AHA Rural Legislative Update

Lisa Kidder, V.P., AHA Legislative Affairs

October 17, 2011

2011 Rural Issues

- Extend Expiring Provisions
- Reinstate Necessary Provider
- Ensure CAHs are paid at least 101% of costs by Medicare Advantage plans
- CAHs in IPAB
- Provider Taxes as Allowable Costs
- CAH Flexibility Act
- The 340B Drug Discount Pricing
- CAH Payments for CRNA Services
- Direct Supervision for Outpatient Services

American Hospital Association

Medicare extenders in current law

Expiring Provisions

- Section 508 area wage index reclassifications [$200 million]*
- Treatment of technical component of physician pathology services [$100 million]
- Payment adjustment for low-volume hospital [$150 million]**
- Reasonable cost reimbursement for laboratory services in small rural hospitals [Less than $50 million]
- Increase payments for ambulance services [$100 million]
- Physician fee-fix [$12-18 billion]
- Hospital outpatient department hold-harmless payments [$200 million]**
- Medicare-dependent hospital [Less than $50 million]**

* Expires September 30, 2011
* * Expires September 30, 2012

American Hospital Association

Rural Budget Deficit Implications

- **CBO "options" document - $62B in savings if eliminate CAH, MDH, SCH**
- **Biden Group/Cantor slide - $14B rural hospitals**
- **House Ways and Means "options" document – references CBO options**
- **Pres. Obama proposal to "supercommittee"**
  - **Reduce CAHs payment of 101% of costs to 100%**
  - **Prohibit CAH designation for those CAHs that are less then 10 miles from nearest hospital**
  - **Eliminate Frontier Proposal**

American Hospital Association

R-HoPE

The R-HoPE Act (S.1680)

- **Extend the outpatient hold harmless**
- **Increase the low-volume adjustment to 2000 discharges**
- **Extend cost-based reimbursement for rural outpatient labs**
- **CAH ambulance payment improvements**
- **Extend the billing for the technical component of pathology services**
- **Reimburse CAHs for CRNA on-call services**
- **“Sense of the Senate” on extenders**

American Hospital Association

Provider Taxes

The Rural Hospital Protection Act (H.R.1398)

Reps. Sam Graves(R-MO)/Ron Kind(D-WI)

- **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**

American Hospital Association

CAH Flexibility

The Critical Access Hospital Flexibility Act

- **Allows CAHs to meet either the current census limit of 25 beds per day, or a limit of 20 beds per day averaged over a cost reporting period**
- **Exempts beds occupied by military veterans from the daily bed count**

American Hospital Association

340B Program

The 340B Program Improvements

- **Would allow CAH, MDH and all SCH and RRC to access 340B discounts for inpatient**
- **Would extend the 340B discount to inpatient drugs for hospitals**
- **Increased GAO scrutiny of 340B program?**

American Hospital Association

CRNA/CAH Payments

Legislation would:

- **Allow a hospital to waive its Lugar status for all purposes, which allows them to go back to being considered rural so they can get CRNA pass thru**

- **Also allow standby payments for CRNAs**

American Hospital Association

Direct Supervision

Senator Jerry Moran (R-KS) S.1486

- **Establish advisory panel of clinicians to set up an exceptions process for those services that would require higher level of supervision**
- **Adopt a default standard of general supervision for outpatient therapeutic services**
- **Establish a special rule for CAHs based upon their Medicare CoPs**
- **Revise the definition of "direct supervision" to allow for telemedicine, telephone or other technology**
- **Put in place a hold harmless from civil or criminal action back to 2001**

American Hospital Association

Advocacy Action

As the Supercommittee Deadline Draws Near. . .

Remind Your Legislators:

Hospital Care Cannot Sustain Further Cuts

Thursday, November 3, 2011
Reserve Officers Association
(The Minuteman Ballroom, Fifth Floor)
One Constitution Avenue, NE
Washington, DC

http://www.aha.org/advocacy-issues/action/pfa.shtml

American Hospital Association

Contact Information

Lisa Kidder
Vice President
AHA Legislative Affairs
Washington, DC
202-626-2369
lkidder@aha.org

American Hospital Association

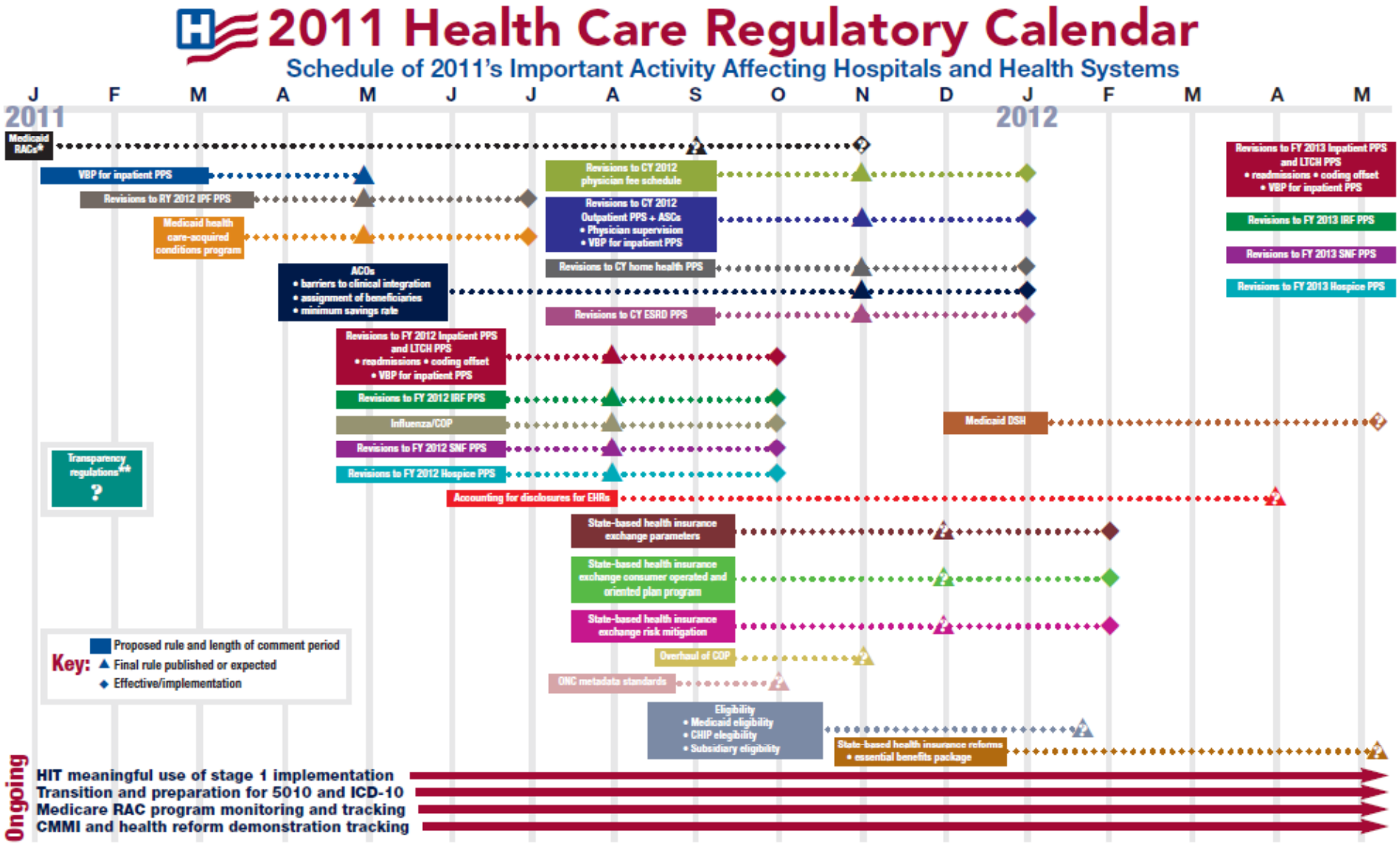
AHA Rural Regulatory Update

Joanna Kim, Sr. Assoc. Director

AHA Policy

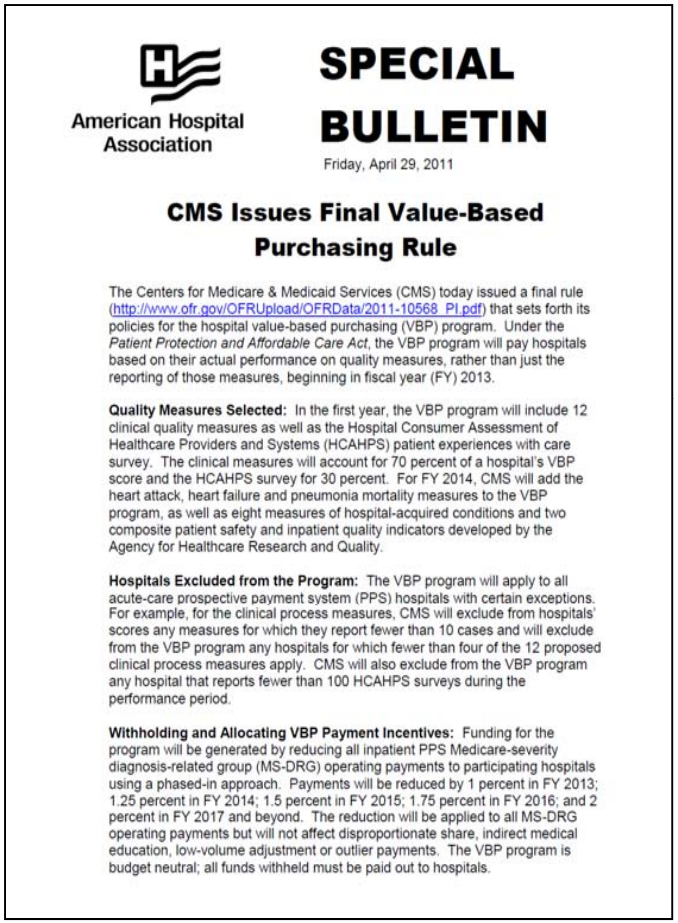
October 17, 2011

2011-2012 Regulatory Calendar



VBP Rulemaking Timeline

- **Final rule issued April 29**
- **Additional provisions in FY 2012 IPPS final rule and CY 2012 OPPS proposed rule**
- **Begins FY 2013**



American Hospital Association

SPECIAL BULLETIN

Friday, April 29, 2011

CMS Issues Final Value-Based Purchasing Rule

The Centers for Medicare & Medicaid Services (CMS) today issued a final rule (http://www.ofr.gov/OFRUpload/OFRData/2011-10568_PI.pdf) that sets forth its policies for the hospital value-based purchasing (VBP) program. Under the *Patient Protection and Affordable Care Act*, the VBP program will pay hospitals based on their actual performance on quality measures, rather than just the reporting of those measures, beginning in fiscal year (FY) 2013.

Quality Measures Selected: In the first year, the VBP program will include 12 clinical quality measures as well as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experiences with care survey. The clinical measures will account for 70 percent of a hospital's VBP score and the HCAHPS survey for 30 percent. For FY 2014, CMS will add the heart attack, heart failure and pneumonia mortality measures to the VBP program, as well as eight measures of hospital-acquired conditions and two composite patient safety and inpatient quality indicators developed by the Agency for Healthcare Research and Quality.

Hospitals Excluded from the Program: The VBP program will apply to all acute-care prospective payment system (PPS) hospitals with certain exceptions. For example, for the clinical process measures, CMS will exclude from hospitals' scores any measures for which they report fewer than 10 cases and will exclude from the VBP program any hospitals for which fewer than four of the 12 proposed clinical process measures apply. CMS will also exclude from the VBP program any hospital that reports fewer than 100 HCAHPS surveys during the performance period.

Withholding and Allocating VBP Payment Incentives: Funding for the program will be generated by reducing all inpatient PPS Medicare-severity diagnosis-related group (MS-DRG) operating payments to participating hospitals using a phased-in approach. Payments will be reduced by 1 percent in FY 2013; 1.25 percent in FY 2014; 1.5 percent in FY 2015; 1.75 percent in FY 2016; and 2 percent in FY 2017 and beyond. The reduction will be applied to all MS-DRG operating payments but will not affect disproportionate share, indirect medical education, low-volume adjustment or outlier payments. The VBP program is budget neutral; all funds withheld must be paid out to hospitals.

American Hospital Association

VBP Quality Measures: 2013

- **For FY 2013, CMS finalized 13 total measures**
  - 12 process measures in process measures domain
  - HCAHPS patient experiences with care in patient experiences domain
- **For FY 2013, performance measured**

  July 1, 2011 – March 31, 2012

VBP Quality Measures

For FY 2014, there are 15 additional measures

Measure	FY 2014 Performance Period
Postoperative urinary catheter removal (process domain)	April 1, 2012 – December 31, 2012
3 mortality measures (outcomes domain)	July 1, 2011 – June 30, 2012
2 composite measures (outcomes domain)	March 3, 2012 – September 30, 2012
8 HACs (outcomes domain)	March 3, 2012 – September 30, 2012
1 per-beneficiary spending measure (efficiency domain)	May 15, 2012 – February 14, 2013

** Baseline period is 2 years prior to performance period*

VBP Quality Measure Minimums

- **Clinical Process Measures**
  - 10 cases to be eligible for measure
  - 4 measures to be eligible for program
- **HCAHPS**
  - 100 HCAHPS surveys to be eligible for program
- **Outcomes (proposed)**
  - 10 cases to be eligible for mortality measure
  - 3 cases to be eligible for each composite measure
  - 1 Medicare claim to be eligible for HAC measure
  - 10 of 13 measures to be eligible for program (must have at least 7 HACs)
- **Efficiency**
  - No proposal related to measure minimums

CMS estimates 353 PPS hospitals will be excluded from VBP in FY 2013 because they do not meet the minimum number of measures.

American Hospital Association

Scoring Hospitals' VBP Performance

- Hospitals will receive the higher of their attainment or improvement score on each measure
- Score on each domain equals points earned out of total possible points

- FY 2013 payment based on:

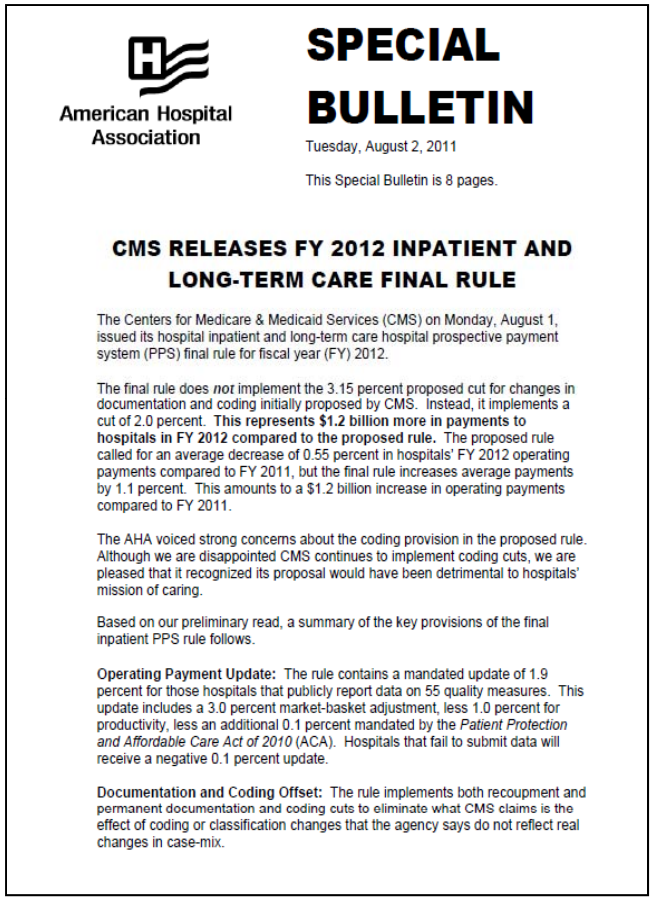
FY 2014 payment based on:

- **Payment details next year**

American Hospital Association

FY 2012 Medicare IPPS Final Rule

- **Issued August 1**
- **Key Issues**
  - Coding Offset
  - Rural Floor Adjustment
    - (Cape Cod lawsuit)
  - Readmissions



American Hospital Association

SPECIAL BULLETIN

Tuesday, August 2, 2011

This Special Bulletin is 8 pages.

CMS RELEASES FY 2012 INPATIENT AND LONG-TERM CARE FINAL RULE

The Centers for Medicare & Medicaid Services (CMS) on Monday, August 1, issued its hospital inpatient and long-term care hospital prospective payment system (PPS) final rule for fiscal year (FY) 2012.

The final rule does *not* implement the 3.15 percent proposed cut for changes in documentation and coding initially proposed by CMS. Instead, it implements a cut of 2.0 percent. **This represents $1.2 billion more in payments to hospitals in FY 2012 compared to the proposed rule.** The proposed rule called for an average decrease of 0.55 percent in hospitals' FY 2012 operating payments compared to FY 2011, but the final rule increases average payments by 1.1 percent. This amounts to a $1.2 billion increase in operating payments compared to FY 2011.

The AHA voiced strong concerns about the coding provision in the proposed rule. Although we are disappointed CMS continues to implement coding cuts, we are pleased that it recognized its proposal would have been detrimental to hospitals' mission of caring.

Based on our preliminary read, a summary of the key provisions of the final inpatient PPS rule follows.

Operating Payment Update: The rule contains a mandated update of 1.9 percent for those hospitals that publicly report data on 55 quality measures. This update includes a 3.0 percent market-basket adjustment, less 1.0 percent for productivity, less an additional 0.1 percent mandated by the *Patient Protection and Affordable Care Act of 2010* (ACA). Hospitals that fail to submit data will receive a negative 0.1 percent update.

Documentation and Coding Offset: The rule implements both recoupment and permanent documentation and coding cuts to eliminate what CMS claims is the effect of coding or classification changes that the agency says do not reflect real changes in case-mix.

American Hospital Association

Net Update: Proposed v. Final

ADJUSTMENT	PROPOSED	FINAL
• Inflation rate (hospital market-basket)	+ 2.8%	+ 3.0%
• Prospective coding adjustment	- 3.15%	- 2.0%
• Rural floor lawsuit (Cape Cod)	+ 1.1%	+ 1.1%
• PPACA reduction	- 0.1%	- 0.1%
• PPACA productivity adjustment	- 1.2%	- 1.0%
• NET UPDATE FACTOR	-0.55%	+1.1%
DOLLAR IMPACT (as compared to FY 2011 levels)	**- $498 M**	**+$1.2 B**

Net Update: SCHs and MDHs

ADJUSTMENT	PROPOSED	FINAL
• Inflation rate (hospital market-basket)	+ 2.8%	+ 3.0%
• Prospective coding adjustment	- 2.5%	- 2.0%
• Rural floor lawsuit (Cape Cod)	+ 0.9%	+ 0.9%
• PPACA reduction	- 0.1%	- 0.1%
• PPACA productivity adjustment	- 1.2%	- 1.0%
• NET UPDATE FACTOR	-0.1%	+0.8%

Readmissions Reduction Program

- CMS will use existing 30-day readmissions measures: heart attack, heart failure, pneumonia
- ACA: exclude unrelated, planned
- Hospitals with fewer than 25 discharges for each condition be excluded
- Hospitals with "excess" readmissions penalized up to 1% in FY 2013
- Payment details next year

AMERICAN HOSPITAL ASSOCIATION
SEPTEMBER 2011

TRENDWATCH

Examining the Drivers of Readmissions and Reducing Unnecessary Readmissions for Better Patient Care

Nearly one-fifth of Medicare beneficiaries—roughly 2 million beneficiaries per year[1]—discharged from a hospital return within 30 days, according to the Medicare Payment Advisory commission (MedPAC).[2] Some of the readmissions are planned, some are unplanned and others are unrelated to the initial reason the patient came to the hospital. Identifying and reducing avoidable readmissions will improve patient safety, enhance quality of care, and lower health care spending. That is why policymakers, consumers, hospital leaders and the medical community are focused increasingly on readmissions to hospitals.

Policymakers are proposing incentives to reduce hospital readmissions by publicly posting data on readmission rates and lowering payments to hospitals with high rates. First, in 2009, hospitals began voluntarily reporting hospital readmission rates to the Centers for Medicare & Medicaid Services (CMS) for public review on its website, *Hospital Compare*. Rates of readmission occurring for any reason following hospitalization for one of three common conditions—heart attack, heart failure, and pneumonia—are displayed.[3] Most recently, in the *Patient Protection and Affordable Care Act* (ACA), Congress enacted the Hospital Readmissions Reduction Program (HRRP) under which Medicare will penalize hospitals for higher-than-expected rates of readmissions beginning in FY 2013.[4]

Careful planning is warranted to ensure that the HRRP achieves its dual aims of improving quality and reducing costs. There are opportunities to achieve cost savings by reducing readmissions, but not all readmissions can or should be avoided. Additionally, as CMS proceeds with the HRRP, evidence is mounting that the link between readmissions and quality of care is more complex than assumed. Further, the role of other factors—such as a patient's demographic and socioeconomic characteristics, social support structure, and co-morbid conditions, all of which are crucial to appropriate risk adjustment of readmission rates—is still not fully understood.

America's hospitals are committed to improving the safety and quality of care they deliver, and many are already working to reduce avoidable readmissions. Innovative programs focus on improving care transitions, bolstering post-discharge monitoring and follow-up care, and strengthening linkages with other community providers. Payment rules should encourage hospitals to invest in programs proven effective, and should avoid unintended adverse consequences for other aspects of patient care.

This TrendWatch examines recent research on hospital readmissions, including the linkages between readmissions and quality of care, and the various circumstances that may drive readmissions. It also discusses the changes put in place by the ACA and highlights the considerations and additional research that are warranted as policymakers implement the new HRRP.

Rural Provisions

CAHs

- **Cost-based Ambulance Reimbursement**
  - **Cost-based if no other provider within 35 miles of CAH, not of "CAH or CAH ambulance provider"**
  - **If no one within 35 miles of CAH, cost-based if closes to CAH**

American Hospital Association

CY 2012 Medicare OPPSFinal Rule

- **Issued July 1**
- **Key Issues**
  - Physician Supervision

American Hospital Association

Regulatory Advisory

July 21, 2011

Medicare Outpatient PPS and ASC Proposed Rule for CY 2012

AT A GLANCE

The Issue:

On July 1, the Centers for Medicare & Medicaid Services (CMS) released the outpatient prospective payment system (OPPS) and ambulatory surgical center (ASC) proposed rule for calendar year (CY) 2012. In addition to updating OPPS and ASC payment weights and rates, the proposed rule includes the implementation of an ASC quality reporting program, inpatient value-based purchasing (VBP) changes, quality reporting through electronic health records (EHRs) and physician self-referral rule changes. Major OPPS proposals include:

- A mandated 1.3 percentage point reduction to the CY 2012 market basket update of 2.8 percent, resulting in an adjusted market basket update of 1.5 percent.
- No enforcement in CY 2012 of the direct supervision policy for outpatient therapeutic services provided in critical access hospitals (CAHs) and in small rural PPS hospitals with 100 or fewer beds.
- Using an existing federal outpatient advisory committee as an independent review body to evaluate individual outpatient therapeutic services for potential changes in supervision level.
- The addition of nine new quality measures for 2014 and one in 2015.
- A voluntary Electronic Reporting Pilot in 2012 to test automated reporting from the EHR for the quality measures required under the EHR incentive program.
- A payment adjustment for 11 cancer hospitals.
- Significant payment reductions for hospital-based partial hospitalization program services.

Comments on the OPPS and ASC proposed rule are due to CMS by August 30. The final rule, expected in November, takes effect January 1, 2012.

Our Take:

The AHA appreciates the steps that CMS has taken over the last several years to address some hospital issues and concerns around its direct supervision policy, particularly the extended delay in enforcement of direct supervision requirements in CAHs and small rural PPS hospitals. We continue to believe that there are many procedures that can be, and are, safely furnished in hospital outpatient departments under the general supervision of a physician. Therefore, we are encouraged by the proposed implementation of an independent review process that will be used to consider and revise supervision levels for certain outpatient therapeutic services. However, we are concerned that the proposal will not fairly represent the interests of small rural PPS hospitals, could result in more burdensome supervision requirements for services without justification, and does not allow for formal public notice and comment on CMS' decisions. In addition, the AHA continues to disagree with CMS' repeated assertion that it has required direct supervision of outpatient therapeutic services since 2001. We will continue to advocate for changes to meet the needs of hospitals and their patients.

What You Can Do:

- ✓ Share this advisory with your chief financial officer and other members of senior management, billing and coding staff, nurse managers and key physician leaders. A 115-page summary also is available.
- ✓ Model the impact of the APC changes on your expected 2012 Medicare revenue. Spreadsheets comparing the changes in APC payment rates and weights from 2011-2012 are available on the AHA's Outpatient PPS Web page under "Resources." Please note: AHA members must be logged on to the website to access the spreadsheets.

Further Questions:

Please contact Roslyne Schulman at rschulman@aha.org for OPPS issues; Lisa Grabert at lgrabert@aha.org for quality reporting issues; Joanna Kim at jkim@aha.org for VBP issues; Ellen Pryga at epryga@aha.org for self-referral issues.

AHA's Regulatory Advisories are produced whenever there are significant regulatory developments that affect the job you do in your community. A 25-page, in-depth examination of this issue follows.

Supervision of Outpatient Therapeutic Services

- Establishes APC Panel as independent review body to review requests for re-assignment of supervision levels
  - Would add 2-4 CAH representatives to Panel
  - CAH reps would participate only in supervision decisions, not other APC Panel issues
- Panel would re-assign supervision levels both up (i.e. personal) or down (i.e. general) from current (i.e. direct)
  - Must consider clinical, payment and quality context & likelihood that patients' care would need to be modified by supervisor
  - Must consider service's complexity, acuity of patient population receiving service, probability of unexpected/adverse event, expectation of rapid clinical changes during procedure.

American Hospital Association

Supervision, continued

- **CMS final decisions on recommendations handled through sub-regulatory process**
  - **won't be completed Posting on CMS Web site**
  - **Only informal public comment accepted.**
- **CMS estimates policy decisions on many key services until mid-2012.**
- **So… CMS proposes to further delay enforcement of through CY 2012 of supervision requirements in CAHs and small rural hospitals with 100 or fewer beds.**

NOTE: CMS states that extension is *intended to allow these hospitals time to meet the direct supervision standard* while policy alternatives are debated.

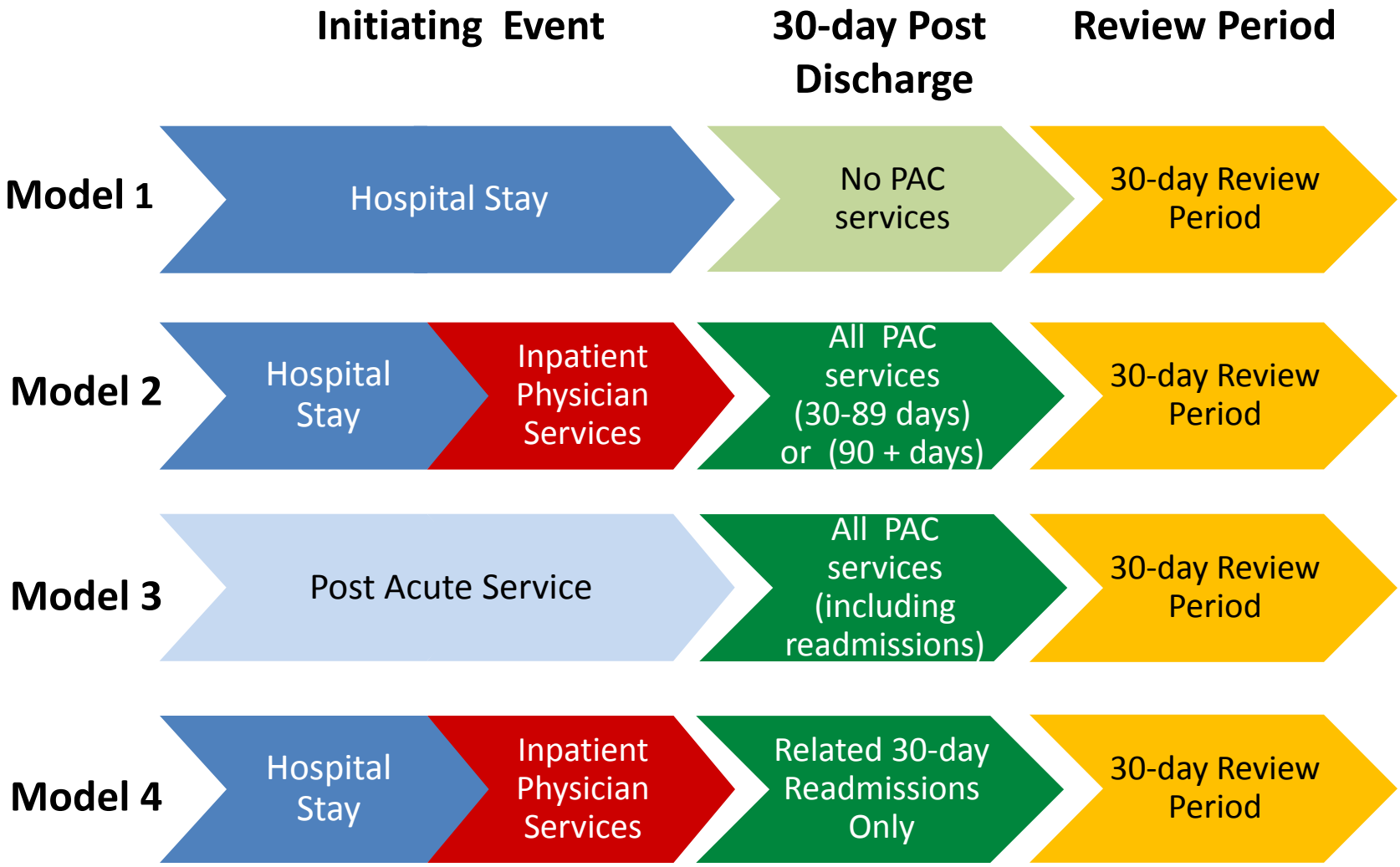
American Hospital Association

CMMI Bundled Payment Initiative

- Announced August 23
- 4 bundling models offered
- Ranges from all MS-DRGs to selected MS-DRGs
- Incentives to reduce spending and improve care
- Organizations can request specific waivers and gainsharing opportunities in applications

American Hospital Association

CMMI Bundled Payment Initiative



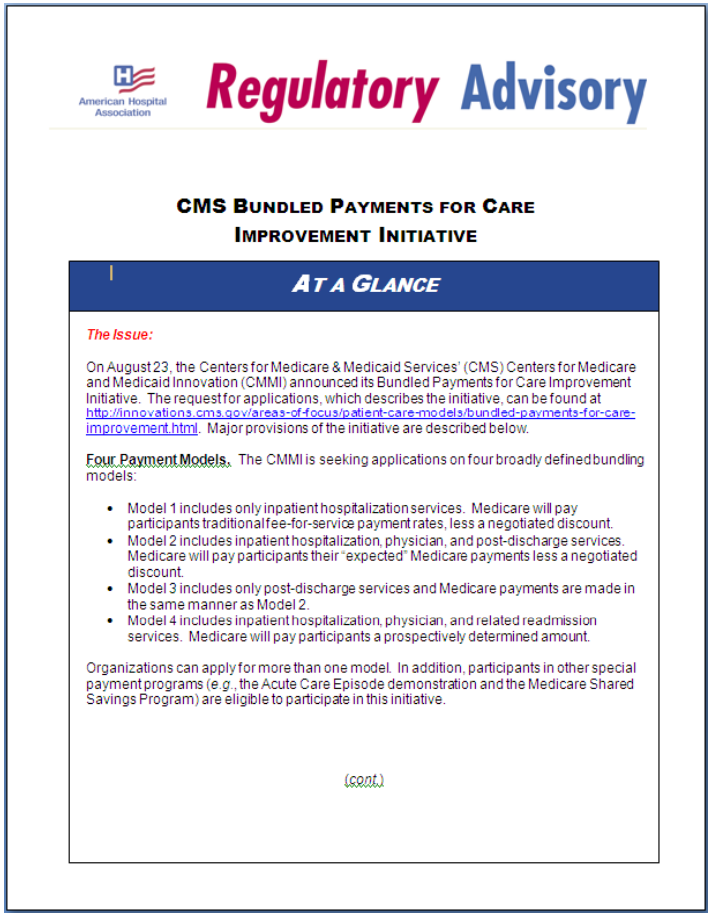
Other Provisions

- **CMMI allows for "gainsharing" among providers**
- **CMMI does not automatically waive any specific barriers to clinical integration, but providers can request waivers**
- **No "lock-in" or restrictions on beneficiary choice of provider**

American Hospital Association

Timeline

- **Bundling Model 1**
  - **Non-binding letter of intent by Oct 6 [new]**
  - **Application by Nov 18 [new]**
- **Bundling Models 2-4**
  - **Non-binding letter of intent due Nov 4**
  - **application by Mar 15, 2012**



American Hospital Association Regulatory Advisory

CMS Bundled Payments for Care Improvement Initiative

At a Glance

The Issue:

On August 23, the Centers for Medicare & Medicaid Services' (CMS) Centers for Medicare and Medicaid Innovation (CMMI) announced its Bundled Payments for Care Improvement Initiative. The request for applications, which describes the initiative, can be found at http://innovations.cms.gov/areas-of-focus/patient-care-models/bundled-payments-for-care-improvement.html. Major provisions of the initiative are described below.

Four Payment Models. The CMMI is seeking applications on four broadly defined bundling models:

- Model 1 includes only inpatient hospitalization services. Medicare will pay participants traditional fee-for-service payment rates, less a negotiated discount.
- Model 2 includes inpatient hospitalization, physician, and post-discharge services. Medicare will pay participants their "expected" Medicare payments less a negotiated discount.
- Model 3 includes only post-discharge services and Medicare payments are made in the same manner as Model 2.
- Model 4 includes inpatient hospitalization, physician, and related readmission services. Medicare will pay participants a prospectively determined amount.

Organizations can apply for more than one model. In addition, participants in other special payment programs (*e.g.*, the Acute Care Episode demonstration and the Medicare Shared Savings Program) are eligible to participate in this initiative.

(cont.)

American Hospital Association

MedPAC Rural Report

Key Findings

- **1300+ CAHs not all isolated**
  - 17% more than 35 miles from another hospital
  - 67% are 15 to 35 miles
  - 16% are less than 15 miles
- **MedPAC concludes the program keeps neighboring hospitals open even if there is excess capacity in the market**

American Hospital Association

Contact Information

Joanna Kim

Senior Associate Director

AHA Policy

Washington, DC

202-626-2340

jkim@aha.org

American Hospital Association

American Hospital Association