American Hospital Association

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The Section for Small or Rural Hospitals of the American Hospital Association represents and advocates on behalf of more than 1,630 rural hospitals, including 975 critical access hospitals (CAHs). ***CAH Update*** *provides our members updates on legislative and regulatory activities, as well as on Section programs and services. This issue of* ***CAH Update*** *highlights the latest events on Capitol Hill and recent rules from the Centers for Medicare & Medicaid Services (CMS).*

Washington Focuses on Federal Deficit

Congress passed and President Obama signed into law the *Budget Control Act of 2011* that raises the debt ceiling and reduces the deficit by at least $2.1 trillion. The two-part measure raises the debt ceiling by $900 billion – $400 billion immediately and $500 billion in September, following a presidential request – and enacts cuts of $917 billion over 10 years. Medicare and Medicaid would not be impacted by the initial cuts.

The second part of the agreement then calls for the formation of a 12-member, bipartisan congressional committee that is tasked with making recommendations for $1.2-1.5 trillion in additional savings by Nov. 23. The committee's recommendations are subject to a simple up-or-down vote before Dec. 23. If the recommendations pass, the president could request an additional increase in the debt ceiling of $1.5 trillion. If Congress fails to either act on the committee's proposal or send a balanced budget amendment to the states before the end of the year, automatic across-the-board spending cuts totaling $1.2 trillion would go into effect. The cuts would apply to both mandatory and discretionary spending programs beginning in 2013. **Medicaid would not be subject to the cuts, but Medicare provider payments could face a cut of no more than 2% over nine years (2013-2021)**. The president could then be authorized to request an additional increase in the debt ceiling of $1.2 trillion.

The AHA is extremely concerned about further reductions to hospital payments. Hospitals are already absorbing $155 billion in payment reductions as a share of health care reform, and Medicare and Medicaid pay hospitals less than the cost of providing care. Cuts to Medicare funding for hospital care could overload emergency rooms, shut down trauma units and reduce patient access to the latest treatments.

Legislative Update

For rural hospitals, extending the provisions in the 2010 *Medicare and Medicaid Extenders Act* remains a high priority. This law included a physician payment fix through December 31, 2011 as well as an extension of many Medicare provisions that support rural hospitals such as:

- Section 508 reclassifications, which is set to expire Sept. 30, 2011
- Medicare work geographic adjustment floor
- Exceptions process for Medicare therapy caps
- Direct billing for the technical component of certain physician pathology services
- Ambulance add-ons
- Outpatient hold-harmless
- Reasonable cost payments for clinical lab tests to patients in rural areas, which expired July 31, 2011.

With Capitol Hill primarily focused on the debt-ceiling limit and reducing the deficit, there has been limited attention to introducing new legislation. However, five bills have been introduced that address areas of need for CAHs.

The Rural Protection Act – Introduced by Rep. Sam Graves (R MO), the *Rural Protection Act* (H.R. 1398) would amend the *Social Security Act* to ensure that the full cost of certain provider taxes are considered allowable costs for purposes of Medicare reimbursements to CAHs.

The Protecting Access to Rural Therapy Services* (PARTS) *Act – Introduced by Sen. Jerry Moran (R-KS), PARTS (S. 778) would establish an advisory panel of clinicians to set up an exceptions process for outpatient therapy services that would require higher level of physician supervision than general supervision. In addition, the bill would adopt a default standard of general supervision for outpatient therapeutic services, establish a special rule for CAHs based upon their Medicare Conditions of Participation, revise the definition of “direct supervision” to allow for telemedicine, telephone or other technology, and put in place a hold harmless from civil or criminal action back to 2001.

Repealing the IPAB - Introduced by Rep. David Roe (R-TN), the *Medicare Decisions Accountability Act* (H.R. 452) would repeal the Independent Payment Advisory Board (IPAB), which is authorized by the *Patient Protection and Affordable Care Act* (ACA) to set Medicare reimbursement rates. Under the ACA, IPAB would submit cost-reduction proposals to Congress if Medicare spending grows faster than gross domestic product plus 1%. If Congress declined to approve those cuts or make equivalent cuts of its own, the Secretary of Health and Human Services would be required to enforce them. Hospitals – except for CAHs – are shielded from IPAB’s recommendations until 2020. Sen. John Cornyn (R-TX), introduced a companion measure, the *Health Care Bureaucrats Elimination Act* (S. 668) in the Senate.

The 340B Improvement Act - Introduced by Reps. Cathy McMorris Rodgers (R-WA), Bobby Rush (D-IL) and Jo Ann Emerson (R-MO), the *340B Improvement Act of 2011* (HR 2674) would extend the 340B drug discount program to inpatient prescriptions providing significant savings to patients, hospitals, the federal government, and state Medicaid programs. The AHA supports extending the 340B discounts to inpatient hospital stays for safety-net hospitals, CAHs, SCHs, RRCs, and MDHs; allowing MDHs access to the program; repealing the orphan drug exclusion and allowing rural and free-standing cancer hospitals access to discounted pharmaceuticals through the 340B program.

The Rural Health Care Capital Access Act of 2011 – This bipartisan bill (S. 1431) would extend through July 2016 an exemption that allows all CAHs to participate in the Federal Housing Administration's Hospital Mortgage Insurance Program. Without the exemption, which expired July 31, many rural hospitals would not qualify for the low-cost loan insurance based on patients' average length of stay, raising their financing costs for construction and renovation loans. The bill's sponsors are Sens. Herb Kohl (D-WI), Kent Conrad (D-ND), Tim Johnson (D-SD), John Thune (R-SD), Mike Johanns (R-NE), and Jon Tester (D-MT). AHA supports the bill. Since 2006, 10 rural hospitals in 10 states have received mortgage insurance through the program as a result of the exemption.

Other legislative priorities for the AHA and our rural members include:

- Reinstating necessary provider status for CAHs
- Ensuring CAHs are paid 101% of costs by Medicare Advantage plans
- Removing unreasonable restrictions on CAHs' ability to rebuild
- Payments to CAHs for certified registered nurse anesthetist (CRNA) services

Regulatory Update
Centers for Medicare & Medicaid Services (CMS)

CMS issued several rules with implications for CAHs including the 2012 inpatient prospective payment system (PPS) final rule, value-based purchasing final rule, outpatient PPS proposed rule, telemedicine final rule, and a proposed Medicare condition of participation (CoP) for seasonal flu vaccine.

Inpatient PPS Final Rule for FY 2012 - On August 1, CMS issued its hospital inpatient and long-term care hospital PPS final rule for FY 2012. It included changes in operating payments, a documentation and coding adjustment, new quality measure and hospital acquired conditions reporting requirements, capital adjustment, and rural and DSH payment adjustments. Of particular interest for CAHs, the rule adopted CMS's proposal to align CAH payment for ambulance services to be consistent with statute and revise the cost reporting periods of CAHs for payment of CRNA services.

Payment of CAH Ambulance Services

Under current regulation, payment for ambulance services furnished by a CAH or an entity owned and operated by a CAH is 101 percent of reasonable costs if the CAH or the entity is the only provider or supplier of ambulance services *within a 35-mile drive of the CAH or* ***the entity****.* However, the statute states that payment is 101 percent of reasonable costs if the CAH or entity is the only provider or supplier of ambulance services *within a 35-mile drive of* ***the CAH.***

CMS will revise its regulations to state that effective for cost-reporting periods beginning on or after October 1, 2011, payment for ambulance services furnished by a CAH or by an entity owned and operated by a CAH is 101 percent of reasonable costs if the CAH or the entity is the only provider or supplier of ambulance services *within a 35-mile drive of* ***the CAH.*** If there is another provider or supplier of ambulance services within a 35-mile drive of the CAH, payment would be made under the ambulance fee schedule.

CMS also finalized its proposal that, effective for cost-reporting periods beginning on or after October 1, 2011, if there is no provider or supplier of ambulance services within a 35-mile drive of the CAH, but there is a CAH-owned and -operated entity that is more than a 35-mile drive of the CAH, the CAH-owned and -operated entity would be paid 101 percent of reasonable cost as long as that entity is the closest provider or supplier of ambulance services to the CAH.

Payment of CRNA Services Furnished in Rural Hospitals and CAHs

CMS regulations provide that effective for cost reporting periods beginning on or after October 1, 2010, CAHs and hospitals that have reclassified as rural are eligible to be paid based on reasonable cost for anesthesia services and related care furnished by a qualified non-physician anesthetist.

In the final rule, CMS changed the effective date from October 1, 2010 to December 2, 2010 because under the earlier effective date hospitals with cost reporting periods beginning on or after January 1, 2011 would be ineligible for CRNA pass-through payments before January 1, 2012. CMS did not apply this change to hospitals located in "Lugar" counties.

Value Based Purchasing Program Final Rule - On April 29, CMS issued a final rule for the hospital value-based purchasing program. CAHs are excluded from the program. However, the ACA established two demonstration programs for CAHs and hospitals with an insufficient number of patient cases or applicable measures. The demonstration programs, which also are budget neutral, must begin by March 23, 2012 and will run for a three-year period. CMS did not make proposals around these demonstrations in this rule. We anticipate the agency will release additional information about the demonstrations and how hospitals may apply to participate later this year.

Outpatient and Ambulatory Surgical Center PPS Proposed Rule - On July 1, CMS released the outpatient PPS and ASC proposed rule for CY 2012 updating of the outpatient PPS and ASC payment weights, rates and policies. The rule also addressed supervision of outpatient therapeutic services that has implications for CAHs.

CMS proposes to use the federal Advisory Panel on Ambulatory Payment Classifications Groups (APC Panel) as an independent review body that would evaluate individual services for a potential change in supervision level. The panel will evaluate potential assignment to either a lower level (general supervision) or a higher level (personal supervision) of supervision. CMS proposes clinical and other evaluation criteria that the APC Panel would use in recommending a supervision level for individual outpatient therapeutic services. The Panel's recommendations will inform CMS's final decisions, which it will make using a sub-regulatory process in which only informal public input would be sought.

CMS estimates that policy decisions on many key services would not be completed until sometime in 2012. Thus, the agency proposes to extend through CY 2012 its enforcement

moratorium on the direct supervision policy for outpatient therapeutic services provided in CAHs and in small and rural hospitals with 100 or fewer beds.

Comments are due by August 30. An AHA Regulatory Advisory provides a detailed summary of the proposed rule.

Credentialing and Privileging for Telemedicine Final Rule - CMS issued a final rule implementing changes to the Medicare CoPs for the credentialing and privileging of telemedicine physicians and practitioners. The final rule allows the hospital or CAH receiving the telemedicine services to rely upon credentialing and privileging information from the hospital providing the telemedicine services as long as certain conditions are met. In an expansion of what was proposed, CMS also agreed to allow hospitals to receive telemedicine services from another telemedicine entity, such as a physician group or other entity. In its comments to CMS on the proposed telemedicine rule, the AHA advocated for this expansion as many hospitals contract with non-hospital entities for the provision of some telemedicine services, such as radiology interpretation services. The changes implemented by the rule should enable hospitals to make greater use of telemedicine services.

Influenza Vaccination Standard - On May 4, the CMS issued a proposed rule that would revise the Medicare and Medicaid CoPs to require hospitals, CAHs and other facilities to offer all inpatients and outpatients an annual influenza vaccination. Specifically, CMS would require hospitals to develop and implement policies and procedures to offer annual vaccination for seasonal influenza and pandemic influenza. Within its policies and procedures, the hospital would be required to ensure that:

- Patients receive education on the benefits, risks and potential side effects of the vaccine.
- Each patient is offered vaccination annually from the time the vaccine is available on or after September 1 through the end of February of the following year, unless the patient has medical contraindications or has already been vaccinated.
- Patients have the opportunity to decline vaccination.
- Patients' health records include certain documentation.

In its letter to CMS, the AHA agrees that increasing the number of individuals who receive the annual influenza vaccination is a key factor in decreasing the morbidity and mortality rates from influenza. However, the ideal location for individuals to receive influenza vaccination is in their primary care physician's office or through the local public health department. We also believe that using the CoP to impose this requirement is unnecessarily heavy-handed in that enforcement may result in hospitals being terminated from the Medicare and Medicaid programs.

Other Agency Rulemaking

340B Drug Discount Pricing Program - On May 20, the Health Resources and Services Administration (HRSA) proposed its rule on exclusion of orphan drugs for certain covered entities under the 340B drug discount pricing program. The rule offers added flexibility to CAHs and would permit them to purchase outpatient orphan drugs at 340B prices as long as they can demonstrate that the drugs are not used to treat the orphan drug's designated rare conditions or diseases. CAHs would be required to maintain separate records to ensure compliance. In its letter to HRSA, the AHA supports HRSA's narrow interpretation of the ACA orphan drug exclusion and look forward to working with the agency on the future implementation issues for the 340B program.

IRS From 990 Schedule H - On July 5, the IRS published its notice for request for comments regarding the Community Health Needs Assessment (CHNA) requirements for tax-exempt hospitals. A CHNA is mandated by the ACA and will be required of all 501(c)(3) hospitals. In April, the AHA, Healthcare Financial Management Association and VHA Inc. urged the IRS to promulgate proposed regulations implementing the new requirements for tax-exempt hospitals with proper notice and comment period. According to IRS, hospitals can rely on the provisions in the July 5 notice until any further guidance is issued. The AHA will submit comments before the Sept. 23 deadline.

Designation Process for Medically Underserved Populations (MUPS) and Health Professional Shortage Areas (HPSAs) - The HRSA Negotiated Rulemaking Committee for the designation of MUPs and HPSAs continues to meet monthly. The final report is due in October. Modest progress has been made by the committee regarding a designation process.

Meaningful Use – The **AHA commented on Stage 2 meaningful use proposal for EHRs.** In a letter to the Office of the National Coordinator for Health Information Technology, the AHA recommended guiding principles for decision-making on Stage 2 requirements for meaningful use of EHRs and commented on the Health IT Policy Committee's preliminary recommendations. If accepted, the committee's recommendations would form the basis of Stage 2 requirements for hospitals and eligible professionals to qualify for Medicare and Medicaid incentive payments.

In a June letter to the HITPC, the AHA said Stage 2 requirements should begin no sooner than FY 2014, and only when at least 75% of all eligible hospitals and physicians/professionals have successfully reached Stage 1.

CAH PEPPERS

CMS released the first annual Program for Evaluating Payment Patterns Electronic Reports for CAHs. The PEPPERs provide hospital-specific data for Medicare discharges at risk for improper payments, which hospitals can use to support internal auditing and monitoring activities and compare their Medicare billing practices with other CAHs in the state, nation and Medicare administrative contractor/fiscal intermediary jurisdiction. CMS has contracted with TMF Health Quality Institute to develop and distribute the reports via My QualityNet. https://tmfevents.webex.com. For more information, including the PEPPER distribution schedule and a sample report, visit www.pepperresources.org.

Visit the Section for Small or Rural Hospitals Web site at http://www.aha.org/smallrural

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