Winter 2012

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.

Advocacy Action

With the continued threat of cuts to hospital and health system payments, the AHA is organizing additional ways for your voice to be heard. The AHA Advocacy Alliances are special interest member groups created to engage on the issues about which you care deeply. Currently, there are four alliances: rural, graduate medical education, 340B and coordinated care. Alliance activities include special briefing calls and e-mails to keep members up-to-date on key developments, special breakout sessions at AHA Advocacy Days, direct member outreach, and other issue-specific resources. If you are interested in one or more of these issues, please visit www.aha.org/joinAlliance.

Fiscal Year 2013 Federal Budget

In late September, the Senate passed a continuing resolution (H.J. Res. 117) to fund most federal programs at their current levels through March 27, 2013. The six-month measure, signed by President Obama, eliminated the threat of a government shutdown when the fiscal year ended Sept. 30, as Congress has not yet approved all appropriations bills for fiscal year (FY) 2013. It also cleared the way for lawmakers to tackle more difficult issues – the fiscal cliff – in the post-election lame duck session.

In his February FY 2013 budget, President Obama proposed $320 billion in reductions to Medicare and Medicaid as part of his $3.8 trillion fiscal year (FY) 2013 proposal. The President's plan, which is similar to a proposal the White House released in September 2011, calls for cutting Medicare by about $268 billion and Medicaid by $52 billion over 10 years. The President also proposes cuts to other programs, including funding for hospital emergency preparedness.

The President's budget proposed to reduce CAH payments from 101% to 100% of reasonable costs, and eliminate CAH designation for hospitals that are less than 10 miles from the nearest hospital. Together, the administration estimates these rural proposals would save approximately $2 billion over 10 years. He also proposed to reduce bad debt payments to 25% (from the current 70%) over three years starting in FY 2013, saving approximately $36 billion over 10 years from all providers. Both proposals remain viable as the President negotiates with Congress a resolution to the fiscal cliff.

AHA Legislative Update and Advocacy Agenda for Rural Hospitals

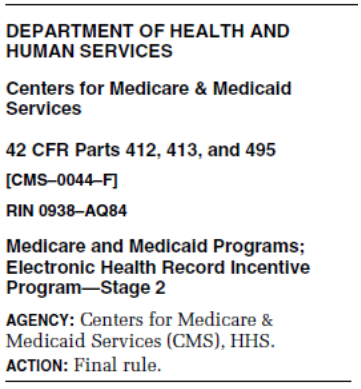
Congress is working to address a host of critical issues before the end of the year. Among the items legislators are considering:

1. the physician fix and several health care programs that are set to expire at the end of the year; and
2. the looming fiscal cliff, including the sequestration of Medicare payments.

Medicare payments to providers are set to be hit with a 2% reduction, or "sequestration," at the beginning of next year as a result of the *Budget Control Act of 2011*. This cut could have a devastating impact on the hospital field, specifically reductions in payments to hospitals for assistance to low-income Medicare beneficiaries (bad debt). It puts rural hospitals and the patients they serve under severe stress, as their small size leaves them with more limited cash flow and less of an ability to absorb such losses. In addition, rural hospitals have Medicare bad debt levels that are 60% higher than urban hospitals, on average.

Legislators are considering reductions to payments for hospital services to help pay for the cost of the physician fix, the health care extenders, and other non-health care related items that are part of the "fiscal cliff." ***Action is needed:*** It is critical that you share your concerns with both of your senators and your representative, particularly if your representative is a member of the Republican leadership or the Ways and Means Committee.

Electronic Health Record (EHR) Incentive Program


DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, and 495

[CMS–0044–F]

RIN 0938–AQ84

Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

On Sept. 4, CMS released a final rule specifying the Stage 2 criteria that eligible hospitals and CAHs must meet in order to qualify for Medicare and/or Medicaid EHR incentive payments. In addition it specifies penalties under Medicare for hospitals and CAHs failing to demonstrate meaningful use of certified EHR technology. The rule took effect Nov. 5 and a summary is found in an AHA Regulatory Advisory.

CMS finalized a total of 22 hospital objectives for Stage 2, including seven new objectives. In Stage 2, hospitals will need to meet (or qualify for an exception to) each of 16 core objectives and three of six menu-set objectives. Hospitals also must electronically generate a report on 16 clinical quality measures from a menu of 29 using certified EHR technology. This includes, but is not limited to, use of CPOE for more than 60 percent of medication, 30 percent of laboratory, and 30 percent of radiology orders created by authorized providers of a CAH's inpatient or emergency department.

CAHs must meet the CPOE and other criteria and by statute, the reductions will be applied to cost-based reimbursement. Penalties will be applied starting on October 1, 2014, beginning with the fiscal year 2015 cost reporting period. The Medicaid EHR incentive program has no penalties.

CMS will continue to permit an eligible hospital or CAH to indicate that certain objectives/measures do not apply to them. For core measures, an exclusion reduces the number of objectives required to demonstrate meaningful use. Beginning in 2014, an exclusion for a menu-set objective will no longer count toward the number of menu-set objectives needed to meet meaningful use. Providers will need to report on all relevant menu-set items before reporting exclusions.

The following seven objectives have specific exclusion criteria that are spelled out in the rule:

- Patient portal – exclusion for hospitals located in counties with limited broadband availability for households.
- Record smoking status – exclusion for hospitals with no patients aged 13 or older
- ePrescribing of discharge prescriptions – exclusion for hospitals with no internal pharmacy or pharmacy within 25 miles that can accept electronic prescriptions.
- Record advance directive – exclusion for hospitals that admit no patients age 65 or older.
- Public health measures – all three of the public health measures (immunization registries, reportable lab results, and syndromic surveillance) benefit from exclusions. An additional exclusion to the immunization registry requirement is provided for hospitals that do not provide immunizations for which data are collected.

As in Stage 1, however, CMS will require attestation only for exclusions, but providers should maintain documentation to support their exclusions.

Outpatient Prospective Payment System

CMS on Nov. 1 released a final rule for the outpatient prospective payment system (PPS) and ambulatory surgical center (ASC) for calendar year (CY) 2013. A summary of the rule can be found in the Dec. 6 Regulatory Advisory. It takes effect Jan. 1. Highlights are below:

Electronic Health Records Pilot: CMS is extending the 2012 Medicare EHR Incentive Program Electronic Reporting Pilot for Eligible Hospitals and CAHs through 2013, exactly as finalized for 2012. Eligible hospitals and CAHs may continue to report clinical quality measure results as calculated by CEHRT by attestation for FY 2013, as they did for FYs 2011 and 2012.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1597–N]

Medicare Program; Semi-Annual Meeting of the Advisory Panel on Hospital Outpatient Payment (HOP Panel)—March 11 and 12, 2013

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Notice.

Physician Supervision: As supported by the AHA, CMS delays for an additional year its enforcement of the direct supervision policy for outpatient therapeutic services provided in CAHs and small and rural hospitals through CY 2013.

Advisory Panel on Hospital Outpatient Payment

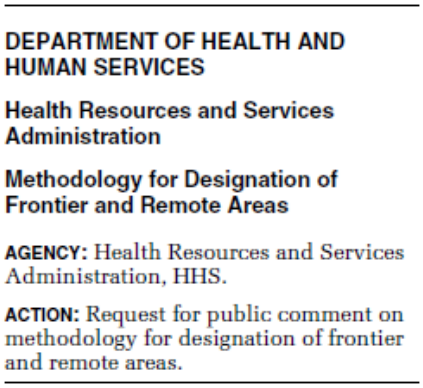
The Advisory Panel on Hospital Outpatient Payment (HOP Panel) advises CMS regarding the appropriate level of supervision for individual hospital outpatient therapeutic services. On Nov. 27, CMS

issued a final decision reducing the supervision level for 22 outpatient services from direct to general supervision effective Jan. 1. This represents an increase from the 15 services included in the agency's preliminary decision in September, but fewer than the 28 recommended by the HOP Panel. The seven additional services include wound care and bladder irrigation services, as well as certain flu and other drug or therapeutic injections. Based on recommendations made by five hospitals who presented at the HOP Panel's February and August meetings, CMS has reduced the level of supervision for 49 outpatient therapeutic services from "direct" to "general" supervision.

The next HOP Panel meeting is March 11-12, 2013. This may be one of the last opportunities to have outpatient therapeutic services designated as general supervision before CMS begins enforcing the agency's direct supervision requirements across the board in 2014. **The AHA strongly encourages hospitals with an interest in this issue to have their clinical staff identify outpatient therapeutic services that require only general supervision and request an opportunity to provide testimony during the next** HOP Panel meeting **in Baltimore.** For more details please see the Nov. 30 Advocacy Action Alert.

Regulatory Policy Priorities

Bad Debt: Included in the Nov. 2 final rule from CMS for end-stage renal dialysis (ESRD) was language on bad debt. As required by statute, CMS implements reductions to bad debt reimbursement for all Medicare providers, suppliers, and other eligible entities. Specifically, beginning in FY 2013, for CAHs the bad debt reduction will be phased-in over a three-year period: 88% in FY 2013, 76% in FY 2014, and 65% in FY 2015. The ESRD rule was published in the Nov. 9 *Federal Register*; and it takes effect Jan.1, 2013. It is reviewed in an AHA Special Bulletin.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Health Resources and Services Administration

Methodology for Designation of Frontier and Remote Areas

AGENCY: Health Resources and Services Administration, HHS.

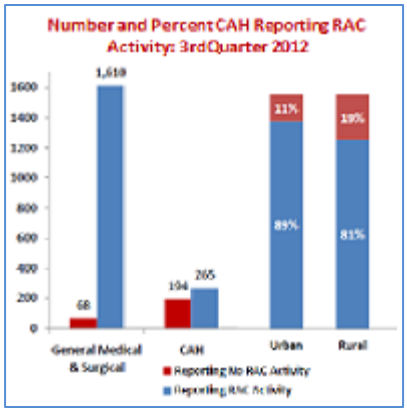
ACTION: Request for public comment on methodology for designation of frontier and remote areas.

Methodology for Designation of Frontier and Remote Areas: On Nov. 5, the Health Resources and Services Administration (HRSA) announced a request for public comment on a methodology derived from the Frontier and Remote (FAR) system for designating U.S. frontier areas. This methodology was developed in a collaborative project between the HRSA Office of Rural Health Policy and the Economic Research Service (ERS) in the U.S. Department of Agriculture (USDA). As used in this methodology, the term ''frontier'' denotes territory characterized by some combination of relatively low population density and high geographic remoteness. Two features distinguish the methodology described here from earlier classifications. First, the approach strives for the most accurate measures of distance possible for the smallest units of geography containing population data. Second, travel time thresholds around urban areas were allowed to vary by urban-area population size. Comments are due Jan. 4, 2013.

Unfair Medicare Practices

The AHA recently filed suit against the U.S. Department of Health and Human Services (HHS) for refusing to meet its financial obligations for hospital services provided to some Medicare patients. The AHA was joined in the suit by four hospital systems in states including Michigan, Missouri, and Pennsylvania.

At issue is HHS's refusal to reimburse hospitals for reasonable and necessary care when the government in hindsight believes that such care could have been provided in an outpatient facility or department instead of in the inpatient portion of the hospital itself. This "re-billing" issue is of significant concern to the hospital field, particularly as RACs have increased their reviews of hospital claims. The AHA is asking the court to overrule this non-payment policy and reimburse hospitals that have been denied payment in the past.



Recovery Audit Contractors: According to the most recent results of the AHA's RACTrac survey through the third quarter of 2012, the number of RAC claim denials is up 23% relative to last quarter. AHA analysis of survey data shows 89% of hospitals report activity and, of these, 265 CAHs reported activity through September 2012. While RACs concentrate more on urban hospitals, 81% of rural hospitals reported RAC activity.

Overutilization is the key issue for CAHs. Medical necessity denials represented the top reason for RAC denials; however, 61% of these were for care found to be provided in the wrong setting not because the care provided was medically unnecessary. CAH compliance personnel should look for services that were ordered by physicians and then provided, but for which the medical necessity is questionable. Another issue that extends to CAHs is that of the three-day inpatient qualifying stay engaged prior to a skilled nursing placement.

Hospital representatives are invited to attend a free Dec. 19 webinar on the survey results and 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/RACTrac.

In October, Reps. Sam Graves (R-MO) and Adam Schiff (D-CA) introduced the *Medicare Audit Improvement Act of 2012* (H.R. 6575), AHA-supported legislation that would make much needed improvements to the RAC program, and other Medicare audit programs.

To help hospitals manage the growing number of payment audits from government contractors and reduce their vulnerability to payment denials, the AHA has held a series of educational webinars. As part of our Audit Education Series, we're also issuing educational resources to help members navigate the audit and appeals process. For more information and to access previous webinars, see www.aha.org/auditseries.

RURAL HEALTH CARE LEADERSHIP CONFERENCE

The 2013 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 as well as the health of your rural community. We'll examine the

most significant operational, financial, and environmental challenges you face and present proven models and innovative strategies that will enable you to transform care delivery and business practices. Register by Dec. 14th for the greatest savings with early bird tuition pricing.

Shirley Ann Munroe Leadership Award

The Shirley Ann Munroe Leadership Award honors small or rural hospital CEOs and administrators who have achieved improvements in local health delivery and health status through their leadership and direction. James J. Bleicher, M.D., president and CEO, Verde Valley Medical Center, Cottonwood, AZ, was selected as the recipient of the 2012 award. Dr. Bleicher was recognized for his commitment to ensuring access to comprehensive cancer care services for his community through development of an innovative and collaborative relationship with the University of Arizona Cancer Center, support of a population health strategy across the Native American and underserved residents of his community, and implementing evidenced-based practice guidelines among other things.

Helping Sandy's Heroes

United Hospital Fund

The AHA supports the Hurricane Sandy Health Care Employee Relief Fund established to provide assistance to employees of hospitals and other health care organizations in affected communities who have suffered serious personal losses. Funds will be administered by the United Hospital Fund and distributed to employees in need through area hospitals and other health care organizations. Those interested in contributing should visit http://www.uhfnyc.org/hurricane_sandy_relief_fund.

Visit the Section for Small or Rural Hospitals website 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.