider-based departments ... is included in H.R. 3281, passed by the E&C Health S... expected to consider this on May 24 as part of H.R. 3...

State	1-Year Dollar Impact	1-Year Percent Impact
U.S.	-$54.2 M	-0.07%
AK	-$39.1 K	-0.03%
AL	-$738.5 K	-0.07%
AR	-$187.3 K	-0.02%
AZ	-$570.6 K	-0.04%
CA	-$4.3 M	-0.06%
CO	-$644.9 K	-0.06%
CT	-$1.5 M	-0.13%
DC	-$4.0 K	0.00%
DE	-$325.7 K	-0.08%
FL	-$2.2 M	-0.06%
GA	-$2.7 M	-0.13%
HI	-$4.6 K	0.00%
IA	-$314.1 K	-0.03%
ID	-$766.2 K	-0.14%
IL	-$2.6 M	-0.07%
IN	-$1.6 M	-0.08%
KS	-$1.4 M	-0.14%
KY	-$1.1 M	-0.08%
LA	-$96.0 K	-0.01%
MA	-$1.6 M	-0.06%
ME	-$820.8 K	-0.18%
MI	-$2.0 M	-0.08%
MN	-$787.4 K	-0.06%
MO	-$900.4 K	-0.06%
MS	-$726.2 K	-0.07%
MT	-$34.5 K	-0.01%
NC	-$2.0 M	-0.07%
ND	-$516.1 K	-0.10%
NE	-$289.1 K	-0.06%
NH	-$139.2 K	-0.02%

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www.aha.org

Site-neutral Payment Policies Threaten Access to Hospital-level Care

Americans depend on hospitals providing 24/7 access to care.

- Hospitals serve all patients, regardless of their ability to pay.
- Hospitals serve as a safety net for vulnerable populations.
- Hospitals must have the resources to respond to local disasters.

Given Their Unique Role, Hospitals Are Held to Higher Standards than Ambulatory Surgery Centers and Physician Offices

Regulatory Requirements/Roles	Hospital Outpatient Department	Ambulatory Surgery Center	Physician Office
24/7 Standby Capacity for ED Services	✓		
Backup for Complications Occurring in Other Settings	✓		
EMTALA	✓		
Uncompensated Care/Safety Net	✓		
Teaching/Graduate Medical Education	✓		
Special Capabilities (burn, trauma, neonatal, psychiatric services, etc.)	✓		
Required Government Cost Reports	✓		
Equipment Redundancy Requirements	✓		
Disaster Preparedness and Response	✓	✓	
Annual Hazard Vulnerability Analysis	✓	✓	
Stringent Ventilation Requirements and Infection Control Codes	✓	✓	
Fire and Life Safety Codes (NFPA 101)	✓	✓	
Essential Electrical System (NFPA 99)	✓	✓	
Evacuation and Relocation and Quarterly Fire Drills	✓	✓	
Infection Control Program	✓	✓	
Quality Assurance Program	✓	✓	
Joint Commission Accreditation	✓	✓	

None of these roles are specifically funded. Instead, hospitals must cover the costs of complying with these requirements through their direct patient care revenue.

Medicare fails to pay its fair share of these costs.

Medicare reimburses hospitals only 84 cents for every dollar hospitals spend providing care to Medicare beneficiaries.

- Site-neutral payment policies have contributed to this shortfall and have been a significant blow to hospitals' financial stability.
- Hospitals are already struggling to manage the aftermath of the most significant public health crisis in a century, crushing workforce shortages, broken supply chains and historic inflation — all increasing the cost to care for patients.
- Additional cuts will only worsen the problem, further erode hospitals' ability to respond to emergencies and threaten access to care for everyone.

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- **Grandfathered Drug Administration Services: $3 billion / 10 years**
- **Grandfathered Non-Evaluation and Management Services: $31.2 billion / 10 years**
- **All HOPDs MedPAC Site-neutral Proposal: $180.6 billion / 10 years**

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Financial Stability & Adequate Reimbursement

- **Rural Hospital Support Act (S. 1110)**
- **Save Rural Hospitals Act (S. 803)**
- **Ambulance Add-on Payment (H.R. 1666 / S.1673)**
- **CAH Relief Act (H.R. 1565)**
- **Reopen Necessary Provider Designation**
- **Commercial Insurer Accountability**
- **Infrastructure Funding**
- **AHA Appropriations Letter**

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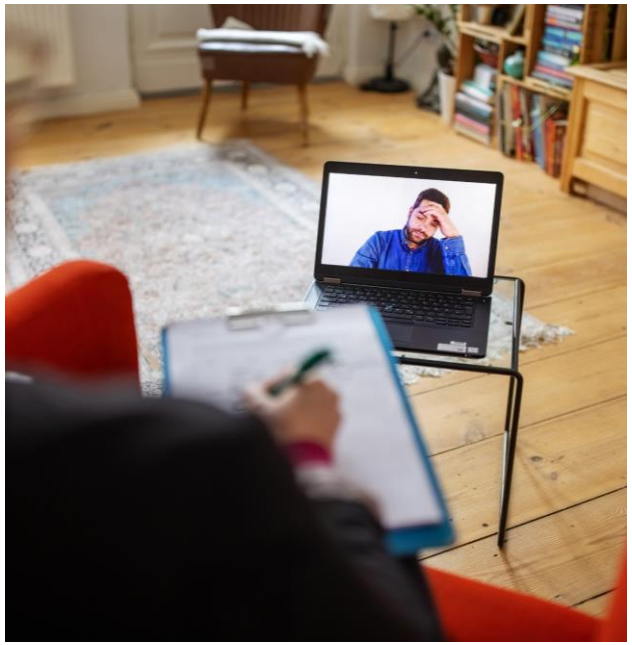
Telehealth

- **Protecting Rural Telehealth Access Act (HR 3440)**
- **KEEP Telehealth Options Act (HR 1110)**
- Permanently **eliminating** originating and geographic site **restrictions**
- Permanently **eliminating in-person** visit requirement for behavioral telehealth
- **Removing distant site restrictions** on FQHCs and RHCs
- Ensuring **reimbursement parity** based on place of service
- Continuing **payment and coverage for audio-only** telehealth services
- Permanently **expanding the eligible provider** types
- **Removing unnecessary barriers** to licensure
- Establishing **DEA Special Registration Process for Telemedicine** for administration of controlled substances
- Expanding **cross-agency collaboration on digital infrastructure** and literacy initiatives



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FY 2024 Appropriations Request

- **Rural Residency Planning and Development Program-** $14.5m
  - Expand the number of rural residency training programs and increase the number of physicians choosing to practice in rural areas
- **Medicare Rural Hospital Flexibility Grant Program** - $73m
  - Used by states to implement new technologies, strategies, and plans in CAHS, in addition to technical assistance funds for REHs
- **Behavioral Health and SUD treatments**
  - Rural Communities Opioid Response Program - $165 million
  - Rural Health Clinic Behavioral Health Initiative - $10 million

ADVOCATE WITH US!

https://www.ruralhealth.us/advocate/rural-health-advocacy-campaigns

FY 2024 Appropriations Request (con't.)

- **CDC Office of Rural Health** - $10m
  - The office will enhance implementation of CDC's rural health portfolio, coordinate efforts across CDC programs, and develop a strategic plan for rural health

- **Increase funding for Rural Maternal and Obstetric Management Strategies** – $24.6m
  - To improve maternal health outcomes, NRHA is requesting an increase across all three RMOMS programs: RMOMS grantee program cohorts, Rural Obstetrics Networks Grants programs, and the Rural Maternal and Obstetric Care Training Demonstration

- **Rural Hospital infrastructure and sustainability**
  - USDA Technical Assistance Program - $5m
  - Financial and Community Sustainability for At-Risk Hospital Program - $10m
  - Rural Hospital Stabilization Pilot Program - $20m

Support the Rural Health Infrastructure

- NEW: S. 1571: Rural Hospital Closure Relief Act of 2023
  - Would allow states to waive the "35-mile rule" (Requirement that a hospital be at least 35 miles from nearest hospital to become a Critical Access Hospital (CAH) under Medicare)
  - This bill would help increase the number of CAHs available to serve rural communities
  - Currently before the Senate Finance Committee

Support the Rural Health Infrastructure (cont.)

- New! H.R. 3730 Rural Health Clinic Burden Reduction Act
- Modernize the RHC program
  - S. 198/H.R. 3730, Rural Health Clinic Burden Reduction Act
  - Developing RHC Quality Reporting Program with enhanced payment
- Ensure the 340B Drug Pricing Program remains a viable lifeline
  - H.R. 2534: PROTECT 340B Act of 2023
  - Evaluating other 340b reform proposals
- Extending authorization for CHC and NHSC.
  - H.R. 2559: Strengthening Community Care Act of 2023

GREAT CONNECTIONS
GREAT SUCCESS JULY 19-20
2023 FLEX PROGRAM REVERSE SITE VISIT

Addressing burnout and strengthening resiliency are two ways to address workforce shortages, what other solutions are you seeing for relief?

National Rural Health Association

Strengthen the Rural Health Workforce

- Expand the Medicare Graduate Medical Education (GME) program
  - S. 230/H.R. 83 Rural Physician Workforce Production Act
  - S. 665 Conrad State 30 and Physician Access Reauthorization Act
  - H.R. 751 Fair Access in Residency Act
- Support development and capacity of health care providers
  - H.R. 2761 Reintroduce Improving Care and Access to Nurses Act
- Support loan repayment programs
  - S. 940 Rural America Health Corps Act

Workforce

- Resident Physician Shortage Reduction Act of 2023 (S. 1302 and H.R. 2389)
- Conrad State 30 and Physician Access Reauthorization Act (S. 665)
- Restoring America's Health Care Workforce and Readiness Act (S. 862)
- The Rural America Health Corps Act (S. 940 and H.R. 1711)
- AHA Appropriations Letter

STRENGTHENING THE HEALTH CARE WORKFORCE

STRATEGIES FOR NOW, NEAR AND FAR

SECTION 1

Supporting the Team

CHAPTER 1

Addressing Well-Being

CHAPTER 2

Supporting Behavioral Health

CHAPTER 3

Workplace Violence Prevention

SECTION 2

Data and Technology to Support the Workforce

CHAPTER 4

Data and Analytics

CHAPTER 5

Technological Supports

SECTION 3

Building the Team

CHAPTER 6

Recruitment and Retention Strategies

CHAPTER 7

Diversity, Equity and Inclusion

CHAPTER 8

Creative Staffing Models

[Workforce | AHA]

American Hospital Association

Advancing Health in America

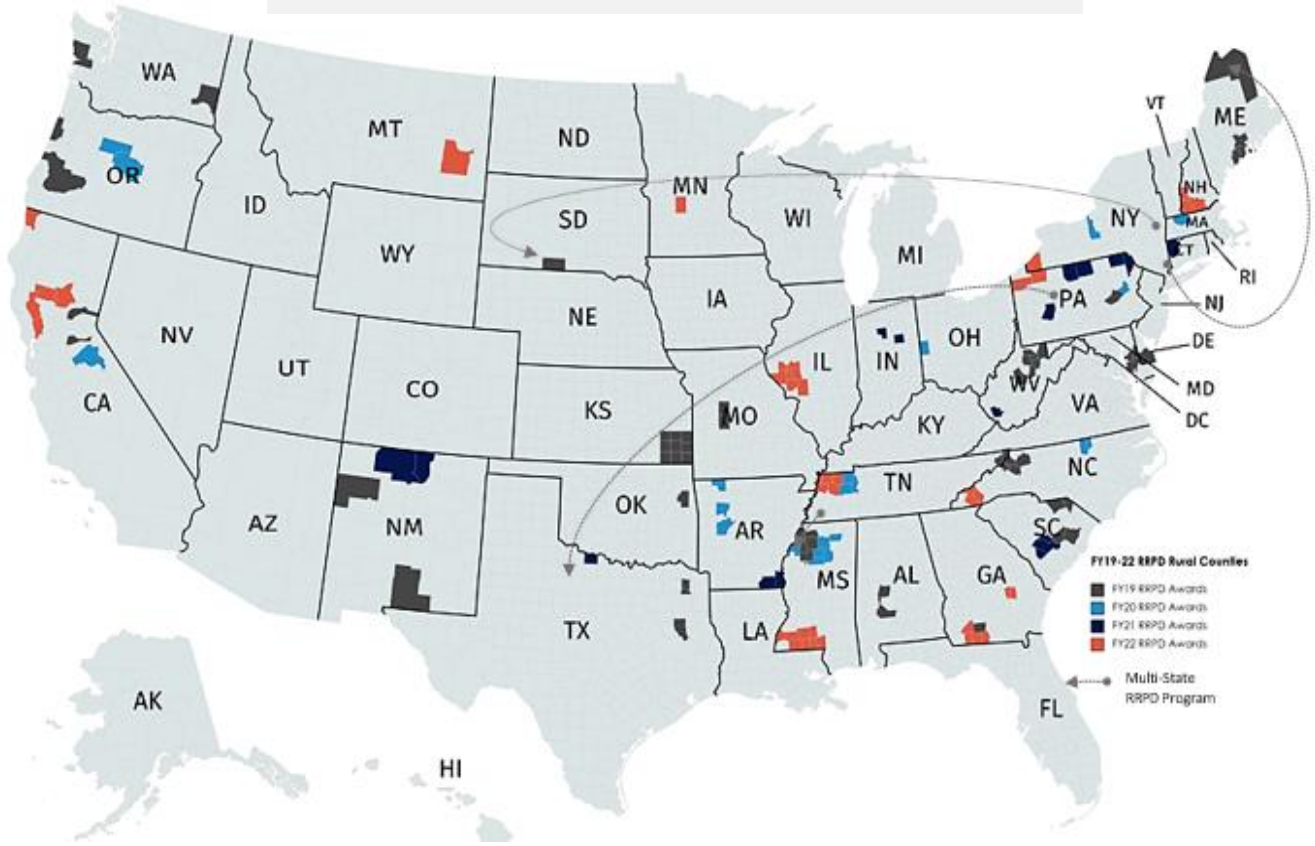
RRPD Program

Creating Sustainable Rural Residencies

FY19-FY22 RRPD Grant Program

- Since 2019, HRSA awarded **$43.4M** to 58 award recipients spanning across 32 states and 5 medicine disciplines.
- Awards up to $750,000 total to organizations to establish **new, accredited and sustainable rural residency programs** in family medicine, internal medicine, psychiatry, general surgery, preventive medicine, and obstetrics and gynecology, over a 3-year grant period.
- Supports planning and development costs, such as accreditation, faculty development and recruitment, curriculum development and resident recruitment.

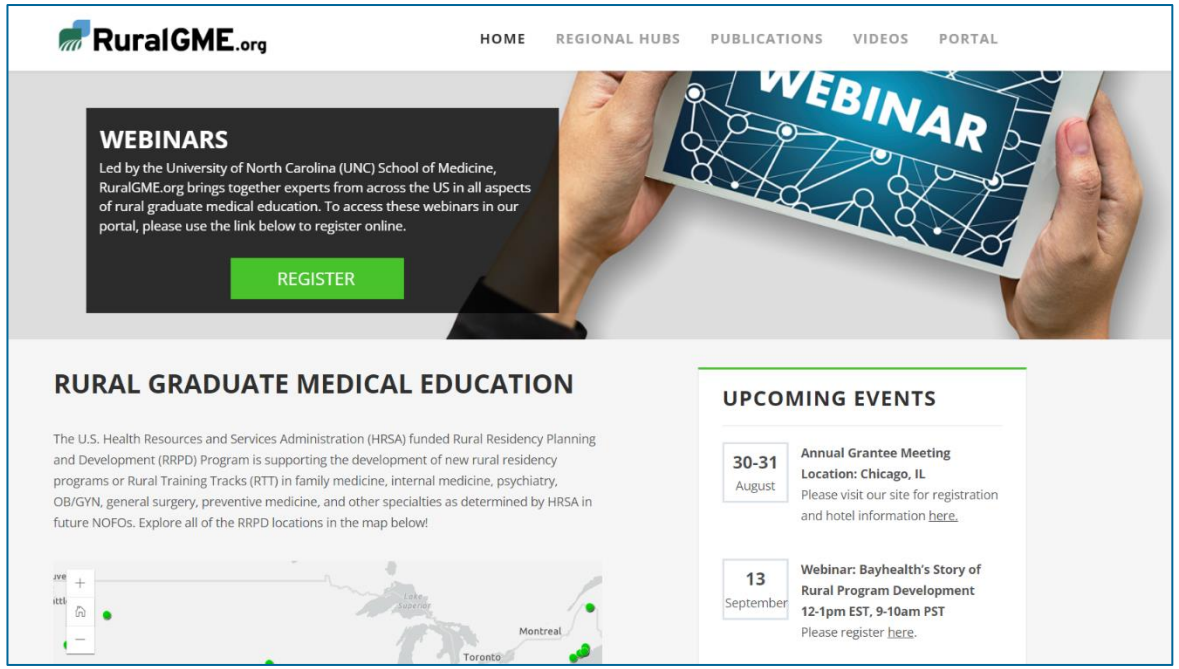
FY19-22 RRPD Rural Counties



Rural Residency Planning & Development (RRPD) Program
Creating Sustainable Rural Residencies

RRPD Technical Assistance (RRPD-TA), a cooperative agreement

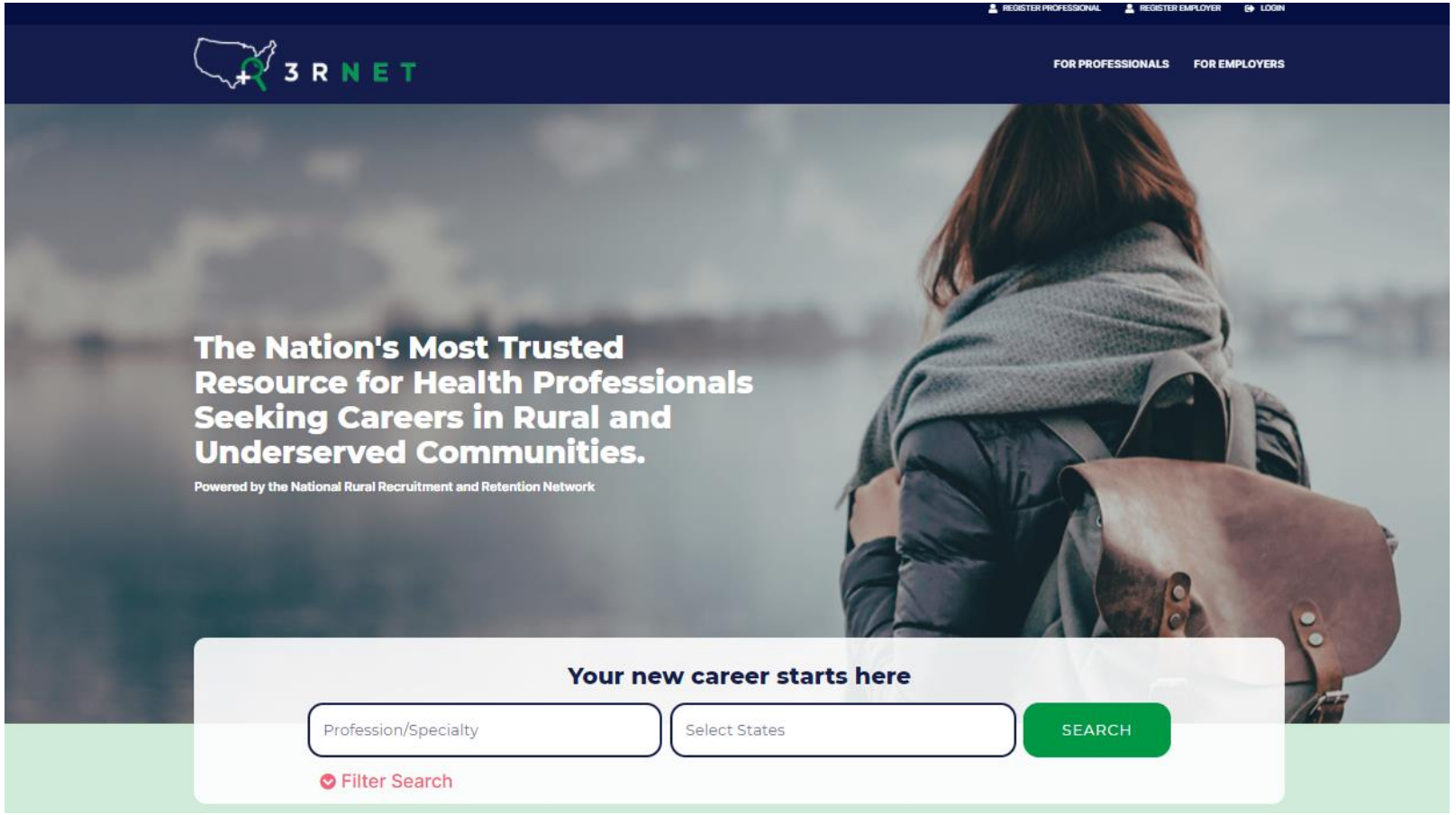
- Awarded $2M in FY18 to establish the RRPD-TA Center and again $4.3M in FY21 to provide direct technical assistance and resources to RRPD awardees and applicants.
- Consortium led by the University of North Carolina (UNC) at Chapel Hill consists of **experts in all aspects of rural residency development** and structured into 3 regional hubs (central, eastern, and western).
- Free resources and tools (e.g., webinars, presentations) are available on the RuralGME.org portal for key topics such as **program accreditation, financing, faculty development, and resident recruitment and training**.
- **Website:** https://www.ruralgme.org/



U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

3RNET

Recruitment Platform for Rural Health Professionals

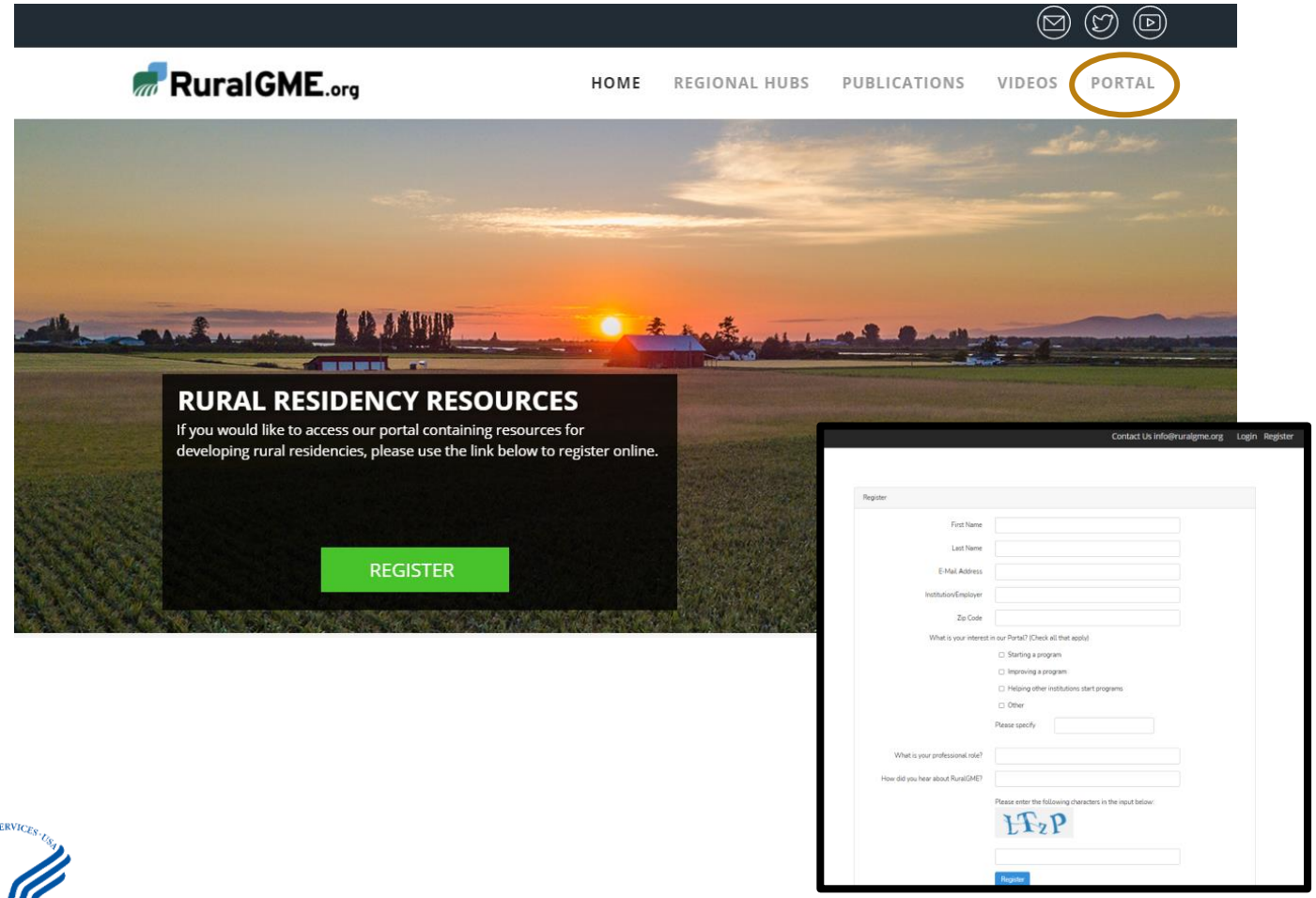


- State-Level resource for job seekers and employers
- Recruiting Platform for Health Professionals : https://www.3rnet.org/

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

RRPD Grant Program & TA Resources

Funding Opportunities



- **FY24 RRPD NOFO Forecast**
- Rural GME development resources and tools available via the RuralGME.org portal
- To register for access to portal resources, visit: https://portal.ruralgme.org/register

U.S. Department of Health & Human Services
HRSA
Federal Office of Rural Health Policy

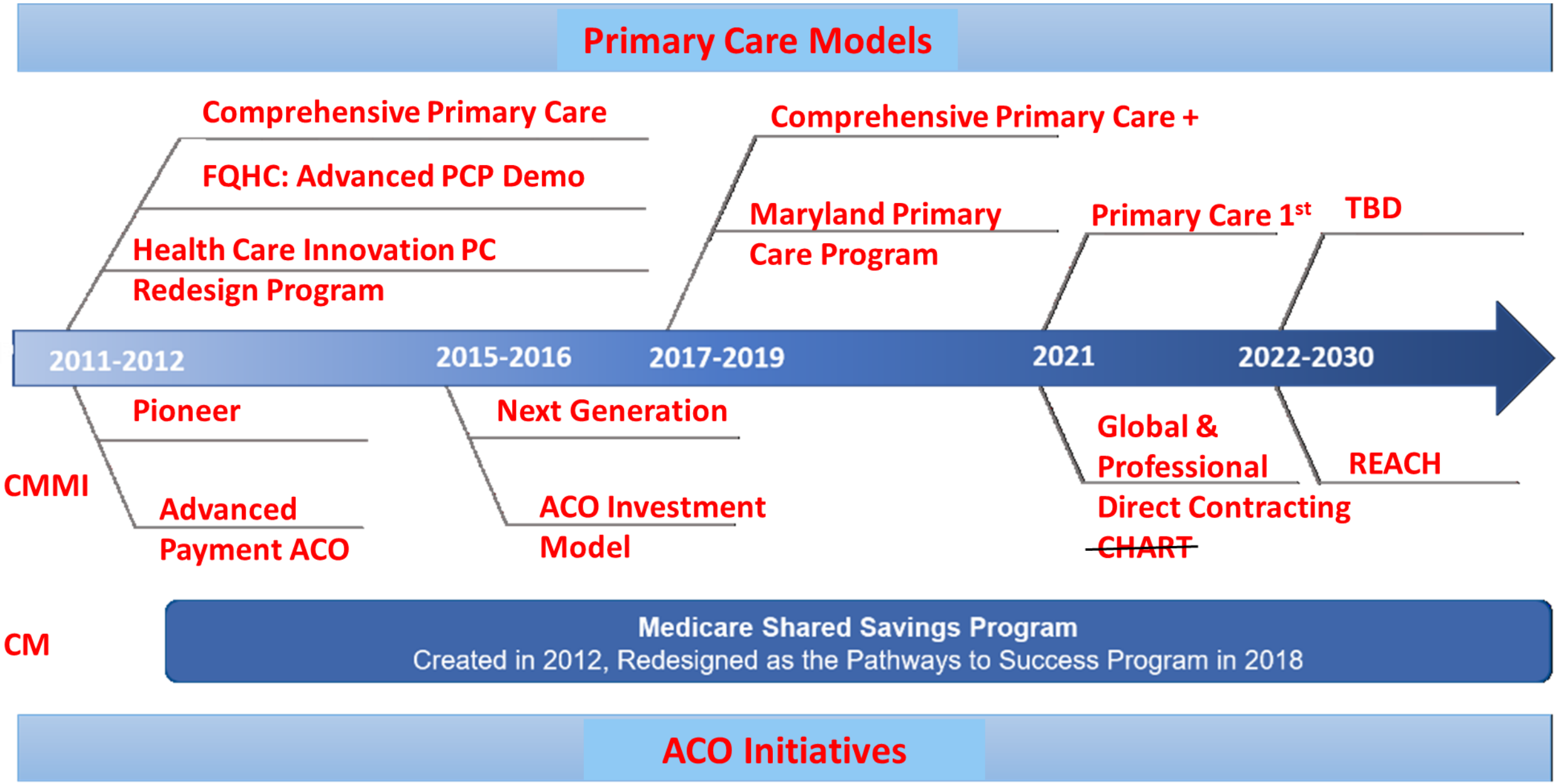
To get engaged in the transition to value-based payment, how can Flex Programs and CAH leaders participate, even if cost – based reimbursement is still the primary payment method?

Driving Health System Transformation - A Strategy for the CMS Innovation Center's Second Decade

A bold new strategy with the goal of achieving equitable outcomes through high quality, affordable, person-centered care.

To achieve this vision, the Innovation Center is launching a strategic refresh organized ***around five objectives***.

Source: Strategic Direction | CMS Innovation Center


Primary Care Models
Comprehensive Primary Care
FQHC: Advanced PCP Demo
Health Care Innovation PC Redesign Program
Comprehensive Primary Care +
Maryland Primary Care Program
Primary Care 1st
TBD
2011-2012
2015-2016
2017-2019
2021
2022-2030
CMMI
Pioneer
Advanced Payment ACO
Next Generation
ACO Investment Model
Global & Professional Direct Contracting
CHART
REACH
CM
Medicare Shared Savings Program
Created in 2012, Redesigned as the Pathways to Success Program in 2018
ACO Initiatives

Advancing health equity is critical to rural providers transitioning to value-based care and we recognize that the path will be unique for rural. Please share opportunities to advance health equity in rural communities?

CMS Framework for Health Equity Priorities

Source: https://www.cms.gov/files/document/cms-framework-health-equity-ad.pdf

National Rural Health Association

Address Rural Health Equity

- Expand Access to Maternal Health Services
  - S. 948 Healthy Moms and Babies Act
  - H.R. 3305 Black Maternal Health Momnibus Act
- Permanently Expand Telehealth Provisions
  - S. 1636 Protecting Rural Telehealth Access Act
  - S. 1642 Reconnecting Rural America Act
  - Reintroduction of CONNECT for Health Act – Coming Soon!
    - Including in person payment parity for RHC and FQHC services
- Expand Access to Emergency Medical Services (EMS)
  - S. 1673/ H.R. 1666 Protecting Access to Ground Ambulance Medical Services Act
- Support Rural Public Health Capacity
  - Reauthorize and increase funding for new CDC Office of Rural Health

Source: [The Health Equity Roadmap | Equity (aha.org)]

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2023 FLEX PROGRAM REVERSE SITE VISIT

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Thank You To Our Panelists!