# STATE OF THE HEALTHCARE INDUSTRY: UPDATES FOR RURAL

NOSORH Quarterly Updates for Rural Strategy

April 11, 2025

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STROUDWATER

# PANELIST

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# AGENDA

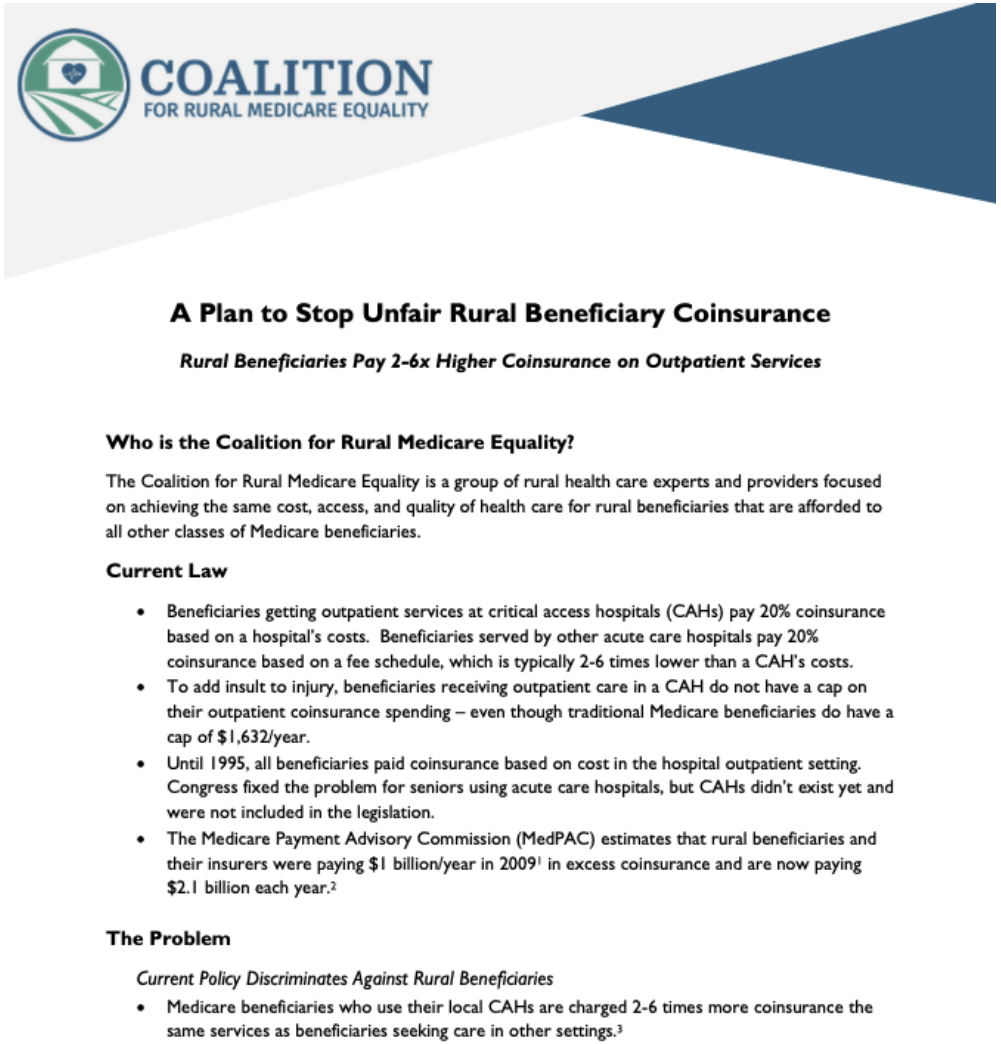
1 Legislative/Regulatory Updates

2 Other Market Updates

# LEGISLATIVE/REGULATORY UPDATES

# PLAN TO STOP UNFAIR RURAL BENEFICIARY COINSURANCE (11/26/2024)

- On November 26, 2024, Coalition released new approach focusing singularly on CAH coinsurance
  - Proposed Solution
    - Calculate the CAH coinsurance based on 20% of costs (proposed by MedPAC at September 2024 meeting)
    - Annual OP out-of-pocket cap would be set at $1,632 for rural beneficiaries (equal to cap for urban beneficiaries)
  - Costs
    - MedPAC's proposal would lower rural beneficiary coinsurance by $2.1B or $350/year per rural beneficiary
    - Increase beneficiary premiums by $13 year
    - Increase payments to Medicare Advantage Plans by $1.3B due to the benchmark being changed to reflect Medicare covering 80% of costs versus the current 50%
- ***New approach does not address alternative payment models and Medicare Advantage plans from diverting services from CAHs***



COALITION
FOR RURAL MEDICARE EQUALITY

**A Plan to Stop Unfair Rural Beneficiary Coinsurance**

***Rural Beneficiaries Pay 2-6x Higher Coinsurance on Outpatient Services***

**Who is the Coalition for Rural Medicare Equality?**

The Coalition for Rural Medicare Equality is a group of rural health care experts and providers focused on achieving the same cost, access, and quality of health care for rural beneficiaries that are afforded to all other classes of Medicare beneficiaries.

**Current Law**

- Beneficiaries getting outpatient services at critical access hospitals (CAHs) pay 20% coinsurance based on a hospital's costs. Beneficiaries served by other acute care hospitals pay 20% coinsurance based on a fee schedule, which is typically 2-6 times lower than a CAH's costs.
- To add insult to injury, beneficiaries receiving outpatient care in a CAH do not have a cap on their outpatient coinsurance spending – even though traditional Medicare beneficiaries do have a cap of $1,632/year.
- Until 1995, all beneficiaries paid coinsurance based on cost in the hospital outpatient setting. Congress fixed the problem for seniors using acute care hospitals, but CAHs didn't exist yet and were not included in the legislation.
- The Medicare Payment Advisory Commission (MedPAC) estimates that rural beneficiaries and their insurers were paying $1 billion/year in 2009[1] in excess coinsurance and are now paying $2.1 billion each year.[2]

**The Problem**

*Current Policy Discriminates Against Rural Beneficiaries*

- Medicare beneficiaries who use their local CAHs are charged 2-6 times more coinsurance the same services as beneficiaries seeking care in other settings.[3]

# MEDPAC REPORT: COST SHARING FOR OUTPATIENT SERVICES AT CRITICAL ACCESS HOSPITALS (9/5/2024) WITH UPDATE(3/07/2025)

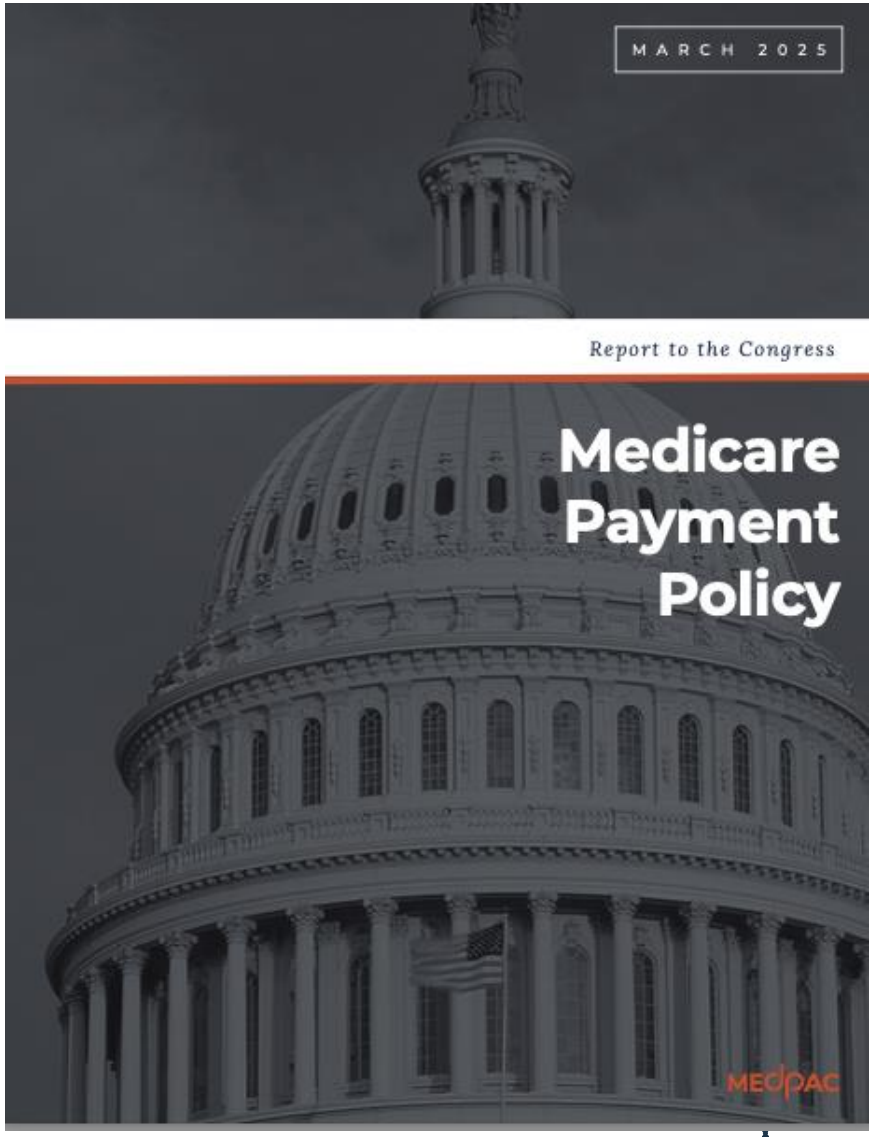
- On September 5, 2024, MedPAC staff presented a report to MedPAC Commissioners on the issue with CAH OP Coinsurance and a possible solution
  - Important Findings (based on FY 2022)
    - 50% of CAH's OP costs are paid by coinsurance
    - 1.9M Medicare beneficiaries (or supplemental plans) were billed an average of $1,750 in CAH cost sharing (84% by supplemental plans)
    - No cap on CAH coinsurance vs. $1,632 cap on OPPS services
  - Proposed Solution
    - Set CAH coinsurance at 20% of payment rate
      - Total payment to CAH remains the same
      - Consistent with how OP supplement payments work for Sole Community Providers
  - Impacts (based on 2022 data)
    - Taxpayers would have funded 75% of $3.2B and Part B premiums would have increased by $0.8B or $13/beneficiary


- ***March 7, 2025 Update: MedPAC unanimously voted to recommend that Congress Set CAH outpatient coinsurance at 20% of the Medicare payment amount (instead of 20% of charges) and implement a cap on coinsurance equal to the inpatient deductible.***

https://www.medpac.gov/wp-content/uploads/2023/10/Tab-D-CAH-Sept-2024-FINAL.pdf; https://www.fiercehealthcare.com/providers/medpac-votes-recommen...l&utm_campaign=HC-NL-FierceHealthcare&oly_enc_id=4124G2638990J1I

# MEDPAC MARCH 2025 REPORT TO CONGRESS: HIGHLIGHTS (3/15/25)

- MedPAC recommends Congress update the 2026 inpatient and outpatient payment rates be increased by statutory amounts (2.0%), plus 1.0%
  - Recommendation reflects significant underpayment in FY2022
  - Congress should begin a transition to redistribute existing safety-net payments to hospitals using the Commission's Medicare Safety-Net Index and increase pool by $4B
- MedPAC recommends for calendar year 2026, Congress replace the current-law updates to Medicare payment rates for physician and other health professional services with a single update equal to the projected increase in the MEI minus 1 percentage point (approximately 1.3%)
  - Enact the Commission's March 2023 recommendation to establish safety-net add-on payments under the physician fee schedule for services delivered to low-income Medicare beneficiaries
- MedPAC recommends 3% decrease in payment to SNFs, 7% decrease in payments to home health agencies and Inpatient Rehab Facilities, and 0% update to hospice providers
- Study on Medicare Advantage (MA) plans using 2016 to 2024 data showed 54% of eligible Medicare beneficiaries enrolled in MA plans, which costs 20% ($84B) more than Medicare FFS
- Study on Rural Emergency Hospitals




Source: MedPAC Report to the Congress: Medicare and the Health Care Delivery System, March 15, 2025
https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf

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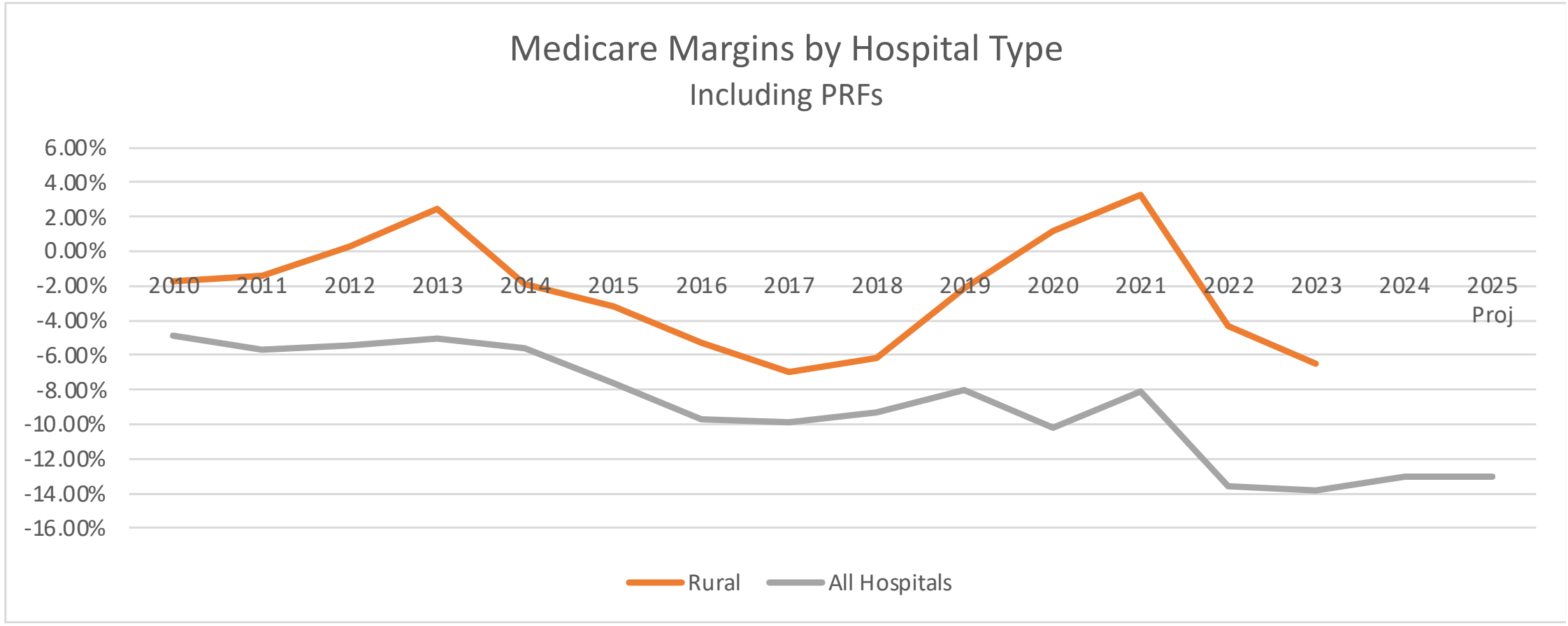
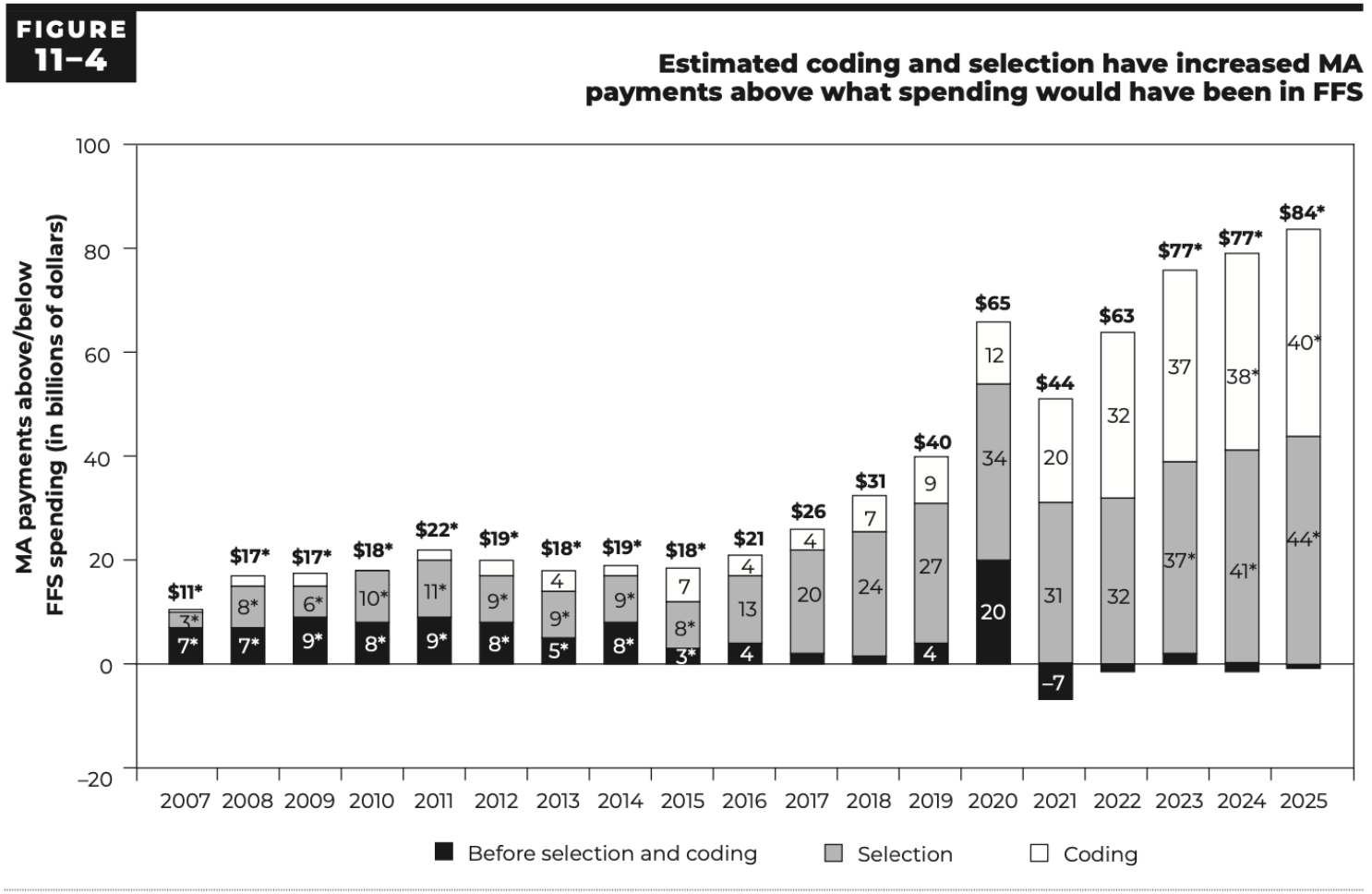



Source: MedPAC Report to the Congress: Medicare and the Health Care Delivery System, March 15, 2025
https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf

# MEDPAC: THE MEDICARE ADVANTAGE (MA) PROGRAM: STATUS REPORT (3/15/2025)

- Key findings in the report:
  - In 2024, 54% (33.6M) of eligible beneficiaries are enrolled in MA plan (up from 26% in 2010)
  - Risk Scores – Risk scores grew 6% faster than FFS in year one of enrollment and 2% faster in year 2
  - MA plans also are estimated to have favorable selection leading to overpayments between 2017 – 2021 of between 6% and 13%
  - Overall MA spend relative to FFS is estimated to be over ***$585B*** between 2007-2025




Source: MedPAC Report to the Congress: Medicare and the Health Care Delivery System, March 15, 2025
https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_MedPAC_Report_To_Congress_SEC.pdf

# CONSUMER FINANCIAL PROTECTION BUREAU (CFPB) FINAL RULE (UPDATED 2/9/2025)

- On 1/7/2025, the CFPB finalized a June 2024 proposed rule to block medical debt from appearing in a consumer's credit report
  - In addition, credit reporting agencies generally will be barred from including medical debt in information sent to lenders
  - Final rule will remove $49B in unpaid medical bills from the credit reports of 15M Americans
  - Credit scores from affected individuals can be expected to rise 20 points
- ***On 2/9/2025, the administration ordered the CFPB to stop nearly all work, effectively shutting down the agency***

JANUARY 07, 2025

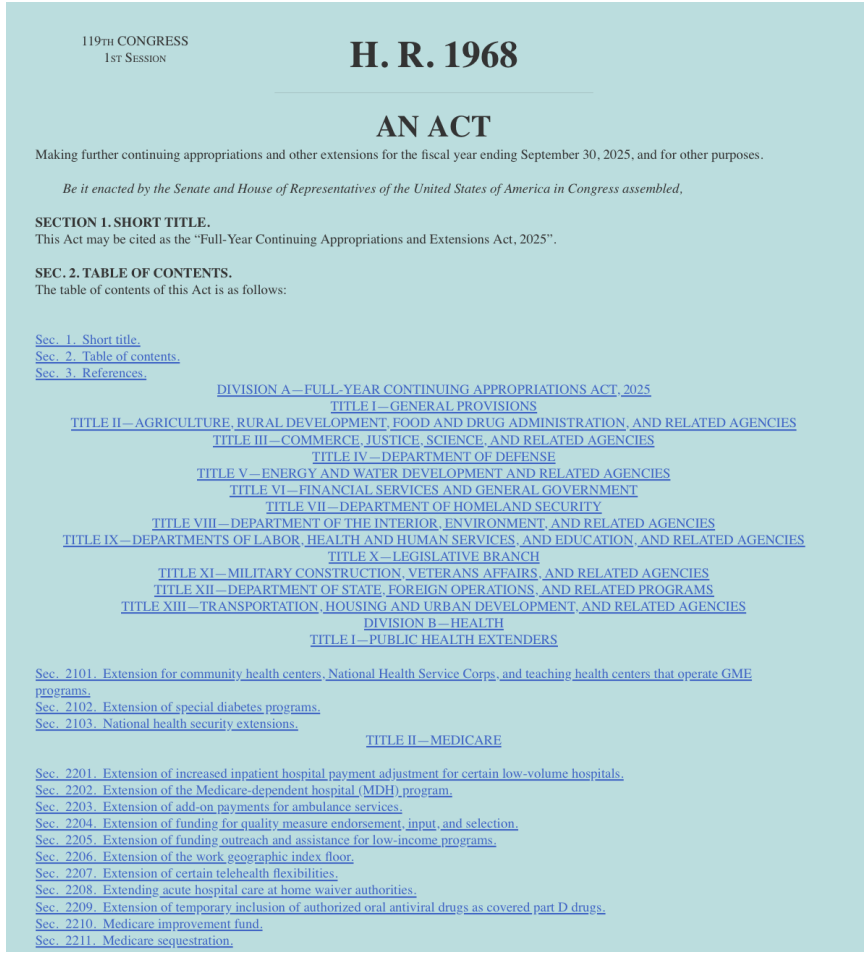
FACT SHEET: Vice President Harris Announces Final Rule Removing Medical Debt from All Credit Reports

*Today's final rule will remove $49 billion in unpaid medical bills from the credit reports of 15 million Americans. In addition, the Vice President is announcing that States and Localities have already Eliminated Over $1 Billion in Medical Debt Thanks to Biden-Harris Administration Support*

Sources: https://www.hfma.org/revenue-cycle/in-pushing-through-restrictions-on-medical-debt-reporting-cfpb-brushes-off-criticisms-and concerns/?utm_medium=email&utm_source=rasa _io&utm_campaign=newsletter; FACT SHEET: Vice President Harris Announces Final Rule Removing Medical Debt from All Credit Reports | The White House; https://apnews.com/article/trump-consumer-protection-cease-1b93c60a773b6b5ee629e769ae6850e9

# FULL-YEAR CONTINUING APPROPRIATIONS AND EXTENSIONS ACT, 2025 (3/15/2025)

- On 3/15/2025, the Continuing Appropriations and Extensions Act of 2025 was signed into law averting a government shutdown, largely keeping spending at current levels trimming of non-defense spending by $13B and increases defense spending by $6B
  - Key provisions
    - Extended a short-term Continuing Resolution through 9/30/25
    - Extended certain designations and programs through 9/30/2025
      - Medicare Dependent hospital designation,
      - Medicare Low-Volume hospital adjustment,
      - Medicare add-on payments for rural Ambulance services,
      - Medicare Telehealth flexibilities, including geographic requirements, in-person requirements for behavioral health services, allowance of audio-only services,
      - Mandatory funding for Community Health Centers, National Health Service Corps, and Teaching Health Center GME,
      - Acute Hospital at Home waiver authorities,
      - Medicare physician quality programs,
      - State Health Insurance Assistance programs for Medicare enrollment support
    - Delayed Disproportionate Share Hospital payment cuts through October 1, 2025
    - CR left in place a 3% Physician Fee Schedule payment cut, effective 1/1/2025



119TH CONGRESS
1ST SESSION

**H. R. 1968**

**AN ACT**

Making further continuing appropriations and other extensions for the fiscal year ending September 30, 2025, and for other purposes.

*Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,*

**SECTION 1. SHORT TITLE.**
This Act may be cited as the "Full-Year Continuing Appropriations and Extensions Act, 2025".

**SEC. 2. TABLE OF CONTENTS.**
The table of contents of this Act is as follows:



Sources: https://www.congress.gov/bill/119th-congress/house-bill/1968/text; NRHA Grass Roots Advocacy Forum

# TRUMP 2025 ADMINISTRATION HEALTHCARE PROPOSALS: AREAS WITH POTENTIAL NEGATIVE EFFECTS

- **Medicare Site Neutrality**
  - Although site neutrality could lead to $146 billion in government savings over ten years, many rural hospitals rely on current payment differentials to sustain operations.
- **Eliminate Medicare Coverage of Bad Debt and Uncompensated Care Payments**
  - This proposal would phase out Medicare reimbursement for hospital bad debt, placing excessive financial strain on already struggling rural hospitals. Uncompensated care payments would shift funding from the Medicare Trust Fund to a new system, redistributing payments based on a broader definition of charity care.
- **Significant Medicaid Reforms**
  - Proposals include imposing work requirements for certain Medicaid populations; reducing provider tax safe harbors, potentially affecting access to care in underserved areas; imposing per capita caps within states; lowering the 90% rate for the expansion population FMAP to equal the rate set by the traditional Medicaid formula ($561 billion); and removing the 50% floor for any state's FMAP ($400 billion)
- **Changes to the ACA**
  - The new administration may repeal ACA subsidies "Family Glitch" final rule, reversing a 2022 rule expanding ACA subsidies to dependents of employees with employer-based coverage deemed unaffordable for family members. Changes to premium tax credits, aiming to target subsidies to the most financially vulnerable Americans while reducing overall costs, are also proposed.

Sources: NRHA's Grassroots Advocacy Forum, Marguerite Peterseim, 1/21/25; hfma.org, *GOP puts ideas for major healthcare spending cuts in writing,* Nick Hut, 1/20/25 *https://www.hfma.org/payment-reimbursement-and-managed-care/gop-puts-ideas-for-major-healthcare-spending-cuts-in-writing;* ModernHealthcare, The Trump executive orders that impact healthcare, Bridget Early, 1/22/25 *https://www.modernhealthcare.com/policy/trump-executive-orders-insurance-drug-pricing*

# TRUMP 2025 ADMINISTRATION HEALTHCARE PROPOSALS: AREAS WITH POTENTIAL NEGATIVE EFFECTS

- **Public Health Concerns**
  - The President rescinded five executive orders related to the COVID-19 pandemic
  - Another order issued 1/21/25 began the process of withdrawing from the World Health Organization, for which the US is the major funding source. This puts both American and global public health at significant risk.
- **Elimination of Non-Profit Status for Hospitals**
  - The new administration proposes taxing hospitals as for-profit entities, which could jeopardize the financial stability of rural facilities and their ability to serve vulnerable populations. Approximately 57% of rural hospitals are not-for-profit.
- **Drug Pricing**
  - A significant proposal eliminates Medicare's ability to negotiate drug prices, costing about $20 billion over 10 years.
- **Nondiscrimination Policies**
  - An executive order mandates that federal agencies only accept sex at birth, rather than gender, and ensure official documents include accurate information about people's biological sex. The order overrides Biden's orders that created additional protections for LGBTQ+ people in healthcare settings.
- **Rollbacks of AI Regulations**
  - Eliminated a 2023 executive order requiring federal agencies to create a regulatory framework for AI safety and transparency. With healthcare providers increasingly using AI in patient care. The technology has resulted in high rates of alleged incorrect prior authorization denials, which heightened calls for oversight.

Sources: NRHA's Grassroots Advocacy Forum, Marguerite Peterseim, 1/21/25; hfma.org, *GOP puts ideas for major healthcare spending cuts in writing,* Nick Hut, 1/20/25 *https://www.hfma.org/payment-reimbursement-and-managed-care/gop-puts-ideas-for-major-healthcare-spending-cuts-in-writing;* ModernHealthcare, The Trump executive orders that impact healthcare, Bridget Early, 1/22/25 *https://www.modernhealthcare.com/policy/trump-executive-orders-insurance-drug-pricing*

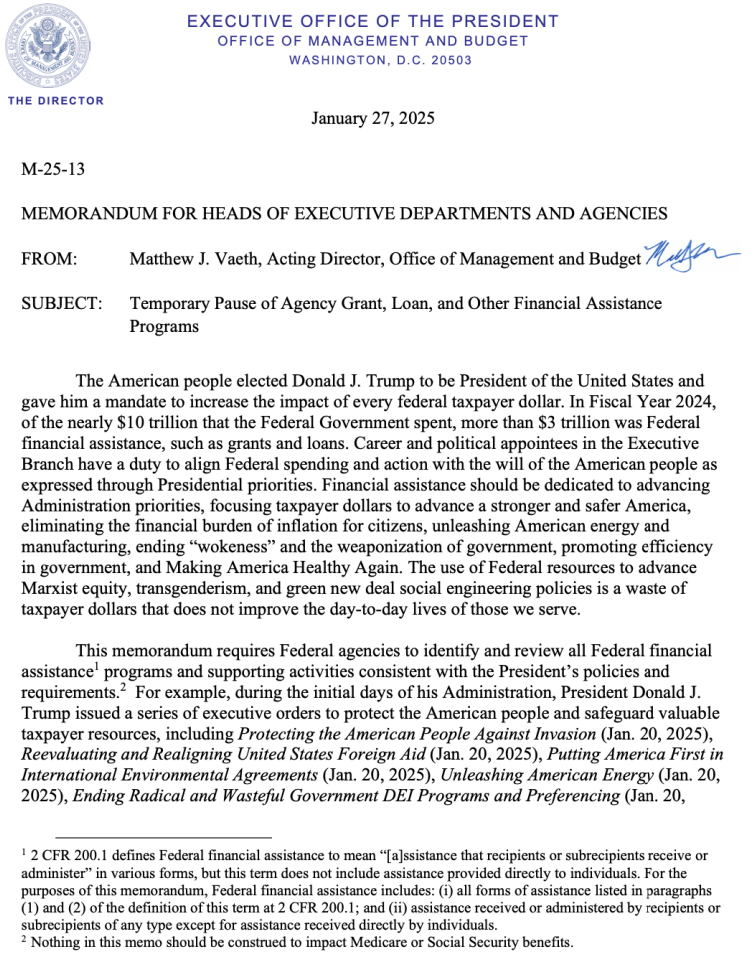
# TRUMP 2025 ADMINISTRATION HEALTHCARE PROPOSALS: **AREAS WITH POTENTIAL BENEFITS FOR RURAL HOSPITALS**

- **Second Chances for Rural Hospitals Act**
  - This proposed legislation would expand eligibility for rural emergency hospital designation. This concept was in H.R. 8246 during the 118th Congress.
- **Rural Health Extenders**
  - $20 billion would be slotted within Medicare for improving access to care innovation, such as advanced screening that can detect multiple forms of cancer, and telehealth. The proposed legislation extends Medicare telehealth flexibilities, rural ground ambulance add-on payments, hospital at-home program, and Medicare-dependent hospital designation and low-volume hospital adjustment.
- **Rural-Focused GME Reform**
  - This proposal ensures that 10% of newly enacted GME slots are allocated to truly rural teaching hospitals, which could strengthen the rural healthcare workforce pipeline and mitigate provider shortages in underserved areas.
- **Reform Medicare Physician Payments**
  - Proposal to reform the Medicare Physician Fee Schedule to encourage more predictability and certainty, partly to end a string of several years in which physicians have seen their payment rates reduced. That includes a 2.83% cut for 2025.
- **Proposals to Expand Direct Contracts and Value-Based Care**
  - Encourages innovative care models within employer-sponsored health insurance, which could improve access and affordability for rural workers, provided rural providers are integrated into these models.
- **Rural Emergency Care**
  - This proposal allots $10 billion over 10 years to improve access to rural emergency care and facilitate the transition to post-acute care in rural areas.

Sources: NRHA's Grassroots Advocacy Forum, Marguerite Peterseim, 1/21/25; hfma.org, *GOP puts ideas for major healthcare spending cuts in writing,* Nick Hut, 1/20/25 *https://www.hfma.org/payment-reimbursement-and-managed-care/gop-puts-ideas-for-major-healthcare-spending-cuts-in-writing;* ModernHealthcare, The Trump executive orders that impact healthcare, Bridget Early, 1/22/25 *https://www.modernhealthcare.com/policy/trump-executive-orders-insurance-drug-pricing*

# TEMPORARY PAUSE OF AGENCY GRANT, LOAN, AND OTHER FINANCIAL ASSISTANCE PROGRAMS (1/27/2025)

- **On 1/27/2025, the Office of Management and Budget issued a temporary pause of agency grant, loan and other financial assistance programs**
  - Stated purpose is to allow internal review by political appointees to ensure funding is in line with administration's priorities
  - Effective date 1/28/2025 at 5pm
- **Affected entities/organizations include:**
  - FORHP
    - Medicare rural hospital flexibility program
    - Funding for State Offices of Rural Health
    - Small hospital improvement program
    - Etc.
  - USDA
- **No later than February 10, 2025, agencies shall submit to OMB detailed information on any programs, projects or activities subject to this paus.**
  - Each agency must pause:
    - (i) issuance of new awards;
    - (ii) disbursement of Federal funds under all open awards; and
    - (iii) other relevant agency actions that may be implicated by the executive orders, to the extent permissible by law, until OMB has reviewed and provided guidance to your agency
- **On 1/28, Federal judge placed hold on the temporary pause that will expire on 2/3**
- **On 1/29, original memo rescinded by administration**



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

THE DIRECTOR

January 27, 2025

M-25-13

MEMORANDUM FOR HEADS OF EXECUTIVE DEPARTMENTS AND AGENCIES

FROM: Matthew J. Vaeth, Acting Director, Office of Management and Budget

SUBJECT: Temporary Pause of Agency Grant, Loan, and Other Financial Assistance Programs

The American people elected Donald J. Trump to be President of the United States and gave him a mandate to increase the impact of every federal taxpayer dollar. In Fiscal Year 2024, of the nearly $10 trillion that the Federal Government spent, more than $3 trillion was Federal financial assistance, such as grants and loans. Career and political appointees in the Executive Branch have a duty to align Federal spending and action with the will of the American people as expressed through Presidential priorities. Financial assistance should be dedicated to advancing Administration priorities, focusing taxpayer dollars to advance a stronger and safer America, eliminating the financial burden of inflation for citizens, unleashing American energy and manufacturing, ending "wokeness" and the weaponization of government, promoting efficiency in government, and Making America Healthy Again. The use of Federal resources to advance Marxist equity, transgenderism, and green new deal social engineering policies is a waste of taxpayer dollars that does not improve the day-to-day lives of those we serve.

This memorandum requires Federal agencies to identify and review all Federal financial assistance[1] programs and supporting activities consistent with the President's policies and requirements.[2] For example, during the initial days of his Administration, President Donald J. Trump issued a series of executive orders to protect the American people and safeguard valuable taxpayer resources, including *Protecting the American People Against Invasion* (Jan. 20, 2025), *Reevaluating and Realigning United States Foreign Aid* (Jan. 20, 2025), *Putting America First in International Environmental Agreements* (Jan. 20, 2025), *Unleashing American Energy* (Jan. 20, 2025), *Ending Radical and Wasteful Government DEI Programs and Preferencing* (Jan. 20,

[1] 2 CFR 200.1 defines Federal financial assistance to mean "[a]ssistance that recipients or subrecipients receive or administer" in various forms, but this term does not include assistance provided directly to individuals. For the purposes of this memorandum, Federal financial assistance includes: (i) all forms of assistance listed in paragraphs (1) and (2) of the definition of this term at 2 CFR 200.1; and (ii) assistance received or administered by recipients or subrecipients of any type except for assistance received directly by individuals.
[2] Nothing in this memo should be construed to impact Medicare or Social Security benefits.

Sources: https://www.washingtonpost.com/documents/deb7af80-48b6-4b8a-8bfa-3d84fd7c3ec8.pdf?itid=lk_inline_manual_41; NRHA Grassroots Advocacy Forum: Executive Action to Freeze Federal Grant Funding

# HOUSE BUDGET PROPOSAL (2/12/2025)/SENATE BUDGET COMMITTEE (4/10/2025)

- On 2/12/2025, the House of Representatives Budget Committee released its 2025 budget proposal, which tasks the primary healthcare committee with making **$880B** in cuts to federal healthcare programs
  - The highest-cost mandatory federal healthcare spending funds Medicare, Medicaid, and Social Security
  - House Speaker Mike Johnson stated that the cuts would target "fraud, waste and abuse", including **state provider taxes**, within Medicaid but also confirmed that the House GOP plans to narrow Medicaid eligibility standards and impose work requirements for Medicaid recipients
  - Beyond cutting Medicaid, the budget reduction could be supplemented through other cuts such as implementing site-neutral payments for outpatient care
- On 4/2/2025, the Senate Budget Committee released Budget Resolution proposing two steps to reduce $880B in healthcare cuts:
  - Proposes budget accounting method that allows the Senate to ignore most of the deficit impact of renewing the tax cuts ($3.8T)
  - Resolution would direct the Finance Committee to add $1.5T to the deficit
- On 4/10/2025, House passed final version of the fiscal 2026 budget resolution calling for $1.5T in cuts, following a Senate vote on 4/7/2025, which called for $4B in cuts

Source: Modern Healthcare, *House GOP eyes $880B in healthcare cuts,* Michael McAuliff, 2/12/25 https://www.modernhealthcare.com/politics-policy/house-budget-healthcare-cuts-2025; 4/2/25: https://www.modernhealthcare.com/politics-policy/senate-budget-resolution-medicaid-cuts?utm_source=modern-healthcare-am-thursday&utm_medium=email&utm_campaign=20250402&utm_content=article4-readmore; 4/10/2025: https://www.modernhealthcare.com/politics-policy/congress-passes-budget-teeing-up-huge-healthcare-cuts?utm_source=modern-healthcare-alert&utm_medium=email&utm_campaign=20250410&utm_content=hero-readmore

# PRICE TRANSPARENCY EXECUTIVE ORDER (2/25/2025)

- A 2/25/25 Executive Order (EO), “Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information,” updated the requirements and timeline for Price Transparency
- Per the EO, in addition to current Price Transparency regulations, the Departments of Health and Human Services (HHS), Labor, and Treasury must “rapidly implement and enforce the healthcare price transparency regulations" within 90 days
  - The EO requires the disclosure of the actual prices of items and services, not estimates;
  - Issues updated guidance or proposed regulatory action ensuring pricing information is standardized and easily comparable across hospitals and health plans; and
  - Issues guidance or proposed regulatory action updating enforcement policies designed to ensure compliance with the transparent reporting of complete, accurate, and meaningful data.
- In the past 6 months the CMS Hospital Price Transparency (HPT) team has ramped up their review processes resulting in an increase in Violation Notices and Corrective Action Plans


Sources: whitehouse.gov Executive Order “Making America Healthy Again by Empowering Patients with Clear, Accurate, and Actionable Healthcare Pricing Information” https://www.whitehouse.gov/presidential-actions/2025/02/making-america-healthy-again-by-empowering-patients-with-clear-accurate-and-actionable-healthcare-pricing-information; NRHA Grassroots Advocacy Forum, Alexa McKinley Abel, 3/5/25

# UNDER KENNEDY, HHS WILL FORGO SOME TRANSPARENCY PRACTICES (2/28/2025)

HHS will comply with the legal requirements of the Administrative Procedures Act of 1946 but will abandon transparency policies in use since the Nixon Administration

While the APA does not expressly require a public process for policies such as grant distribution and contract creation, the Nixon administration believed that "The public benefit from such participation should outweigh any administrative inconvenience or delay which may result from use of the APA procedures"

Per Kennedy, HHS can now skip notice and comment periods if it deems them unnecessary or "contrary to the public interest."

The full impact of the policy change is yet to be determined. Some CMS regulations, such as the Medicare Physician Fee Schedule, are legally required to pass through a notice and comment period. For others, HHS can decide on a case-by-case basis when to invite public comment.

Source: Modern Healthcare, *HHS scraps transparency practices for policymaking*, Bridget Early, 2/28/25 https://www.modernhealthcare.com/policy/hhs-public-comment-rfk

# PROPOSED ROADBLOCKS TO ACA ENROLLMENT (3/10/2025)

- Administration is proposing an “integrity rule” that would make ACA enrollment more challenging and expensive, citing concerns of fraud and abuse
- 24 million Americans enrolled in ACA plans this year under prior administration policies that made the process easier and cheaper
- Under the proposed rule, ACA enrollees would have to provide more information proving their eligibility for subsidies and special enrollment periods, and would be charged an additional monthly cost until they do so
- The rule would also shorten the annual open enrollment period for ACA plans by one month, from January 15 to December 15, and cancel a monthly opportunity for those with very low incomes to enroll
- ***If the rule is implemented as proposed, CMS estimates that between 750,000 and 2 million people will lose ACA insurance coverage***

Sources: Modern Healthcare, *Trump administration plans to limit ACA enrollment period,* Rachel Cohrs Zhang and Skylar Woodhouse, 3/10/25 https://www.modernhealthcare.com/politics-policy/aca-enrollment-period-trump; Healthcare Dive, *Trump administration proposes ACA program integrity rule that would decimate enrollment*, Rebecca Pifer, 3/11/25 https://www.healthcaredive.com/news/trump-affordable-care-act-proposed-rule-fraud-abuse-enrollment

# CMS ANNOUNCES IT WILL END FOUR MEDICARE PAYMENT MODELS EARLY (3/12/2025)

- CMS will end four experimental payment models ahead of schedule “to align with its statutory obligation and strategic goals.”
- The models that will end early are:
  - **Maryland Total Cost of Care**
  - **Primary Care First**
  - **ESRD Treatment Choices (will propose termination through rulemaking)**
  - **Making Care Primary**
- Despite terminating several primary-care-focused payment models, CMS claims this does not indicate “a retreat from the Center’s support of primary care providers”
- Conservative lawmakers and The Heritage Foundation have questioned the value of CMMI’s payment models.
  - While Project 2025 calls for canceling the Medicare Shared Savings program, it remains in place for now, along with the ACO REACH model and Transforming Episode Accountability Model (TEAM).
- CMS indicated it will pursue a “new strategic vision, modifications to models to improve their potential for certification and expansion and new models that empower Americans to live healthier lives while protecting taxpayers”

CMS.gov Centers for Medicare & Medicaid Services

Newsroom Press Kit

Newsroom Homepage › Fact Sheets › CMS Innovation Center Announces Model Portfolio Changes To Better Protect Taxpaye

Fact Sheets Mar 12, 2025

**CMS Innovation Center Announces Model Portfolio Changes to Better Protect Taxpayers and Help Americans Live Healthier Lives**

Administration

Share

***What's changing:***

Today, the CMS Innovation Center announced changes to its model portfolio to align with its statutory obligation and strategic goals.

Innovation Center Models are time-limited experiments that provide a controlled environment to determine, through rigorous evaluation, what approaches should be expanded nationwide, what specific components of an approach need further testing in successor models and what approaches are not viable for expansion. As is the nature of innovation, not every model will work, and the Center must be efficient and effective in its response.

Sources: CMS.gov Fact Sheet 3/12/25 *CMS Innovation Center Announces Model Portfolio Changes to Better Protect Taxpayers and Help Americans Live Healthier Lives* https://www.cms.gov/newsroom/fact-sheets/cms-innovation-center-announces-model-portfolio-changes-better-protect-taxpayers-and-help-americans; Modern Healthcare, *CMS terminates 4 Medicare pay models ahead of schedule,* Bridget Early,3/12/25 https://www.modernhealthcare.com/policy/cms-terminates-medicare-payment-models

# CMS WILL MOVE FORWARD WITH MEDICARE DRUG PRICE NEGOTIATIONS (3/14/2025)

CMS nominated administrator Mehmet Oz, will proceed with a Biden-era plan to negotiate prices for 15 common drugs. Oz has said he will defend the program in court.

Drug manufacturers will participate in negotiations with CMS to negotiate maximum fair prices for the selected drugs under Medicare

The 15 selected drugs represent $41 billion in spending under Medicare Part D

This round of negotiations includes Ozempic, Rybelsus, Wegovy, Trelegy Ellipta, Xtandi, Pomalyst, Ibrance, Ofev, Linzess, Calquence, Austedo, Breo Ellipta, Tradjenta, Xifaxan, Vraylar, Janumet, and Otezla

Fact Sheets Mar 14, 2025

## CMS Announces Manufacturer Participation in Second Cycle of Medicare Drug Price Negotiation

Administration

Share

**CMS Announces Manufacturer Participation in Second Cycle of Medicare Drug Price Negotiation**

-

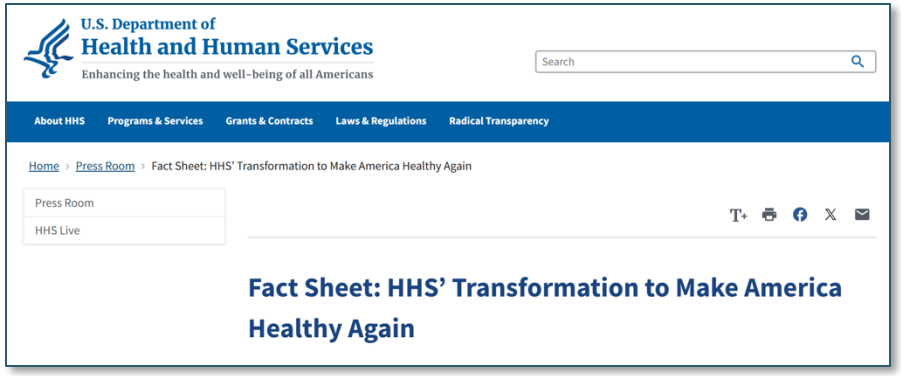
Today, the Centers for Medicare & Medicaid Services (CMS) announced that agreements have been signed with manufacturers of the 15 drugs covered under Medicare Part D selected for the second cycle of the Medicare Drug Price Negotiation Program (Negotiation Program). This is an important step in the process which initiates the negotiation period between the manufacturer and CMS. All 15 drugs selected for the second cycle of the Negotiation Program and the associated manufacturers are listed below:

| Drug Name | Participating Manufacturer |
|---|---|
| Austedo; Austedo XR | Teva Branded Pharmaceutical Products R&D, Inc. |
| Breo Ellipta | GlaxoSmithKline Intellectual Property Development Ltd. England |
| Calquence | AstraZeneca UK Limited |

Sources: Becker's Hospital Review, *CMS doubles down on Medicare drug price negotiations,* Jakob Emerson, 3/17/25 CMS doubles down on Medicare drug price negotiations; CMS.gov Fact Sheet: *CMS Announces Manufacturer Participation in Second Cycle of Medicare Drug Price Negotiation,* https://www.cms.gov/newsroom/fact-sheets/cms-announces-manufacturer-participation-second-cycle-medicare-drug-price-negotiation

# HHS TO RESTRUCTURE PER DOGE EXECUTIVE ORDER (3/27/2025)

- Following February 11th Executive Order, “Implementing the President's 'Department of Government Efficiency' Workforce Optimization Initiative,” HHS announced significant restructuring
- Specific contents of the plan include:
  - **Reduction of force of 10,000 employees**
  - **Creation of the Administration for a Healthy America (AHA),** which will combine multiple agencies into one entity focused on Primary Care, Maternal and Child Health, Mental Health, Environmental Health, HIV/AIDS, and Workforce development
  - **Transferring the Administration for Strategic Preparedness and Response (ASPR) to the CDC**
  - **Creation of a new Assistant Secretary for Enforcement** to oversee the Departmental Appeals Board (DAB), Office of Medicare Hearings and Appeals (OMHA), and Office for Civil Rights (OCR)
  - **Merging the Assistant Secretary for Planning and Evaluation (ASPE) with the Agency for Healthcare Research and Quality (AHRQ) to create the Office of Strategy**
  - **Reorganization of the Administration for Community Living (ACL):** Critical programs that support older adults and people with disabilities will be integrated into other HHS agencies, including the Administration for Children and Families (ACF), ASPE, and the Centers for Medicare and Medicaid Services (CMS).
    - The order specifies that this reorganization will not impact Medicare and Medicaid services


Sources: whitehouse.gov, https://www.whitehouse.gov/presidential-actions/2025/02/implementing-the-presidents-department-of-government-efficiency-workforce-optimization-initiative; hhs.gov Fact Sheet: *HHS' Transformation to Make America Healthy Again, https://www.hhs.gov/press-room/hhs-restructuring-doge-fact-sheet.html;* hhs.gov Press Release: *HHS Announces Transformation to Make America Healthy Again,* 3/27/25 https://www.hhs.gov/press-room/hhs-restructuring-doge.html; NRHA's Grassroots Advocacy Forum, *HHS Announces Transformation to Make America Healthy Again,* Carrie Cochran-McClain 3/27/25

# CMS FINALIZES MEDICARE ADVANTAGE AND PART D RULES, (4/4/2025 AND 4/7/2025)

Fact Sheets Apr 04, 2025

**Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-F)**

Administration

Share

The Centers for Medicare & Medicaid Services (CMS) issued a final rule on April 4, 2025, that modernizes and improves Medicare Advantage (MA), Medicare Prescription Drug Benefit (Part D), Medicare cost plan, and Programs of All-Inclusive Care for the Elderly (PACE) programs. The Contract Year (CY) 2026 MA and Part D final rule implements changes related to prescription drug coverage, the Medicare Prescription Payment Plan, dual eligible special needs plans (D-SNPs), Star Ratings, and other programmatic areas,

Newsroom Press Kit

Newsroom Homepage › Press Releases › CMS Finalizes 2026 Payment Policy Updates For Medicare Advantage and Part D P

Press Releases Apr 07, 2025

**CMS Finalizes 2026 Payment Policy Updates for Medicare Advantage and Part D Programs**

Administration

Share

Today, the Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2026 Rate Announcement for the Medicare Advantage (MA) and Medicare Part D Prescription Drug Programs that finalizes the payment policies for these programs. This release — combined with the CY 2026 MA and Part final rule that was released on April 4 — makes annual routine and technical updates to the MA and Part D programs.

The actions taken by CMS help protect beneficiaries and taxpayers from waste, fraud, and abuse, while also driving access to high-quality, affordable healthcare through Medicare Advantage. By finalizing these payment policies, CMS is ensuring that Medicare Advantage continues to offer access to critical services in an efficient, accountable manner, further strengthening the program's ability to serve beneficiaries.

Payments from the government to MA plans are expected to increase on average by 5.06% from 2025 to 2026. This is an increase of 2.83 percentage points since the CY 2026 Advance Notice, which is largely attributable to an increase in the effective growth rate. The method for setting the effective growth rate is set in statute and represents the average expected change in the benchmarks, used to determine payment for MA plans, based on the growth in Medicare per capita costs. The effective growth rate is 9.04%, which is

- The Trump administration issued its first rules on Medicare Advantage payment and policy in early April
- Per the **4/4/25 Policy and Technical Changes** rule:
  - CMS will ***not*** implement a Biden-era proposal to cover obesity drugs under Medicare and Medicaid and will eliminate a health equity adjustment, a decision met with approval by MA insurers
  - The agency finalized a provision holding MA insurers responsible for paying inpatient claims already approved through prior authorizations but declined to implement regulations on the controversial use of AI in the prior auth process
  - CMS delayed decisions on MA marketing and Part D networks, but finalized provisions requiring integrated health risk assessments for dual eligibles, set coverage limits for Special Supplemental Benefits for the Chronically Ill, tweaked aspects of the appeals process, and implemented Part D coverage requirements included in the Inflation Reduction Act
- The **4/7/25 Payment Policy Updates** rule, which "makes annual routine and technical updates to the MA and Part D programs," increases government payments to MA plans by 5.06% for 2026. This is up from the expected 4.33% increase and is attributed to a higher-than-estimated effective growth rate of 9.04%.

Sources: CMS.gov Press Release: *CMS Finalizes 2026 Payment Policy Updates for Medicare Advantage and Part D Programs* CMS CMS Finalizes 2026 Payment Policy Updates for Medicare Advantage and Part D Programs | CMS; CMS.gov Fact *Sheet Contract Year 2026 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4208-F), https://www.cms.gov/newsroom/fact-sheets/contract-year-2026-policy-and-technical-changes-medicare-advantage-program-medicare-prescription-final* Modern Healthcare, CMS punts on Medicare Advantage AI prior authorization, marketing, Bridget Early, 4/4/25 https://www.modernhealthcare.com/policy/medicare-advantage-prior-authorization-ai

# CMS FINAL RULE: MINIMUM STAFFING STANDARDS FOR LONG-TERM CARE FACILITIES AND MEDICAID INSTITUTIONAL PAYMENT TRANSPARENCY REPORTING (UPDATE 4/6/2025)

- On April 22, 2024, CMS finalized the Minimum Staffing Standards for Long-Term Care (LTC) Facilities and Medicaid Institutional Payment Transparency Reporting proposed rule (CMS 3442-P), to establish comprehensive nurse staffing requirements to improve the quality of care at Medicare and Medicaid-certified LTC facilities
- The final rule consists of three core staffing proposals:
  1. Minimum nurse staffing standards of 0.55 hours per resident day (HPRD) for Registered Nurses (RNs) and 2.45 HPRD for Nurse Aides (NAs)
  2. A requirement to have an RN onsite 24 hours a day, seven days a week
  3. Enhanced facility assessment requirements
- ***On April 6, 2025, a Federal Judge in TX blocked the nursing home staffing mandate stating the HHS did not have the authority to go beyond laws passed by Congress as it relates to Nursing Home staffing standards***

Source: CMS.gov Fact Sheet: Medicare and Medicaid Programs: Minimum Staffing Standards for Long-Term Care Facilities and Medicaid Institutional Payment Transparency Reporting (CMS 3442-P) 9/1/23 https://www.cms.gov/newsroom/fact-sheets/medicare-and-medicaid-programs-minimum-staffing-standards-long-term-care-facilities-and-Medicaid;; 4/7/25; https://www.modernhealthcare.com/providers/nursing-home-staffing-mandate-struck-down?utm_source=modern-healthcare-am-tuesday&utm_medium=email&utm_campaign=20250407&utm_content=article3-readmore

# OTHER MARKET UPDATES

# MEDICARE ACOS 2025 UPDATE: **CMS FAST FACTS**

- As of January 2025, 53.4% of people with Traditional (fee-for-service) Medicare are in an accountable care relationship with a provider. This represents more than
  - 14.8 million people
  - 4.3% increase from January 2024, the largest annual increase since CMS began tracking accountable care relationships
  - CMS has also seen a 16% increase in the number of Federally Qualified Health Centers, Rural Health Clinics, and Critical Access Hospitals participating in the Shared Savings Program from last year

## Shared Savings Program Fast Facts – As of January 1, 2025

CMS | MEDICARE SHARED SAVINGS PROGRAM

PROGRAM CHARACTERISTICS (as of Jan 1) / PERFORMANCE YEAR RESULTS

| Performance Year | ACOs | Assigned Beneficiaries | Total Earned Shared Savings | Quality Score |
|---|---|---|---|---|
| 2025 | 476 | 11.2 million | TBD | TBD |
| 2024 | 480 | 10.8 million | TBD | TBD |
| 2023 | 456 | 10.9 million | $3.1 billion | 82%* |
| 2022 | 483 | 11.0 million | $2.5 billion | 81%* |
| 2021 | 477 | 10.7 million | $2.0 billion | 91% |
| 2020 | 517 | 11.2 million | $2.3 billion | 97% |
| 2019 | 487 | 10.4 million | $1.5 billion | 92% |
| 2018 | 561 | 10.5 million | $983 million | 93% |
| 2017 | 480 | 9.0 million | $799 million | 92% |
| 2016 | 433 | 7.7 million | $700 million | 95% |
| 2015 | 404 | 7.3 million | $645 million | 91% |
| 2014 | 338 | 4.9 million | $341 million | 83% |
| 2012 / 2013 | 220 | 3.2 million | $315 million | 95% |

*The elimination of MIPS bonus points resulted in lower MIPS Quality performance category scores for ACOs

| ACO Tracks | ACOs | Percent |
|---|---|---|
| One Sided (29% of ACOs) | | |
| BASIC Track Levels A&B | 137 | 29% |
| Two Sided (71% of ACOs) | | |
| BASIC Track Levels C&D | 5 | 1% |
| BASIC Track Level E | 81 | 17% |
| ENHANCED Track | 253 | 53% |

HIGH / LOW REVENUE ACOs

| | ACOs | Percent |
|---|---|---|
| High Revenue | 183 | 38% |
| Low Revenue | 293 | 62% |

ACOs BENEFICIARY ASSIGNMENT METHODOLOGY

| | ACOs | Percent |
|---|---|---|
| Prospective | 145 | 30% |
| Preliminary Prospective with Retrospective Reconciliation | 331 | 70% |

| Enrollment Type | Percent |
|---|---|
| Aged Non-Dual | 87% |
| Disabled | 7% |
| Aged Dual | 6% |
| End Stage Renal Disease (ESRD) | <1% |

ADVANCE INVESTMENT PAYMENTS (AIP)

| | |
|---|---|
| Participating ACOs | 28 |
| Beneficiaries assigned to ACOs receiving AIP | 282,724 |
| Percent of AIP beneficiaries eligible for Medicaid or Low-Income Subsidy (LIS) | 28% |
| Percent of AIP beneficiaries with Area Deprivation Index (ADI) scores ≥ 85 | 9% |
| Percent of AIP beneficiaries living in a Health Provider Shortage Area (HPSA) or Medically Underserved Area (MUA) | 50% |

ACO PARTICIPANT LIST COMPOSITION

| | |
|---|---|
| Participant TINs | 15,135 |
| Physicians and non-Physicians | 643,768 |
| Hospitals | 1,502 |
| Federally Qualified Health Centers (FQHCs) | 7,036 |
| Rural Health Clinics (RHCs) | 2,872 |
| Critical Access Hospitals | 547 |

Skilled Nursing Facility (SNF) AFFILIATES & SNF 3-DAY RULE WAIVER

| | |
|---|---|
| ACOs approved for a SNF 3-Day Rule Waiver | 162 |
| Total number of SNF affiliates | 2,732 |

1

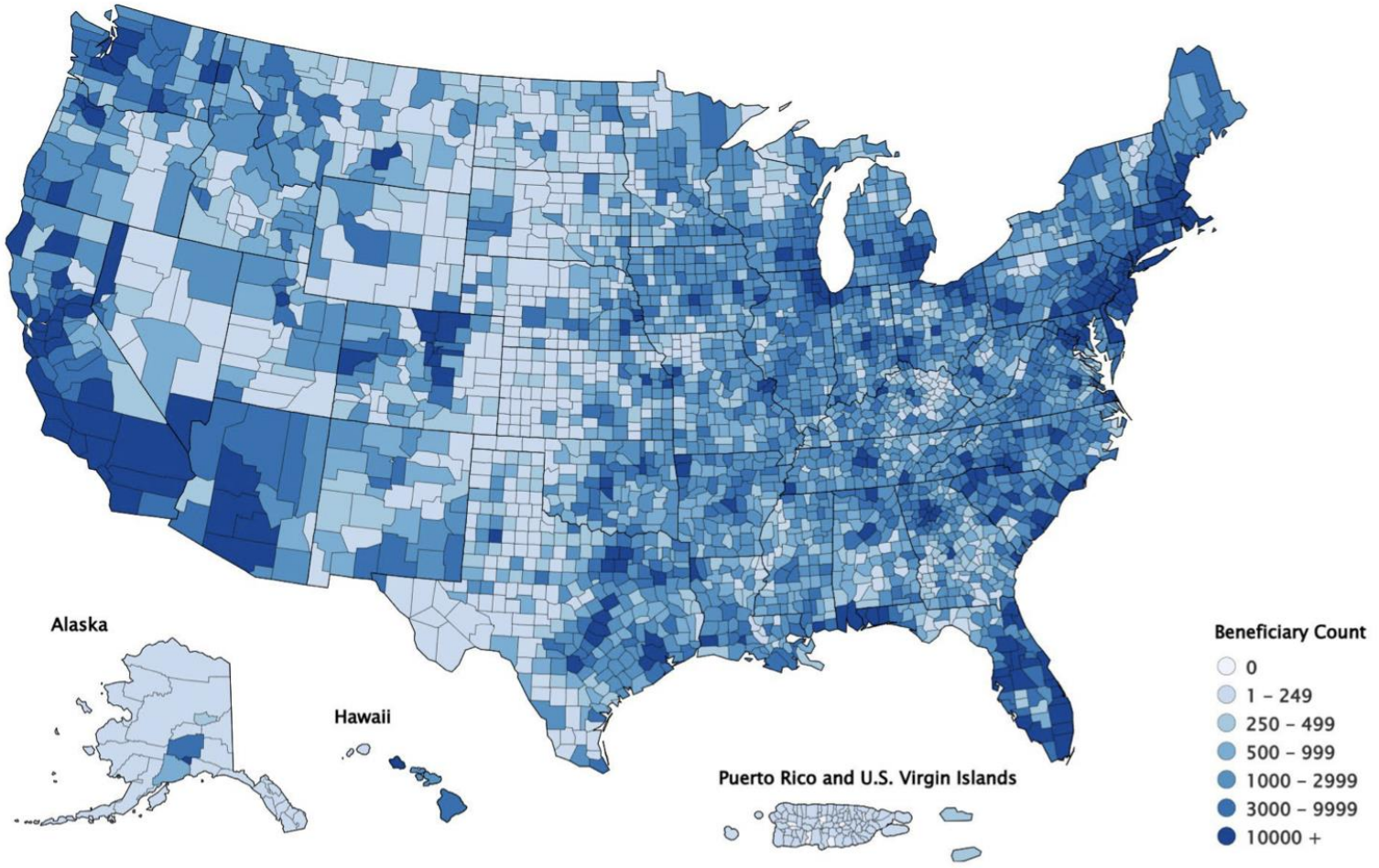


Source: https://www.cms.gov/files/document/2025-shared-savings-program-fast-facts.pdf; https://www.cms.gov/newsroom/fact-sheets/cms-moves-closer-accountable-care-goals-2025-aco-initiatives

## Shared Savings Program Fast Facts – As of January 1, 2025

CMS | MEDICARE SHARED SAVINGS PROGRAM

### Medicare Shared Savings Program ACO Assigned Beneficiary Population by County

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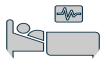
Source: https://www.cms.gov/files/document/2025-shared-savings-program-fast-facts.pdf

# CVS AND PRIMARY CARE: MARCH 2025 UPDATE*

CVS works with Amwell to roll out the virtual care platform it announced in May, which provides virtual access to primary care, on-demand care, chronic condition management and mental health services and to eligible Aetna and CVS Caremark members



In early September 2022, CVS and Signify Health announce that CVS will buy the Dallas-based home health company for $8B. The Signify Health purchase represents a key milestone in CVS's effort to provide comprehensive healthcare offerings, as it now includes home health and value-based care in addition to its retail clinics.

In early May, CVS Health reports that it had finalized the purchases of both private-equity-backed Signify Health and Oak Street Health for a combined $18.6 billion. Oak Street Health, which serves a 42% dual-eligible population, provides primary care that addresses social determinants of health.

CVS's ACO division and Chicago-based Rush University System for Health are now collaborating to coordinate care at area MinuteClinics as participants in the Medicare ACO REACH program

In April 2024, CVS announces plans to add 50 to 60 Oak Street Health clinics within the year, most as stand-alone locations but some within its retail pharmacy stores. Competitors Walmart and Walgreens have both walked back some of their primary care clinics in recent months. [11/24 update: Despite company-wide restructuring, Oak Street Health expansion plans will move ahead]

In October 2024, following other retail giants like Walgreens and Amazon in the healthcare space, CVS announces layoffs of 1% of its workforce as part of a plan to cut $2B in costs, and is reportedly considering a corporate breakup of its retail and insurance arms

As of late October '24, Aetna members in select Texas, Georgia, and Florida locations can use Minute Clinic as their in-network primary care provider, with plans to add North Carolina in the coming weeks

***In February '25, in its first primary care partnership with a health system, CVS joins Emory Healthcare Network to offer in-network MinuteClinic services to Emory Healthcare patients at 35 cobranded locations in Georgia***

***In early March '25, as part of $2B in cuts as insurance subsidiary Aetna continues to struggle, CVS sells its MSSP ACO to care management company Wellvana***

**Please see bibliography on corresponding "Sources" slide*

# CVS SELLS MSSP ACO BUSINESS TO WELLVANA (3/12/2025)


As CVS cuts costs to balance Aetna's financial struggles, it announced in early March that it has sold its MSSO ACO management business to physician-enablement vendor Wellvana in a stock-only transaction

Per Wellvana's CEO Kyle Wailes, the privately-held company hopes to enroll providers across the industry in risk-based models using a methodical, step-by-step approach

Before purchasing CVS's ACO arm, Wellvana had worked with providers under the Medicare ACO REACH model and with Medicare Advantage insurers such as Humana and Centene. The company manages 500 accountable care organization clients, including large hospitals, primary care providers, and independent physician practices.

Through the acquisition, Wellvana has acquired approximately 1 million patient lives associated with $12.5B in healthcare spending under management

Sources: Modern Healthcare, *CVS Health sells ACO asset to Wellvana,* Nona Tepper, 3/4/25 https://www.modernhealthcare.com/mergers-acquisitions/cvs-health-mssp-wellvana; Modern Healthcare, *Wellvana CEO dishes on CVS deal, Medicare Advantage, ACO REACH,* Nona Tepper, 3/12/25 https://www.modernhealthcare.com/accountable-care/wellvana-kyle-wailes-cvs-medicare-advantage

# CVS AND PRIMARY CARE: SOURCES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- HFMA.org, *CVS Health gains capabilities in home healthcare and value-based care with massive deal to buy Signify Health*, Nick Hut, 9/27/22 https://www.hfma.org/topics/news/2022/09/cvs-health-gains-new-capabilities-in-home-healthcare--value-base.html
- Becker's Hospital Review, *CVS exploring acquisition of Oak Street Health*, Naomi Diaz, 1/10/23 https://www.beckershospitalreview.com/disruptors/cvs-exploring-acquisition-of-oak-street-health.html
- Modern Healthcare, *CVS Health taps Rush for ACO REACH collaboration,* 1/23/23; hfma.org, *Healthcare News of Note: CVS finalizes purchases of Signify Health, Oak Street Health, moving into home healthcare and primary care,* Deborah Filipek, 5/8/23
- Modern Healthcare, *CVS' Oak Street Health to open clinics at retail pharmacies,* Caroline Hudson, 4/16/24
- Healthcare Dive, *CVS to lay off 2,900 employees amid reports of strategic review*, Rebecca Pifer, 10/1/24
- Modern Healthcare, *Oak Street Health expansion to continue amid CVS review,* Caroline Hudson, 10/10/24 https://www.modernhealthcare.com/providers/oak-street-health-expansion-cvs-strategic-review
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- Modern Healthcare, *CVS Health, Emory expand MinuteClinic primary care services,* Caroline Hudson, 2/20/25 https://www.modernhealthcare.com/providers/cvs-health-emory-minuteclinic-primary-care
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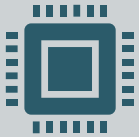
# VALUE-BASED CARE COMPANY ALEDADE ADDS 500+ PRIMARY CARE PRACTICES TO NETWORK



ACO partner Aledade has added over 500 practices to its value-based care networks for 2025, and now works with over 2400 PCPs serving nearly 3 million people in 46 states and DC

Aledade's network of primary care providers includes participants in the Medicare Shared Savings Program, Medicare Advantage, Medicaid, and commercial plans

In 2023, ACOs in Aledade's network generated $801 million in savings, the highest of any ACO partner in the U.S.

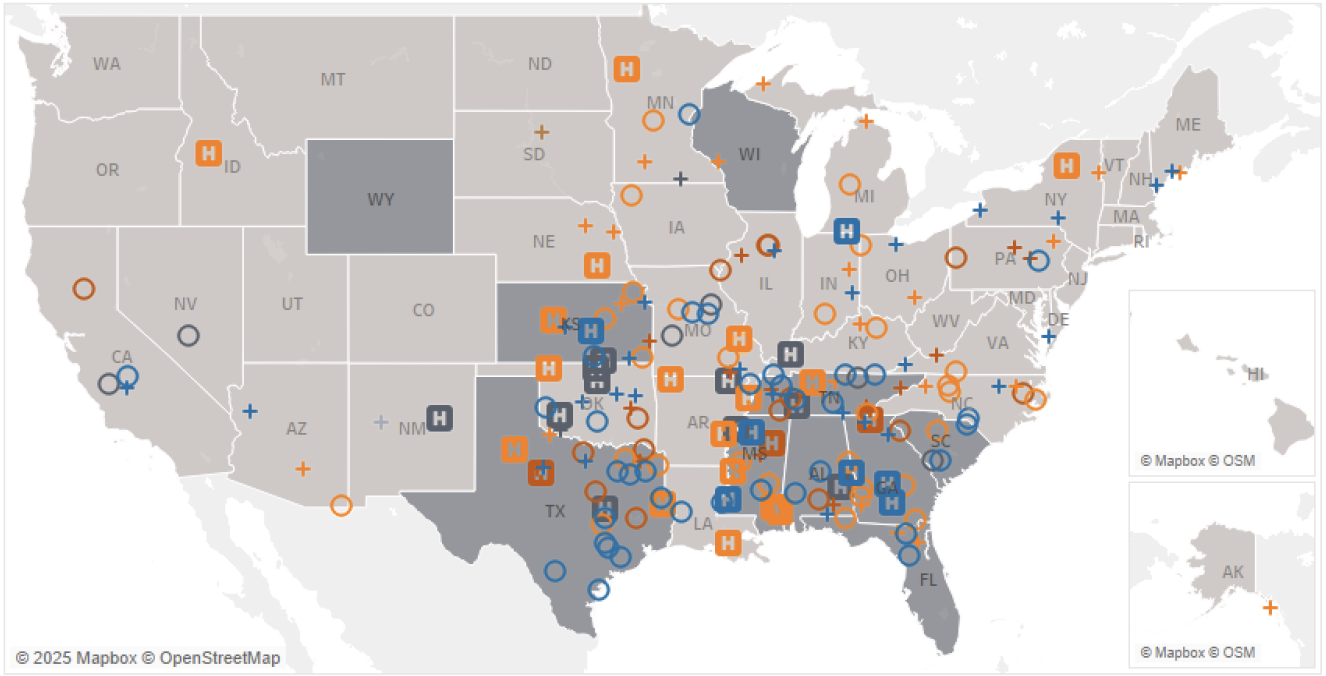
"With every new practice that joins the Aledade network, we gain a greater ability to improve patient outcomes, support practice growth, and move health care forward nationwide"

*Aledade CEO Farzad Mostashari*

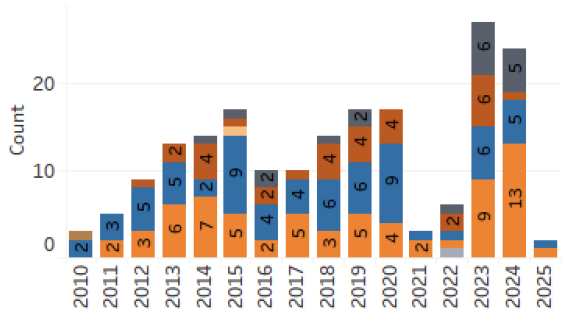
# RURAL HOSPITAL CLOSURES (4/08/2025)

## 191 Closed or Converted Rural Hospitals

There have been 191 Rural Hospital closures or conversions since 2010 and 234 since 2005, these numbers include **thirty-eight (38) REH Conversions since 2023**




| Year | Hospital Name |
|---|---|
| 2025 | REH- Cascade Medical Center-ID |
| | Valley Community Hospital-OK |
| 2024 | REH- EAMC - Lanier-AL |
| | REH- Wayne Medical Center-TN |
| | REH- Clifton-Fine Hospital-NY |
| | REH- Progressive Health Group of Houston.. |
| | MercyOne Primghar Medical Center-IA |
| | Thomasville Regional Medical Center (TRM.. |
| | REH- Elkview General Hospital-OK |
| | REH- Taylor Regional Hospital-GA |
| | REH- DeWitt Hospital and Nursing Home-AR |




| ST | Count |
|---|---|
| TX | 26 |
| TN | 17 |
| KS | 12 |
| OK | 12 |
| GA | 11 |
| MO | 11 |
| MS | 11 |
| AL | 9 |
| NC | 8 |
| AR | 5 |
| FL | 5 |
| MN | 5 |
| PA | 5 |
| CA | 4 |
| IL | 4 |
| KY | 4 |
| MI | 4 |
| NY | 4 |
| SC | 4 |
| AZ | 3 |
| IN | 3 |
| ME | 3 |
| NE | 3 |
| OH | 3 |
| IA | 2 |
| LA | 2 |
| NM | 2 |
| VA | 2 |
| AK | 1 |
| ID | 1 |
| MD | 1 |
| NV | 1 |
| SD | 1 |
| WI | 1 |
| WV | 1 |

| Year | Prospective Payment System | Critical Access Hospital | Medicare Dependent Hospital | Sole Community Hospital | IHS | Re-based Sole Community Hospital | Rural Referral Center | Total |
|---|---|---|---|---|---|---|---|---|
| 2010 | 2 | | | | | 1 | | 3 |
| 2011 | 3 | 2 | | | | | | 5 |
| 2012 | 5 | 3 | 1 | | | | | 9 |
| 2013 | 5 | 6 | 2 | | | | | 13 |
| 2014 | 2 | 7 | 4 | 1 | | | | 14 |
| 2015 | 9 | 5 | 1 | 1 | | | 1 | 17 |
| 2016 | 4 | 2 | 2 | 2 | | | | 10 |
| 2017 | 4 | 5 | 1 | | | | | 10 |
| 2018 | 6 | 3 | 4 | 1 | | | | 14 |
| 2019 | 6 | 5 | 4 | 2 | | | | 17 |
| 2020 | 9 | 4 | 4 | | | | | 17 |
| 2021 | 1 | 2 | | | | | | 3 |
| 2022 | 1 | 1 | 2 | 1 | 1 | | | 6 |
| 2023 | 6 | 9 | 6 | 6 | | | | 27 |
| 2024 | 5 | 13 | 1 | 5 | | | | 24 |
| 2025 | 1 | 1 | | | | | | 2 |
| Total | 69 | 68 | 32 | 19 | 1 | 1 | 1 | 191 |

Medicare Payment Type
- Prospective Payment System
- Critical Access Hospital
- Medicare Dependent Hospital
- Sole Community Hospital
- Re-based Sole Community Hospital
- Rural Referral Center
- IHS

Current Status
- REH
- Complete Closure
- Convert to Other

Current Status of Medicaid Expansion Decision
- Adopted the Medicaid Expansion
- Not Adopting the Medicaid Expansion at this Time

Updated:4/8/2025

Sources: The North Carolina Rural Health Research Program (NC RHRP) at the Cecil G. Sheps Center for Health Services Research & kff.org

STROUDWATER

# RURAL EMERGENCY HOSPITAL CONVERSIONS (4/08/2025)

## 38 Rural Emergency Hospital (REH) Conversions

STROUDWATER


*"To be eligible for REH status, hospitals must have 50 or fewer beds and either be in a rural area or have an active rural reclassification. The Centers for Medicare & Medicaid Services (CMS) uses Office of Management and Budget's Core Based Statistical Areas (CBSA) to identify micropolitan and noncore counties as rural counties."* Source:www.ruralhealthinfo.org

Medicare Payment Type
- Critical Access Hospital
- Medicare Dependent Hospital
- Prospective Payment System
- Sole Community Hospital

Updated:4/8/2025

Sources: The North Carolina Rural Health Research Program (NC RHRP) at the Cecil G. Sheps Center for Health Services Research

# QUESTIONS?