DRCHSD Summit

Delta Region Community Health Systems Development Program | 2023

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Plenary Session – Rural Policy and Regulatory Updates

Rural Policy and Regulatory Updates

Delta Region Community Health Systems Development Program

Summit

September 14, 2023

ruralcenter.org

What are some of the regulatory issues that small, rural hospitals face including upcoming final and proposed rules to be aware of?

Regulatory Priorities

- Inpatient Prospective Payment System (IPPS) Final Rule
- Outpatient Prospective Payment System (OPPS) Notice of Proposed Rulemaking (NPRM)
- Medicare Physician Fee Schedule (MPFS) NPRM
- Mental Health Parity NPRM
- CY 2024 Medicare Advantage Final Rule
- 340B Program Update
- Medicaid NPRM
- Rural Emergency Hospital (REH)

Medicare Hospital Policy

Increase: Medicare IPPS rates by a net 3.1% in FY 2024.

Policy	Avg. Impact on Payments
Market-basket update	+3.3%
Productivity cut per ACA	-0.2%
Total	+3.1%

- Continue the low-wage-index hospital policy and treat rural reclassified hospitals as geographically rural for the purposes of calculating the average-wage-index (AWI).
- Allow hospitals to count resident training in REHs for purposes of medical education
- Codify the requirements for enrollment as an REH.

Medicare Hospital (Rural and Urban) Policy

Increase Medicare OPPS rates by a net 2.8% in CY 2024

Medicare Hospitals	OPPS Rates
All Hospitals	3.0%
Urban Hospitals	2.8%
Large Urban	2.8%
Other Urban	2.8%
Rural	4.4%
Sole Community	4.4%
Other Rural	4.3%

- Pay for 340B drugs at ASP plus 6%.
- Adopt the FY inpatient PPS wage index as the CY wage index for OPPS
- Continue paying rural SCHs by 7.1%
- Rural Emergency Hospital – adopt one chart-abstracted and three claims-based measures into the REHQR beginning CY 2024
- Create a standardized template for hospital price transparency
- Expand access to behavioral health for IOP, add MFT and adopt the standards for Rural Health Clinics

Medicare Provider Policy

Reduce Physician Fee Schedule (PFS) conversion factor by 3.34% in CY 2024

- Several telehealth-related provisions of the CAA 2023 that would continue the flexibilities of the PHE.
- Part B coverage and payment for the services of marriage and family therapists and mental health counselors.
- General supervision of therapy assistants by PTs and OTs in private practice for remote therapeutic monitoring
- Payment for telehealth services furnished in RHCs and FQHCs and delaying the in-person requirements under Medicare for mental health visits.
- Extending three existing add-on payments to the ambulance base and mileage under the Ambulance Fee Schedule.

Mental Health Parity Notice of Proposed Rulemaking (NPRM)

ruralcenter.org

CY24 Medicare Advantage (MA) Final Rule

- Increases **health plan oversight** and accountability
- Requires greater **alignment with Medicare FFS**
- Regulates plan use of **prior authorization**
- Strengthens **behavioral health** network adequacy standards
- Restricts **MA plan marketing** and increases **consumer protections**
- **Expands plan requirements** for culturally appropriate care and provider directories
- Includes **quality** and **health equity** provisions

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Center for Medicare & Medicaid Services

Office of the Secretary

42 CFR Parts 417, 422, 423, 455, and 460
(CMS-4201-F)
RIN 0938-AU96

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 for All-Inclusive Care for the Elderly

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).
ACTION: Final rule.

U.S. Department of Health and Human Services
Office of Inspector General

- Some Medicare Advantage
- Organization Denials of Prior
- Authorization Requests Raise
- Concerns about Beneficiary
- Access to Medically Necessary Care

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. owed to the approximately 1,600 affected 340B covered entity hospitals
2. HHS proposes to recoup funds in a budget neutral approach
   a. adjusting the OPPS conversion factor by minus 0.5% starting in 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 on policy solutions that would ensure the program has stability and oversite to continue to serve eligible patients.

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 Average Commercial Rates, comply with certain non-federal share financing requirements in addition to other safeguards
- **Looming DSH cuts of $8 B in FY 2024**
- **Unwinding the PHE and continuous coverage**

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 430, 438, and 457
[CMS-2439-P]
RIN 0938-AU99

Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care Access, Finance, and Quality

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).
ACTION: Proposed Rule.

Rural Emergency Hospital

Eight REH Conversions as of August 31, 2023

Three barriers for conversion:

- 340b
- Swing bed
- State licensure

What are the legislative issues your organizations are pursuing to support hospitals and clinics?

Legislative Priorities

- Bipartisan Rural Health Care Caucus
- FY 2024 Appropriations Request
- Preparing for All Hazards and Pathogens Reauthorization Act
- Rural Health Infrastructure

Senate Appropriations

118TH CONGRESS
1ST SESSION

S. 2624

[Report No. 118-84]

Making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2024, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JULY 27, 2023

Ms. BALDWIN, from the Committee on Appropriations, reported the following original bill; which was read twice and placed on the calendar

A BILL

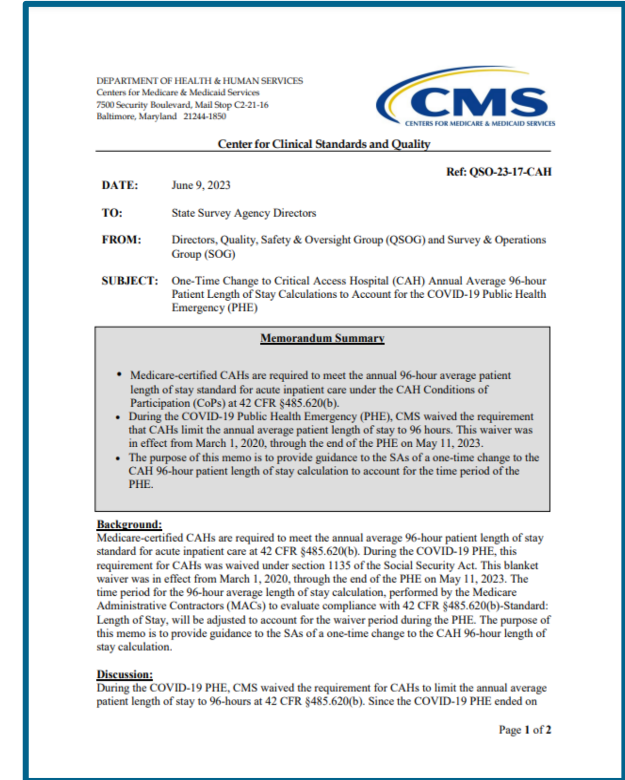
Making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2024, and for other purposes.

- **Senate Appropriations Committee advanced a $224.4 B spending bill**
- **Committee members voted 26-2 to approve the bill**
- **Give $117 B to HHS in fiscal 2024, in line with 2023 levels.**
- **Committee recommendation for Rural Health programs is $364,4 M an increase of $12 M above the fiscal year 2023 enacted level.**

Preparing for All Hazards and Pathogens Reauthorization Act

CAH Specific Legislative Issues

- **96-hour average length of stay**
  - Longer waits for tertiary transfer
  - PAC placement more difficult due to staffing shortages
  - Increased Obs. Status by commercial insurance/Medicaid MCOs
  - Solutions:
    - Remove requirement altogether
    - Raise the average to 120 hours, for example
    - Other ideas?
- **72-hour qualifying length of stay for Swing Bed placement**
  - Solution: Remove requirement altogether or lower the threshold to 36 hours, for example. Other?


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

CAH Change for COVID-19 PHE

Rural Health Infrastructure

- Rural Hospital Closure Relief Act S1571
- CAH Relief Act HR1565
- Rural Hospital Support Act S1110
- Save America's Rural Hospital Act HR 833
- Rural Health Clinic Burden Reduction Act S198/HR3730
- Strengthening Community Care Act HR2559
- Farm Bill Reauthorization

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

Workforce Priorities

- **Expand the Medicare Graduate Medical Education (GME) program**
  - Resident Physician Shortage Reduction Act of 2023 (S. 1302/H.R. 2389)
  - 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**
  - Restoring America's Health Care Workforce and Readiness Act (S. 862)
  - S. 940 Rural America Health Corps Act
- **3RNet National Rural Recruitment and Retention Network**

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

Source

SECTION 3

Building the Team

CHAPTER 6

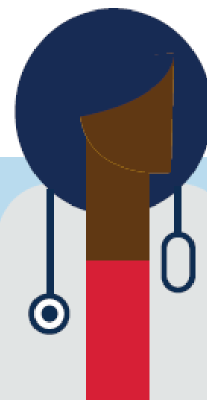
Recruitment and Retention Strategies

CHAPTER 7

Diversity, Equity and Inclusion

CHAPTER 8

Creative Staffing Models



5 Steps to Strengthening the Health Care Workforce

Research by the American Hospital Association, which included focus groups and interviews with hospital leaders, examined ongoing workforce challenges since the onset of the COVID-19 pandemic. The findings include five key insights for strengthening the health care workforce to combat ongoing challenges.

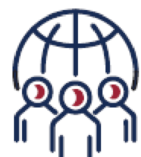
1 Refresh Training & Onboarding

- Grow preceptor and mentor programs
- Focus on communication and leadership skills needed in a new hybrid environment

2 Focus on Recruitment and Retention

- Leverage technology
- Rexamine staffing patterns
- Get input from the front line

3 Reinforce the Culture



- Address psychological safety as a key factor in a strong culture
- Support open communication and reporting to reduce safety issues

"Some of the new graduate nurses are finding that they are not prepared so they feel overwhelmed and we have limited resources to support them."
Registered nurse at a suburban community hospital

A longitudinal study found that four in 10 nurses who intended to leave the workforce indicated burnout and exhaustion as the primary reason.

4 Support Team Mental Health and Well-being

- Address trauma and burnout among staff using leadership-supported protocols
- Implement strategies to destigmatize mental health
- Remove perceived risk of accessing mental health resources among health care staff

5 Invest in Efforts to Mitigate Workplace Violence

- Evaluate, update, and promote organization's plan to address workplace violence
- Advocate for legislation to protect staff from assault and intimidation

To download the whitepaper "Supporting the Health Care Workforce: Lessons Following the COVID-19 Pandemic" visit www.aha.org/system/files/media/file/2023/07/WorkforceWhitePaper.pdf

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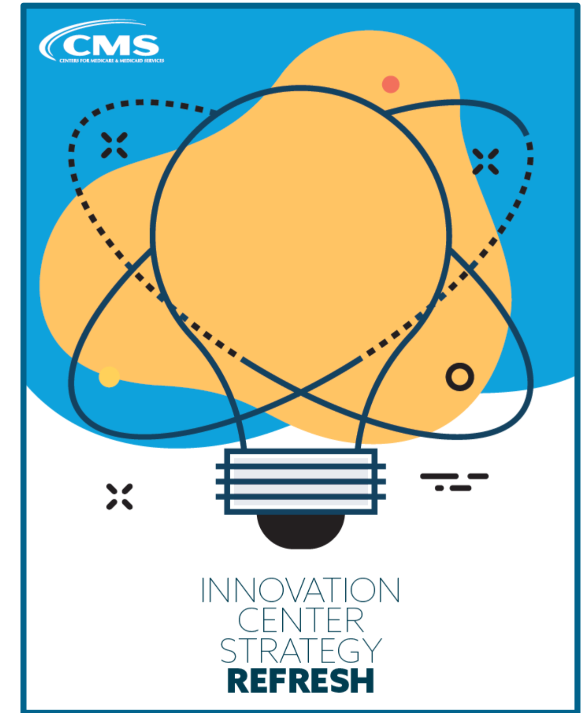
To get engaged in the transition to value-based payment, how can Delta hospital and clinic leaders and community champions participate, even if cost – based reimbursement is still the primary payment method?

Transition To Value

- CMMI Strategy Refresh
- AHEAD Model: CMMI is set to release a new model for up to 8 states as a successor to the Pennsylvania Global Budget Program
- CMS Advanced Investment Payment (AIP) Up-front funding to start a MSSP program
- Bundled Payments for Care Improvement Advanced (BPCI Advanced) Model



Source: Strategic Direction | CMS Innovation Center

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?

Health Equity in Legislation

- **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

    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

  3 percent increase in the rate for ground ambulance services that originate in rural areas. Super Rural Bonus 22.6 percent increase in the base rate for ground ambulance transports that originate in an area in the lowest 25th percentile of all rural areas
- Support Rural Public Health Capacity
  - Reauthorize and increase funding for new CDC Office of Rural Health

Health Equity in Rule Making

CMMI Strategy Refresh: Strategic Area #2: Embedding health equity in all models through mandatory reporting of demographic and, as appropriate, social determinants of health data, and including underserved populations and safety net providers in new models.

Reimagined to Achieve Equity and Community Health (REACH) Accountable Care Organization Model. It includes new health equity requirements, changes to risk adjustment and additional application scoring criteria.

CMS Contract Year 2024 Medicare Advantage Final Rule. It includes a series of **requirements related to health equity** and **expands plan requirements for culturally appropriate care.**

Making Care Primary (MCP) ACO Model. All participants must **create a health-equity plan** that identifies health disparities among their patients and how to address them. The equity component is a relatively new **requirement for payment models**.

Inpatient PPS Final Rule FY 2024. CMS finalized changes to a new **health equity adjustment** to ensure its VBP programs help advance health equity by "reduc[ing] avoidable differences in health outcomes experienced by people who are disadvantaged or underserved."

IFDHE

AHA Institute for Diversity and Health Equity

The Health Equity Roadmap

Culturally Appropriate Patient Care

Equitable and Inclusive Organizational Policies

Collection and Use of Data to Drive Action

Diverse Representation in Leadership and Governance

Community Collaboration for Solutions

Systemic and Shared Accountability

Source

Exploring

Committing

Immersing

Affirming

Transforming

Brock Slabach, NRHA
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John Supplitt, AHA
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Thank You To Our Panelists!

Breakout Sessions 10:30 – 11:45 am

- Adolescent Mental Health Initiatives
- The Key to Independence is Partnership
- Defending Against Cyberthreats – Why you need to and how you can do it on a rural budget

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