Policy & Practice: A CMS Update

A presentation to the Oregon Critical Access Hospital Quality Workshop

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This publication is a general summary that explains certain aspects of the Medicare, Medicaid/CHIP, and Marketplace Programs, but is not a legal document. The official Program provisions are contained in the relevant laws, regulations, and rulings. The Centers for Medicare & Medicaid policy changes frequently, and links to the source documents have been provided within the document for your reference

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Objectives

- Review recent CMS announcements related to quality, digital transformation and innovation
- Describe key policies specific to Critical Access Hospitals including
  - Implementation of the Medicare Promoting Interoperability Program
  - Swing Beds
  - Obstetric Services Conditions of Participation
  - Telehealth
- Review available resources to support CAHs
- Questions and Discussion

CMS Mission

Ensure our most vulnerable receive
high-value care by leading all payors and supporting providers.

Strategic Objectives

Leading Payor

Establish the CMS team as the indisputable leading payor in the country

Crush Fraud

Crush fraud and reduce inappropriate spending

Empower Beneficiaries

Empower beneficiaries with personalized, actionable health tools to support informed decision making + care navigation

Incentivize Providers

Incentivize providers to maximize focus on delivering their best, data-driven care possible

Align Spending & Value

Partner intentionally with CMS stakeholders to better align spending and value

Health Technology Ecosystem

Health Tech Ecosystem Categories

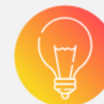
To unlock the full potential of a modern, patient-centered healthcare system, CMS is aligning common infrastructure with private-sector innovation across a set of clearly defined categories.

Learn more about the ecosystem →

Interoperability Framework

Build a national healthcare directory starting with provider and payer information focusing on interoperability.

Read the framework →



Early Adopters

Several companies in different categories have committed to improving health tech.

View who has committed →

Health Technology Ecosystem webpage

Administrative Simplification; Adoption of Standards for Health Care Claims Attachments Transactions and Electronic Signatures Final Rule

Health Care Claims Attachments Standards:

- **X12 Standards**: For administrative transaction data; this final rule adopts Version 6020 of the X12N 275 (Additional Information to Support a Health Care Claim or Encounter - 006020X314) and X12N 277 (Health Care Claim Request for Additional Information – 006020X313) standards as the finalized standards for health care claims attachments transactions, providing implementation specifications (Technical Reports Type 3, or TR3) to facilitate secure, efficient electronic data exchanges.
- **Health Level 7 (HL7®) Standards**: For clinical data integration; the HL7 Implementation Guides (IGs) adopted in this final rule will be HIPAA standards for the attachment information included in the health care attachments transactions. This final rule adopts the HL7 Consolidated Clinical Document Architecture (C-CDA) IG Volume One, the HL7 C-CDA IG Volume Two and the HL7 Attachments IG.
- **Electronic Signature Requirements**: Establishes secure, verified electronic signature standards to authenticate transactions and ensure compliance with federal regulations.

CMS National Standards Group Events and Latest News

Final Rule FAQs

Interoperability Standards and Prior Authorization for Drugs Proposed Rule

Improving Communications and Decision Timeframes for Prior Authorizations and Timeframes for Prior Authorization Decisions

- To ensure prompt notification and align prior authorization decision processes across different CMS programs, CMS proposes that certain payers be required to provide notice of drug-related prior authorization decisions within specific timeframes.
- To align patient protections and create consistent requirements across the Medicaid and CHIP programs, state Medicaid FFS programs, Medicaid managed care plans, and CHIP managed care entities would be **required to make prior authorization decisions for all drugs within a timeframe that aligns with existing decision timeframe requirements for covered outpatient drugs** (no later than 24 hours after receiving a prior authorization request) or items and services (7 days for standard requests, 72 hours for expedited requests).
- Impacted payers would also be required to publicly report prior authorization metrics for drugs, including:
  - Approval and denial rates;
  - Appeal outcomes; and
  - Decision timeframes
- CMS proposes **compliance dates beginning October 1, 2027** for these decision timeframe proposals. Shortening and aligning decision timeframes for prior authorization across CMS programs could improve timely access to medications, which is essential for maintaining health and preventing complications in these populations.

2026 Interoperability Standards and Prior Authorization for Drugs Proposed Rule Fact Sheet

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Rural Health Transformation Program (RHTP)

The Rural Health Transformation (RHT) Program was authorized by the One Big Beautiful Bill Act (Section 71401 of Public Law 119-21) and empowers states to strengthen rural communities across America by improving healthcare access, quality, and outcomes by transforming the healthcare delivery ecosystem. Through innovative system-wide change, the RHT Program invests in the rural healthcare delivery ecosystem for future generations.

Five Strategic Goals:

- **Make rural America healthy again:** Support rural health innovations and promote preventive care.
- **Sustainable access:** Ensure rural providers can become long-term access points for care by improving efficiency and sustainability.
- **Workforce development:** Build and retain a strong rural health care workforce.
- **Innovative care:** Test new models of care delivery to improve rural health outcomes and lower the cost of care.
- **Tech innovation:** Expand use of technologies that promote access and efficiency in rural settings.

Rural Health Transformation Webpage

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Priorities in the Center for Medicare

Medicare Advantage

Drive Quality with Better Star Ratings
- Rebalance measures, reduce complexity, improve incentives.

Reform Risk Adjustment
- Advance payment accuracy & competition on quality of coverage.

Stop Gaming with Smarter Regulation
- More targeted CMS oversight to improve beneficiary experience.

Lower Drug Costs
- Fight for affordable & stable drugs and drug coverage.

Reduce Prior Authorization Burden
- Remove barriers to care, limit paperwork, avoid FWA.

Original Medicare

Evolve Beyond Fee-for-Service
- Promote value through market-based pricing, appropriate payment for tech-enabled care, site neutrality, bundling, and other cost-sharing reforms

Accountable Care Acceleration
- Increase savings generated by risk-bearing entities through improved incentives and tooling

Best-in-Class Operations
- Maintain excellent operational support for providers and beneficiaries
- Implement real-time claims processing system to allow us to better combat FWA, improve CF for providers, and enable faster data visibility
- Support agency efforts to promote price and quality transparency
- Advance interoperable claims and clinical data exchange

“Aging” Initiative

Policy Efforts
- Consider programs that promote “aging in place,” e.g., access to in-home dialysis, Medicare-only PACE
- Improve institutional and nursing facility experience
- Safeguard seniors and program from FWA (especially hospice, home health, DMEPOS)
- Improve end-of-life care, including through expansion of palliative care outside hospice

Cultural Change
- Promote celebration of seniors and their integration into our daily lives
- Highlight policy wins that improve quality of care and coverage for seniors

Original Medicare Policy Priorities

- **Evolve Beyond Fee-for-Service**
  - Orient OM payment systems towards better data, market-based pricing, site neutrality, episode-based payments, and rationalized cost-sharing
  - Ensure the program promotes deflationary innovation through appropriate payment of tech-enabled services
- **Accountable Care Acceleration**
  - Enable dramatic scale-up of savings in MSSP and other ACO programs through payment policies and regulatory flexibilities that empower accountable care arrangements to increase per capita savings and incentivize greater participation
- **Best-in-Class Operations/ ClaimsCore**
  - Improve operational capabilities to support providers and beneficiaries, particularly through a modernized claims processing systems, with an eye towards achieving capability for real-time payment and exchange of clinical and claims information

Part C/D Highlights

- **Drive Quality with Better Star Ratings**
  - Nov 2025: Proposed significant streamlining of Star Rating measures
    - Rebalance to meaningful measures for enrollees: Clinical, outcomes-based, preventive
    - Remove measures where performance is topped-out and/or has low variability
- **Reform Risk Adjustment**
  - Jan 2026: Proposed steps to modernize risk adjustment system
    - Bring data from pre-Covid (2018 diagnoses/2019 spend) to post-Covid world (2023/2024)
    - Excluded diagnoses from "unlinked" chart review records to require clear connection to clinical care
  - CMS aims to promote simplicity, competition, and payment accuracy

Strategic Roadmap for the Center for Clinical Standards and Quality

CCSQ's FY2025–2028 Strategic Plan builds on a foundation of safety, quality, and accountability. It reflects the Center's evolution toward a more data-driven, prevention-focused, and person-centered approach to healthcare quality.

This plan serves as a roadmap for how CCSQ will integrate public health and quality through prevention and chronic disease management; modernize regulatory frameworks; leverage technology and interoperability; accelerate access to innovative treatments; and strengthen accountability and transparency.

Updates to policies specifically related to Critical Access Hospitals

CAHs Participation in the Medicare Promoting Interoperability Program

The American Recovery and Reinvestment Act of 2009 authorized incentive payments under Medicare as well as downward payment adjustments for the meaningful use of certified electronic health record technology (CEHRT). As of 2016, CAHs that don't successfully demonstrate meaningful use of CEHRT are subject to a reduction of their payments from 101% to 100% of reasonable costs. Hardship exceptions are available, but by law, we limit a CAH to 5 years of these exceptions. See Promoting Interoperability Programs for more information.

Starting January 1, 2026:

- The Medicare Promoting Interoperability Program defines the electronic health record reporting period as a minimum of any continuous 180-day period within that CY
- CAHs must attest "yes" to conducting security risk management along with the existing requirement for attesting "yes" to security risk analysis
- CAHs have to attest "yes" to completing an annual self-assessment using the 8 SAFER Guides published in January 2025
- We add an optional bonus measure under the Public Health and Clinical Data Exchange objective for data exchange to occur with a public health agency using the Trusted Exchange Framework and Common Agreement

Updates to policies specifically related to Critical Access Hospitals (2)

CAH Swing Beds

- We pay for CAH swing bed services as section 1883(a)(3) of the Social Security Act and 42 CFR 413.114(a)(2) require.
- CAH swing bed services aren't subject to skilled nursing facility (SNF) PPS. Instead, we pay CAHs based on 101% of reasonable costs.
- We require a 3-day hospital stay, commonly known as the SNF 3-day rule, before admitting a patient to a swing bed. Starting January 1, 2026, we'll allow acute care hospitals participating in the Transforming Episode Accountability Model (TEAM), a mandatory model, to discharge patients without a 3-day hospital stay to a participating CAH, under swing bed arrangements, for post-acute care. See MLN Matters® article MM14098 for more information and payment criteria on the SNF 3-day rule waiver.
- CAHs may bill for:
  - Bed and board, nursing, and other related services
  - Using CAH facilities
  - Medical social services
  - Drugs
  - Biologicals
  - Supplies, appliances, and equipment for inpatient hospital care and treatment and diagnostic or therapeutic items or services they, or others, provide under arrangement

Obstetrics Services Conditions of Participation (CoPs) and New Requirements

- Effective July 1, 2025, CAHs must comply with these emergency services readiness requirements:
  - CAHs must have adequate provisions and protocols to meet emergency patient needs in accordance with the complexity and scope of services offered
  - Protocols must be consistent with nationally recognized, evidence-based guidelines for caring for patients with emergency conditions, including, but not limited to, patients with obstetrical emergencies, complications, and immediate post-delivery care
  - Applicable CAH staff must complete annual training on these protocols and provisions, with documentation of completion required

Obstetrics Services Conditions of Participation (CoPs) and New Requirements (2)

- Effective January 1, 2026, CAHs offering OB services must comply with these organization and staffing and delivery of service requirements:
  - CAHs must have appropriate organization and supervision of OB services as well as integration of OB services with other CAH departments.
  - OB services must be consistent with CAH needs and resources.
  - OB care policies must be designed to ensure consistent high standards of medical practice, patient care, and safety.
  - CAHs must have equipment readily available for treating OB cases to meet the needs of patients, including a call-in system, cardiac monitor, and fetal doppler or monitor.
  - CAHs must have adequate provisions and protocols for obstetrical emergencies, complications, immediate post-delivery care, and other patient health and safety events. Provisions include equipment, supplies, and medication used in treating emergency cases and must be readily available in the CAH.

Obstetrics Services Conditions of Participation (CoPs) and New Requirements (3)

- Effective January 1, 2027, CAHs must comply with staff training and Quality Assessment and Performance (QAPI) program requirements. CAHs must:
  - Develop policies and procedures to ensure relevant staff are trained on topics aimed at improving the delivery of maternal care, with documentation of completion required
  - Require OB services leadership to participate in OB QAPI activities
  - Incorporate publicly available maternal mortality review committee (MMRC) data and recommendations into the QAPI program, as available
  - Use its QAPI program to assess and improve health outcomes and disparities among OB patients on an ongoing basis

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Best practice guides

Licensure

Billing for telehealth

Telehealth policy

Updates to policies specifically related to Critical Access Hospitals (3)

Telehealth Services Payment

We pay for telehealth services at 80% of PFS when the distant site physician or other practitioner location is in a CAH electing the optional payment method and the physician or other practitioner reassigns their billing rights to the CAH. Submit such claims with the GT modifier. CAHs bill their regular Part A MAC for professional services provided at the distant site via telehealth, with revenue codes 096X, 097X, or 098X. All requirements for billing distant-site telehealth services apply.

Visit the CMS Telehealth webpage for the latest information. It's intended to help physicians, practices, and health systems navigate changes to Medicare telehealth policy.

For telehealth services, CAH-based renal dialysis centers (including satellites) must use revenue code 078X when billing for the originating site facility fee. Use HCPCS code Q3014, telehealth originating site facility fee, on a separate revenue line from any other services provided to the patient.

Non-Behavioral/Mental Health Telehealth Policy Update
The Consolidated Appropriations Act, 2026

- Medicare patients can receive telehealth services for non-behavioral/mental health care in their home **through December 31, 2027**.
- There are no geographic restrictions for originating site for Medicare non-behavioral/mental telehealth services **through December 31, 2027**.
- Telehealth services can be provided by all eligible Medicare providers **through December 31, 2027**.
- Non-behavioral/mental telehealth services in Medicare can be delivered using audio-only communication platforms **through December 31, 2027**.
- Interactive telecommunications systems may **permanently include two-way, real-time audio-only** communication technology for any telehealth service furnished to a patient in their **home if the distant site physician or practitioner is technically capable** of using an interactive telecommunications system, **but the patient is not capable of, or does not consent to, the use of video** technology.

Updated Telehealth Services FAQ
HHS Telehealth Policies webpage
Medicare All Fee-for-Service Providers webpage

Behavioral/Mental Health Telehealth Policy Update

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- To support access to tele-behavioral health care, current telehealth policies allow Medicare patients can **permanently** receive telehealth services for behavioral/mental health care in their home.
  - FQHCs and RHCs can **permanently** serve as a Medicare distant site provider for behavioral/mental telehealth services.
  - Marriage and family therapists and mental health counselors can **permanently** serve as Medicare distant site providers.

- There are no geographic restrictions for originating site for Medicare behavioral/mental telehealth services on a **permanent** basis.

- Behavioral/mental telehealth services in Medicare can **permanently** be delivered using audio-only communication platforms.

- An in-person visit within six months of an initial Medicare behavioral/mental telehealth service, and annually thereafter, is not required **through December 31, 2027**.

Introducing the Midwest QIN-QIO

In 2025, CMS **awarded five-year regional contracts to serve as Quality Innovation Network-Quality Improvement Organizations (QIN-QIOs).** Telligen, in partnership with Mountain Pacific, was awarded **the Midwest Region (Region 6).**

Midwest CMS QIN-QIO
Telligen, MPQH & Partners

The Quality Improvement Organization (QIO) Program, one of the largest federal programs dedicated to improving health quality for Medicare beneficiaries, is an integral part of the U.S. Department of Health and Human Services' National Quality Strategy for providing better care and better health at lower cost.

QIN-QIOs

WHAT THEY DO

Work alongside local providers as true partners to strengthen care and make measurable improvements that matter to patients and communities.

Support communities in advancing CMS and national quality priorities by focusing on meaningful, locally driven solutions that foster collaboration and long-term impact.

Offer hands-on and virtual guidance, resources and peer learning opportunities, at no cost, to empower providers and build stronger networks for healthcare quality improvement across communities, states and regions.

The Midwest QIN-QIO focuses on:

Improve Behavioral Health Outcomes and Decrease Opioid Misuse

Increase Patient Safety

Increase Chronic Disease Self-Management

Increase Quality of Care Transitions

Improve Nursing Home Quality

Visit https://midwestcmsqinqio.com/ or email contact@midwestcmsqinqio.com.

Focus Areas

Additional Resources

Other Medicare Learning Network (MLN) Articles of Interest

[Information for Critical Access Hospitals MLN Booklet]

[Telehealth Resources Page]

[Updated Telehealth Services FAQ]

Check https://www.cms.gov/training-education/medicare-learning-network/resources-training for more information and future guidance

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