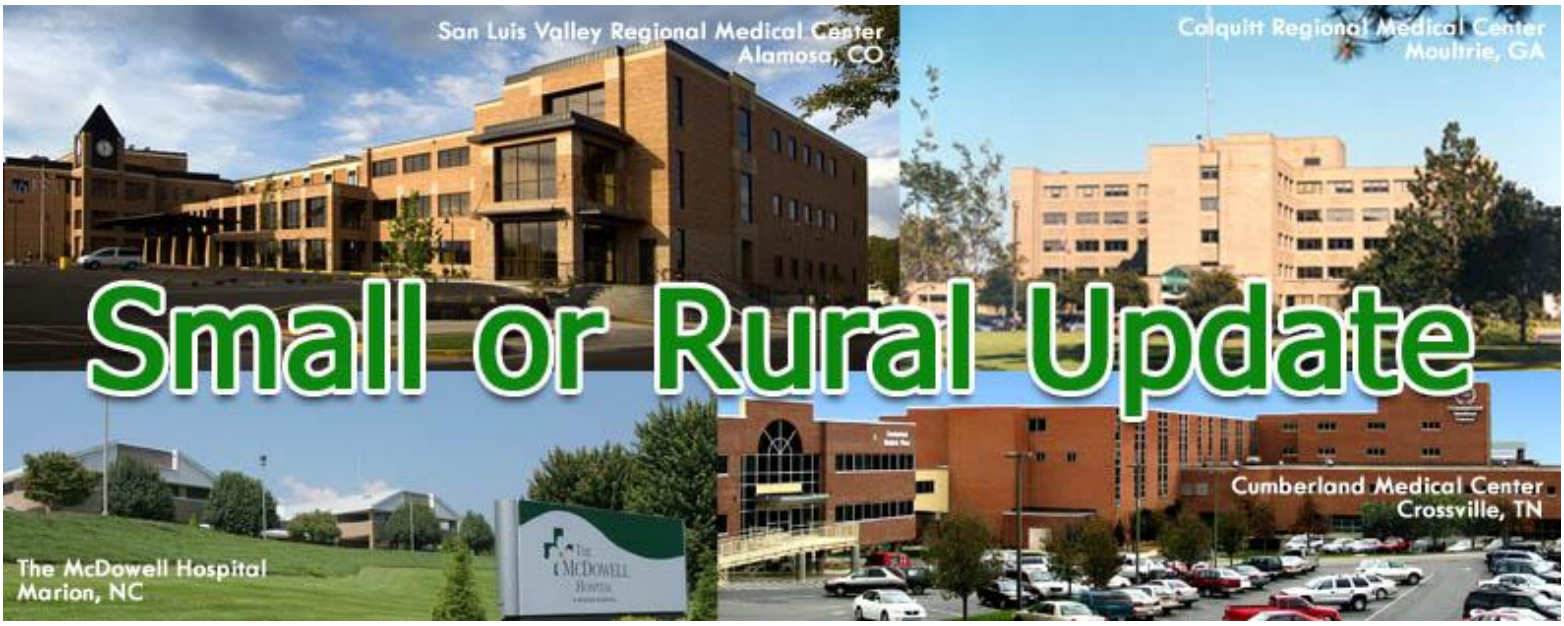


American Hospital Association

SUMMER 2011

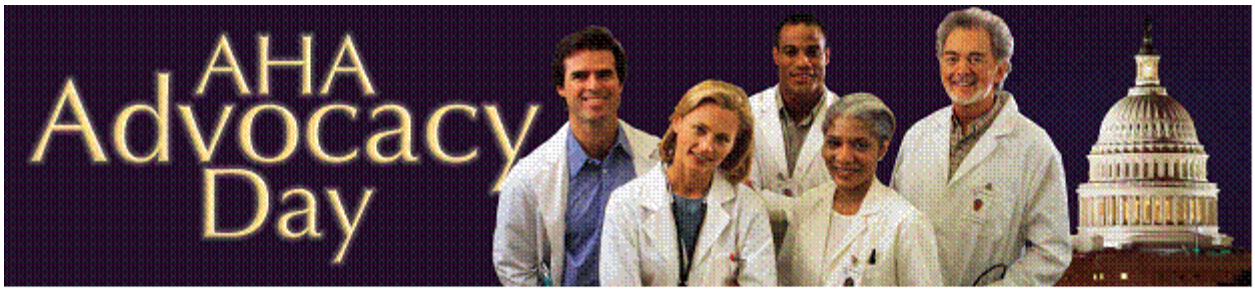
The Section for Small or Rural Hospitals of the American Hospital Association represents and advocates on behalf of more than 1,630 rural hospitals, including 975 critical access hospitals (CAHs). Small or Rural Update provides our members updates on legislative and regulatory activities, as well as on Section programs and services. This issue of Small or Rural Update highlights the latest events on Capitol Hill, both legislative and regulatory, and examines a new report on rural hospitals.

Washington Focuses on Federal Deficit

The primary focus of the Administration and Congress continues to be on the national debt. The raising of the federal debt limit must take place by Aug. 2 in order to prevent the nation from defaulting on its existing financial obligations. Legislation to increase the debt limit is likely to be a vehicle to reduce the deficit through spending cuts and/or tax increases. Given that Medicare and Medicaid comprise more than 20% of all federal spending – and, on average, around 55% of hospital revenues – the debate over federal debt limit and deficit reduction has significant implications for the hospital field.

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.

We are working aggressively to avoid any new reductions to hospitals. We have launched the "Enough is Enough" advertising campaign to stave off new cuts to hospitals. As part of our grassroots strategy, we are urging AHA members to contact their legislators and ask them to protect funding for hospital care under Medicare and Medicaid. See our *Advocacy Action Alert* for more information. In addition, we are sponsoring an Advocacy Day for hospital leaders to come to Washington to deliver a unified message to Capitol Hill.



Enough is Enough. No More Cuts to Hospital Care.

Wednesday, July 13, 2011
Washington, DC

Everything is on the table for potential cuts. Hospital leaders need to talk to their member of Congress. Please join your colleagues in delivering a unified message to Capitol Hill—*no more cuts to hospital payments*. We need to protect funding for hospital services under Medicare and Medicaid during the current deficit reduction debate. R.S.V.P. to Debra Thomas at 312.422.3327 or *dthomas@aha.org*

Legislative Update

With federal priorities focused on the debt-ceiling limit and reducing the deficit, there's been a limited focus on introducing new legislation. However, three bills have been introduced that tackle areas of concern for rural hospitals: *The Rural Protection Act*, which addresses CAH provider taxes, and the *Protecting Access to Rural Therapy Services Act*, which focuses on direct physician supervision for therapeutic services, and the *Medicare Decisions Accountability Act,* which repeals the Independent Payment Advisory Board (IPAB).

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 Act (PARTS) – 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 Medicare's IPAB, which is authorized by the 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. Rep. David Roe, R-TN, introduced H.R. 452. Sen. John Cornyn, R-TX, introduced a companion measure, the "Health Care Bureaucrats Elimination Act," S. 668, in the Senate.

Regulatory Update

CMS and other federal agencies issued several rules including the 2012 inpatient PPS proposed rule, accountable care organization (ACO) proposed rule, value-based purchasing (VBP) final rule, a telemedicine final rule and CAH PEPPERs. CMS also addressed several aspects of meaningful use and the RACs.

FY 2012 Inpatient PPS and Long-Term Care Proposed Rule

On April 19, CMS issued its hospital inpatient and long-term care hospital prospective payment system (PPS) proposed rule for FY 2012. A final rule will be released by August 1, and changes will take effect October 1. This proposed rule affects the inpatient PPS, as well as long-term care and critical access hospitals.

In our comment letter to CMS, the AHA urged the agency to revise its proposed rule to reduce the proposed documentation and coding offset. The proposed offset would cut hospital payments by 6.05%, or $6.3 billion, and create substantial volatility in inpatient PPS rates. Together with other policy changes, the cut would decrease FY 2012 payments to hospitals by 0.55% on average, or $498 million total, compared to FY 2011 payments. The AHA believes CMS' methodology for determining the offset is flawed and that much of the change CMS found is actually the "continuation of historical increases in the case-mix index," not the effect of documentation and coding changes due to the implementation of the Medicare severity diagnosis-related groups.

The AHA also strongly disagrees with CMS' proposal for the Hospital Readmission Reduction Program, set to begin in FY 2013, which only exclude a very limited set of planned readmissions. We believe the agency has ignored Congress' intent that the measures be modified to explicitly exclude unrelated and planned readmissions. The AHA urged CMS to conduct a study to thoroughly determine the common reasons for planned readmissions, as well as determine a subset of readmissions that are unrelated to the initial admission for the relevant conditions. In the interim, CMS should take steps to improve the existing measures, such as adjusting for patient characteristics beyond age, gender and medical diagnosis.

Rural floor budget-neutrality adjustment. The AHA has repeatedly urged CMS to correct errors in the inpatient PPS's rural floor budget-neutrality adjustment that have resulted in hospitals receiving inappropriately low Medicare payments for more than a decade. In January, the U.S. Court of Appeals for the District of Columbia issued an order questioning CMS' justification for the prior application of the adjustment and suggesting that the agency must recalculate payments due to hospitals under a formula that removes the effects of the prior adjustments, if CMS could offer no other rationale for its previous actions. In the FY 2012 proposed rule, CMS attempts to remedy the problem by proposing to increase the standardized amount by 1.1 percent and to increase the sole-community and Medicare-dependent hospitals specific rates by 0.9 percent. In the interest of transparency, in its letter to CMS, the AHA urged CMS to identify and release the methodologies and data necessary for hospitals to verify the agency's calculation of the 1.1 and 0.9 percent corrections.

Accountable Care Organizations (ACOs)

On March 31, CMS released the proposed regulation for the Medicare Shared Savings Program, which encourages the voluntary formation of ACOs. The program encourages groups of providers to form ACOs to improve the quality and efficient delivery of patient care, and to share in the cost

savings they achieve with the Medicare program. Also on March 31, four other government entities – the Office of Inspector General (OIG), Department of Justice (DOJ), Federal Trade Commission (FTC) and Internal Revenue Service (IRS) – released additional guidance on ACO development to address antitrust, fraud and abuse, and tax exemption barriers. The AHA produced an advisory on each of the four ACO-related proposed rules and notices. In addition, the association submitted comment letters to the various agencies involved. Materials are available at www.aha.org under "Advocacy." Below is a brief statement of AHA's position on the four ACO-related proposals:

ACO Proposed Rule: CMS places too much risk and burden on providers with little opportunity for reward in the form of shared savings, especially in light of the significant start-up and operating costs that providers must bear with little or no assistance. Perhaps the biggest disappointment associated with the proposed ACO program is the continued barriers to clinical integration. In order for hospitals to participate in the program in a meaningful way, a more appropriate balance is needed.

Fraud & Abuse Proposed Notice: The CMS-OIG Notice falls far short of what is needed. We have urged the Secretary to use the authority granted under the ACA to create an ACO waiver from fraud and abuse laws that covers ACO activities from formation through the end of their participation in the Medicare ACO program.

Tax-exemption Proposed Notice: The AHA requested that the IRS issue 1) a clear statement for tax-exempt hospitals that participating in an eligible ACO will not result in an impermissible inurement and private benefit and will not generate unrelated business income tax, so long as the ACO complies with regulations promulgated by CMS; 2) a clear statement indicating whether the Service will consider granting tax-exempt status to ACOs; and 3) clear guidance that the Service will extend its existing joint-venture precedents to other clinically integrated organizations that do not choose to participate in the ACO program, but provide similar benefits, and do so in a flexible manner.

Antitrust Proposed Statement: While there are several positive aspects of the Proposed Statement, the resulting regulations, particularly those applicable to the antitrust laws, are disappointing in a number of important respects. We urged the FTC, DOJ and CMS to abandon the proposed regulatory scheme in favor of guidance that restores antitrust to its historic role of creating or maintaining the conditions of a competitive marketplace.

Value-Based Purchasing Final Rule

CMS issued a final rule that sets forth its policies for the hospital VBP program. Under the ACA, the VBP program will pay hospitals based on their actual performance on quality measures, rather than just the reporting of those measures, beginning in FY 2013. An AHA Regulatory Advisory examines the final rule in depth

In the first year, the VBP program will include 12 clinical quality measures as well as the HCAHPS patient experiences with care survey. The clinical measures will account for 70% of a hospital's VBP score and the HCAHPS survey for 30%. 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.

The VBP program will apply to all acute-care PPS hospitals with certain exceptions such a CAHs. 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.

Credentialing and Privileging for Telemedicine Final Rule

CMS issued a final rule implementing changes to the Medicare Conditions of Participation 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, 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.

Recovery Audit Contractors (RACs)

Medicare's recovery audit contractors have collected $313.2 million in alleged overpayments from health care providers since October 2009, and paid them $52.6 million in underpayments, according to a report from CMS. The report identifies the top overpayment issues in each of the four RAC regions nationwide, which involve coding errors and inappropriate billing of bundled services separately.

Medical necessity denials are the top reason Medicare RACs have denied claims since first-quarter 2010, according to 1,960 hospitals responding to the AHA's *RAC*Trac survey. The majority of these medical necessity denials were for one-day stays found to be in the wrong setting, not because the care was medically unnecessary. The latest *RAC*Trac report, which contains new data from enhancements AHA recently made to the survey, reveals that more than half of hospitals participating in *RAC*Trac are experiencing problems with reconciling RAC recoupments and untimely RAC correspondence. Hospital representatives are invited to attend a free July 6 webinar on the survey results and learn how to participate in the free web-based survey, which helps hospitals monitor the impact of RACs and advocate for needed changes to the program. For more information, visit www.aha.org/aha/issues/RAC/ractrac.html.

Meaningful Use

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 PEPERS

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.

Shirley Ann Munroe Leadership Award

The Shirley Ann Munroe Leadership Award recognizes small or rural hospital CEOs and administrators who have achieved improvements in local health delivery and health status through their leadership and direction. The Award offers professional development opportunities to outstanding small or rural hospital CEOs and includes a $1,500 stipend to offset the cost of attending an AHA educational program. The deadline for 2011 applications is July 29. For more information, please contact Jihan Palencia Kim, Section for Small or Rural Hospitals, at (312) 422-3345.

Rural Hospital TrendWatch

AHA's April TrendWatch report examines rural hospitals as they implement the *Patient Protection and Affordable Care Act* (ACA). Many of the ACA provisions can be made to work for rural hospitals through the development of thoughtfully crafted guidance and regulation. This issue of *TrendWatch* paints a clear picture of the challenges, such as limited financial and workforce resources, rural hospitals face and the critical role they play in our nation's health care system. We are sharing the report with legislators and policymakers to ensure reform provisions meet the unique needs of rural America. Contact Jihan Palencia Kim at (312) 422-3345 if you would like a copy.

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

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