American Hospital Association

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Visit the Web site of the Section for Small or Rural Hospitals at http://www.aha.org/aha/key_issues/rural/index.html

On March 23, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA). A companion bill, the Health Care and Education Affordability Reconciliation Act, was enacted shortly thereafter. Together, this historic legislation constitutes the largest change to America's health care system since the creation of Medicare and Medicaid.

CAH Update *provides critical access hospitals (CAH) and other rural health care providers with the latest information on federal legislative and regulatory activity affecting payment, quality and access to care. This issue reviews provisions of the PPACA and companion bill, including provisions for Medicare payment, protections, and extenders as well as workforce and graduate medical education opportunities that are especially important to CAHs. It also reviews rules affecting CAHs that were proposed by CMS in its inpatient PPS regulation on April 19, and the implemented rule on May 21.*

Information on the Shirley Ann Munroe Leadership Award also is included along with a link to the application. This annual award recognizes the contributions of rural health care leaders who work to expand access to patients in rural communitie.

Major Provisions

The AHA's April 19 *Legislative Advisory* provides a 90-page summary of the reform legislation. Below is a brief description of some of the law's most sweeping changes affecting hospitals.

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. 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 of Health and Human Services (HHS) 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. Participants will be required to submit data on the quality measures in each year of the program. 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. CAHs and post-acute care providers are exempt.

Independent Payment Advisory Board: The law establishes an Independent Payment Advisory Board (IPAB) 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. 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 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.

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 other hospitals including sole community hospitals (SCH) and rural referral centers (RRC). 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. 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.

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.

Rural Physician Payment

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.

Protections for Rural Hospitals

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

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.

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.

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.

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.

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 Federally Qualified Health Centers (FQHCs): The law establishes a fund for an expanded and sustained national investment in community health centers (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 a

National Health Care Workforce Commission to analyze the supply, distribution, diversity and skill needs of the health care workforce of the future. In addition, the law:

- Allows for a redistribution of unused residency positions as a way to encourage increased training of primary care physicians and general surgeons.
- Authorizes $4 million for each of FYs 2010-2013 for the HHS Secretary, acting through Health Resources and Services Administration (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.
- 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 FQHCs, community mental health centers, rural health clinics, and health centers operated by the Indian Health Service.

AHA's 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, the 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.

The AHA's new website "Health Care Reform Moving Forward" features numerous resources and tools to help hospital leaders understand health care reform and be able to inform their board, employees and community about its implications for the hospital. For example, there are two PowerPoint presentations that can be downloaded and tailored and an implementation timeline that depicts key milestones for the next 10 years.

Inpatient Proposed Rules for FY 2011

Recently, CMS issued two proposed rules for FY 2011 inpatient PPS. The first was released on April 19 and a second supplemental rule specific to provisions included in the PPACA was released on May 21. Each has provisions affecting CAHs that are summarized here.

CAH Payments. The rule ensures CAHs will be paid 101 percent of reasonable costs for all outpatient services they provide, regardless of the billing method elected. In FY 2010, CMS set outpatient service reimbursement for CAHs electing Method 2 at 100 percent of cost instead of at 101 percent of cost. The provision in this rule is retroactive, meaning CAHs will continuously receive the 101 percent reimbursement, despite CMS' previous policy.

Method 2. Effective for CAH cost reporting periods beginning on or after October 1, 2010, once a CAH has elected to receive payments under the "optional method" (also known as Method 2), the

election will remain in place until terminated. CAHs will no longer have to re-elect the optional method annually.

Allowable Costs. CMS proposes to "clarify" its policy concerning when provider taxes are considered allowable costs under Medicare. Medicare contractors will determine the allowability of provider taxes on a case-by-case basis, based on reasonable cost principles, and will determine if a reduction of the allowable tax expenses is proper to account for payments providers receive that are associated with the assessed tax.

Transfers. When a patient is transferred, the transferring hospital is paid based on a graduated per diem rate. The receiving hospital receives the full DRG payment. This acute care transfer policy does not currently apply to inpatient PPS transfers to CAHs. That is, the inpatient PPS hospital would receive the full DRG and the CAH cost-based reimbursement. The proposed rule would limit payment to the transferring hospital to a graduated per diem rate regardless of the destination of the transfer.

Payments for CRNA Services. Under existing regulations, neither CAHs that have reclassified from urban to rural nor CAHs located in "Lugar" counties are eligible to receive pass-thru payments for CRNA services. CMS proposes to permit urban CAHs that have been reclassified as rural to qualify for these payments. Effective for cost reporting periods beginning on or after October 1, 2010, CAHs are eligible for CRNA cost-based reimbursement. However, CMS is not proposing to allow CAHs located in Lugar counties to be eligible for CRNA cost-based reimbursement.

Shirley Ann Munroe Leadership Award

Application Deadline is July 16, 2010

Shirley Ann Munroe was an advocate for small and rural hospitals and was instrumental in the creation of the AHA's Section for Small or Rural Hospitals, a forum working to support small and rural hospitals as they improve their community's health. Her legacy is a benchmark for professional hospital management, rural community health development, and health care representation and advocacy.

This award is presented annually to a hospital administrator or CEO who has displayed outstanding leadership in meeting the ongoing challenges of small or rural hospital management. Recipients are selected through a two-phase process administered by the American Hospital Association. First, applications are screened for innovation, practicality, effectiveness, and sustainability of activities as described by the applicant's accompanying materials. After finalists are identified, a selection committee drawn from the governing council of AHA's Section for Small or Rural Hospitals selects a winner after in-depth application reviews. The stipend amount for 2010 is $1,500 and will help to defray the recipient's expenses to attend the AHA Annual Meeting or Health Forum Leadership Conference.

The Section for Small or Rural Hospitals of the American Hospital Association invites you to apply for this prestigious award. For more information, please contact Jihan Palencia, Section for Small or Rural Hospitals, at (312) 422-3345 or click here for additional details.

For more information, contact John T. Supplitt, senior director, Section for Small or Rural Hospitals, at (312) 422-3306 or jsupplitt@aha.org.