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
- CBO Options Document
- Provider Taxes as Allowable Costs
- CAH Flexibility Act
- The 340B Drug Discount Pricing
- CAH Payments for CRNA Services
- Direct Supervision for Outpatient Services
Expiring Rural Provisions

- Extend increased ambulance rates, including super rural
- Direct billing for technical component of pathology services
- Outpatient hold harmless extension
- Reasonable cost payments for clinical diagnostic laboratory tests in rural areas
- Section 508 wage reclassification beyond FY 2011.
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
The Critical Access Hospital Flexibility Act

Sen. Ron Wyden (D-OR) and Rep. Greg Walden (R-OR)

- 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
The 340B Program Improvements

• Would all MDH and all SCH and RRC to access 340B discounts for outpatient

• Would extend the 340B discount to inpatient drugs for hospitals
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
Direct Supervision

Legislation would:

- 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
House and Senate Activity

- RHCC and SRHC
  - House: Mike Thompson (D-CA), Cathy McMorris Rogers, (R-WA)
  - Senate: Tom Harkin (D-IA), Pat Roberts (R-KS)
- Equalize DSH Payments for rural hospitals
- CAH Ambulance Payment Improvements
- Outpatient Hold Harmless
- Direct Supervision Outpatient Therapeutic Services?
- CAH/Independent Payment Advisory Board?
AHA Annual Meeting

Special Rural Briefing
Regulatory Update
April 10, 2011

Joanna Hiatt Kim
Agenda

• ACOs
• VBP Proposed Rule
• OPPS Final Rule
• IPPS Proposed Rule
• HIT Rule
CMS Releases Proposed Rule for Accountable Care Organizations Program

Thursday, March 31, 2011

The Centers for Medicare & Medicaid Services (CMS) today, March 31, released a proposed rule for the new accountable care organization (ACO) program. At the same time, CMS and the Department of Health and Human Services' (HHS) Office of the Inspector General (OIG), the Department of Justice (DOJ) in conjunction with the Federal Trade Commission (FTC), and the Internal Revenue Service (IRS) issued proposed policy statements regarding the legal issues around establishment of ACOs.

The Patient Protection and Affordable Care Act of 2010 (ACA) requires the HHS Secretary to establish an ACO program that will measure quality and total cost of care for assigned beneficiaries, beginning in calendar year (CY) 2012. ACOs would share in savings with the Medicare program if quality and cost objectives are met. The ACO program is voluntary and requires a three-year agreement from participating providers. The CMS Office of the Actuary estimates that ACOs could save the Medicare program as much as $960 million over a three-year period.

CMS will accept comments on the rule through June 6. The DOJ/FTC will accept public comments through May 31, and the IRS will accept public comments through May 21.

Key provisions of the proposed rule are summarized below.
ACO Proposed Rule

Quick Reaction

• Administration deserves credit for trying to accommodate needs of range of stakeholders
• Historic, coordinated effort
• Hospitals already working to coordinate care…reflects the direction field is moving in
• Positives
  - Option with no downside risk for two years
  - Better access to data
• Concerns
  - Providers want beneficiary assignment to be prospective
  - Doubles the number of quality measures currently required
  - Needs to go further in eliminating barriers to clinical integration
ACO Proposed Rule

Rural Provisions

• Allows small and rural ACOs to share in first dollar savings for low-risk track
• Allows PPS hospitals + CAHs electing Method 2 to be ACO participants
• Allows RHCs and FQHCs to partner with ACOs
• Provides shared savings bonus for strong use of RHCs and/or FQHCs
ACO Proposed Rule

Next Steps

• Regulatory advisory
• Member education
• Identifying key issues in comment process
  – Membership engagement
  – Comments due June 6
• Meetings with executive branch officials and hospital leaders
• Getting Congress to share hospital concerns with CMS
• Issued January 7
• Comments due March 8
• Final Rule by May 1

Key Issues
– HACs
– Minimums
– HCAHPS
Payment incentives begin FY 2013

Applies only to PPS hospitals – critical access hospitals are excluded

Also excluded: hospitals determined to have too few patient cases or applicable measures

Funding generated by reducing MS-DRG payments:
- 1 percent in FY 2013...2 percent in FY 2017 and beyond.

Will not affect DSH, IME, low-volume adjustment or outlier payments
Quality Measures

• For FY 2013, CMS proposes 18 total measures
  – 17 process measures
  – HCAHPS patient experiences with care

• For FY 2014, CMS proposes 20 additional measures
  – 3 mortality measures
  – 9 ARHQ patient safety measures
  – 8 HACs

• For FY 2013, performance measured
  July 1, 2011 – March 31, 2012
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

CMS estimates 353 PPS hospitals will be excluded from VBP because they do not meet the minimum number of measures. At least 83 of these hospitals are rural.
VBP Demonstrations

2 VBP Demonstrations for Certain Excluded Hospitals

• Critical Access Hospitals
• Hospitals with a small number of cases or quality measures
  – Test innovative methods of measuring and rewarding quality and efficient health care
  – Begin by March 23, 2012; 3-year period
  – Budget neutral
  – Number of sites to be selected by the Secretary
  – No more than 18 months after demo, report to Congress on recommendations to establish permanent program
Scoring Hospitals’ Performance

- Hospitals will receive the higher of its attainment or improvement score on each measure.
- For FY 2013, process measures account for 70% of total performance score, HCAHPS 30%.
- CMS proposes linear scale to translate total performance score into incentive payment.
- Program budget neutral...some hospitals receive more than withheld, others less.
Physician Supervision

• CMS modified level of supervision for specified outpatient therapeutic services in 2011 – direct supervision only for the initiation followed by general supervision

• 16 “nonsurgical extended duration therapeutic services”
  • observation, intravenous and subcutaneous infusions and various therapeutic prophylactic or diagnostic injections
Physician Supervision

- Changed definition of “immediately available”
- Will convene clinical panel
- Extended and expanded moratorium
IPPS Proposed Rule for FY 2012

- Coding offset
  - 2.9% cut in FY 2011
  - Expect maintenance of that cut plus maybe additional 1%

- Readmissions
  - Could be in FY 2012 IPPS
  - Math error
HIT: The Era of Meaningful Use

• Medicare EHR incentive program has begun
  – October 1, 2010 for hospitals
  – January 1, 2011 for physicians
• Medicaid EHR incentive program live in 12 states, including South Carolina
• Hospitals are very interested in program
• But few can meet all of the requirements today
• AHA will work to help hospitals meet the definition and improve IT adoption
Operational Challenges

• A new program with many policy and operational nuances to be worked out
• Crosses Medicare, Medicare Advantage, and 50 State Medicaid programs
• Detailed and proscriptive…
• …But still being clarified
  – ONC FAQs (23 and counting)
  – CMS FAQs (113 and counting)
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