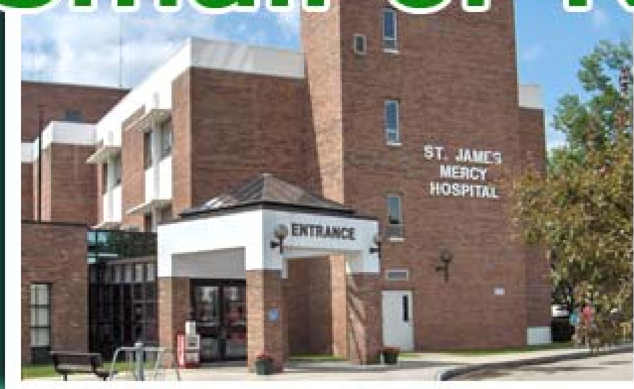
Small or Rural Update



St. James Mercy Hospital
Hornell, NY

Winona Health
Winona, MN

SUMMER 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.*

Hospitals Take to the Hill

By the end of the year, Congress must make some tough decisions that will critically affect America's hospitals, including what to do with the Medicare physician payment fix, Medicare extenders, and other expiring tax provisions. And on Jan. 3, automatic Medicare cuts contained in last year's *Budget Control Act* kick in.

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 one of the AHA's Advocacy Days this fall. You'll have the opportunity to meet with your legislators and talk to them directly about the challenges facing your patients and your community. *Save these dates:* Sept. 11, Nov. 29, and Dec. 11. Contact Michael McCue, director of Member Relations/Grassroots Events, at 312-422-3319 or mmccue@aha.org for additional information.

Taking Action … Introducing 'We Care, We Vote'

In this critical election year, the debate over the national deficit and what to do about it has taken on particular urgency. The hospital field is more than 5 million strong, and legislators - and potential legislators - need to understand that we care - not just for patients, but about the health and well-being of our communities and our nation. And we vote.

At www.aha.org/wecarewevote, you'll find resources to help you encourage your employees to register and vote. You'll also find a guide to help you engage candidates for office to gauge their positions on health care and the deficit and to educate them on the challenges ahead for the hospital field. In addition, you'll find resources to help enhance your interactions with lawmakers so that you can be a more effective advocate for your patients, your hospital and your community.

AHA encourages you to work together with your organization's leadership to engage your extended hospital family at this important time. **The time is now to work together toward long-term solutions that will set these programs on a path toward future sustainability.** Our patients and communities deserve the care they need to always be there. Join our Partnership for Action and become an advocate for rural hospitals.

AHA LEGISLATIVE UPDATE AND ADVOCACY AGENDA FOR RURAL HOSPITALS

The ACA: In an historic decision, the U.S. Supreme Court on June 28 upheld the *Patient Protection and Affordable Care Act* (ACA), ruling 5-4 that the law's individual mandate to purchase health insurance was within Congress's taxing authority. The Court also upheld the ACA's expansion of the Medicaid program by a vote of 5-4, but with a significant limitation on the penalty for states that elect not to participate (i.e., states can now choose to either expand or not expand their Medicaid program to cover those up to 138% of the federal poverty level). AHA and the five other major national hospital associations argued in favor of the constitutionality of both the individual mandate and the changes to the Medicaid program in multiple amicus briefs submitted to the Court. The ruling puts an end to two years of speculation and clears the way for implementation of the ACA to proceed; this includes expanded access to health insurance coverage for up to 32 million Americans and fundamental insurance and delivery system reforms.

AHA has published a Member Advisory that describes the Court's decision and the potential impact on the Medicaid expansion, and includes a partial list of the ACA's major insurance and delivery system reforms, all of which remain unaffected.

Extenders: As the legislative year winds down, the AHA is focused on ensuring all hospitals have the resources they need to provide high-quality care and meet the needs of their communities. That means:

- Advocating for appropriate Medicare and Medicaid payments;
- Working to extend expiring Medicare provisions;
- Improving federal programs to account for special circumstances in rural communities; and
- Seeking adequate funding for annually appropriated rural health programs.

In February, Congress passed the *Middle Class Tax Relief and Job Creation Act of 2012*, which contained many provisions important to rural hospitals and beneficiaries. The AHA sent letters to every member of the House and Senate in support of renewing the expiring Medicare and rural extenders. AHA encourages you to continue reach out to your House and Senate members on these important programs as well.

The specific extenders are:

- Payments for the technical component of certain physician pathology services.
- Ambulance add-on payments.

- The outpatient hold-harmless provision for rural hospitals and Sole Community Hospitals.
- Medicare cost payments for clinical diagnostic laboratory tests furnished in certain rural areas.
- Section 508 hospital wage index reclassifications.
- The Medicare-dependent hospital program.
- The enhanced low-volume adjustment for inpatient prospective payment system hospitals.

In addition, the letters express support for *the R-HoPE Act* (H.R.3859/S.1680), which would extend several of the provisions including the outpatient hold harmless and the direct billing for the technical component of pathology services, and for *the Rural Hospital Access Act* (H.R.5943/S.2620), which extends the Medicare-dependent hospital program and enhanced Medicare low-volume adjustment until September 30, 2013.

FISCAL YEAR 2013 FEDERAL BUDGET

President's Budget: In February, President Obama released a budget outline for fiscal year (FY) 2013. The outline, which is similar to a proposal the White House released last September, calls for cutting Medicare by about $268 billion and Medicaid by $52 billion over 10 years. This budget proposal, as well as other deficit and spending reduction bills, will put rural hospitals at risk of cuts in several areas.

The administration proposes changes to payments for rural providers. Starting in FY 2013, it would reduce CAH payments from 101 percent to 100 percent of reasonable costs. In addition, effective in FY 2014, it would eliminate the 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.

Rural health programs such as the Medicare Rural Hospital Flexibility Grant Program, Rural Health Outreach and Network Development, State Offices of Rural Health, Rural Telehealth, Rural Policy Development and other health care programs are vital to ensuring that needed services remain available in America's rural communities. The president's FY 2013 budget proposes a $15 million cut to rural programs.

House Budget: In May, the U.S. House of Representatives today voted 218-199, mainly along party lines, to approve a Republican budget reconciliation package that would cancel $98 billion in automatic defense spending cuts scheduled for January 2013 and replace them with across-the-board cuts to other discretionary and mandatory programs. The legislation retains the 2% across-the-board cut to Medicare spending under the *Budget Control Act*, adds more stringent eligibility reviews for Medicaid enrollees and caps damages on medical liability awards, among other provisions. The Senate is not expected to take up the measure, and the administration has said the president would veto it.

REGULATORY POLICY PRIORITIES

Capital leases allowable cost for CAH EHR incentive payments: After extensive meetings and discussions on the issue with the AHA, CMS announced in July that it has agreed to change its policy and to now allow CAHs to include the cost of capital leases for certified electronic health record technology in their Medicare EHR incentive payments. A capital lease "is essentially the same as a virtual purchase agreement" and "meets the intent of the statute and regulation to qualify the leased asset as a purchased asset," CMS states in a new Frequently Asked Question on its website. "Therefore, the CAHs' incentive payment may include the 'cost' of such leased asset, which must be based on the fair market value of the asset…at the date the lease was initiated."

IOM Recommendations on Examining Rural Payment Programs and Medicare Extenders: On July 17, the Institute of Medicine (IOM) issued a report that includes a recommendation that CMS re-examine rural hospital payment programs, such as the critical access and Medicare-dependent hospital programs, to determine whether they are effective at ensuring adequate access to appropriate care. In our Rural Hospital Policy Update AHA explains our disappointment that that the IOM believes that these programs have not helped improve the access challenges beneficiaries face in rural America. In contrast, these and other adjustments have helped improve rural hospitals' financial stability significantly; resulting in fewer rural hospital closures and thereby helping ensure rural beneficiaries are able to access care.

AHA urges HUD not to increase hospital mortgage insurance premiums: The AHA urged the Department of Housing and Urban Development to withdraw its proposal to increase premiums for the Hospital Mortgage Insurance Program by 20 basis points in fiscal year 2013, which would raise the program's financing costs by 30-40%. In comments submitted to the agency, AHA said the proposal "could put the program out of reach for many community hospitals in need of affordable financing. As a result, many necessary renovations, refinancings or new construction projects will not be feasible, threatening access to high-quality health care services for those least able to afford it." In addition, the proposed increase is unnecessary to maintain the program's positive financial balance.

MedPAC June Report to Congress: On June 15, the Medicare Payment Advisory Commission (MedPAC) issued a report to Congress that includes a chapter on health care provided to Medicare beneficiaries living in rural America. As stated in our Rural Hospital Alert AHA is disappointed to see that, in many ways, this chapter presents an incomplete picture. For example, it does not consider the fact that physicians serving rural beneficiaries are older on average than those serving urban beneficiaries. Specifically, the report does not draw the obvious next conclusion that once these physicians begin to retire in earnest, access to care in rural areas may be severely impacted, and ongoing monitoring is warranted.

In addition, the report states that, in general, payments to rural health care providers are adequate because payment adequacy indicators were similar in urban and rural areas. However, comparing urban and rural areas is not a good indicator of whether payments are adequate – margins are, and both urban and rural hospitals have negative Medicare margins. Finally, although the report shows that rural hospitals have a much higher Medicare utilization than urban hospitals, it does not discuss the implication of this higher Medicare utilization combined with negative Medicare margins. These two factors taken together mean that rural hospitals are still at a disadvantage because they are disproportionately affected by Medicare payments that remain below the cost of care.

INPATIENT PROSPECTIVE PAYMENT SYSTEM (PPS)

In April, CMS issued its FY 2013 inpatient PPS proposed rule. A summary of the rule may be found in an AHA Regulatory Advisory, while issues of specific concern to rural hospitals are reviewed below.

Payment Update: The rule proposes a cut of 1.9% to inpatient PPS payments to permanently eliminate what CMS claims is the effect of documentation and coding changes from FYs 2008 and 2009 that the agency says do not reflect real changes in case-mix. Additionally, it proposes a new 0.8% cut to permanently eliminate documentation and coding cuts from FY 2010. **This represents a total proposed coding cut of 2.7%, or $2.9 billion, for FY 2013.** CMS also proposes to restore the 2.9% cut that was made in FY 2012 to recoup past overpayments. Thus, as of the end of FY 2012, CMS's recoupment of past overpayments will be complete. In addition, CMS proposed how it intends to manage payments under the hospital inpatient value-based purchasing (VBP) and the readmissions reductions programs, both beginning in FY 2013.

Documentation and Coding Offset: AHA is deeply disappointed that CMS has proposed additional coding cuts related to FY 2010. CMS believes that implementation of the Medicare Severity diagnosis-related groups (MS-DRGs) in FY 2008 led to documentation and coding changes that increased aggregate hospital payments compared to the previous DRG system, without corresponding increases in actual patient severity of illness. However, it is inappropriate for the agency to continue to compare hospital documentation and coding in FY 2010 to documentation and coding under the DRG system in FY 2007.

Proposals for Sole Community Hospitals (SCHs): CMS makes two proposals related to SCHs. First, the agency states that it has become aware of a number of Medicare-dependent hospitals (MDHs) that intend to apply for SCH classification upon the expiration of the MDH program. In order to facilitate a seamless transition for such hospitals, CMS proposes to add an exception to its SCH effective-date policy that would allow qualifying hospitals to obtain SCH status the day after the MDH program expires. In addition, CMS's other proposal relates to the duration of an SCH classification. Currently, a hospital's SCH classification remains in effect without the need for reapproval unless there is a change in the circumstances under which the classification was approved. However, the agency states that these regulations do not explicitly address a situation where a hospital never met the requirements to be classified as an SCH to begin with, but was nonetheless granted such classification. CMS is thus proposing to revise its regulations to state that if it determines a hospital was incorrectly classified as an SCH, the agency can revoke that classification retroactive to when it was first granted. **The AHA strongly disagrees with this proposed policy and believes it is patently unfair and inappropriately punitive.**

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

In July, CMS released the outpatient PPS and ambulatory surgical center (ASC) rule for calendar year (CY) 2013. The OPPS/ASC rule would increase hospital outpatient payment rates by 2.1%, based on the projected inpatient market basket increase of 3.0% minus a proposed multifactor productivity adjustment of 0.8 percentage points and a 0.1 percentage point adjustment required by the ACA. The rule also extends through 2013 the direct supervision enforcement delay for critical access hospitals

and small rural hospitals, and would pay for drugs and biologicals that do not have pass-through status at the statutory default of average sales price plus 6%.

A summary of the rule may be found in an AHA Regulatory Advisory. Comments are due Sept. 4. Also, hospitals need to weigh in on the supervision policy for outpatient therapeutic services. An Action Alert describes the next meeting on the advisory panel on Hospital Outpatient Payment.

In April, CMS released Transmittal 2457 with changes to outpatient therapy services – physical therapy, occupational therapy and speech-language pathology – effective Oct. 1. These changes are required by *The Middle Class Tax Relief and Job Creation Act of 2012*. The transmittal affects therapy services provided in hospital outpatient departments (HOPDs), outpatient rehabilitation facilities, comprehensive outpatient rehabilitation facilities, skilled nursing facilities and medical offices. Services provided in critical access hospitals are excluded.

The AHA strongly opposed expanding the therapy caps to services provided in HOPDs. This provision expires on Dec. 31, 2012. While AHA continues to support an extension of the therapy cap exceptions process for calendar year 2013 and beyond, AHA will urge Congress to extend the exceptions process without expanding the cap to therapy services provided in hospital outpatient settings. A summary of the transmittal can be found in an AHA Regulatory Advisory.

MEDICARE PHYSICIAN FEE SCHEDULE

In July, CMS released the Medicare physician fee schedule proposed rule for calendar year (CY) 2013. Without congressional action, the PFS rule would reduce Medicare physician payments by an estimated 27% on Jan. 1.

Primary Care and Care Coordination: CMS proposes to explicitly pay physicians and qualified non-physician practitioners (NPP) 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. This would include non-face-to-face care management provided by clinical staff members.

Certified Registered Nurse Anesthetists (CRNA) and Pain Management Services: The rule would allow CRNAs to independently bill Medicare for chronic pain management services (rather than "incident to" a physician or NPP) as long as the CRNA is able to furnish these services in accordance with state scope of practice laws.

CMS Proposes Claims-Based Data Collection Strategy for Therapy Services: The rule includes a proposal to collect data on patient function related to physical and occupational therapy, and speech language pathology services. Beginning on Jan. 1, CMS must implement a claims-based data collection strategy that is designed to assist in reforming the Medicare payment system for outpatient therapy services. Such strategy shall be designed to provide for the collection of data on patient function during the course of therapy services in order to better understand patient condition and outcomes.

A summary of the rule can be found in an AHA Regulatory Advisory. The proposed rule appeared in the July 30 Federal Register.

Home Health Prospective Payment System

The home health rule, also released this July, provides a net increase of 0.1% ($20 million) in Medicare payments for home health services over CY 2012 levels. The increase reflects a 2.5% market-basket update which, in addition to other adjustments, is offset by mandatory cuts under the ACA and a 1.32% coding offset, which is part of a multi-year offset.

Face-to-Face Encounter: CMS proposes to allow Non-physician practitioners in the inpatient setting to conduct the face-to-face encounter required to certify the need for home care.

New Provider Sanctions: The proposed rule adds further sanctions for agencies that fall out of compliance with Medicare conditions of participation, including monetary penalties, payment suspension and temporary management. Due to the CMS and state-level infrastructure changes that would be required to implement the new sanctions, the proposed sanctions would take effect one year after the final rule is issued.

A summary of the rule can be found in an AHA Special Bulletin. Comments are due Sept. 4.

Medicare Conditions of Participation

In May, CMS released a final regulation to revise a number of the existing Conditions of Participation (CoP) for hospitals and CAHs, as well as a final rule that addresses more than two dozen regulatory requirements for a broader range of providers, including hospitals, ambulatory surgical centers, end-stage renal disease facilities and durable medical equipment suppliers. A summary of the CoP rule can be found in an AHA Regulatory Advisory.

CMS says the rules aim to promote efficiency and transparency, and to reduce health care providers' overall regulatory burden. CMS estimates the rules will save $5 billion over five years. In the CoP rule, CMS finalized its proposal to recognize a single governing body over multiple hospitals within a health system. However, CMS stated in the preamble to the rule that a multi-hospital system may not elect to have a single organized medical staff. CMS also finalized its proposal to allow CAHs to provide certain services (diagnostic, therapeutic, laboratory, radiology and emergency services) under service arrangements. Previously, CAHs were required to provide these services directly.

Internal Revenue Service Section 501(r) for Tax-exempt Hospitals

In June, the Department of the Treasury and the Internal Revenue Service (IRS) released long-anticipated proposed regulations implementing three of the four new requirements created by the ACA for tax-exempt hospitals**:** adoption of a written financial assistance policy and a policy relating to emergency medical care; limitations on the amounts a hospital charges to individuals eligible for financial assistance for emergency or other medically necessary care; and limits on engaging in extraordinary collection actions before making reasonable efforts to determine an individual's eligibility for financial assistance. The new requirements are found in Section 501(r) of the Internal Revenue Code. The provisions of Section 501(r) became effective for tax years beginning after March 23, 2010,

except for the community health needs assessment requirement, which is effective for tax years beginning after March 23, 2012.

A summary of the rule can be found in an AHA Legal Advisory. Comments on the proposed regulation are due Sept. 24.

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. For more information, please contact Jihan Palencia Kim, Section for Small or Rural Hospitals, at (312) 422-3345.

RURAL HOSPITAL TRENDWATCH

AHA's March 2011 TrendWatch report examines rural hospitals as they implement the 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. 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.