Healthcare Regulatory Roundup #92

Here We Go Again:
Medicare Rulemaking in Full Swing

April 16, 2025

Housekeeping

- Slides, handouts, and forms available in **Resources Panel**
- Enter questions in **Q&A Panel**
  - If question not addressed during webinar, will follow-up via e-mail
- Enlarge, rearrange, or close panels as you prefer

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You **must remain logged in for the entire session** and you **must answer five polling questions**.

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Introductions

Martie Ross
Principal
mross@pyapc.com

Kathy Reep
Senior Manager
kreep@pyapc.com

Today's Agenda

1. Plan Year (PY) 2026 Policy and Technical Changes To Medicare Advantage (MA)
2. PY 2026 MA Rate Announcement
3. April 9 Presidential Memorandum: Directing the Repeal of Unlawful Regulations
4. Update on Budget Reconciliation Process
5. Federal Fiscal Year (FFY) 2026 Hospital Inpatient Prospective Payment System Proposed Rule
6. FFY 2026 Skilled Nursing Facility Prospective Payment System Proposed Rule
7. FFY 2026 Inpatient Rehabilitation Facility Prospective Payment System Proposed Rule
8. FFY 2026 Inpatient Psychiatric Facility Prospective Payment System Proposed Rule
9. FFY 2026 Hospice Payment Rate Update
10. Late-Breaking News: Executive Order – Lowering Drug Prices

1. PY 2026 Policy and Technical Changes To MA

Better Medicare Alliance Reaction To Final Rule

"As we continue to review the final rule, we are encouraged that the Administration took a measured approach and declined to make major changes at this time.

With millions of Medicare Advantage beneficiaries still facing significant impacts from two years of Medicare Advantage cuts and other policy changes, this is the right decision to protect seniors and the Medicare Advantage program."

https://bettermedicarealliance.org/news/better-medicare-alliance-statement-on-the-2026-medicare-advantage-and-part-d-final-rule/

What's In the Final Rule – Organizational Determinations

- Cannot deny coverage for lack of medical necessity if:
  - Gave prior authorization
  - Pre-service determination of coverage/payment
  - Concurrent determination during enrollee's receipt of inpatient/outpatient service absent good cause/reliable evidence of fraud
- Cannot use clinical information obtained after initial organizational determination to establish good cause for reopening approved inpatient hospital admission
- Must notify enrollee and provider seeking organizational determination of such determination
  - Provider may appeal failure to provide such notice

What's In the Final Rule – Other Provisions

- Special Supplemental Benefits for Chronically Ill
  - Benefits offered to enrollees with complex chronic conditions (including non-health-related items) to improve and/or maintain their health or function
  - New regulatory provision with non-exclusive list of benefits with no reasonable expectation of improving and/or maintaining health or function
    - Solely cosmetic treatments/procedures
    - Hospital indemnity or life insurance
    - Funeral planning and expenses
    - Alcohol, tobacco, cannabis products
    - Broad membership programs inclusive of multiple unrelated services /discounts
    - ***Non-healthy food***
- Special Needs Plans
  - Integrated ID cards and coordination of health risk assessments

What's Not In the Final Rule

- Enhanced rules on internal coverage criteria
- Prohibiting MA plans from imposing in-network cost sharing for behavioral health services in excess of cost-sharing in traditional Medicare
- Changes to Star Ratings measures
  - Adding Initiation and Engagement of Substance Use Disorder Treatment
  - Updating Plan Makes Timely Decisions About Appeals and Reviewing Appeals Decisions
- Requiring agents/brokers to inform potential enrollees of:
  - Potential eligibility for Low-Income Subsidy and Medicare Savings Program
  - Potential impact of MA enrollment on future Medigap guaranteed issue rights

More That's Not In the Final Rule

- Requiring plans and third-party marketing organization to submit 'generic' MA ads for review and approval before use
  - Since 2023, CMS has issued denials for over 1,500 TV ad submissions as being non-compliant and misleading to consumers
- Requiring plans to provide and regularly update provider directory data to CMS to populate Medicare Plan Finder
- Clarification of expenses excluded from inclusion in medical cost ratio

Still More That's Not In the Final Rule – Health Equity

- Did **not** finalize:
  - Guardrails on use of artificial intelligence in making organizational determinations
  - "acknowledge the broad interest in regulation of AI"
  - New reporting requirements as part of annual health equity assessment of utilization management policies
  - Changes to calculation of Health Equity Index Reward for Star Ratings (to be implemented in 2026)
- CMS now reviewing the following for consistency with Executive Order 14192, "Unleashing Prosperity Through Deregulation"
  - Excellent Health Outcomes for All (EHO4all) Reward (f/k/a Health Equity Index Reward) for Star Ratings
    - To be implemented beginning with 2027 Star Ratings
  - Annual health equity assessment of utilization management policies
  - Requirement for MA plans to provide culturally and linguistically appropriate services
  - Quality improvement and health risk assessments focused on equity and social determinants of health

2. PY 2026 MA Rate Announcement

MA Plan Capitation Payment Rates

- **Standard benchmark**
  - Calculate effective growth rate
    - Projected increase in Traditional Medicare per capita costs for upcoming plan year
    - Takes into consideration enrollment trends, utilization, changes in payment policy
  - Apply county adjustments
    - Assign each county to quartile based on county per capita costs:
    - Quartile 1 (lowest cost) = per capita x 1.15
    - Quartile 2 = per capita X 1.075
    - Quartile 3 = per capita
    - Quartile 4 (highest cost) = per capita x 0.95
  - Apply quality bonuses
    - 5% increase in benchmark for plans with 4 or 5 stars, with double-bonus for low per capita cost counties

- **Risk-adjusted benchmark (RAB)**
  - Adjust standard benchmark based on MA plan's risk score
    - Based on enrollee demographics and HCC scores (driven by diagnosis coding)
    - By statute, CMS must lower risk scores by ≥ 5.9% to account for coding intensity

MA Plan Bids

- If MA plan's bid ≥ RAB, CMS pays RAB
- If MA plan's bid < RAB, CMS pays bid + rebate
  - Rebates = 50 – 70% of difference between plan's bid and RAB, depending on plan's Star Rating
  - Rebates may only be used to provide additional services or lower enrollee costs
    - Which, in turn, drives favorable selection
- MedPAC
  - In 2025, rebates will account for projected 17% percent of payments to all MA plans.

https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf

MedPAC March 2025 Report To Congress

- In 2023, standard benchmarks averaged 109% of projected Medicare FFS per capita costs.
- In 2025:
  - Favorable selection will increase MA payments by ~11% ($44B) above what CMS would have paid under Traditional Medicare
  - MA risk scores will be ~16% higher (vs. 5.9% statutory minimum) than scores for similar Traditional Medicare beneficiaries, increasing MA payments by $40B over what CMS would have paid under Traditional Medicare
  - Part B premium payments will be ~$13 billion higher because of higher Medicare payments to MA plans (~$198 per beneficiary per year)

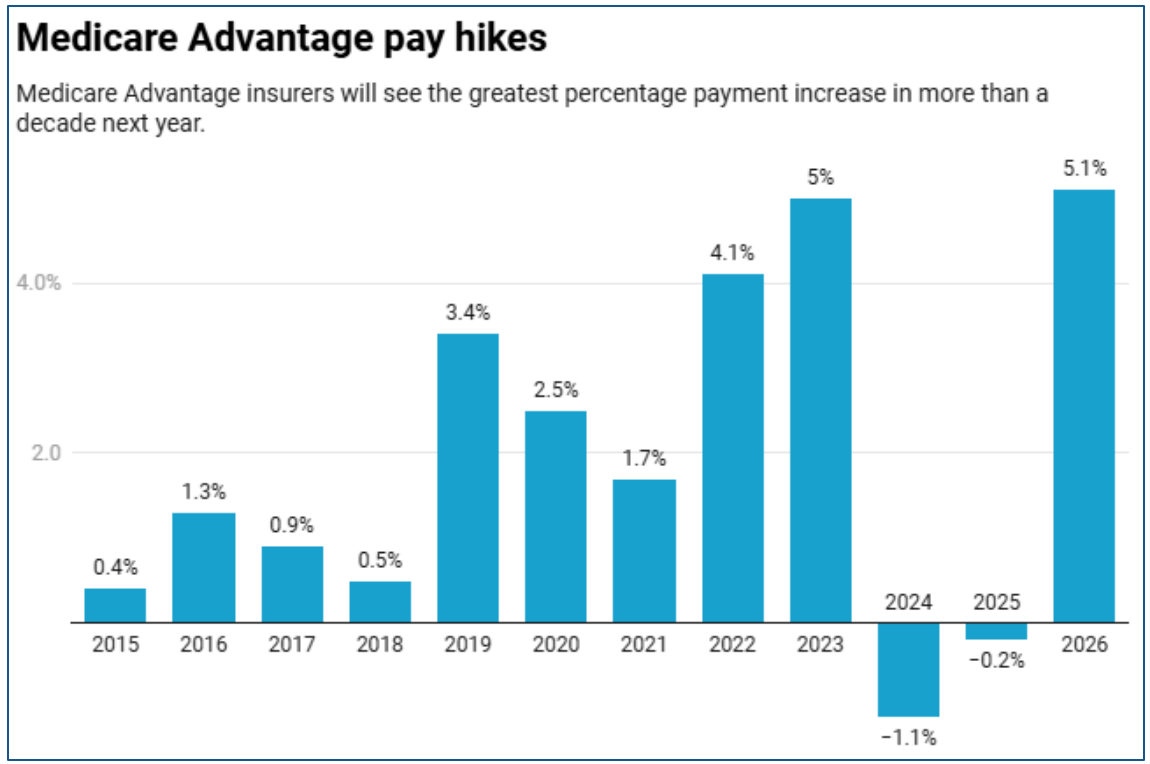
https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf

2026 Rate Announcement

- Projects **5.06% increase** ($25B) in payments to MA plans for PY 2026
  - Advance Notice published in early January projected 2.23% increase
- Increase attributable to changes in effective growth rate between January and April
  - Up from 5.93% to 9.04%
  - Inclusion of additional data, including Q4 2024 utilization
- Continue to apply statutory minimum coding intensity adjustment of 5.9%
- Fully implement technical adjustment to effective growth rate calculation relating to indirect and direct medical education costs
  - Pausing implementation = $7B in additional payments to MA plans for 2026
- Fully implement 2024 CMS-HCC risk adjustment model
  - Pausing implementation = $3.4B in additional payments to MA plans in 2026

https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics/announcements-and-documents/2026

Winners and…



https://www.modernhealthcare.com/insurance/medicare-advantage-pay-rate-reaction

Health insurance stocks soar after boost to Medicare reimbursement rates

https://finance.yahoo.com/news/health-insurance-stocks-rise-best-101046907.html

3. April 9 Presidential Memorandum: Directing the Repeal of Unlawful Regulations

Next Steps in the Review and Repeal Process

- February 19 Executive Order 14219 directed departments and agencies to identify unlawful/potentially unlawful regulations by April 19 and begin plans to repeal them
- April 9 memorandum
  - Beginning April 19, "agencies shall immediately take steps to effectuate the repeal of any regulation, or the portion of any regulation, that clearly exceeds the agency's statutory authority or is otherwise unlawful"
    - "[A]gency heads shall finalize rules without notice and comment, where doing so is consistent with the "good cause" exception in the Administrative Procedure Act."
    - "Retaining and enforcing facially unlawful regulations is clearly contrary to the public interest….Agencies thus have ample cause and the legal authority to immediately repeal unlawful regulations….The repeal of each unlawful regulation shall be accompanied by a brief statement of the reasons that the 'good cause' exception applies."
  - By May 19, agencies must submit written explanation why any regulation identified under Executive Order 14219 has not been repealed

https://www.whitehouse.gov/presidential-actions/2025/04/directing-the-repeal-of-unlawful-regulations/

4. Update on Budget Reconciliation Process

How We Got Here

- Reconciliation process starts with budget resolution
  - Establish revenue and spending targets over ten-year period; authorize increases in federal deficit
  - Committee instructions for drafting implementing legislation
- Getting to go:
  - **Senate budget resolution passed February 21**
    - Did not address tax cuts
  - **House budget resolution passed February 25**
    - Authorized $2.3T increase in deficit ($1.5T in mandatory spending cuts to offset $4.5T in tax cuts
  - **Senate amended budget resolution passed April 5**
    - Authorizes $2T increase in deficit (uses “current policy” baseline assuming expiring tax cuts extended in perpetuity; otherwise, $5.7T increase)
    - Requires House committees to offset tax cuts by at least $1.7T in mandatory spending cuts (or tax cuts reduced dollar-for-dollar); Senate committees to identify $4B in spending cuts
  - **House adopted Senate amended budget resolution April 10**

Promises Made

- To win over House holdouts, Speaker Johnson and Majority Leader Thune promised $1.5T spending reduction while preserving essential programs.
- Work starts in earnest April 28; committees expected to report draft legislation by May 9.
- Medicaid funding to states?
- Medicare provider payments?

5. FFY2026 Hospital Inpatient Prospective Payment System Proposed Rule

Comments Due June 10

Request for Information – Unleashing Prosperity Through Deregulation of the Medicare Program

- Included in all four proposed FY2026 payment rules in response to Executive Order 14219
- CMS "seeks public input on approaches and opportunities to streamline regulations and reduce administrative burdens on…stakeholders participating in the Medicare program"
  - Streamline regulatory requirements
  - Opportunities to reduce administrative burden of reporting and documentation
  - Identification of duplicative requirements
  - Additional recommendations
- **Responses due June 10**; submitted via https://www.cms.gov/medicare-regulatory-relief-rfi (vs. submission via Federal Register site)

IPPS Payment Update

- Rebase and revise IPPS operating and capital market basket to reflect 2023 base year
  - 2.4% increase in base rate, based on market basket increase of 3.2% less 0.8 percentage point productivity adjustment (vs. 2.9% increase for FFY 2025)
- Apply national labor-related share of 66% (i.e., portion subject to wage index adjustment) for hospitals with wage index >1.0 (currently 67.6%)
  - Remains at 62% for hospitals with wage index of ≤1.0
- Increase capital payment rate to $528.95 (currently $510.51)
- Decrease IPPS outlier threshold to $44,305 (currently $46,152)
- Increases Medicare uncompensated care pool for DSH hospitals by $1.4B (total pool $7.140B compared to 2025 pool of $5.705B)
- Increase of $234M for new technology payments

IPPS Payment Rates

TABLE 1A. NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS; LABOR/NONLABOR (66.0 PERCENT LABOR SHARE/34.0 PERCENT NONLABOR SHARE IF WAGE INDEX GREATER THAN 1)							
Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.4 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.0 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.6 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.8 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$4,511.41	$2,324.06	$4,405.67	$2,269.59	$4,476.16	$2,305.90	$4,370.43	$2,251.43

TABLE 1B. NATIONAL ADJUSTED OPERATING STANDARDIZED AMOUNTS, LABOR/NONLABOR (62 PERCENT LABOR SHARE/38 PERCENT NONLABOR SHARE IF WAGE INDEX LESS THAN OR EQUAL TO 1)							
Hospital Submitted Quality Data and is a Meaningful EHR User (Update = 2.4 Percent)		Hospital Submitted Quality Data and is NOT a Meaningful EHR User (Update = 0.0 Percent)		Hospital Did NOT Submit Quality Data and is a Meaningful EHR User (Update = 1.6 Percent)		Hospital Did NOT Submit Quality Data and is NOT a Meaningful EHR User (Update = -0.8 Percent)	
Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related	Labor-related	Nonlabor-related
$4,237.99	$2,597.48	$4,138.66	$2,536.60	$4,204.88	$2,577.18	$4,105.55	$2,516.31

Transition for Discontinuation of Low Wage Index Hospital Policy

- "Officially" discontinuing low wage index hospital policy for FY 2026 and beyond
- Adopting budget-neutral narrow transitional exception policy
  - Applies to hospitals that benefitted from the FY 2024 policy
  - If proposed FY 2026 wage index is decreasing by > 9.75% from FY 2024 wage index, hospital will be paid as if FY 2026 wage index is equal to 90.25% of FY 2024 wage index
  - Transitional exception policy would be budget neutral through adjustment to standardized rates for all hospitals

Calculating Pass-through Payment for Nursing/Allied Health Programs (or When Is a Change Not a Change)

- "Change" proposed because of recent litigation, *Mercy Health-St. Vincent Medical Center LLC v. Becerra*
- Current formula: per regulation

  Total Costs (Direct and Indirect) – Tuition = Net Costs

- Proposed formula: follows current cost report instructions

  Direct Costs – Tuition + Indirect Costs = Net Costs

- Formula change impacts allocation of Administrative and General costs by reducing share of direct costs relative to other departments within hospital

LTCH PPS Payment Update

- Update of 2.6% to LTCH PPS (same update as FFY 2025)
  - Increase in LTCH outlier threshold to $91,247 (increase of $14,199 over current threshold)

TABLE 1E- PROPOSED LTCH PPS STANDARD FEDERAL PAYMENT RATE		
	Full Update (2.6 Percent)	**Reduced Update* (0.6 Percent)**
Standard Federal Rate*	$50,728.77	$49,739.90

* For LTCHs that fail to submit quality reporting data for FY 2026 in accordance with the LTCH Quality Reporting Program (LTCH QRP), the annual update is reduced by 2.0 percentage points as required by section 1886(m)(5) of the Act.

RFI on Digital Quality Measurement

- Seeking comment on continued advancements to digital quality measurement and use of Health Level 7® Fast Healthcare Interoperability Resources® (FHIR®) standard
  - Anticipated approach to FHIR-based electronic clinical quality measure (eCQM) reporting in quality reporting programs
  - Potential use of FHIR-based patient assessment instrument reporting for inpatient psychiatric facilities

Hospital Inpatient Quality Reporting Program

- Modify 4 existing measures:
  - For two measures, include MA patient cohort data and shorten performance period from 3 years to 2 years
    - Risk-Standardized Complication Rate Following Elective Primary THA/TKA beginning with FY 2027 payment determination (4/1/2023 – 3/31/2025 reporting period(?))
    - 30-Day, All-Cause, Risk-Standardized Mortality Rate Following Acute Ischemic Stroke Hospitalization beginning with FY 2027 payment determination (7/1/2023 – 6/30/2025 reporting period(?))
  - For two measures, modifications to reporting requirements
    - Hybrid Hospital-Wide Readmission Rate for FY 2028 payment determination (7/1/2025 – 6/30/2026 reporting period)
    - Hybrid Hospital-Wide All-Cause Risk Standardized Mortality Rate for FY 2028 payment determination (7/1/2025 – 6/30/2026 reporting period)

Hospital Inpatient Quality Reporting Program

- Remove COVID-19 diagnosed patients measure denominator exclusions beginning with FY 2027 program year
- Remove 4 existing measures for FY 2026 payment determination
  - Hospital Commitment to Health Equity
  - Screening for Social Drivers of Health
  - Screen Positive Rate for Social Drivers of Health
  - COVID–19 Vaccination Coverage among Healthcare Personnel
- Update and codify Extraordinary Circumstances Exception (ECE) policy to clarify that CMS may extend time for data submission in response to ECE request

Promoting Interoperability Program

- Amend regulatory definition of 'EHR reporting period for a payment adjustment year' as minimum of any continuous 180-day period within calendar year
  - Codifying change from 90-day period in CY 2024
- Modify Security Risk Analysis measure to require hospitals/CAHs to attest "yes" to having conducted security risk management (in addition to attesting "yes" to having conducted security risk analysis)
  - Required implementation specification for risk analysis and risk management under HIPAA Security Rule
- Modify SAFER Guides measure by requiring hospitals/CAHs to attest "yes" to completing annual self-assessment using 8 SAFER Guides published in January 2025
- Add optional bonus measure to Public Health and Clinical Data Exchange objective for submission of health information to public health agency using Trusted Exchange Framework and Common Agreement (TEFCA)

Hospital Readmission Reduction Program

- Hospital with higher-than-expected 30-day readmission rates penalized up to 3% of hospital's base Medicare inpatient payments
- Proposed changes
  1. Refine all six readmission measures to add MA patient cohort data beginning with FY 2027 program year
     - Modify formula for calculating aggregate payments for excess readmissions (numerator in formula to calculate percentage reduction in hospital's base Medicare inpatient payments) to include MA payments
  2. Reduce the applicable period from 3 years to 2 years
     - E.g., for the FY 2027 program determination, claims/encounter data with admission dates beginning from 7/1/2023 through 6/30/2025 would be used (vs. 7/1/2022 through 6/30/2025)
  3. Remove COVID-19 diagnosed patients measure denominator exclusion from all six readmission measures beginning in FY 2027 program year
  4. Update ECE policy to give CMS discretion to grant extension of deadlines for data submission

Hospital Value-Based Purchasing Program

- Across-the-board 2% withhold of Medicare payments (~$1.7B) redistributed to top performers on 14 measures across 4 domains
  - Person and community engagement, safety, clinical outcomes, cost savings and efficiency
- **Proposed changes:**
  1. Modify THA/TKA Complications measure beginning in FY 2033 program year
     - Include MA patient cohort data; change performance period from 3 years to 2 years (4/1/2029 to 3/31/2031)
  2. Remove COVID-19 exclusion from clinical outcomes domain measures beginning in FY 2027 program year
  3. Technical update to 4 CDC NHSN HAI measures in safety domain beginning in FY 2028 program year
  4. Remove Health Equity Adjustment for hospitals serving higher percentage of dual eligibles
     - "[s]implifying the…scoring methodology by removing the HEA will improve hospitals' understanding of the program and provide clearer incentives to hospitals as they seek to improve the quality of care for all patients"
  5. Provide previously and newly established performance standards for the FY 2028 – FY 2031 program years
  6. Update ECE policy to give CMS discretion to grant extension for data submission

Hospital Acquired Condition (HAC) Reduction Program

- 1% reduction in payment for all Medicare discharges for hospitals in worst-performing quartile on HAC measures
- No proposed changes to HAC measures except technical update to CDC NHSN HAI Measures (CAUTI, CDI, CLABSI, and MRSA)
  - Implement changes to the standard population data used to calculate the standardized infection ratio beginning in FY2025
- Update ECE policy to give CMS discretion to grant extension for data submission

TEAM – 12 Proposed Technical Changes

1. Limited deferment period for new hospitals
2. Track 2 participation eligibility for hospitals currently designated as Medicare Dependent Hospitals
3. Adding the Information Transfer Patient Reported Outcome-based Performance Measure in PY3
4. Applying neutral quality measure score for hospitals with insufficient quality data
5. Methodology to construct target prices to account for coding changes
6. Reconstructing the normalization factor and prospective trend factor
7. Replace Area Deprivation Index with Community Deprivation Index
8. Lookback period and HCC v28 for beneficiary risk adjustment
9. Aligning date range used for episode attribution
10. Removing voluntary health equity plan submission and health-related social needs data reporting
11. Expanding SNF 3-Day Rule Waiver to include swing beds
12. Removing the Decarbonization and Resilience Initiative

6. FFY2026 Skilled Nursing Facility (SNF) Prospective Payment System Proposed Rule

Comments Due June 10

Payment Update

- Update payment rates by 2.8% (vs. 4.2% update for FFY 2025)
  - Based on SNF market basket increase of 3.0%, *plus 0.6% market basket forecast error adjustment* and less 0.8 percentage point productivity adjustment
- Changes to Patient-Driven Payment Model (PDPM) code mapping to maintain consistency with ICD-10 coding guidance

SNF Quality Reporting Program

- Reverse last years' addition of 4 standardized patient assessment data elements
  - Living situation, food (2 elements), utilities; previously adopted SDOH-related data elements remain
- Amend reconsideration policy and process –
  - Allow SNFs to request extension to file request for reconsideration of noncompliance determination if SNF impacted by extraordinary circumstance beyond its control
  - Update bases on which CMS can grant reconsideration request
- CMS seeks stakeholder input regarding -
  - Future measure concepts on the topics of delirium, interoperability, nutrition, and well-being
  - Revisions to current data submission deadlines for assessment data (4.5 months to 45 days)
  - Advancing digital quality measurement and use of FHIR® in SNF QRP
- Request for information regarding current state of health IT use in SNFs

SNF Value-Based Purchasing Program

- Remove Health Equity Adjustment to benefit SNFs that serve higher proportions of dual eligibles
- Apply previously finalized scoring methodology to SNF Within-Stay Potentially Preventable Readmission measure beginning with FY 2028 program year (1st year measure will be applied)
- Adopt reconsideration process to allow SNFs to appeal CMS' initial decisions for Review and Correction requests prior to any affected data being publicly available
- Provide estimated performance standards for FY 2028 and FY 2029 program years

Gentle Reminder…
May 1 Deadline for CMS-855 SNF Attachment

- SNFs must disclose information from additional disclosable parties (ADPs), i.e., person or entity who:
  - Exercises operational, financial, or managerial control over SNF (or a part thereof)
  - Provides SNF with:
    - Policies or procedures for any of SNF's operations
    - Financial, cash management, or accounting services
    - Management or administrative services
    - Management or clinical consulting services
  - Leases or subleases real property to SNF or has interest ≥ 5% of total value of such real property
- For each ADP, SNF must list services provided, organizational structures, and any shared ownership between ADP and SNF (specified on SNF Attachment).
- Failure to provide ADP disclosures may be subject SNF to administrative penalties from CMS, including the denial or revocation of their Medicare enrollment

7. FFY2026 Inpatient Psychiatric Facility (IPF) Prospective Payment System Proposed Rule

Comments Due June 10

Payment Update

- Update payment rates by 2.4% based on 2021 data (vs. 2.8% increase for FFY 2025)
  - Uses 2021-based IPF market basket increase of 3.2% less 0.8 percentage point productivity adjustment
  - Will use more current data in Final Rule, if available
- Labor-related share of 78.9% (currently 78.8%)
- Potential increases to IPF PPS facility-level adjustments for teaching status and rural location
  - Rural location = 18% adjustment to the rates (currently 17%)
  - Teaching status = 0.7981 adjustment to rates (currently 0.5150)

Quality Reporting Program

- Remove 4 existing measures for FY 2026 payment determination
  1. Hospital Commitment to Health Equity
  2. Screening for Social Drivers of Health
  3. Screen Positive Rate for Social Drivers of Health
  4. COVID–19 Vaccination Coverage among Healthcare Personnel
- Modify reporting period for 30-Day Risk-Standardized All-Cause Emergency Department Visit Following an Inpatient Psychiatric Facility Discharge measure
  - From one-year (calendar year) to two-year (fiscal year) period
- Update ECE policy to give CMS discretion to grant extension for data submission
- Seek stakeholder feedback regarding:
  - Potential future star rating system for the IPF QRP
  - Future measure concepts on the topics of nutrition and well-being
  - Use of FHIR® in patient assessment reporting in IPF QRP
- Request for information regarding current state of health IT use in IPFs

8. FFY2026 Inpatient Rehabilitation Facility (IRF) Prospective Payment System Proposed Rule

Comments Due June 10

Payment Update

- Update payment rates by 2.6% (vs. 3.0% update for FFY 2025)
  - Based on IRF market basket increase of 3.4% less 0.8 percentage point productivity adjustment
- Decrease outlier threshold from $12,043 to $11,971

Quality Reporting Program

- Remove two measures for program year 2026
  - COVID-19 Vaccination Coverage among Healthcare Personnel
  - COVID-19 Vaccine: Percent of Patients/Residents Who Are Up to Date
- Reverse last years' addition of 4 standardized patient assessment data elements
  - Living situation, food (2 elements), utilities; previously adopted SDOH-related data elements remain
- Amend reconsideration policy and process:
  - Allow SNFs to request extension to file request for reconsideration of noncompliance determination if SNF impacted by extraordinary circumstance beyond its control
  - Update bases on which CMS can grant reconsideration request

- Seek stakeholder input regarding:
  - Future measure concepts on the topics of delirium, interoperability, nutrition, and well-being
  - Potential revisions to the IRF-Patient Assessment Instrument
  - Revisions to current data submission deadlines for assessment data (4.5 months to 45 days)
  - Advancing digital quality measurement and use of FHIR® in IRF QRP
- Request for information regarding current state of health IT use in IRFs

9. FFY2026 Hospice Payment Rate Update

Comments Due June 10

Rate Setting

- Update payment rates by 2.4% (vs. 2.9% update for FFY 2025)
  - Based on inpatient PPS market basket less productivity
- FFY 2026 Rates
  - Routine home care days 1-60: $230.33 (currently $224.62)
  - Routine home care days 61+: $181.51 (currently $176.92)
  - Continuous home care: $1,665.23 (currently $1,618.59)
  - Inpatient respite care: $531.60 (currently $518.78)
  - General inpatient care: $1,197.40 (currently $1,170.04)
- Increase hospice cap to $35,292.51 (currently $34,465.34)

Policy Clarifications

- Physician member of interdisciplinary group may recommend admission to hospice care.
  - Aligns with certification regulations and CoPs
  - Previous requirement allowed only medical director or physician designee to recommend admission
- Clarify that hospice face-to-face encounter attestation must include physician/practitioner signature and date.

Quality Reporting Program

- Beginning 10/1/2025, new CMS submission and reporting system (iQIES) will begin accepting data from Hospice Outcomes and Patient Evaluation (HOPE) instrument, in line with start of HOPE data collection.
  - Provider reports will also be available in new system beginning 10/1/2025
  - QIES system will stop accepting HIS records for hospice admissions and discharges prior to 10/1/2025 (including any corrections) on 2/15/2026
- Seek stakeholder input regarding:
  - Future measure concepts on the topics of interoperability, nutrition, and well-being
  - Use of FHIR® in patient assessment reporting, specifically HOPE data
- Request for information (RFI) regarding current state of health IT use by hospices

10. April 15 Executive Order Lowering Drug Prices by Once Again Putting Americans First

Key Provisions for Providers

- "Within 180 days… the Secretary shall publish in the *Federal Register* a plan to conduct a survey… to determine the hospital acquisition cost for covered outpatient drugs at hospital outpatient departments."
- "Within 90 days… the Secretary shall take action to ensure future grants available under section 330(e) of the Public Health Service Act … are conditioned upon health centers establishing practices to make insulin and injectable epinephrine available at or below the discounted price paid by the health center grantee or sub-grantee under the 340B Prescription Drug Program (plus a minimal administration fee) to individuals with low incomes…"
- "Within 180 days…the Secretary shall… propose regulations to ensure that payment within the Medicare program is not encouraging a shift in drug administration volume away from less costly physician office settings to more expensive hospital outpatient departments."
- "Within 1 year … the Secretary shall take appropriate steps to develop and implement a rulemaking plan and select for testing … a payment model to improve the ability of the Medicare program to obtain better value for high-cost prescription drugs and biological products covered by Medicare…."

Our Next Healthcare Regulatory Roundup Webinar:

April 30, 2025

Deregulation-o-Rama!

Please leave a comment regarding topics for future HCRR webinars!

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What do the policy changes mean for the healthcare industry?

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