

On March 23, President Obama signed into law *The Patient Protection and Affordable Care Act* (H.R. 3590). A companion bill, *The Health Care and Education Affordability Reconciliation Act of 2010* (H.R. 4872), was enacted into law shortly thereafter. This issue of *Small or Rural Update* reviews provisions in the legislation for Medicare payment, protections, and extenders as well as workforce and graduate medical education opportunities that are important to all hospitals, but especially small or rural hospitals. Information on the Shirley Ann Munroe Leadership Award also is included along with a link for the application.

### Health Care Reform

Two major bills and related managers' amendments comprise what is recognized as health care reform. They are:

1. Patient Protection and Affordable Care Act (HR 3590) and Senator Reid's amendment SA 3276 to HR 3590 December 20, 2009. HR 3590 became Public Law No: 111-148, March 23, 2010
2. Health Care and Education Affordability Reconciliation Act of 2010 (HR 4872), passed by the House and Speaker Pelosi's amendment to HR 4872 passed March 21 and then by the Senate on March 25. HR 4872 became Public Law No: 111-152, March 30, 2010

Together, this historic legislation is estimated by the CBO to expand coverage to 32 million people (95 percent of all those legally residing in the U.S., or 92 percent of all those residing in the country) at a cost of \$940 billion over 10 years (fiscal years 2010-2019). The legislation contains an individual mandate, low-income subsidies, an expansion of Medicaid, insurance reforms, and the creation of state-based health insurance exchanges. It also calls for new, non-profit, consumer-owned and -oriented plans (or CO-OPs), as well as multi-state health plans overseen by the federal Office of Personnel Management to compete with other private health plans in the insurance exchanges. Financing includes taxing high-premium health insurance plans, raising the Medicare tax for high-income individuals and imposing annual fees on the pharmaceutical, medical device, clinical laboratory and health insurance industries, as well as reducing Medicare and Medicaid provider payments.

### Major Provisions

Included in the legislation are provisions of importance to all hospitals. A description of some of the most sweeping changes affecting hospitals follows.

**Value-Based Purchasing (VBP):** The law establishes a VBP program to pay hospitals for their actual performance on quality measures, rather than just the reporting of those measures, beginning in FY 2013. The VBP program will apply to all acute-care prospective payment system (PPS) hospitals. Measures will be selected from those used in the Medicare pay-for-reporting program, including measures for heart attack, heart failure, pneumonia and surgical care, and measures assessing patients' perception of care (HCAHPS).

Certain hospitals are excluded, including those that do not have a sufficient number of patients within the related conditions. Two demonstration projects will be created to test VBP models for CAHs and small hospitals that do not qualify, due to an insufficient number of qualifying cases, for the VBP program. These demonstration projects shall be implemented by March 23, 2012

(two years after enactment) and completed by March 23, 2015. The Secretary shall submit a report to Congress by September 23, 2016.

**National Pilot Program on Payment Bundling:** The law requires the HHS Secretary, beginning in 2013, to establish a national, voluntary pilot program to be conducted initially for five years on bundling. However, at any point after January 1, 2016, if the Secretary determines that expanding the pilot program does not reduce quality, but does reduce costs, or has improved quality and reduced spending, the Secretary can extend its duration and scope indefinitely. Entities comprised of groups of providers including a hospital (including inpatient rehabilitation facilities (IRFs) and long-term care hospitals (LTCHs)), a physician group, a skilled-nursing facility (SNF) and a home health agency (HHA) may apply to participate in the pilot. In addition, the Secretary has the authority to waive Medicare statutory provisions as necessary to carry out the pilot program.

Participants will be required to submit data on the quality measures in each year of the program. The pilot program may cover inpatient and outpatient hospital services, physician services (both in the inpatient and outpatient settings), post-acute care services (IRFs, LTCHs, SNFs and HHAs), and other services that the Secretary deems appropriate. The episode of care will start three days prior to a qualifying hospital admission and end 30 days after the patient's discharge. However, the Secretary has the authority to use another timeframe if appropriate.

The law requires that the Secretary consult with representatives of small and rural hospitals, including CAHs, regarding their participation in the pilot program. The Secretary will be required to consider innovative methods of bundling, including how to address challenges due to low volume.

**Readmissions:** Beginning in FY 2013, inpatient PPS hospitals with higher-than-expected readmissions rates will experience decreased Medicare payments for all Medicare discharges. Performance evaluation will be based on the 30-day readmission measures for heart attack, heart failure and pneumonia that are currently part of the Medicare pay-for-reporting program and reported on *Hospital Compare*. The base inpatient payment for hospitals with *actual* readmission rates higher than their Medicare-calculated *expected* readmission rates will be reduced by an adjustment factor. CAHs and post-acute care providers are exempt.

**Independent Payment Advisory Board (IPAB):** The law establishes an Independent Payment Advisory Board that will develop and submit proposals to Congress to extend the solvency of Medicare, slow Medicare cost growth, and improve the quality of care delivered to Medicare beneficiaries. The board will be composed of 15 members, appointed by the President and confirmed by the Senate, who will serve six-year terms. This new, independent board would make binding recommendations on Medicare payment policy and non-binding recommendations for changes in private payer payments to providers. PPS hospitals are scheduled to receive such reductions, and therefore are exempt from payment reduction proposals, but CAHs are not.

**Tax-exempt Hospital Requirements:** The law applies several new requirements to section 501(c)(3) hospitals that are in addition to the requirements otherwise applicable for tax exemption. For organizations that operate more than one hospital facility, these new requirements apply separately to each and any specific facility that fails to separately meet any requirement will not be treated as a tax-exempt charitable organization. The new requirements,

with the exception of the requirement related to community health needs assessment, are applicable for tax years that begin after March 23, 2010.

- **Community Health Needs Assessment:** Each hospital is required to conduct a community health needs assessment at least once every three years and adopt an implementation strategy to meet the needs identified through the assessment. The community needs assessment requirement applies to tax years that start after March 23, 2012.
- **Financial Assistance Policy and Limits on Charges:** Each hospital is required to adopt, implement, and publicize a written financial assistance policy. The policy must include:
  1. eligibility criteria for financial assistance and whether the assistance includes free or discounted care;
  2. the basis for calculating amounts patients are charged;
  3. how to apply for financial assistance; and
  4. any actions that may be taken for non-payment, including collections actions and reporting to credit agencies if the organization does not have a separate billing and collections policy.

In addition, each hospital must have a written policy that obligates it to provide emergency medical care, without discrimination, to individuals regardless of whether or not they qualify for assistance under the hospital's financial assistance policy.

- **Debt Collection:** A hospital may not undertake extraordinary collection actions against a patient without first making "reasonable efforts" to determine whether the individual is eligible for the hospital's financial assistance policy.
- **Reporting and Disclosure:** Hospitals are required to report annually to the IRS how they are meeting identified community needs, including a description of any needs not being addressed and the reasons why they are not, and provide audited financial statements. The IRS must review information about a hospital's community benefit activities (currently reported on Form 990, Schedule H) at least once every three years.

### Medicare Payment Provisions

The law takes a number of steps to reduce the rate of increase in Medicare spending. Hospitals are estimated to contribute \$155 billion in savings over 10 years through reduced payment updates, decreases in Medicare and Medicaid disproportionate share hospital payments, and financial penalties. The law also provides enhanced payments to rural hospitals, extends a number of expiring Medicare provisions, expands the 340B drug discount program, and provides additional payments to primary care physicians. Of special interest are several provisions that change how Medicare pays hospitals that are of particular interest to small or rural hospitals.

**Expansion of 340B Drug Discount Pricing Program:** For drugs purchased on or after January 1, 2010, the law expands eligible participants in the 340B drug discount program to include CAHs and certain non-PPS children's hospitals, free-standing non-PPS cancer hospitals, and sole community hospitals (SCHs) and rural referral centers (RRCs) that have disproportionate share adjustment percentages equal to or greater than 8 percent. However, orphan drugs are exempted from the expansion of the 340B program to these hospitals and the program was *not* expanded to include inpatient drugs.

**Medicare Hospital Wage Index:** The law requires the HHS Secretary to provide a plan to Congress by December 31, 2011 to comprehensively reform the Medicare hospital wage index.

This plan will take into account the goals in the June 2007 MedPAC report, including establishing a new hospital compensation index system that:

- Uses Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages;
- Minimizes wage index adjustments between and within metropolitan and statewide rural areas;
- Includes methods to minimize the volatility of wage index adjustments that result from implementation of policy, while maintaining budget neutrality in applying such adjustments;
- Analyzes the effect that implementation of the proposal would have on health care providers and on each region of the country;
- Addresses issues related to occupational mix, such as staffing practices and ratios, and any evidence on the effect on quality of care or patient safety as a result of implementation of policy; and
- Provides for a transition period.

In addition, the law requires the Secretary from FY 2011 through FY 2013, to use the wage index reclassification (average hourly wage) thresholds that were in effect prior to FY 2009; and requires the Secretary to apply the wage index rural floor budget-neutrality adjustment on a national basis for FY 2011 and beyond.

**Geographic Variation in Low-cost Counties:** For FYs 2011 and 2012, the law provides \$200 million in each year to hospitals located in counties that rank in the lowest quartile of Medicare per-beneficiary spending, adjusted by age, sex and race. Each hospital will receive funding in an amount that is proportional to the Medicare inpatient hospital payments made to the individual hospital as a percentage of the Medicare inpatient hospital payments made to all hospitals receiving the funding.

**Protections for Frontier States:** In FY 2011 and beyond, the law sets a wage index floor of 1.0 for Medicare inpatient and outpatient PPS payments to hospitals in frontier states and a geographic practice expense index floor of 1.0 for Medicare payments physicians in frontier states. Frontier states are those states where at least 50 percent of the counties have fewer than six people per square mile; under the provision, Alaska and Hawaii are not eligible for the floors. States that are eligible are: Nevada; North Dakota; South Dakota; Montana; Wyoming; and Utah. However, wage indices and geographic practice expense indices in NV are already above 1.0.

### **Rural Physician Payments**

The law includes improved payments under Medicare for physicians which would benefit hospitals located in rural communities.

**Medicare Bonus for Primary Care/General Surgery Providers:** Primary care services delivered by a primary care practitioner will receive a 10 percent bonus payment under the Medicare fee schedule for five years, beginning January 1, 2011. In addition, qualifying practitioners providing care in a health professional shortage area (HPSA) also will receive the 10 percent bonus on hospital visit codes that are typical of primary care medicine. In addition, general surgeons providing care in a HPSA will receive a 10 percent bonus on major procedure codes for five years, beginning January 1, 2011.

**Extension of Floor on Medicare Work Geographic Adjustment:** The Medicare physician fee schedule payment rates for work relative value units is adjusted by a geographic practice cost index (GPCI) to account for geographic variation in the cost of practicing medicine in different areas of the country. The law extends the 1.00 floor for the geographic index for physician work RVU for an additional year through December 2011. The law also provides an additional \$400 million for the practice expense RVU geographic adjustment through December 2011. The law also provides an additional \$400 million for the practice expense RVU geographic adjustment through December 2011.

### **Protections for Rural Hospitals**

The law includes specific protections for rural hospitals under Medicare payment.

**Payment Adjustment for Low-volume Hospitals:** The law improves the low-volume adjustment for FYs 2011 and 2012. For these years, a low-volume hospital will be defined as one that is more than 15 road miles from another comparable hospital and has up to 1,600 Medicare discharges. An add-on payment will be given to these hospitals in an amount to be determined by the HHS Secretary using a continuous linear sliding scale ranging from 25 percent for low-volume hospitals with Medicare discharges below 200, to no adjustment for hospitals with more than 1,600 Medicare discharges.

**Demonstration Project on Community Health Integration Models:** The law revises a demonstration project that allows eligible entities to develop and test new models for the delivery of health care services in certain rural counties for the purpose of improving access to, and better integrating delivery of, acute care, extended care and other essential health care services to Medicare beneficiaries. The law removes the existing cap on the number of counties that can participate in each state. It also deletes the requirement for rural health clinic services and it allows physician services to be included within the scope of the demonstration.

**Adequacy of Medicare Payments for Health Care Providers Serving Rural Areas:** The law requires MedPAC to report to Congress on Medicare payment adequacy for rural health care providers by January 1, 2011. MedPAC will analyze rural payment adjustments, beneficiaries' access to care in rural communities, adequacy of Medicare payments to rural providers and quality of care, and make recommendations on appropriate changes to rural payment adjustments.

**CAH Payments:** The law ensures that CAHs are paid 101 percent of costs for all outpatient services they provide, regardless of the billing method elected, and for providing qualifying ambulance services.

**Criteria for Designating MUPs and HPSAs:** The Health Secretary shall establish through a negotiated rulemaking process a comprehensive methodology and criteria for designation of medically underserved populations (MUPs) and health professions shortage areas (HPSAs). The Secretary shall consult with relevant stakeholders such as national, state, and regional organizations representing affected entities. The Secretary shall publish a notice within 45 days after the date of enactment with a target date of July 1, 2010 for the final rule.

## Medicare Extenders

The law extends many payment provisions and adjustments important to rural hospitals that have sunset or are scheduled to sunset in the next several months.

**Hospital Outpatient Hold-harmless Payments:** The law extends the hospital outpatient hold-harmless payments for small rural hospitals with 100 or fewer beds for one additional year, through December 31, 2010. It also would make all SCHs eligible to receive these hold-harmless payments, regardless of their bed size in 2010 only. Hospitals will receive 85 percent of the difference between outpatient PPS payments and those that would have been made under the prior reimbursement system. This provision is retroactive to January 1, 2010.

**Reasonable Cost Reimbursement for Laboratory Services in Small Rural Hospitals:** The law reinstates reasonable cost payment for clinical diagnostic laboratory services for qualifying rural hospitals with fewer than 50 beds in certain states with low density rural areas for cost reporting periods *beginning* from July 1, 2010 through June 30, 2011. This could affect services performed as late as June 30, 2012 if a hospital's cost reporting period began on June 30, 2011.

**Rural Community Hospital Demonstration Program:** The law extends the Rural Community Hospital Demonstration Program for five additional years through December 31, 2014, increases the maximum number of participating hospitals from 15 to 30 and expands the eligible sites to rural areas in 20 states with low population densities. For hospitals currently in the demonstration, the inpatient payment amount is re-based.

**Medicare Rural Hospital Flexibility Program:** The law extends the Medicare Rural Hospital Flexibility Grant Program through 2012 and allows the use of other grant funds to assist rural hospitals with delivery system reform implementation.

**Increased Payments for Ambulance Services under Medicare:** The law extends the existing add-on payment for ground ambulance services – a 3 percent add-on for rural areas and a 2 percent add-on for urban areas – through December 31, 2010. It also extends through December 31, 2010 the air ambulance and “super rural” ambulance add-ons. This provision is retroactive to January 1, 2010.

**Section 508 Reclassifications Section:** The law extends Section 508 wage index reclassifications for the inpatient PPS for one year through September 30, 2010. This provision is retroactive to October 1, 2009.

**Extension of Medicare Therapy Caps Exceptions:** The law extends the exceptions process for outpatient therapy caps for one year through December 31, 2010. These caps do not apply to hospital outpatient therapy departments. This provision is retroactive to January 1, 2010.

**Extension of Treatment of Certain Medicare Physician Pathology Services:** The law extends through December 31, 2010 the grandfathering provision that allows certain independent laboratories to receive direct payments for the technical component for physician pathology services that are furnished to certain hospital inpatients and outpatients. This provision is retroactive to January 1, 2010.

**Medicare Dependent Hospital Program:** The law extends the MDH program for one year through September 30, 2012.

**Part B Payments to Indian Hospitals and Clinics:** The law permanently extends retroactive to January 1, 2010 a provision that expired on December 31, 2009, which allowed Indian Health Service (IHS) facilities to bill for Medicare Part B services that were not previously covered. It also expanded the scope of items and services for which payment under Medicare Part B would be made to IHS providers, suppliers, physicians and other practitioners.

**Reinstatement of Rural Home Health Payment Adjustment:** The law provides a 3 percent add-on payment for home health providers serving rural areas for episodes ending on April 1, 2010 and before January 1, 2016.

**Spending for FQHCs:** The law establishes a fund for an expanded and sustained national investment in CHCs, including new construction and renovation of CHCs. Federally certified rural health clinics and certain rural hospitals including low-volume, CAH, SCH, or MDH that contract with community health centers may receive funds as long as the hospital has a sliding scale fee schedule for low-income patients and does not discriminate based on a patient's ability to pay.

### **Workforce and Graduate Medical Education**

The law provides grants and loans to enhance workforce education and training, to support and strengthen the existing workforce, and to help ease health care workforce shortages. It creates the National Health Care Workforce Commission to analyze the supply, distribution, diversity and skill needs of the health care workforce of the future. Most importantly, the law does not reduce indirect medical education funding to teaching hospitals, and allows for a redistribution of unused residency positions as a way to encourage increased training of primary care physicians and general surgeons. Unfortunately, it does not increase sufficiently the overall number of residency training positions, which the AHA will continue to pursue.

**National Health Care Workforce Commission:** The law creates a National Health Care Workforce Commission to develop a national strategy to address workforce shortages and encourage training in key areas. The commission will be comprised of 15 individuals and no later than September 30, 2010, members will be appointed by the Comptroller General to serve three-year terms.

To help with critical workforce shortages, the law implements a number of policies to decrease the financial burden of pursuing a career in health care. Hospitals, schools of medicine and other public or private nonprofit entities will be eligible for various grants to develop, expand and enhance educational training programs in primary care, dentistry, geriatrics, mental and behavioral health, advanced nursing, nursing, public health and other health-related careers.

**Redistribution of Unused Residency Positions:** The law will redistribute unused residency training positions as a way to encourage increased training of primary care physicians and general surgeons. For cost-reporting periods beginning on or after July 1, 2011, hospitals will lose 65 percent of their unused or unfilled residency positions (based on the three most recent cost-reporting periods ending March 23, 2010) and qualifying hospitals will be able to request up to 75 new positions. Certain hospitals, including rural teaching hospitals with fewer than 250

beds, will be exempt from redistribution of any of their unused positions. Priority for the new positions will be distributed such that:

- 70 percent of positions will be allocated to hospitals in states with resident-to-population ratios in the lowest quartile; and
- 30 percent of positions will be allocated to hospitals located in rural areas and hospitals located in the top 10 states in terms of population living in a HPSA relative to the general population.

**Physician Training in Underserved Communities:** The law authorizes \$4 million for each of FYs 2010-2013 for the HHS Secretary, acting through HRSA, to establish a grant program to assist schools of allopathic or osteopathic medicine in: recruiting students most likely to practice medicine in underserved rural communities; providing rural-focused training and experience; and increasing the number of recent medical school graduates who practice in underserved rural communities.

**Teaching Health Centers' GME Programs:** The law amends title VII of the *Public Health Service Act* to allow the HHS Secretary to provide grants to eligible "teaching health centers" from FY 2010-2012 to establish new or expand existing accredited primary care residency programs. Teaching health centers include federally qualified health centers, community mental health centers, rural health clinics, and health centers operated by the Indian Health Service.

### **Our Position**

The AHA applauds the historic steps that the health care reform legislation will take toward expanding health coverage and acknowledges the hospital field's significant contribution toward financing the coverage expansion as part of all stakeholders' shared responsibility. However, AHA cautions that the impact of these reductions, and other policies contained in the legislation, must be closely monitored to ensure that hospitals are able to continue providing access to high quality services that are essential to the patients we serve and the communities that depend on us every single hour of every single day. The AHA expects to work with Congress in making refinements to the legislation, which will be inevitable given the scope of any reform of this magnitude.