



## December 2011

*The Budget Control Act of 2011* created the Joint Select Committee on Deficit Reduction or “supercommittee,” a bipartisan 12-member panel tasked to craft a far-reaching plan to reduce the national deficit by at least \$1.2 trillion. The co-chairs recently announced that they failed to come to an agreement on a deficit reduction strategy. As the calendar year winds down, Congress is facing a full slate of issues that it must address including deficit reduction, funding the federal government and several key Medicare payment provisions which are set to expire at the end of the year. On the regulatory front, several regulations have been finalized with implications for rural hospitals.

This issue of **Small or Rural Update** highlights the latest legislative events on Capitol Hill and rulemaking by CMS and others.

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### LEGISLATIVE ADVOCACY

#### Deficit Reduction

Following the failure of the supercommittee to reach an agreement on deficit reduction, sequestration is invoked. As a result, automatic spending cuts totaling \$1.2 trillion split between defense spending and non-defense programs will take effect in January 2013. Under the trigger, reductions in Medicare payments to hospitals and other providers of 2 percent over nine years (2013 to 2021) will take effect.

Prior to the supercommittee’s announcement, the AHA hosted two Advocacy Days emphasizing among other issues the threats to rural and small hospitals, particularly critical access hospitals (CAH), sole community hospitals (SCH), Medicare-dependent hospitals (MDH), and Rural Referral Centers (RRC). The [President’s Plan for Economic Growth and Deficit Reduction](#) proposed three changes to payments for rural providers of concern to the hospital field including eliminating add-on payments for hospitals and physicians in low-population frontier states, reducing payments to CAHs and eliminating the CAH designation for hospitals that are fewer than 10 miles from the nearest hospital. Earlier this year, the [Congressional Budget Office](#) offered a budget cutting option that would eliminate CAH, SCH, and MDH programs all together.

More than 300 people participated in Advocacy Days briefings and visits to their members of Congress reminding our legislators that enough is enough — no additional cuts to hospital care. Protecting Medicare and Medicaid funding for hospital services means protecting access to critical health care services and protecting much needed jobs in every community.

In addition, AHA worked with our member hospitals to rally support for an effort by Reps Jo Ann Emerson (R-MO) and Ron Kind (D-WI). They penned a [“Dear Colleague”](#) in the House to the supercommittee co-chairs

Sen. Patty Murray (D-WA) and Rep. Jeb Hensarling (R-TX) asking them to carefully consider the potentially devastating consequences of cuts to CAHs on access to care for patients and economic development in rural communities. The outcome was a respectable 68 members cosigning the letter from a potential 198 congressional districts that are home to CAHs.

### Funding the Federal Government

The federal fiscal year (FY) 2011 budget was completed in May, but Congress has yet to fund the FY 2012 budget. On November 17, Congress gave final approval to H.R. 2112, the Agriculture, Rural Development, Food and Drug Administration, and Related Agencies Appropriations Act. The minibus appropriations bill of \$182 billion in domestic spending covers major science agencies and five Cabinet departments. President Obama signed the bill that includes a continuing resolution funding the remaining federal programs through December 16.

On Dec. 14, The House Committee on Appropriations announced a FY 2012 Appropriations bill package that includes three separate pieces of legislation (H.R. 3671, H.R. 3672, and H.Con.Res. 94): a consolidated bill that includes the remaining nine FY 2012 Appropriations bills that have yet to be enacted; a bill providing funding for disaster emergencies; and a bill containing offsets for the disaster funding. On Dec. 15, the House approved the budget bill to fund the federal government through September 2012 with a vote of 296-121. It now goes to the Senate where approval is likely and a government shutdown is avoided. Congress continues to negotiate a fix for Medicare payments to physicians. At issue are length (2 month, 1-year or 2-year) and how it will be funded.

### Appropriations

On December 15, the joint House-Senate Appropriations Conference on H.R. 2055 that includes funding of appropriations for the Department of Health and Human Services and related agencies [reported its conference agreement](#). In September, the Senate Labor, Health and Human Services, and Education, and Related Agencies Appropriations Subcommittee [reported](#) its \$158 billion FY 2012 appropriations bill (S. 1599). Also in September, the House Appropriations Committee for Labor, Health and Human Services, Education, and Related Agencies [reported](#) its \$153.4 billion draft FY 2012 funding bill (H.R. 3070).

Following are the proposed spending levels for select programs of interest to small or rural hospitals.

**Senate Appropriations Subcommittee for Labor, HHS, and Education, and Related Agencies  
House Appropriations Committee for Labor, HHS, Education, and Related Agencies  
FY 2012 Recommended Funding Levels - Select HHS Programs  
(in millions of dollars)**

PROGRAM	FY 2011 FUNDING LEVEL	FY 2012 PRESIDENT REQUEST	FY 2012 SENATE SUBCOMMITTEE	FY 2012 HOUSE COMMITTEE DRAFT
Rural Health Outreach Grants+	\$55.658	\$57.266	\$55.658	55.658
Rural Health Research	\$9.885	\$9.929	\$9.885	9.885
Rural Hospital FLEX grants	\$41.118	\$26.200	\$41.118	41.118*
Rural AED	0.24	0	2.521	2.521
State Offices of Rural Health	\$10.055	\$10.075	\$10.055	10.055
Telehealth	\$11.524	\$11.575	\$13.524	11.524
National Health Service Corps	\$24.848**	\$123.477**	\$24.848**	141.925**

+includes the Delta States Network Grant Program

\*The House Draft bill provides that \$15 million from the Rural Hospital FLEX grant program shall be available for the SHIP Grant

\*\*These funds are in addition to \$295.0 million which was provided for the National Health Service Corps in FY 2012 under the ACA.

### The AHA's Rural Hospital Advocacy Agenda

In addition to advocating on behalf of small or rural hospitals against deficit cuts and for spending on vital programs, the AHA has continued its pursuit of its advocacy agenda for extending expiring Medicare payment provisions. In September, AHA President and CEO Rich Umbdenstock [testified](#) before the House Ways and Means Health Subcommittee at a hearing on "Expiring Medicare Provider Payment Provisions." In November, AHA sent [letters](#) to the chairman and ranking members of the House Committee on Ways and Means and

Senate Committee on Finance asking them to extend funding of critical Medicare payment programs. Our legislative agenda advocates extending Medicare funding for programs including:

- Low-volume payment adjustment
- Medicare dependent hospital program
- Outpatient hold-harmless payments for small rural hospitals and SCHs
- Payment for the technical component of physician pathology services
- Medicare cost payments for clinical diagnostic laboratory tests furnished in certain rural areas
- Ambulance add-on payments
- Section 508 hospital wage index reclassifications
- The sunset for CAHs under the HUD 242 hospital mortgage insurance program.

The AHA continues its support of freestanding legislation that has the promise of improving access and enhancing quality of care to the communities served by small or rural hospitals. [Such bills include:](#)

- The Craig Thomas Rural Hospital and Provider Equity Act (R-HoPE) (S.1680).
- The Rural Health Care Capital Access Act (S. 1431)
- The Protecting Access to Rural Therapy Services Act (S. 778)
- Health Care Bureaucrats Elimination Act (S. 668)
- The 340B Drug Improvement Program (H.R. 2674)
- The Rural Protection Act (H.R. 1398)
- Medicare Decisions Accountability Act (H.R. 452)

## REGULATORY AND POLICY UPDATE

While Congress continues to debate how to fund the federal government and reduce the debt, the Centers for Medicare & Medicaid Services (CMS) issued regulations for changes to the Medicare inpatient prospective payment system (PPS), outpatient PPS, physician fee schedule, shared savings program, and conditions of participation. Other agencies including the Health Resources and Services Administration (HRSA) and the Department of Defense (DoD) also have published rules. In addition, the Medicare Payment Advisory Commission (MedPAC) has begun deliberations on its next report to Congress on rural health care access and hospital payments.

### THE FY 2012 INPATIENT PPS FINAL RULE

The final IPPS Rule was released on August 1 and summarized in AHA's Nov. 21 [Regulatory Advisory](#). Below are brief descriptions of the issues of special interest to small or rural hospitals.

**Documentation and Coding Offset.** The final rule implements a documentation and coding cut of 2.0 percent which is less than the 3.15 percent proposed in April. In addition, CMS continues FY 2011's cut of 2.9 percent to recoup documentation and coding overpayments made in FYs 2008 and 2009.

**Rural Floor Budget-Neutrality Adjustment.** CMS improperly implemented the rural floor budget-neutrality adjustment so that it progressively reduced Medicare payments for inpatient services over time. To remedy the situation, CMS recalculated the standardized amount and will permanently increase it – and therefore aggregate inpatient PPS payments – by 1.1 percent, or \$1.2 billion, in FY 2012.

**Quality Reporting.** CMS added three measures to the FY 2014 inpatient quality reporting program (IQR), as well as 17 new measures to the FY 2015 program. Included in the measures CMS finalized for FY 2014 is a Medicare spending per beneficiary measure.

**Readmissions.** CMS will implement a program beginning in FY 2013 under which hospitals with higher-than expected readmission rates will see reductions in their Medicare payments. It also mandates that reductions be based on the number of “excess” readmissions at a hospital, with a cap that would limit penalties in the first year of the program to 1 percent of a hospital's base operating Medicare payments. For the first year of the program, CMS will use the existing 30-day readmission measures for heart attack, heart failure and pneumonia patients. Contrary to statute, CMS includes readmissions from the measures that are unrelated to the prior discharge, as well as planned readmissions.

## THE CY 2012 OPPTS FINAL RULE

On Nov.1, CMS released its final rule with changes for the calendar year (CY) 2012 outpatient PPS. CMS suspended the inclusion of the hospital-acquired condition measures (HAC), Agency for Healthcare Research and Quality (AHRQ) composite measures, and efficiency measure in the FY 2014 hospital value-based purchasing (VBP) program. In addition, the agency extends through 2012 the period of non-enforcement of the direct supervision requirements for outpatient therapeutic services for CAHs and small rural hospitals. The changes are summarized in AHA's Dec. 13 [Regulatory Advisory](#).

**Payment Update:** The final rule includes a *Patient Protection and Affordable Care Act* (ACA)-required productivity reduction of 1.0 percentage point and an additional reduction of 0.1 percentage point to the CY 2012 market basket update of 3.0 percent. This results in a market basket update of 1.9 percent for those hospitals that publicly report data on 15 quality measures. Hospitals not submitting data will receive a negative 0.1 percent update. CMS projects that total payment for services furnished in hospital outpatient departments will be approximately \$41.1 billion in CY 2012.

**Direct Supervision of Outpatient Therapeutic Services:** CMS will use the federal Advisory Panel on Ambulatory Payment Classifications Groups (APC Panel) as an independent review body that will evaluate individual services for a potential change in supervision level. On Nov. 25, CMS published a notice on the changes to the Panel and a request for nominations to add four new members to the Panel, two from CAHs and two from non-CAH small rural hospitals. CMS estimates that policy decisions on many key services will not be completed until sometime in 2012. Thus, the agency will 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.

**Hold-Harmless Payments and Adjustment for Rural SCHs:** As required by law, the agency will no longer provide hold-harmless outpatient payments to SCHs or other rural hospitals with 100 or fewer beds. CMS will continue, however, to apply a 7.1 percent payment increase for most rural SCH services and procedures paid under the outpatient PPS. As part of its advocacy agenda, the AHA continues to press Congress to extend the outpatient hold-harmless policy and a number of other measures of importance to rural and other hospitals that are set to expire at the end of 2011.

**Wage Index Floor:** In the proposed rule, CMS raised concerns about hospital actions involving the inpatient PPS wage index rural floor that have resulted in significant wage index disparities and as such, solicited comments on using a modified version of the inpatient PPS wage index for the outpatient PPS, which would address its concerns about the rural floor. In the final rule, the agency acknowledged that there may be inequities in the current application of the wage index policy and its various adjustments. However, given the broader wage index reform that is underway, the agency stated it would maintain the current policy for CY 2012. It also stated it will continue to consider policy options in future rulemaking, especially in the context of other significant wage index revisions.

The AHA agrees that the area wage index is greatly flawed in many respects and warrants a full and comprehensive re-evaluation and redesign. In recognition of the substantial challenges entailed in revising such an imperfect wage index, in July 2011, the AHA Board of Trustees created a Wage Index Task Force to further examine the issue and analyze reports that the Institute of Medicine and CMS are required to complete. The Task Force met in November with another meeting planned in January 2012 when it will continue its discussion of the rural floor issue.

**Hospital Inpatient Value-based Purchasing Policy for FY 2014.** CMS suspended the inclusion of the HAC measures, AHRQ composite measures, and efficiency measure in the FY 2014 hospital VBP program. CMS intends to adopt these HAC, AHRQ and efficiency measures in future years of the VBP program, but did not formally make any proposals around their future inclusion. For FY 2014, CMS had proposed changing the weighting to incorporate outcomes and efficiency measures. However, given that this final rule suspends the inclusion of the HAC measures and AHRQ composite measures in the outcomes domain, and the efficiency

measure that comprised the efficiency domain, CMS finalized that the clinical process of care domain will account for 45 percent of a hospital's total performance score, the patient experience of care domain will account for 30 percent of the total performance score, and the outcomes domain will account for 25 percent of a hospital's total performance score.

**Physician Self-referral and Patient Notices on Physician Availability 24/7.** In the final rule with comment, CMS finalizes the regulations needed to implement the ACA provisions regarding limitations on physician-owned hospitals. The ACA limited the use of the physician self-referral exceptions for hospitals with physician ownership or investment. Only existing physician-owned hospitals may use the "whole hospital" and rural exceptions to the ban on self-referral. Most of the implementing rules were published last year through the outpatient PPS/ASC payment notices.

CMS also proposed to reduce the requirement for provision of patient notices regarding lack of 24/7 availability of doctors at inpatient facilities and that proposal has been finalized without change. The final rule rolls back the outpatient notice procedure to apply only to those outpatient visits that involve observation, surgery, or any other procedure requiring anesthesia, but only those hospitals that are not physician owned.

#### THE MEDICARE PHYSICIAN FEE SCHEDULE FINAL RULE

On Nov. 1, CMS released its final rule for CY 2012 with changes to the Medicare physician fee schedule (PFS) and other Medicare Part B payment policies. These regulations are summarized in AHA's Dec. 6 [Regulatory Advisory](#).

By law, CMS is required to develop separate Geographic Practice Cost Indices (GPCIs) to measure the differences in resource costs associated with physician work, practice expense and malpractice among localities compared to the national average. CY 2012 is the second year of the two-year transition to the latest GPCI rates that began in CY 2011.

CMS finalized its proposal that Medicare payments for physicians' services subject to the three-day payment window delivered in a hospital's wholly owned or operated physician practice will be made at the lower facility rate (rather than non-facility), but delays the implementation date from January 1, 2012 to July 1, 2012 to allow hospital and physician practices more time to coordinate their billing practices.

In addition, CMS is modifying its approval process for Medicare telehealth services. Specifically, beginning January 1, 2013, CMS will modify its Category 2 approval so that services that meet a new "clinical benefit standard" may be approved. Currently, and throughout CY 2012, services must meet a "comparability standard," which requires providers to demonstrate that the clinical outcomes of a service delivered via telehealth are comparable to the outcomes of the in-person service.

Previously, CMS required a physician's or non-physician practitioner's signature on a requisition for clinical diagnostic laboratory tests paid under the clinical laboratory fee schedule. In the PFS final rule, CMS formally reinstates its prior policy that the signature of the physician or non-physician practitioner is not required on a requisition for a clinical diagnostic laboratory test.

CMS will continue to pay independent laboratories for the technical component of physician pathology services for Medicare beneficiaries who are hospital inpatients or outpatients through CY 2011. Unless this provision is further extended by Congress, beginning January 1, 2012, independent laboratories will have to bill hospitals directly for technical component services.

#### THE MEDICARE SHARED SERVICES PROGRAM - ACCOUNTABLE CARE ORGANIZATIONS THE FINAL RULE

On November 2, CMS published in the Federal Register the final rule for the Medicare Shared Savings Program (MSSP), which encourages the voluntary formation of accountable care organizations (ACOs). The rule is summarized in AHA's Nov. 8 [Regulatory Advisory](#).

In the final rule what may be of interest to small or rural hospitals is that CMS states that it will assign patients on a preliminary prospective basis based on historical claims. Also, in order to assist participants with the high up-front costs associated with becoming an ACO, CMS is creating an Advance Payment ACO Model. The

advance payment is designed to provide support to organizations participating in the MSSP whose ability to achieve success would be improved with additional access to capital. The model is open only to two types of ACOs: (1) those that do not include any inpatient facilities AND have less than \$50 million in total annual revenue; and (2) those in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals AND have less than \$80 million in total annual revenue.

#### MEDICARE HOSPITAL AND CAH CONDITIONS OF PARTICIPATION PROPOSED RULE

CMS published in the Oct. 24 Federal Register a proposed rule to revise the existing Medicare and Medicaid Conditions of Participation (CoPs) for hospitals and CAHs. The rule is summarized in AHA's Dec. 5 [Regulatory Advisory](#). CMS's proposed changes, many recommended by the AHA, will allow hospitals and CAHs to deliver more efficient, higher-quality care. While we will likely seek further refinements of the proposed rule, the AHA is supportive of CMS's overall direction to modernize the CoPs and ease outdated regulations.

For small or rural hospitals, key provisions of the proposed rule include changes to the following requirements:

**CAH Services:** CMS proposes to allow CAHs to provide certain services, such as diagnostic, therapeutic, laboratory, radiology and emergency services, under service arrangements. Current regulations require CAHs to provide these services directly.

**Advanced Practice Practitioners:** CMS proposes several changes that would allow advanced practice practitioners (physician assistants, nurse practitioners) to serve in an expanded role. For example, the proposed changes would allow advanced practice practitioners to order medications for patients and to document and sign those orders.

**Elimination of Paperwork:** CMS proposes to eliminate the current criteria around infection control logs and allow hospitals flexibility in their approach to the tracking and surveillance of infections.

**Outpatient Services:** CMS intends to remove the requirement for a sole director over all outpatient services.

#### OTHR REGULATORY POLICY

Regulations governing payments to hospitals by TRICARE and electronic health records and goals for meaningful use have been published. HHS has received a final report on the negotiated rulemaking process for designation of Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/P), and MedPAC discussions on rural health care access and payment are underway.

**TRICARE Payments for Sole Community Hospitals.** TRICARE is required to reimburse SCHs using the same methodology as Medicare, to the extent practicable. TRICARE currently reimburses SCHs in one of two ways: billed charges less a negotiated discount for network hospitals; and billed charges for non-network hospitals.

The DoD states that the current TRICARE method results in reimbursing SCHs substantially more than Medicare for equivalent inpatient care and, thus, a change is needed to conform to the statute. In the proposed rule, DoD states that reimbursing SCHs using Medicare's method is not practicable. AHA [commented on the rule](#) and agrees that differences in the TRICARE and Medicare beneficiary case mix render the Medicare hospital-specific rate not directly applicable for TRICARE purposes and suggests that TRICARE use an alternative methodology based on cost-to-charge ratios.

Furthermore, The AHA urged Congress in [a letter](#) to retain language included in the Senate-passed National Defense Authorization Act to help ensure the availability of hospital care to TRICARE participants. The bill (S.1867), which now must be conferenced with the House-passed version (H.R. 1540), excludes TRICARE network providers from being considered contractors or subcontractors under the Federal Acquisition Regulation or other law.

**MedPAC.** The Patient Protection and Affordable Care Act (ACA) of 2010 requires MedPAC to evaluate access to care, quality of care, special rural payments, and the adequacy of Medicare payments to providers in rural areas. Access to services was discussed in February.

At its September meeting, [MedPAC Commissioners discussed Medicare rural payment adjustments](#) such as CAH payments and low-volume adjustments that have an effect of increasing payments to rural providers. They also discussed Medicare payments for and use of telehealth in rural areas.

At its October meeting, [MedPAC examined quality of care issues](#) such as hospital mortality, readmission, and process measures. They also discussed mandatory reporting of quality data, developing rural-specific quality measures, and addressing the volume/outcomes relationship.

MedPAC will conclude its discussions with a presentation on the adequacy of rural payments. Their report to Congress is due June 15, 2012.

**Meaningful Use.** The Department of Health and Human Services (HHS) announced on Nov. 30, that it intends to delay the proposed start of Stage 2 meaningful use requirements for the Medicare electronic health record (EHR) incentive programs until FY 2014, October 1, 2013 for hospitals. Hospitals can begin later but will incur penalties if they do not achieve meaningful use in FY 2015 or later years. Proposed rules for Stage 2, including a proposal for the delay, are expected in February 2012. The announcement is summarized in AHA's [Special Bulletin](#).

**Health Professional Shortage Areas and Medically Underserved Areas/Populations.** The ACA directed the Secretary of HHS to establish a [Negotiated Rulemaking Committee on Designation of MUA/Ps and HPSAs](#). The purpose was to reexamine the methodology for designating areas and populations that are experiencing medical underservice and/or health professional shortages. The mandate was for primary care and a committee was formed and deliberated 14 months to draft its recommendations to the Secretary. A [final report](#) with [addenda](#) was delivered by the Committee to the Secretary on Oct. 31.

HRSA published in the Nov. 3 Federal Register a [notice](#) listing of all the geographic areas, population groups and facilities designated as primary medical care, mental health, and dental health professional shortage areas (HPSAs) as of Sept. 1, 2011. Annually, lists of designated HPSAs, are provided to all state [Primary Care Offices](#) (PCO) and others with a request to review and update the data on which the designations are based. Any designated HPSA on the [HRSA Web site](#) is subject to withdrawal if new information is not received from the PCO and confirmed by HRSA.

### SHIRLEY ANN MUNROE LEADERSHIP AWARD

Jim Dickson, CEO of Copper Queen Community Hospital (CQCH) in Bisbee, AZ, is the 2011 recipient winner of the AHA's [Shirley Ann Munroe Leadership Award](#). The award recognizes the accomplishments of small or rural hospital leaders who have improved health care delivery in their communities through innovative and progressive efforts. Dickson has formed coalitions seeking funding to care for the rural population, including a recent effort to pool monies with other rural hospitals in Arizona to receive matching federal funds. Dickson has greatly expanded CQCH's use of IT through electronic health records, securing funding for radiology diagnostic imaging and home health telemedicine. Finalists include Ed Bruun, president and CEO of Sparrow Clinton Hospital, St. Johns, MI; Mark Herzog, president and CEO of Holy Family Memorial, Manitowoc, WI and Bryan Slaba, CEO of Wagner (SD) Community Memorial Hospital – Avera.

A [press release](#) with a description of the winning application and finalists for the 2011 award is available. To learn more about submitting your organization's application for the 2012 award, contact Jihan Palencia Kim at 312-422-3345.

### RURAL HEALTH CARE LEADERSHIP CONFERENCE



The 2012 Rural Health Care Leadership Conference brings together top thinkers in the field, and offers you strategies for accelerating performance excellence and improving the sustainability of your rural hospital. For 25 years, the Conference

has brought a unique focus on innovative ideas, thoughtful insights, and proven strategies for improving rural hospitals and developing rural health care leaders. This year will be no exception. [Registration](#) is now open.

### MOST WIRED

Save the Date! The 2012 Most Wired Survey opens **January 17, 2012** and every organization that completes the survey receives:



- **Most Wired Survey Dashboard**, a confidential assessment of your organization's current IT Strategies
- **Detailed Results Report**, which shows *each* of the given responses and its corresponding scoring level
- **Key Findings Report**, which details how Most Wired hospitals and health

systems are leading the way in automating and integrating clinical, patient safety and administrative functions. Find out more at [www.hhnmostwired.com](http://www.hhnmostwired.com).

For more information, contact John Supplitt, senior director, Section for Small or Rural Hospitals, at (312) 422-3345 or [jsupplitt@aha.org](mailto:jsupplitt@aha.org). Also, visit the Section website at [www.aha.org/smallrural](http://www.aha.org/smallrural).