Small or Rural Update

Labette Health
Parsons, KS

Feather River Hospital
Paradise, CA

FALL 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). *Small or Rural 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 one or more of these issues, please visit www.aha.org/joinAlliance.

Legislative Landscape and FY 2013

Continuing Resolution: 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.

The Fiscal Cliff: Upon their return to Washington, DC for a lame duck session, legislators will face the "fiscal cliff" - expiring provisions that include the payroll tax cut, the so-called "Bush-Obama tax cuts," the Medicare physician payment fix and many expiring Medicare payment provisions important to hospitals, particularly small and rural hospitals. And, in January,

automatic Medicare "sequester" cuts contained in last year's *Budget Control Act* kick in. By the end of the year, Congress must make some tough decisions that will critically affect America's hospitals. Learn more about the steps you can take to help the field counter potential reductions, read the Nov. 12 AHA Action Alert.

Jobs at risk. According to a recent report released by the AHA, American Medical Association and American Nurses Association, up to 766,000 health care and other jobs could be lost by 2021 as a result of the 2% Medicare reduction mandated by the *Budget Control Act*. During the first year of sequestration, more than 496,000 jobs will be lost. This includes those workers directly employed by the health care sector, as well as other jobs supported by the purchases of health care organizations and their employees (the so-called "multiplier effect"). This number will swell to 766,000 fewer jobs by 2021. These job losses will affect many economic sectors beyond health care, and will be spread across every state. Hospitals' ability to maintain services needed by their communities is threatened, and service reductions could create devastating job losses where hospitals are an economic mainstay.

The debate over the national debt and what to do about it is the top issue for lawmakers during the congressional lame duck session. Hospitals need to ensure that Congress does not impose arbitrary payment cuts to providers, but instead offers real solutions to our nation's fiscal problems. ***You have the ability to make a difference.*** Plan to attend an upcoming AHA Advocacy Day: Nov. 29 or Dec. 11. This is an opportunity to meet with your legislators and talk to them directly about the challenges facing your patients and your community. Contact Michael McCue, director of Member Relations/Grassroots Events, at 312-422-3319 or mmccue@aha.org for additional information.

AHA Legislative Update and Advocacy Agenda for Rural Hospitals

Reauthorize MDH and Low-Volume Hospital Programs: *The Rural Hospital Access Act of 2012* (S. 2620), introduced by Sens. Charles Schumer (D-NY) and Charles Grassley (R-IA), would reauthorize both the Medicare-dependent hospital (MDH) program and provide an extension of the enhanced low-volume Medicare adjustment for prospective payment system (PPS) hospitals for one year through Sept. 30, 2013. Eyeing an opportunity to get these critical programs reauthorized before Congress adjourns for the year, Schumer and Grassley are asking the Senate Finance Committee to work to include S. 2620 in the expected upcoming Medicare physician payment fix legislation. The AHA supports their efforts and urges members to ask their senators to cosign the Schumer/Grassley letter.

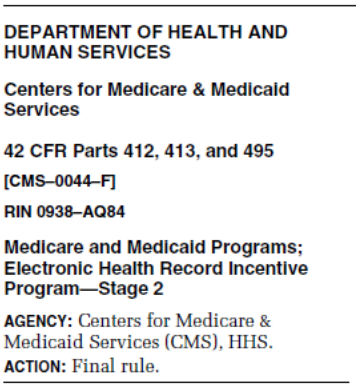
Advocacy for Extenders: During the lame duck session, the AHA continues to focus on extending expiring Medicare provisions and ensuring all hospitals have the resources they need to provide high-quality care and meet the needs of their communities. It is crucial that Congress address the following Medicare extenders:

- Medicare-dependent hospital program (Sept. 30, 2012)
- Payment adjustment for low-volume hospitals (Sept. 30, 2012)

- Hospital outpatient hold-harmless payments (Dec. 31, 2012)
- Section 508 area wage index reclassifications (March 31, 2012)
- Treatment of technical component of physician pathology services (June 30, 2012)
- Reasonable cost reimbursement for laboratory services in small, rural hospitals (June 30, 2012)
- Increase in payments for ambulance services (Dec. 31, 2012)

In addition, we support extension of the work geographic index floor under the Medicare physician fee schedule, the physician fee schedule mental health add-on and removing the cap on the number of eligible counties in a state for the Community Health Integration Models. Again, to learn more our AHA efforts during the lame duck session, see the Nov. 12 AHA Action Alert.

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) each of 16 core objectives and three of six menu-set objectives. Hospitals also must electronically generate and report on 16 clinical quality measures from a menu of 29 using certified EHR technology. Both PPS hospitals and CAHs must meet these criteria.

Eligible hospitals and CAHs will be subject to penalties unless they are meaningful users. Penalties will be applied beginning on October 1, 2014, for Medicare eligible hospitals. Penalties for CAHs will be applied beginning with the fiscal year 2015 cost reporting period. The penalties will be applied to the market-basket update for PPS hospitals and to cost-based reimbursement for CAHs. 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. However, as in Stage 1, 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 an AHA Special Bulletin. It takes effect Jan 1. Highlights are below:

Payment Update: The final rule includes a productivity reduction of 0.7 percentage points required by the *Patient Protection and Affordable Care Act* (ACA) and an additional reduction of 0.1 percentage point to the CY 2013 market basket update of 2.6%. This results in a market basket update of 1.8% for those hospitals that publicly report data on 22 quality measures.

Geometric Mean-Based Relative Payment Weights: In an effort to improve its cost estimation and despite AHA objections, CMS finalizes the use of geometric mean costs of services within an Ambulatory Payment Classification to set the relative payment weights of services, rather than the median costs that have been used since the inception of the outpatient PPS.

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.

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.

Inpatient and Outpatient Status: In the rule, CMS reviews the comments it received in response to its request for input on how to clarify its instructions for inpatient versus outpatient status for Medicare payment policy purposes, but the agency does not propose any regulatory changes at this time.

Medicare Physician Fee Schedule

CMS released Nov. 1 the final rule for the physician fee schedule (PFS) for CY 2013. An AHA Special Bulletin summarizes the rule, which takes effect Jan 1. Highlights are below:

Payment Update: Without congressional action, Medicare physician payments will decline by a mandated 26.5% in CY 2013. The AHA continues to urge Congress to permanently fix the flawed physician payment formula.

Primary Care and Care Coordination: As supported by AHA, CMS will explicitly pay physicians and qualified non-physician practitioners for post-discharge transitional care management services in the 30 days following a hospital, skilled nursing facility, outpatient observation or community mental health center discharge.

Outpatient Therapy: CMS adopts with modification its proposal to collect claims-based data on patient functional status over an episode of physical therapy, occupational therapy and speech language pathology services. Therapists will be required to report new G-codes and modifiers on the claim form at initial evaluation, every 10 visits and at discharge. As supported by AHA, CMS will adopt a testing period through June 30, 2013 to help providers transition to the new system.

Certified Registered Nurse Anesthetists (CRNA): In response to comments by AHA and others, beginning Jan. 1 CRNAs may directly bill and be reimbursed by Medicare for services determined by the state to be within their scope of practice, including chronic pain management services.

Home Health Prospective Payment System

On Nov. 2, CMS released a final rule governing payments for home health services. The rule takes effect Jan. 1 and a summary is found in an AHA Special Bulletin. Highlights are below:

Payment Update: The rule implements a net decrease in payments of -0.01% (-$10 million) from CY 2012 levels. This overall cut includes a 2.3% marketbasket increase; a 1.0% reduction mandated by the ACA; a 1.32% coding offset; a 0.37% cut for the distributional impact of the updated wage index; and a 0.38% increase due to the lowering of the outlier threshold.

Face-to-Face Encounter: CMS finalizes its proposal to allow non-physician practitioners in hospitals and post-acute facilities to conduct the face-to-face encounter as long as they are working with or under the supervision of a physician.

Medicaid Primary Care Services

CMS published a final rule governing payments for Medicaid primary care services in the Nov. 6 *Federal Register*. The agency will make technical assistance available to state Medicaid programs through conference calls and CMS Regional Office staff. A summary of the Medicaid primary care services rule can be found in an AHA Special Bulletin. The rule takes effect Jan. 1, 2013, and highlights are below:

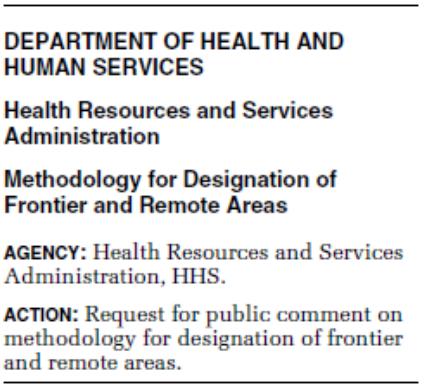
Primary Care Payment Rates: The rule implements an ACA provision requiring Medicaid to reimburse primary care providers at parity with Medicare rates in CYs 2013 and 2014. This minimum payment level applies to specific primary care services reimbursed under fee-for-service and through managed care. It provides 100% federal matching funds for the difference in payment between the applicable Medicare payment in those years and the Medicaid rate in effect as of July 1, 2009.

Eligible Primary Care Services and Providers: Primary care services eligible for the higher Medicaid payment must be delivered by a physician who specializes in family medicine, general internal medicine or pediatric medicine. CMS specifies that certain physician subspecialists who are board-certified in certain specialties or provide primary care within the overall scope of those categories also qualify for the enhanced payment. It clarifies that the higher payment will be made for primary care services rendered by practitioners working under the personal supervision of any qualifying physician.

Regulatory Policy Priorities

Bad Debt: Included in the Nov. 2 final rule from the Centers for Medicare & Medicaid Services (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, Medicare will pay 65% (down from 70%) of allowable bad debt amounts for hospitals and for non-dual eligibles in skilled nursing facilities (SNFs). For dual eligibles in SNFs and for all other providers – such as CAHs, federally qualified health centers and rural health clinics – 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 will be 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.

Federal Communications Commission

FCC Rural Health Care Pilot Program: The Federal Communications Commission (FCC) in 2006 launched the Rural Health Care Pilot Program, which awarded 69 projects one-time funding for a defined period of time (a total of $418 million) to cover up to 85% of the cost of construction and deployment of broadband networks that connect participating health care providers in rural and urban areas.

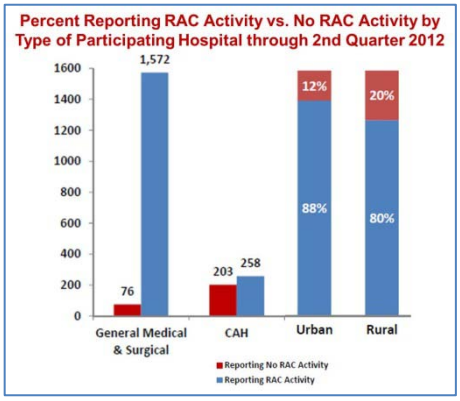
In August, Wireline Competition Bureau published a report, "Evaluation of Rural Health Care Pilot Program," that describes and extracts lessons from the pilot program, which provides universal service support to extend broadband networks for health care providers. Wireline reports that support through the pilot program has helped health care providers obtain broadband capability to implement telemedicine and telehealth applications and provides fertile ground to help the FCC determine how best to reform the existing rural health care program. Although many pilot projects are still assembling their networks, the projects have already demonstrated how broadband health care networks can significantly improve the quality and reduce the cost of providing health care in rural areas. Rural health care providers operate on a thin margin, or in the red, and universal service support helps many to access the benefits of broadband.

Dedicated Spectrum for Wireless Telemetry: The FCC continues to deliberate on whether to maintain TV Channel 37 (608-614 MHz) dedicated for Wireless Medical Telemetry Service (WMTS). The AHA's American Society for Healthcare Engineering (ASHE) needs additional information from hospitals to make the case that Channel 37 should continue to be reserved for health care. Please ensure that your staff has registered with ASHE all your WMTS equipment. To learn more read the Nov. 9 AHA Special Bulletin.

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 second quarter of 2012, the number of RAC claim denials is up 24% relative to last quarter. AHA analysis of survey data show 95% report activity and of these 258 CAHs reported activity through August 2012. While RACs concentrate more on urban hospitals, 80% of rural hospitals reported RAC activity.

Overutilization is the key issue for CAHs. Medical necessity denials represented the top reason for RAC denials; however, two-thirds 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.

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.

AHA Audit Education Series™

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. Contributions are tax-deductible, and 100% will benefit employees in need. Those interested in contributing to the fund are encouraged to go to http://www.uhfnyc.org/hurricane_sandy_relief_fund or send a check made payable to United Hospital Fund with a memo designation of "Hurricane Sandy Health Care Employee Relief Fund" to United Hospital Fund, 1411 Broadway, 12th Floor, New York, NY 10018-3496, Attn: Hurricane 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.