Millinocket Regional Hospital
Millinocket, ME

St. Luke's Hospital
Columbus, NC

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The AHA and its Section for Small or Rural Hospitals represents and advocates on behalf of more than 1,625 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 aimed at CAHs. This issue of *CAH Update* reviews the federal budget, legislative advocacy, regulatory policy, and other proposed rules for Medicare payment and more.

The Federal Budget

In April, President Obama submitted his budget request to Congress for fiscal year (FY) 2014. The outline, which is similar to the White House's 2012 proposal, called for cutting Medicare by about $374 billion and Medicaid by $18.9 billion over 10 years. The specifics are reviewed in an AHA Special Bulletin.

The administration proposed changes to payments for rural providers. Starting in FY 2014, 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 2014 budget proposed a $16 million cut to rural programs.

Legislative Update

Importance of Rural Health Access for American Communities: Sens. Jerry Moran (R-KS) and Amy Klobuchar (D-MN) introduced Senate Resolution 26 – *The Importance of Rural Health Access for American Communities* – calling access to rural hospitals and other health care providers

"essential to the survival and success of communities." Although non-binding it does reinforce several important points such as:

- Access to hospitals and other health care providers is essential;
- Preserving and strengthening access to quality health care in rural areas is crucial;
- Strengthening access to hospitals and other health care providers for patients in rural areas makes Medicare more cost-effective and improves health outcomes for 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
- Celebrates the many dedicated medical professionals who work hard each day to deliver quality care to the nearly 1 in 5 people in the United States living in rural areas.

***Relief from Recovery Audit Contractors*:** *The Medicare Audit Improvement Act of 2013* (H.R. 1250/S. 1012) would make much-needed improvements to the RAC program and other Medicare audit programs. It would establish annual limits on documentation requests, impose financial penalties on RACs if they fall out of compliance with program requirements, make RAC performance evaluations publicly available, and allow denied inpatient claims to be billed as outpatient claims if necessary. In addition, the bill would limit the number of "additional document requests" to 2 percent of hospitals claims, with a maximum of 500 per 45 days. An AHA Fact Sheet on the bill provides more details.

AHA Advocacy Action

The AHA is working to ensure that all hospitals have the resources that they need to provide high-quality care and meet the needs of their communities. This is evident in our Advocacy Agenda for Small or Rural Hospitals. We are advocating for appropriate Medicare payments, extending expiring beneficial Medicare provisions, improving federal programs to account for special circumstances in rural communities, and seeking adequate funding for annually appropriated rural health programs. In addition, existing special rural payment programs – the CAH, sole community hospital (SCH), Medicare-dependent hospital (MDH) and rural referral center (RRC) programs – need to be protected and updated.

The AHA will work with Congress to:

- Extend expiring provisions;
- Allow hospitals to claim the full cost of provider taxes as allowable costs;
- Ensure CAHs are paid at least 101 percent of costs by Medicare Advantage plans;
- Ensure that the CMS appropriately addresses the issue of direct supervision for outpatient therapeutic services for rural hospitals and CAHs;
- Ensure rural hospitals and CAHs have adequate reimbursement for certified registered nurse anesthetist and stand-by services;

Medicare payment systems often fail to recognize the unique circumstances of small, rural hospitals. Many rural hospitals are too large to qualify for CAH status, but too small to absorb the financial risk associated with prospective payment system (PPS) programs. With deficit reduction as a key goal in Washington, rural health care providers continue to be at risk. See the AHA Fact Sheet outlining the advocacy priorities for rural hospitals.

The AHA Advocacy Alliance for Rural Hospitals: The Alliance is an additional avenue for AHA members to engage on issues on which they care deeply. The Rural Advocacy Alliance focuses on extending Medicare provisions that expired in 2012 and those expiring in 2013, including the low-volume hospital payment adjustment, the MDH Program, Section 508 reclassifications and the outpatient hold harmless. In addition, the Alliance will continue to work to protect CAHs and other rural hospital designations. Become a member of the AHA Advocacy Alliance for Rural Hospitals and let your voice be heard.

Inpatient Prospective Payment System Update

In April, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule for FY 2014 for hospital inpatient and long-term care PPS. The rule included quality reporting requirements and conditions of participation for hospitals and CAHs. Comments on the proposed rule will be accepted through June 25. The final rule will be published by August 1, and the policies and payment rates will take effect October 1. See the May 21 AHA Regulatory Advisory for an in-depth analysis. Below are CAH highlights.

Admission and Medical Review Criteria for Hospital Inpatient Services: CMS proposes to clarify the rules governing physician orders of hospital inpatient admissions for payment under Medicare Part A. Specifically, CMS would clarify and specify that an order by a physician or other qualified practitioner is required for payment of hospital inpatient services under Medicare Part A.

In addition, CMS proposes that hospital inpatient admissions spanning two midnights in the hospital would generally qualify as reasonable and necessary for payment under Part A. For beneficiaries who require an inpatient stay that spans two midnights, the agency states that its external review contractors, such as the Medicare Administrative Contractors (MACs) and RACs, would presume that hospital inpatient status is reasonable and necessary.

While the AHA appreciates CMS's efforts to provide clarification around when an inpatient admission is reasonable and necessary, we are concerned that this proposed policy would continue to allow CMS contractors to second guess physicians' judgment. We also object to CMS's proposal to cut inpatient payments by 0.2 percent to offset the estimated $220 million in additional expenditures it believes will result from this proposed policy.

CAH Inpatient Services: CMS states that it has received a number of questions about whether CAHs are required to furnish acute care inpatient services under the CAH 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 proposes to change the regulations to make clear that CAHs are required to provide acute care inpatient services. In the event that a CAH decides that it is no longer able to comply, or that the circumstances no longer warrant compliance, with all of the CAH requirements, such a facility may wish to engage in a dialogue with CMS to explore its options, including avenues other than the CAH program, for continued participation in the Medicare program.

Medical Resident Training at CAHs: CMS proposes that, for purposes of direct graduate medical education or indirect medical education payments, a hospital may not claim full-time equivalent (FTE) resident training that occurred at a CAH. However, if the CAH itself incurs the costs of training these residents when they rotate to the CAH, then the CAH may receive 101 percent of the reasonable costs it incurred with training residents in an approved residency training program.

Other Regulatory and Policy Updates

Sequester Implementation: In March, CMS shared its guidance on implementing sequester. In general, Medicare FFS claims with dates-of-service or discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payments. The claims payment adjustment shall be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments. The 2 percent reduction will be applied to periodic interim payments (PIP) for CAHs and pass-through payments for GME and Medicare Bad Debts. CMS refers questions to the MAC.

Essential Community Provider: The ACA requires that qualified health plans (QHPs) offered on the state-based and federally-facilitated marketplaces in 2014 must include a sufficient number and geographic distribution of essential community providers (ECPs) in their service area to provide access for low-income and medically underserved individuals. Issuers seeking certification of their health plans as QHPs and issuers offering QHPs must comply with the network adequacy and ECP standards. CMS urges issuers offering QHPs to include provider networks with robust ECP participation.

At this time, health insurance issuers that wish to establish QHPs may be approaching you with offers to join their provider networks. Information about QHPs and ECPs is available on the Center for Consumer Information & Insurance Oversight website at http://cciio.cms.gov/.

Direct Supervision of Hospital Outpatient Therapeutic Services: For CY 2013 CMS extended its policy not to enforce the direct supervision policy in CAHs and rural hospitals with 100 or fewer beds. However, CMS warns that this is the final year of the enforcement moratorium. The Advisory Panel on Hospital Outpatient Payment (HOP) advises CMS on the appropriate supervision levels for individual hospital outpatient therapeutic services. Read the fact sheet on Supervision of Hospital Outpatient Therapeutic Services for more information.

With input from the HOP Panel, CMS in 2012 reduced the supervision level for 49 outpatient services from direct to general supervision. That is, these 49 services could be performed under the overall direction of a physician or non-physician practitioner (NPP) without requiring their presence. The proposed services include certain vaccine immunizations; IV infusion hydration, therapeutic infusions and push injections; various urological services; vascular access services; skin or wound care services; and direct admission to observation services. The panel met again in March, but no hospitals proposed any additional recommendations for general supervision.

Presently the AHA advocates that CMS

- Adopt a default standard of “general supervision” and apply reasonable exceptions to identify specific procedures that should be subject to direct supervision;

- Ensure that the definition of "direct supervision" for CAHs is consistent with the conditions of participation allowing a physician or NPP to present within 30 minutes of being called; and
- Prohibit enforcement of CMS's retroactive reinterpretation that the "direct supervision" requirements applied to services furnished since Jan. 1, 2001.

Medicare Conditions of Participation: In February CMS issued a proposed rule on Medicare conditions of participations (CoPs) aimed at reducing burden and eliminating obsolete regulations. CMS proposes to rescind its current requirement that a member of the medical staff serve on the governing board. CMS would instead require periodic consultations between the governing board and a representative of the medical staff. However, CMS also proposes to require that each hospital must have its own distinct medical staff. Therefore, this proposal would preclude multi-hospital systems from implementing unified medical staffs. The AHA believes that each hospital system should be able to determine its medical staff structure.

Other proposed changes to the hospital and CAH Medicare CoPs include:

- CMS would classify swing-beds as an optional service. This change would enable accrediting organizations to assess compliance with swing-bed requirements during a routine accreditation survey, rather than requiring a separate survey.
- Patient diets, including therapeutic diets, could be ordered by a qualified dietitian, if authorized by the medical staff and compliant with state law.
- CMS would clarify that outpatient services may be ordered by non-privileged practitioners when certain criteria are met.
- CAHs do not need to consult with a non-staff member in developing patient care policies.
- CAHs also may determine how often a doctor of medicine or osteopathy should be onsite.

For more information, read AHA's Regulatory Advisory on the proposed rule for burden reduction affecting hospitals and CAHs.

Extension of Therapy Caps: The 2012 *American Taxpayer Relief Act* requires temporary application of the therapy cap to outpatient therapy services provided in CAHs for CY 2013. CMS has confirmed that the dollars accrued for providing PT, OT and SLP services in a CAH will count toward the per-beneficiary annual therapy cap. The cap for CY 2013 is $1,900. CMS has clarified that CAHs will not be subject to the outpatient therapy cap and may continue to provide therapy services above the $1,900 cap and will not need to request an exception or use a modifier on the claim.

However, if a patient receives $1,900 or more of therapy services in a CAH, and then receives additional services in another setting (such as a hospital outpatient department or a medical office), then the other setting would need to request an exception to the therapy cap by using a KX modifier on the claim In addition, CAHs will not be subject to the additional manual medical review process for beneficiaries. CMS indicated that it will revisit the issue of fully applying the outpatient therapy cap to CAHs in the future. For more information, see the AHA Special Bulletin on therapy cap exceptions process for CAHs.

Rebilling of Denied Claims: In a recent Administrator's Ruling, CMS addressed circumstances in which hospitals may be eligible for Part B payment following the denial of a Part A claim. Actions

by CMS permit rebilling for certain denied inpatient claims for services that would have been reasonable and necessary had the beneficiary been treated as a hospital outpatient. The ruling, which took effect March 13, applies to all new denials, prior denials that are still eligible for appeal, and appeals currently in process, and will remain in effect until CMS issues a final rule. The AHA published a Regulatory Advisory on CMS's rules and a proposed rule on rebilling.

While CMS attempts to provide a permanent solution to rebilling problems, the AHA remains concerned that the proposed rule applies only to services provided within the previous year. Since RACs often review claims that are more than a year old, the practical effect would be many denials would be ineligible for rebilling. Therefore, the AHA intends to press ahead with the litigation we initiated last year unless and until a final rule provides full Part B reimbursement without unreasonable restrictions. We also will use the comment process to urge the agency to adopt a final rule that ensures that hospitals receive full reimbursement for all reasonable and necessary services provided to Medicare beneficiaries both in the past and in the future.

Federal Communications Commission Rural Health Care Program: The FCC's revised Rural Health Care Program (RHCP) and the new Healthcare Connect Fund (HCF) are effective this year. The HCF's seeks to improve the quality of health care in rural communities by ensuring providers have access to telecommunications and broadband services. Approximately $400 million in annual funding will be available to health care providers (HCPs) as part of the RHCP, of which $150 million is for the HCF. Key features include:

- Support for broadband connectivity and networks
- Both consortium and individual HCPs may apply
- Covers both broadband services and HCP-owned infrastructure
- Non-rural HCPs can participate if in majority-rural consortia
- Multi-year funding commitments available to consortia
- Connections to off-site administrative offices and data centers covered

Stark and Antikickback Rule: CMS and Department of Health and Human Services Office of Inspector General (OIG) released two proposed rules that would extend the Stark and antikickback regulatory protections for hospitals that want to provide assistance to physicians in adopting certain health information technology. In addition to extending the regulatory protections beyond the end of 2013, both proposals would deem software as interoperable and eligible for protected donation under the rules and eliminate the requirement that donated software must include electronic prescribing capability at the time it is provided to the recipient. CMS and the OIG explain that the proposed December 31, 2016 sunset date corresponds to the last year for which Medicare EHR incentive payments are available. However, both agencies note that they continue to consider for inclusion in any final rules a longer extension to Dec. 31, 2021, which corresponds to the end of the Medicaid EHR Incentive Program. For more information, see the AHA Regulatory Advisory for the Stark and Antikickback Protections and our May 13 comment letters to CMS and OIG.

Electronic Health Records and Meaningful Use: In the first two years of the EHR incentive program, fewer than half of all hospitals and less than one-third of CAHs received incentive payments for achieving meaningful use, according to data from CMS. Nevertheless, HHS is on track to raise the bar significantly in Stage 2 of meaningful use, which takes effect October 1. While

we are pleased CMS heeded our concerns and will delay any rulemaking on Stage 3 until 2014; we believe additional time is necessary.

In addition, the AHA convinced CMS to allow CAHs to include capital lease costs as allowable costs when calculating incentive payments. However, CMS also announced that the ICD-10 implementation deadline of October 1, 2014 will stand firm.

Your input is needed. The AHA is surveying community hospital CEOs to learn how best to help and advocate for members as they transition to the ICD-10 coding system for patient diagnoses and procedures, and to meaningful use of electronic health records. Details on the ICD-10 and Meaningful Use Readiness Survey were emailed to CEOs at all community hospitals. Individual data from the survey will not be released publicly, but will be shared with state hospital associations to assist in joint readiness efforts. For more information, contact AHA's George Arges at (312) 422-3398 or garges@aha.org.

CAH Method II physicians eligible for Medicare EHR incentives: Physicians who provide services in the outpatient departments of CAHs and for whom bills are submitted via the optional or "Method 2" billing approach (CAH II) are now eligible to participate in the Medicare Electronic Health Record Incentive Program. CAH II physicians can begin participation in calendar year (CY) 2013. CAH II physicians will need to register and attest to demonstrating meaningful use of certified EHR technology in order to receive their incentive payment. CAH II physicians who begin participation in CY 2013 will be eligible to earn a maximum Medicare EHR incentive payment of $39,000. However, due to the time required to implement the system changes, they will not be able to submit attestations until January 2014. An AHA Special Bulletin provides background on the CMS action.

CMS is now accepting requests for reassignment of payments to CAHs. If a provider would like to qualify for an EHR incentive payment and is reassigned to a CAH, this information may be verified through PECOS once an 855R form is submitted for an enrolled provider/supplier. If the provider is not currently enrolled, 855I and 855R forms must be submitted and processed. CMS is now accepting these forms for reassignment of payments to CAHs. Medicare may pay: (1) a physician or other supplier's employer if the supplier is required, as a condition of employment, to turn over to the employer the fees for his or her services; or (2) an entity (i.e., a person, group, or facility) that is enrolled in the Medicare program for services furnished by a physician or other supplier under a contractual arrangement with that entity. This means that Part A and Part B entities other than physician/practitioner group practices can receive reassigned benefits, assuming the requirements for a reassignment exception are met and that the reassignee meets all enrollment requirements.

An updated CAH Method II Physician Participation fact sheet is available for more information on how to participate, including additional payment information and guidance for CAH II physicians on reassigning their billing to the CAH.

Community Health Needs Assessments: The Internal Revenue Service (IRS) released an updated Schedule H as well as a proposed rule on the community health needs assessment (CHNA) requirement for tax-exempt hospitals created by the ACA (Section 501(r) of the Internal Revenue Code). In addition, the proposed rule provides guidance on the consequences if a

hospital facility fails to satisfy the requirements of Section 501(r), including the CHNA, financial assistance policy, limitation on charges, and billing and collection provisions.

The CHNA proposed rule largely tracks the guidance that was issued by IRS in 2011. Several modifications respond to concerns raised by hospitals. Importantly, the guidance on how IRS will respond to noncompliance recognizes, as the AHA has urged, that not all infractions are of the same significance and takes a calibrated approach. For more information, read the Legal Advisory for Updated Schedule H and the Regulatory Advisory for CHNA.

Advancing Effective Patient Communication in CAHs: In certain circumstances the failure to ensure that limited-English proficiency (LEP) individuals can effectively participate in, or benefit from, federally funded programs such as Medicare may violate the prohibition under Title VI of the *Civil Rights Act of 1964*. In 2012, the Office for Civil Rights (OCR) piloted a 10-state, on-site examination of CAHs to make certain that their programs comply with Title VI. OCR found that for low-income individuals, racial and ethnic minorities, and other underserved populations, including LEP individuals, there are persistent barriers to obtaining health care services. Through the "Advancing Effective Communication in CAHs" initiative, OCR's intervention led to CAHs in the compliance review implementing a number of effective practices. Building on this success, OCR will continue the initiative by casting a wider net, conducting additional language access compliance reviews, and providing technical assistance to CAHs nationwide.

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 26, 2013.

Visit the Section for Small or Rural Hospitals Web site at http://www.aha.org/smallrural

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