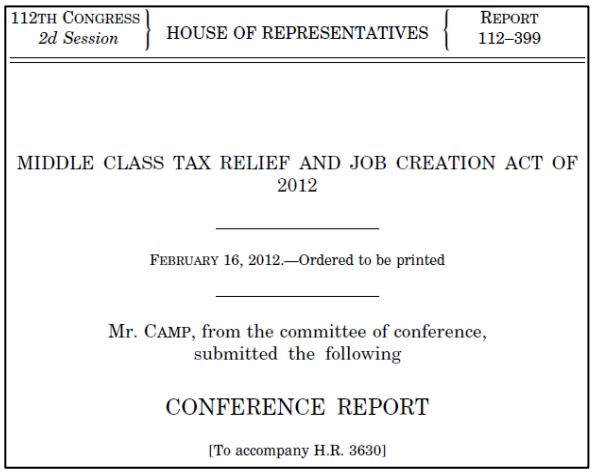
Spring 2012

The AHA's Section for Small or Rural Hospitals represents and advocates on behalf of more than 1,630 rural hospitals, including 975 critical access hospitals (CAHs). Small or Rural Update gives our members news 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.

The Federal Budget



112TH CONGRESS, 2d Session | HOUSE OF REPRESENTATIVES | REPORT 112–399

MIDDLE CLASS TAX RELIEF AND JOB CREATION ACT OF 2012

FEBRUARY 16, 2012.—Ordered to be printed

Mr. CAMP, from the committee of conference, submitted the following

CONFERENCE REPORT

[To accompany H.R. 3630]

The Middle Class Tax Relief and Job Creation Act of 2011 (HR 3630) – Last December 17, Congress passed two separate versions of the *Middle Class Tax Relief and Job Creation Act of 2011*. On February 16, Congress resolved its differences between the House and Senate versions of HR 3630. The final version which was signed into law on February 22 extends the Social Security payroll tax holiday and emergency unemployment insurance benefits through December 31, 2012. It also prevents a 27.4 percent cut to Medicare physician payments that was scheduled to take effect March 1, providing physicians with a zero percent update for the remainder of the year. The estimated cost of the physician payment fix is $20 billion. An AHA Special Bulletin summarizes the agreement.

Cuts to hospitals to pay for the physician payment fix include:

- Reductions in payments to acute care inpatient hospitals for assistance to low-income Medicare beneficiaries (bad debt) from the current 70 percent level to 65 percent in fiscal year (FY) 2013, and from 100 percent to 65 percent over three years for CAHs (88 percent in FY 2013, 76 percent in FY 2014, and 65 percent in FY 2015);
- An extension of the current cap on therapy services - and the exceptions process to it - to those services provided in hospital outpatient departments through December 31, 2012 (this currently applies only to services provided in nursing homes and other freestanding settings);

- Reductions to Medicaid disproportionate share hospital (DSH) payments in 2021.

Not included were the following proposals, all of which were at risk:

- Reductions in payments for evaluation and management services provided in hospital outpatient departments.
- CMS authority to make additional across-the-board cuts to Medicare inpatient hospital rates through the use of retrospective coding adjustments for FYs 2010, 2011 and 2012.
- Changes to significantly weaken the current law and prohibition on physician self-referral to new physician-owned hospitals and loosen the restrictions for growth on grandfathered facilities.

In addition, the agreement extends several expiring provisions of importance to hospitals, including:

- Section 508 hospital wage index reclassifications (through March 31)
- The outpatient hold-harmless provision for rural hospitals and sole community hospitals (through January 1, 2013)
- Payments for the technical component of certain physician pathology services (through June 30)
- Ambulance add-on payments (through December 31)

While temporarily resolving the issue of Medicare payments to physicians, the law adds stress to hospitals that care for vulnerable populations and it limits therapy services provided in hospitals and assistance that helps defray Medicare and Medicaid costs to low-income seniors. While AHA is pleased a number of expiring hospital provisions were extended, we need to ensure that all of the policies are maintained for the remainder of 2012.

Sequester - The supercommittee's failure to reach an agreement as required under the *Budget Control Act of 2011* means automatic spending cuts totaling $1.2 trillion split between defense spending and non-defense programs ***will take effect in January 2013***. Under the sequester, reductions in Medicare payments to hospitals and other providers of up to 2 percent over nine years (2013 to 2021) — an estimated $43 billion cut in hospital payments alone, $123 billion in Medicare overall — would result in the loss of about 194,000 jobs. Medicaid is not subject to cuts.

President's Budget FY 2013 – On February 13, President Obama proposed $320 billion in reductions to Medicare and Medicaid as part of his $3.8 trillion fiscal year (FY) 2013 federal budget proposal. An AHA Special Bulletin summarizes the president's 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.

Proposed reductions to certain Medicare payments:

- Bad debt: The administration proposes to reduce bad debt payments to 25 percent (from the current 70 percent) for all eligible providers, including hospitals, over three years starting in FY 2013, saving approximately $36 billion over 10 years from all providers.
- Indirect Medical Education (IME): The administration proposes to reduce the IME adjustment by 10 percent beginning in 2014, saving approximately $10 billion over 10 years.

- Rural providers: 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.
- Post-acute care: The administration proposes several across-the-board post-acute update cuts, along with lowering inpatient rehabilitation facilities' reimbursement for selected patients to the skilled nursing facility level payment, and raising the current IRF 60% Rule threshold to 75 percent. Altogether, the administration estimates these changes would save $63 billion over 10 years.
- Independent Payment Advisory Board (IPAB): The administration proposes to strengthen IPAB by reducing its growth rate target from GDP per capita plus 1 percent to GDP plus 0.5 percent and providing additional enforcement tools.

Proposed reductions to certain Medicaid payments:

- Medicaid provider taxes: The administration proposes to phase down, but not eliminate, Medicaid provider taxes beginning in 2015, saving $21.8 billion over 10 years.
- Medicaid payment formulas: Beginning in 2017, the administration proposes to replace the current formulas with a single matching rate specific to each state, based on enrollment starting in 2014, that automatically increases if a recession causes enrollment and state costs to rise. The administration then proposes to reduce that rate, which it estimates would save $17.9 billion over 10 years.
- Medicaid DSH payments: Beginning in 2021, the administration proposes to rebase DSH payments, saving $8.3 billion over 10 years.

Legislative and Legal Update

R-HoPE Act – Last October the Senate introduced S. 1680, the *Craig Thomas Rural Hospital and Provider Equity Act of 2011 or R-Hope Act* and in February Rep. Cathy McMorris-Rodgers (R-WA) introduced a companion bill HR 3859.

The bill includes Medicare extenders for:

- Transitional outpatient hold harmless payments through 2013
- Low-volume payment adjustments up to 2000 discharges in 2012
- Cost-based reimbursement for rural outpatient labs
- Elimination of an isolation test for CAH-based ambulance services
- Capital infrastructure revolving loan program
- Billing for the technical component of physician pathology services
- Reimbursement of CAHs for CRNA on-call services
- Funds for State Offices of Rural Health

Also, in the bill is the Sense of the Senate that--

(1) residents of rural and frontier communities should have access to affordable, quality health care;
(2) rural and frontier communities face unique challenges in health care delivery and financing;

(3) Federal health policy must reflect the unique needs of residents of rural and frontier communities and such communities in an equitable and sustainable manner; and
(4) stakeholders should work collectively to identify innovative policies that address the availability, delivery, and affordability of health care services in rural and frontier communities.

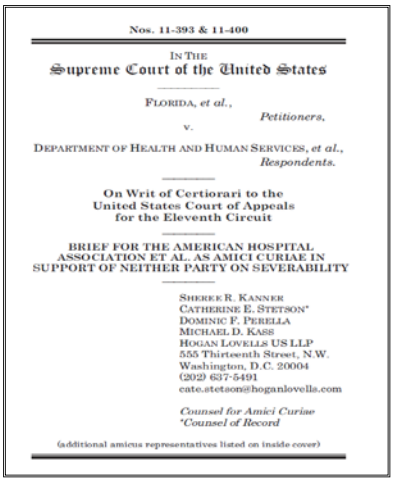
Other Advocacy Priorities – For rural hospitals, AHA's advocacy agenda includes the extenders as outlined in R-HoPE as well as:

- Provider taxes: 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.
- Direct supervision of outpatient therapeutic services: *The Protecting Access to Rural Therapy Services* (PARTS) *Act* (S. 778) would establish an advisory panel of clinicians to set up an exceptions process for outpatient therapy services, 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.
- 340B drug discount pricing: the *340B Improvement Act* (HR 2674) would extend the 340B drug discount program to inpatient prescriptions
- Repealing the IPAB: Companion measures in the House (HR 452) and Senate (S 668) would repeal the IPAB.

Affordable Care Act Legal Challenge – The ACA is being contested in the Supreme Court and scheduled for three days of oral arguments beginning March 26.

There are four separate issues the court has said it would address:

1. If the Anti-Injunction Act bars review of the mandate until after 2014 when the provision goes into effect
2. If the individual mandate is constitutional
3. If the Medicaid provisions are constitutional or represent an illegal commandeering of the states; and
4. Severability or what pieces of the law should fall if the mandate is ruled unconstitutional likely arguing that only the community rating and guaranteed issue provisions should be struck if the mandate is found to be unconstitutional.


Nos. 11-393 & 11-400

IN THE
Supreme Court of the United States

FLORIDA, *et al.*,
Petitioners,
v.
DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*,
Respondents.

On Writ of Certiorari to the
United States Court of Appeals
for the Eleventh Circuit

BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION ET AL. AS AMICI CURIAE IN SUPPORT OF NEITHER PARTY ON SEVERABILITY

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(additional amicus representatives listed on inside cover)

AHA and several other national hospital organizations have filed several friend-of-the-court briefs concerning the ACA. The AHA's amicus briefs state the Association's position that:

- Individual mandated is constitutional
- Medicaid expansions are constitutional
- Severability should be decided by the Supreme Court
- IF coverage expansions are thrown out…then budget reductions (update factor, DSH, readmissions) also must go

A decision is expected by the Court in late June or early July.

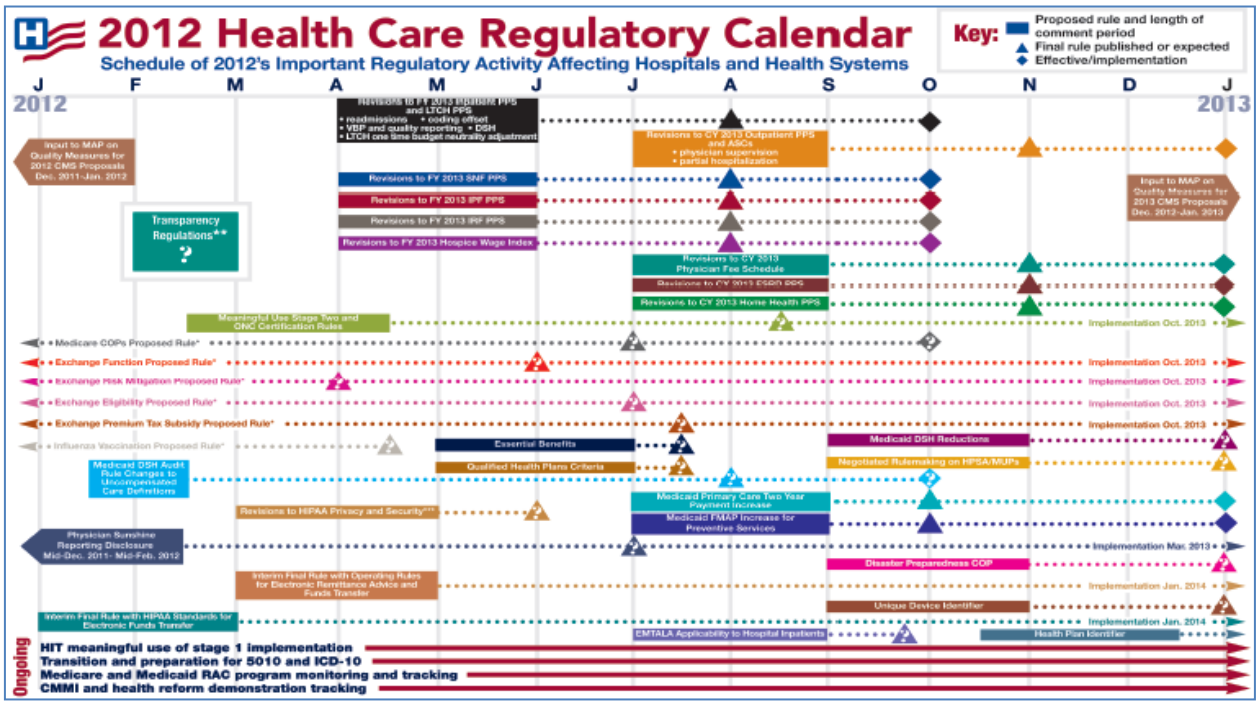
Join the AHA Partnership for Action – Join AHA's Partnership for Action. It is a pledge from you that you will continue what you have already begun. That is you will continue to advocate for action with your state hospital association and the AHA, to educate elected officials in Congress on the importance of these and other advocacy priorities.

Please take a moment to complete and submit the electronic form to become part of Partnership for Action. In return, we ask for a consistent and sustained effort, repeated contact through letters, phone calls, e-mail, visits, whatever is needed to reach the goal when there are opportunities to affect the direction taken on key issues.

Regulatory and Policy Update

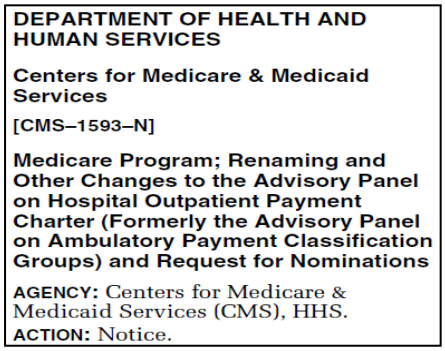
2012 Regulatory Calendar – This very busy timeline includes both the regular rules and ACA rules for 2012. As you can see the standard payment update regulations for Medicare Inpatient PPS, Psych, Rehab, SNF, Hospice, Outpatient PPS and the physician fee schedule for 2013 have not yet been proposed.

In addition, CMS continues to release rules specifically related to health reform implementation, including many around the state insurance exchanges which are being implemented in 2012. Also, the new Center for Medicare and Medicaid Innovation (CMMI) has introduced rules to implement voluntary pilots around payment and delivery system reform.



Meaningful Use Stage 2 – On February 24, CMS published a Stage 2 proposed rule that specifies criteria that eligible professionals (EPs), eligible hospitals, and CAHs must meet in order to qualify for Medicare and/or Medicaid electronic health record (EHR) incentive payments. It is summarized in a CMS fact sheet and an AHA Special Bulletin. CMS proposes to maintain the same core and menu structure for the program for Stage 2. That is the agency proposes for Stage 2 that EPs must meet or qualify for an exclusion to 17 core objectives and three of five menu objectives. Also, CMS proposes that eligible hospitals and CAHs must meet or qualify for an exclusion to 16 core objectives and two of four menu objectives. In addition, it would specify payment adjustments under Medicare for covered professional services and hospital services provided by EPs, eligible hospitals, and CAHs failing to demonstrate meaningful use of certified EHR technology and other program participation requirements.

This proposed rule also would revise certain Stage 1 criteria, as well as criteria that apply regardless of Stage, as finalized in the final rule titled Medicare and Medicaid Programs; Electronic Health Record Incentive Program.



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS–1593–N]

Medicare Program; Renaming and Other Changes to the Advisory Panel on Hospital Outpatient Payment Charter (Formerly the Advisory Panel on Ambulatory Payment Classification Groups) and Request for Nominations

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

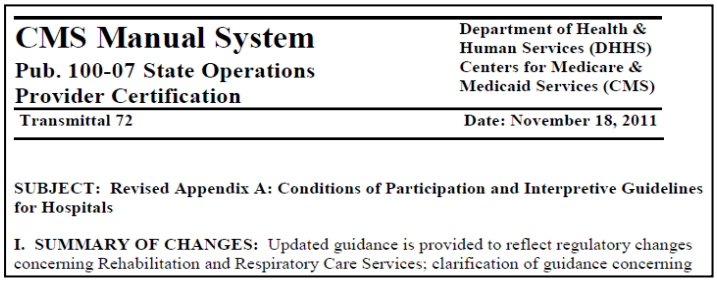
ACTION: Notice.

Late in 2011, CMS and other federal agencies issued guidance including the outpatient PPS rule and conditions of participation for outpatient rehab and respiratory therapy services.

Direct Supervision of Outpatient Services – CMS will use a version of the federal Advisory Panel on Ambulatory Payment Classifications Groups (APC Panel) as an independent review body that will evaluate individual services for a potential change in supervision level. Last November, CMS published a notice on the changes to the Panel and a request for nominations to add four new members to the Panel, two from CAHs and two from non-CAH small rural hospitals. The agency also requested comments on changing supervision levels for individual therapeutic services under the hospital outpatient prospective payment system.

On February 14, CMS posted an announcement in the Federal Register with appointments to the Advisory Panel on Hospital Outpatient Payment (HOP Panel). An announcement of the February 27-28 meeting, and "Requests for Supervision Level Changes for Hospital Outpatient Therapeutic Services" may be found in the Federal Register published December 16, 2011.

CMS estimates that policy decisions on many key services will not be completed until sometime in 2012. Thus, the agency will extend through CY 2012 its enforcement moratorium on the direct supervision policy for outpatient therapeutic services provided in CAHs and in small and rural hospitals with 100 or fewer beds.



CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health & Human Services (DHHS) Centers for Medicare & Medicaid Services (CMS)

Transmittal 72

Date: November 18, 2011

SUBJECT: Revised Appendix A: Conditions of Participation and Interpretive Guidelines for Hospitals

I. SUMMARY OF CHANGES: Updated guidance is provided to reflect regulatory changes concerning Rehabilitation and Respiratory Care Services; clarification of guidance concerning

Medicare Conditions of Participation – On Nov 18 CMS published Transmittal 72 with revised interpretive guidelines for ordering outpatient rehab and respiratory care services. The AHA urged CMS to clarify its position so that hospitals would not be required to privilege each

practitioner who orders these services; CMS should defer to state law and hospital policies.

On February 17, CMS rescinded the interpretive guidance pertaining to rehabilitation and respiratory care services under the hospital Conditions of Participation, issuing revised guidance that allows non-privileged practitioners to order outpatient rehabilitation and respiratory care services in accordance with state license/scope of practice and written hospital policy. The AHA and other stakeholders had raised concerns with the original guidance because it precluded non-privileged practitioners from ordering these services at hospital outpatient departments, thus creating barriers to care for many patients.

Medicare Payment Advisory Committee – In addition to the rules from CMS and other agencies, the Medicare Payment Advisory Committee (MedPAC) is completing work on its ACA mandates as well as making recommendations to Congress on Medicare payment policy. The ACA requires MedPAC to evaluate access to care, quality of care, special rural payments, and the adequacy of Medicare payment to providers in rural areas.

Presently, MedPAC has concluded that when compared to urban hospitals, rural hospitals have:

- Fewer physicians, but patient satisfaction is equivalent
- Consumption of services is equal – ergo access is equal
- Quality is similar, but mortality and process measures are worse
- Payment is adequate for Home Health, SNF, Hospice, inpatient rehab, and hospitals

These will be reported to Congress as principles and not recommendations for rural payment adjustments:

- Target providers that are the sole source of care
- Payments should be empirically justified
- Low-volume adjustments should be tied to total volume
- Don't duplicate adjustments
- Maintain incentives for cost control

MedPAC's report to Congress on ACA mandates for rural hospitals is due June 15, 2012.

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. Applications are due July 27, 2012.

AHA Annual Membership Meeting

Join your colleagues May 6-9 in Washington, D.C., at the 2012 AHA Annual Membership Meeting to hear the latest on the forces impacting health care, and to take hospitals' message to Capitol Hill. The meeting agenda includes keynote speeches from prominent policy makers, the annual breakfast meeting for constituencies, executive briefings on important health topics, an opportunity to earn ACHE credits, and special briefings for small or rural hospitals. In this important election year, speaking with one voice, to Congress and the Administration, to policymakers and opinion leaders, is more important than ever before. You may register on line.

The AHA invites hospitals to help celebrate the many **"champions for care"** in your organizations across the country. Photos and video submissions will be used in promotions for National Hospital Week, at AHA's Annual Membership Meeting and on our YouTube site.
Tell us what makes a champion. Is it a great nursing staff? Sponsoring a mobile van? Who are your champions? **Submissions are due by April 6.**

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.