CAH UPDATE

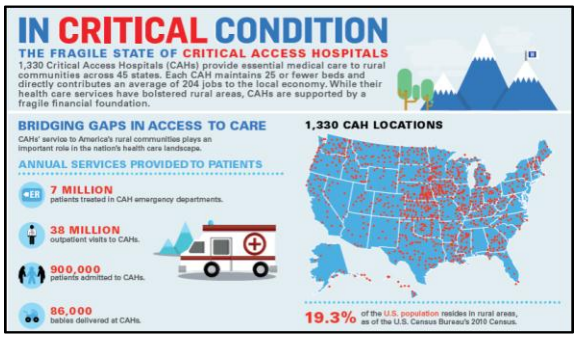
Gifford Medical Center
Randolph,VT

New London Hospital
New London, NH

Fall 2013

The AHA and its Section for Small or Rural Hospitals represents and advocates on behalf of more than 1,600 rural hospitals, including 975 critical access hospitals (CAHs). *CAH Update* gives our members news on legislative and regulatory activities, as well as on Section programs and services. This issue of *CAH Update* reviews the federal budget, legislative agenda and advocacy, regulatory policy, proposed and final rules for Medicare payment, and more.

Inforgraphic Tells the Fragile State of CAHs



The AHA recently released an exclusive resource to educate legislators, the media and the public about the importance of CAHs and their fragile financial foundation. This new infographic uses eye-catching graphics and data to tell the story of 1,330 CAHs caring for rural communities across 45 states. Each CAH directly contributes an average of 204 jobs to the local economy. While their health care services have bolstered rural areas, CAHs are supported by a fragile financial foundation. The AHA infographic demonstrates how CAHs bridge gaps in access to care, represent delicate lifelines for rural communities, and still struggle to survive despite a special Medicare payment structure.

The AHA will continue to work in Congress and with the Administration to make certain that rural hospitals and rural communities are understood and protected.. Hospital leaders are welcome to share this infographic with their community and elected officials to help them better appreciate the importance of CAHs to rural communities as both providers and employers.

The Federal Budget


One Hundred Thirteenth Congress
of the
United States of America

AT THE FIRST SESSION

Begun and held at the City of Washington on Thursday, the third day of January, two thousand and thirteen

An Act

Making continuing appropriations for the fiscal year ending September 30, 2014, and for other purposes.

When Congress agreed to temporarily reopen the government and lift the debt ceiling last month, lawmakers established several new fiscal flashpoints – and opportunities for both hospital funding cuts and health care improvements. By Dec. 13, a budget conference is tasked with resolving differences in the House and Senate budget resolutions passed earlier this year. At the same time, sequester relief could be on the table; we'd welcome relief for hospitals, but hospitals also could be eyed as a source of replacement savings. A physician payment fix to avoid large cuts will be needed by Jan. 1. Then Congress must agree on how to fund the government after Jan. 15 when the continuing resolution expires and lift the debt ceiling again sometime after Feb. 7. See the AHA Legislative Action Alert for important information on payment reductions that threaten access to care and what you can do about it.

Legislative Action

It's crucial that hospital leaders continue to make their voices heard across the weeks and months ahead. Hospitals' ability to maintain access to care is threatened by repeated ratcheting of Medicare and Medicaid payments for hospital services. Please continue to reach out to your legislators' offices and drive home the point that further cuts will only increase hospitals' challenges and could in turn limit patients' access to care. Specifically, urge them to:

1. Reject arbitrary cuts to Medicare and Medicaid funding for hospital services, and support real solutions as Congress looks for ways to reduce the nation's deficit. Options on the table that we're concerned about include:

- Restrictions on Medicaid provider assessments
- Reductions to rural hospital programs, including CAHs
- Changes to the 340B program

2. Provide relief from excessive and harmful policies that undermine hospitals' ability to care. Specifically urge your legislators to support:

- "The DSH Reduction Relief Act," H.R. 1920/S. 1555, which eliminates the first two years of planned cuts to Medicare and Medicaid disproportionate share hospital payments
- "The Medicare Audit Improvement Act," H.R. 1250/S. 1012, which reins in overly aggressive Medicare auditors
- Relief from the Centers for Medicare & Medicaid Services' "two-midnight" admission policy, which creates new challenges for hospitals

3. Support rural health care by extending crucial policies, including:

- The Medicare-dependent Hospital Program
- The low-volume adjustment
- Ambulance add-on payments

For background information and factsheets to help you make your case, please visit the AHA Action Center at www.aha.org/actioncenter.

Advocacy Days: Plan now to attend an AHA Advocacy Day on Dec. 3 and Jan. 8. You'll have the opportunity to talk to your legislators and their staff about the challenges facing your patients and your community. Your voice in Washington is essential to our ability to deliver the message of "No more cuts to hospital funding" and garner support for critical hospital issues.

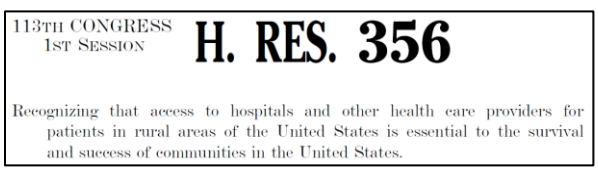
Please **click here to RSVP** or contact Michael McCue at mmccue@aha.org or (312) 422-3319, or Debra Thomas at dthomas@aha.org or (312) 422-3327.

AHA's Advocacy Alliance for Rural Hospitals: Become a member of the AHA Advocacy Alliance for Rural Hospitals and let your voice be heard. The Alliance is an additional avenue for AHA members to engage on issues on which they care deeply. The Rural Hospital Advocacy Alliance focuses on extending Medicare provisions that expired in 2012 and 2013, including the low-volume adjustment, the MDH Program, ambulance add-on payments, and the outpatient hold harmless. In addition, the Alliance will continue to work to protect CAHs and other rural hospital designations.

Rural Hospital Legislative Update

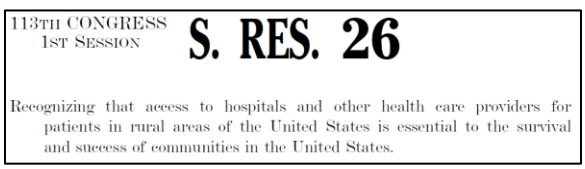
Critical Access Flexibility Act: H.R. 3444 would give CAHs needed flexibility to accommodate fluctuations in patients through the option of meeting an average annual daily census of 20. "Under the current requirements for a CAH, a hospital can have up to 25 patient beds per day," noted AHA Executive Vice President Rick Pollack in letters of support to Reps. Greg Walden (R-OR) and Ron Kind (D-WI), the bill's sponsors. "Unfortunately, hospitals cannot always anticipate the patient count and find that turning patients away is unavoidable. This additional flexible option would allow for hospitals to appropriately accommodate daily and seasonal fluctuations."

Importance of Rural Health Access for American Communities:


113TH CONGRESS
1ST SESSION

H. RES. 356

Recognizing that access to hospitals and other health care providers for patients in rural areas of the United States is essential to the survival and success of communities in the United States.


113TH CONGRESS
1ST SESSION

S. RES. 26

Recognizing that access to hospitals and other health care providers for patients in rural areas of the United States is essential to the survival and success of communities in the United States.

Reps. Jenkins (R-KS), Young (R-IN), Smith (R-NE), Kind (D-WI), and McMorris Rodgers (R-WA) recently introduced House Resolution 356 recognizing that access to hospitals and other health care providers for patients in rural areas of the United States is essential. H.

Res. 356 is a companion to S. Res. 26 that was introduced earlier this year by Sens. Jerry Moran (R-KS) and Amy Klobuchar (D-MN). While non-binding, each:

(1) recognizes that access to hospitals and other health care providers for patients in rural areas of the United States is essential to the survival and success of communities in the United States;
(2) recognizes that preserving and strengthening access to quality health care in rural areas of the United States is crucial to the success and prosperity of the United States;
(3) recognizes that strengthening access to hospitals and other health care providers for patients in rural areas of the United States makes Medicare more cost-effective and improves health outcomes for patients;
(4) recognizes that, in addition to the vital care that rural health care providers provide to patients, rural health care providers are integral to the local economies and are one of the largest types of employers in rural areas of the United States; and
(5) celebrates the many dedicated medical professionals across the United States who work hard each day to deliver quality care to the nearly 1 in 5 people in the United States living in rural areas.

Cosponsors for each resolution are needed as we continue this critical period of debate on the federal budget.

AHA Regulatory Priorities for Rural Hospitals

Changes to CAH Payments: Congress and the administration have called for reduced CAH payments and the elimination of CAH designation based on mileage between CAHs and other hospitals. In a Rural Hospital Alert AHA explains how these proposals are misguided and demonstrate an unfortunate lack of understanding of how health care is delivered in rural America.

Direct Supervision for Outpatient Therapeutic Services: The AHA is disappointed that CMS has not heeded the concerns voiced by CAHs and small rural hospitals that requiring adherence to the direct supervision requirements for outpatient therapeutic services is not only unnecessary but will reduce access to care. Additional information is available in an AHA Fact Sheet.

Changes to the 340B Drug Discount Pricing Program: The 340B program is essential to helping safety-net providers' stretch limited resources to better serve their communities. We support the continuation of this essential program, which saves money for providers and state and federal governments. The AHA supports program integrity efforts but will continue to oppose efforts to scale back this program. An AHA Fact Sheet offers further information.

AHA's full fall legislative and regulatory agenda is available at www.aha.org.

Inpatient Prospective Payment System (IPPS) Final Rule

CMS published its fiscal year (FY) 2014 final rule for the inpatient PPS in the Aug. 19 *Federal Register*. AHA's Regulatory Advisory specifically addressing Medicare inpatient PPS payment. However, the final rule includes several provisions relevant to CAHs.

Critical Access Hospitals: In the proposed rule, CMS stated that it had received a number of questions about whether CAHs are required to furnish acute care inpatient services under the CAH Medicare Conditions of Participation (CoPs). CMS's interpretation of the *Social Security Act* is that CAHs are required to furnish acute care inpatient services. Further, CMS believes that 99 percent of CAHs already do provide these services. Therefore, CMS proposed to change the regulations to make clear that CAHs are required to provide acute care inpatient services. CMS finalized this provision.

IPPS Rebilling: CMS finalized its policy on rebilling Medicare Part A claims as part of its FY 2014 hospital IPPS final rule. AHA has published a Regulatory Advisory that addresses rebilling.

The final rebilling policy allows hospitals to rebill under Part B for most services after a Part A claim has been denied because the admission was found not reasonable and necessary, although the Part B claim must be submitted within one year of the date of service. The AHA is extremely disappointed that CMS's final rule does not fundamentally reform its policy on rebilling and continues to deny hospitals reimbursement for all reasonable and necessary services they provide to their Medicare patients. The AHA and its five hospital system co-plaintiffs recently filed a supplemental brief in their rebilling lawsuit, which was initiated last year.

Admission and Medical Review Criteria for Hospital Inpatient Services: CMS finalized its requirements for admission and medical review criteria, or "two-midnight" policy, to generally consider hospital inpatient admissions spanning two midnights as reasonable and necessary for payment under Part A. AHA has published a Regulatory Advisory that addresses inpatient admissions and medical review criteria. In addition, since the rule was published, CMS has issued additional guidance related to the admission and review criteria. The most recent guidance, issued Nov. 1, included updated instructions on the agency's website and two documents summarizing the technical directions CMS will issue to Medicare Administrative Contractors (MACs) regarding the "Probe and Educate" audits originally announced in the agency's Sept. 26 guidance. Refer to AHA's Special Bulletin for more details. **The AHA will continue to pursue delayed enforcement of the two-midnight policy until Oct. 1, 2014 and seek additional clarifications from CMS.**

In a conference call on Nov. 12, CMS indicated that CAHs will not be part of the "probe and educate" prepayment review process it set forth in its Sept. 26 guidance. CMS also stated that Medicare Recovery Audit Contractors will not conduct post-payment patient status reviews for claims with dates of admission from Oct. 1, 2013 through March 31, 2014.

Below is a summary from the final rule:

The two-midnight ***benchmark*** is guidance for admitting practitioners and reviewers to identify when an inpatient admission is generally appropriate for payment. Specifically, CMS stated that physicians or other practitioners should admit a beneficiary if:

- They expect that the beneficiary will remain in the hospital for more than one Medicare utilization day, which CMS defines as an admission that crosses two midnights; or
- The beneficiary requires a procedure that is specified as inpatient-only.

Conversely, if the physician expects to keep the beneficiary in the hospital for a period of time that does not cross two midnights, and the procedure is not specified as inpatient-only, the services will generally be considered inappropriate for payment under Medicare Part A. AHA helped convince CMS to revise its original proposal to allow the ordering physician to consider time the beneficiary spends receiving outpatient services.

CMS also finalized a two-midnight ***presumption*** for the purposes of medical review of hospital inpatient admissions. Specifically, CMS indicated that its external review contractors will presume that inpatient hospital claims with lengths of stay greater than two midnights after the formal physician order for admission are reasonable and necessary and generally appropriate for Part A payment. Further, these claims will not be the focus of medical review efforts absent evidence of systematic gaming, abuse or delays in the provision of care in an attempt to qualify for the two-midnight presumption. AHA helped convince CMS to restrict auditors to consider only the information available to the admitting physician at the time of admission.

CMS estimates that its policy will increase inpatient PPS expenditures by $220 million. Therefore, the agency finalized its proposed offset to this additional expenditure by permanently and prospectively reducing the operating PPS standardized amount, the capital standard federal payment rate, sole community hospitals' hospital-specific rates (as well as Medicare-dependent hospitals' rates if the program is extended).

Physician Order: CMS finalized its proposal that an order supported by medical information, including physician admission and progress notes, must be made by a physician (or other qualified practitioner, as provided in the regulations) and present in the medical record in order for the hospital to be paid for hospital inpatient services under Medicare Part A.

CMS issued guidance further clarifying physician certification and order requirements for inpatient admissions. CMS's guidance specifically reiterates the existing condition of payment for inpatient CAH services: That is, "***The physician must certify that the beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH.*** CAHs may satisfy this condition of payment by including a physician certification form or statement in the medical record. If physician certification forms or statements are not included in the medical record, CMS's guidance also specifies that this condition of payment may be met by either physician notes or by actual discharge within 96 hours.

Outpatient PPS Proposed Rule for CY 2014

CMS released the outpatient prospective payment system (OPPS) proposed rule for calendar year (CY) 2014. The rule proposes updating OPPS payment weights and rates. AHA's Regulatory Advisory discusses the details of the proposed rule.

OPPS Update: The proposed rule includes an ACA required productivity reduction of 0.4 percentage points and an additional 0.3 percentage point reduction to the CY 2014 market basket update of 2.5 percent. This results in a proposed market basket update of 1.8 percent for those hospitals that publicly report data on 22 quality measures. The 2014 update for hospitals that do not meet quality reporting requirements would be reduced by 2.0 percentage points, to negative 0.2 percent.

Direct Supervision of Hospital Outpatient Therapeutic Services: CMS proposes to end, as of the close of CY 2013, its prohibition on Medicare contractors enforcing the direct supervision policy for outpatient therapeutic services furnished in CAHs and in small rural hospitals having 100 or fewer beds. For CY 2014, the agency, therefore, proposes to require a minimum of direct supervision for all outpatient therapeutic services furnished in hospitals and CAHs, unless the service is on the list of services that may be furnished under general supervision or is designated as a nonsurgical extended duration therapeutic services. These lists of services are available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/CY2013-OPPS-General-Supervision.pdf

The AHA remains concerned that hospitals and CAHs will have difficulty implementing CMS's supervision requirements, even with the level of additional flexibility the agency has provided over the past several years. A number of important changes that would address these concerns are included in AHA-supported legislation, the *Protecting Access to Rural Therapy Services Act of 2013* (S. 1143/H.R. 2801). Read the AHA's fact sheet on Supervision of Hospital Outpatient Therapeutic Services for more information.

Physician Fee Schedule Proposed Rule for CY 2014

CMS published the Medicare physician fee schedule (PFS) proposed rule for CY 2014. Without congressional action, CMS estimates that Medicare payments to physicians and qualifying non-physician providers will decline by a mandated 24.4 percent on Jan. 1 due to the flawed sustainable growth rate formula. An AHA Regulatory Advisory is available for your reference.

Medicare Telehealth: Under current law, Medicare beneficiaries are eligible for telehealth services only when those services are provided from an originating site located outside of a Metropolitan Statistical Area (MSA) or in a rural Health Professional Shortage Area (HPSA). CMS proposes to allow rural census tracts located in MSAs to be considered rural in accordance with a methodology used by the Office of Rural Health Policy (ORHP). The effect of this change is that some rural areas within MSAs will gain access to Medicare

telehealth services and CMS states that it believes this change in policy will expand access to telehealth services.

Therapy Services: *The American Tax Relief Act of 2012* (ATRA) extended a number of temporary changes to Medicare outpatient therapy – physical therapy, occupational therapy and speech-language pathology services. Specifically, the law extended through Dec. 31 the current therapy cap exceptions process; the temporary application of the therapy cap to therapy services provided in hospital outpatient departments (HOPDs); and a manual medical review process for therapy cap exceptions that reach a threshold of $3,700 per year. It also required CMS to count therapy services furnished by a CAH toward the therapy cap using the amount that would be paid for the service under the PFS. However, the ATRA did not apply the therapy cap to services furnished by a CAH – meaning that a CAH could provide therapy services above the cap without following the therapy cap exceptions process.

As a result of the ATRA, CMS reassessed and now proposes to reverse its longstanding interpretation of existing statute by subjecting CAHs to the therapy cap beginning Jan. 1. In so doing, CMS differentiates CAHs from HOPDs, so that CAHs would be subject to the cap on Jan. 1 even though, under current law, HOPDs will no longer be subject to the cap on that date. Further, unless Congress acts, the exceptions process will end on Jan. 1, and claims CAHs submit for services above the cap will be denied. **The AHA opposes application of the therapy caps to CAHs and will urge CMS not to finalize this flawed policy.**

Extension of Ambulance Add-ons: The rule implements the ATRA's extensions to the existing add-on payments for ground ambulance services – a 3 percent add-on for rural areas and a 2 percent add-on for urban areas – through Dec. 31. It also extends through Dec. 31 the "super rural" ambulance add-on. These provisions are retroactive to Jan. 1, 2013.

Electronic Health Record (EHR) and Meaningful Use

The last day that eligible hospitals and CAHs can register and submit attestation for the FY 2013 Medicare EHR Incentive Program is Nov. 30. Eligible hospitals and CAHs must successfully attest to demonstrating meaningful use by Nov. 30 to receive a 2013 incentive payment (the reporting period, however, must end on or before Sept. 30, the last day of FY 2013). Hospitals must attest to demonstrating meaningful use *every year* to receive an incentive and avoid a payment adjustment.

Hospitals participating in the Medicaid EHR Incentive Program need to refer to their state deadlines for attestation. Payment adjustments will be applied beginning FY 2015 (Oct. 1, 2014) to Medicare eligible hospitals that have not successfully demonstrated meaningful use. The adjustment is determined by the hospital's reporting period in a prior year. Read the eligible hospital payment adjustment tipsheet to learn more.

JAMA Letters Criticize CAH Cost Shifting

Letters published in JAMA Internal Medicine conclude that hospital systems that include CAH and non-CAH hospitals could use accounting practices to shift costs to CAHs and maximize cost-based payments, increasing costs by an estimated $150 million a year. However, the study does not examine whether the shifting of costs occurs as a result of cost-based reimbursement or as a result of care being appropriately shifted from a prospective payment system acute hospital to the CAH. “The study attempts to undercut the vital role CAHs play in providing essential medical care to the 19.3 percent of the U.S. population that resides in rural areas,” said Priya Bathija, AHA senior associate director of policy in an Advocacy Update to members of the Rural Hospital Advocacy Alliance.

Shirley Ann Munroe Leadership Award

Susan Starling, CEO, Marcum & Wallace Memorial Hospital, Irvine, KY is the 2013 recipient of the AHA’s Shirley Ann Munroe Leadership Award. The award recognizes the accomplishments of small or rural hospital chief executives and administrators who have achieved improvements in local health delivery and health status through their leadership and direction. Finalists include Marcia Dial, CEO, Scotland County Hospital, Memphis, MO; Michael Franklin, CEO, Atlantic General Hospital, Berlin, MD; and Lisa Heaton, Administrator, Johnson County Community Hospital, Mountain City, TN. Congratulations to them all for their contributions toward improving the health and health care delivery in rural America.

Call for Nominations

A 2014 Call for Nominations for the AHA Section for Small or Rural Hospitals will be posted by Jan. 30, 2014. The Section seeks the names of CEOs interested in serving of the Governing Council or as Section delegates and alternates to the AHA Regional Policy Boards. Visit the Section for Small or Rural Hospitals web site for additional information.

The 2014 Trustee Call for Nominations will be posted on Jan. 7, 2014. The AHA is looking for trustees interested in serving on the Committee on Governance, the Regional Policy Boards, and on various governing councils and committees. Please go to www.aha.org/trusteeopportunities to view the Call for Nominations and the Candidate Application form on Jan. 7.

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.