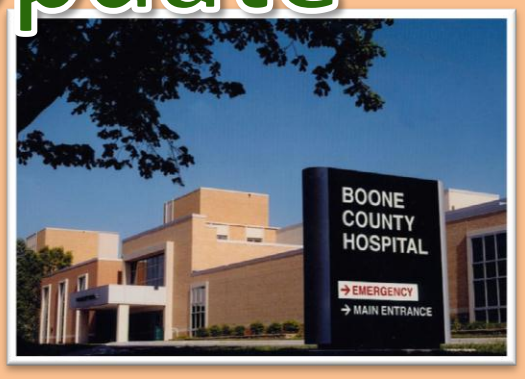
CAH Update

Glendive Medical Center
Glendive, MT



Boone County Hospital
Boone, IA

Summer 2014

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 physician payment policy, legislative advocacy, regulatory policy, proposed rules for Medicare payment, legal resources and more.

PHYSICAN PAYMENT FIXES

Medicare Sustainable Growth Rate Fix: The Protecting Access to Medicare Act of 2014 (PAMA) halted a 24 percent cut to Medicare physician payments that had been scheduled to take effect on April 1 and replaces it with a 0.5 percent update through Dec. 31, 2014 and a 0 percent update from Jan. 1, 2015 through March 31, 2015. AHA has prepared a Legislative Advisory on PAMA.

PAMA contains important hospital-related provisions, including:

- extending ambulance add-on payments through Mar 31, 2015
- delaying the start of the Medicaid DSH cuts for one year, until 2017, while extending the cuts for an additional year through 2024
- extending the partial delay in enforcement of the CMS two-midnight policy for an additional six months, through March 31, 2015
- delaying implementation of the ICD-10 coding system until Oct. 1, 2015
- extending the work GPCI floor
- extending the therapy cap exceptions process

What's missing from PAMA includes:

- eliminating the 96-hour physician certification requirement

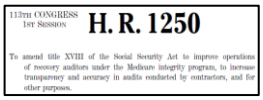
- suspending the direct supervision policy for hospital outpatient therapeutic services
- fixing RAC permanently
- relieving hospitals from cuts to Medicare DSH permanently
- permanent fixes for Medicare extenders

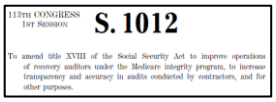
ACA Medicaid Parity Sunsets December 31: Under the ACA, state Medicaid programs must pay primary care physicians Medicare rates for primary care services. Federal funding for the two-year payment enhancement will expire at the end of 2014. While some state Medicaid programs are planning to extend the enhanced payments for primary care beyond 2014 using state dollars, most states will discontinue the payment enhancement absent an extension of federal funding.

ADVOCACY AGENDA

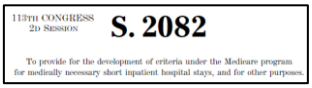
General Hospitals Advocacy Agenda

The advocacy agenda for hospitals addresses those items missing from PAMA; those that were extended, but need to be fixed permanently; and other priorities. Advocacy priorities include legislation that has been introduced in congress for all hospitals including rural such as:

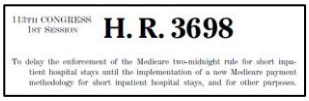

113TH CONGRESS 1ST SESSION
H. R. 1250
To amend title XVIII of the Social Security Act to improve operations of recovery auditors under the Medicare integrity program, to increase transparency and accuracy in audits conducted by contractors, and for other purposes.


113TH CONGRESS 1ST SESSION
S. 1012
To amend title XVIII of the Social Security Act to improve operations of recovery auditors under the Medicare integrity program, to increase transparency and accuracy in audits conducted by contractors, and for other purposes.

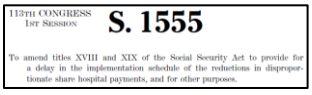
Medicare Audit Improvement Act: Support of H.R. 1250/S. 1012 would establish a consolidated limit for medical record requests, impose financial penalties on RACs that fail to comply with program requirements, make RAC performance evaluations publicly available and allow denied inpatient claims to be billed as outpatient claims when appropriate.

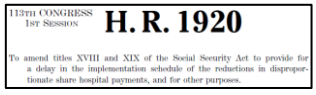

113TH CONGRESS 2D SESSION
S. 2082
To provide for the development of criteria under the Medicare program for medically necessary short inpatient hospital stays, and for other purposes.

Two-Midnight Rule Coordination and Improvement Act (S. 2082) would require CMS to implement a new payment methodology for short inpatient stays in FY 2015.


113TH CONGRESS 1ST SESSION
H. R. 3698
To delay the enforcement of the Medicare two-midnight rule for short inpatient hospital stays until the implementation of a new Medicare payment methodology for short inpatient hospital stays, and for other purposes.

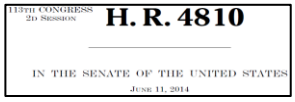
Two Midnight Rule Delay Act of 2013 (H.R. 3698): would require CMS to implement a new payment methodology for short inpatient stays in FY 2015.


113TH CONGRESS 1ST SESSION
S. 1555
To amend titles XVIII and XIX of the Social Security Act to provide for a delay in the implementation schedule of the reductions in disproportionate share hospital payments, and for other purposes.


113TH CONGRESS 1ST SESSION
H. R. 1920
To amend titles XVIII and XIX of the Social Security Act to provide for a delay in the implementation schedule of the reductions in disproportionate share hospital payments, and for other purposes.

DSH Reduction Relief Act of 2013 (H.R. 1920/S. 1555) would eliminate DSH cuts for two years to allow for coverage expansions to be more fully realized and better data to become available.


113TH CONGRESS 2D SESSION
H.R. 3230
HOUSE AMENDMENT TO SENATE AMENDMENT


113TH CONGRESS 2D SESSION
H. R. 4810
IN THE SENATE OF THE UNITED STATES
JUNE 11, 2014

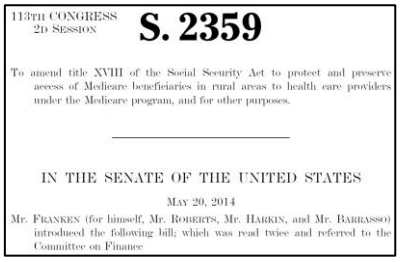
Veteran Access to Care Act: Both the Senate-passed bill (H.R. 3230) and House-passed bill (H.R. 4810) would offer care from a civilian health care provider at the department's expense to any veteran enrolled in the VA health system who cannot get an appointment within the department's current wait-time goal (14 days),

or who lives more than 40 miles from a VA medical facility. However, there are several crucial details to be finalized. It is important that the final bill:

- Maintain the ability of hospitals to contract directly with the VA.
- Set adequate payment rates for non-VA providers at the rate set by the VA, Tricare or Medicare, whichever is greatest.
- Include language to establish and implement a system for prompt payment of claims from non-VA providers.

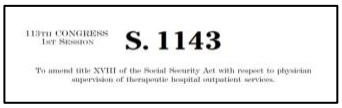
Rural Hospital Advocacy Agenda

In addition to the advocacy priorities for all hospitals, the AHA has an advocacy agenda specific to the needs of rural hospitals. Advocacy priorities include legislation that has been introduced in congress for rural hospitals such as:


113TH CONGRESS
2D SESSION
S. 2359
To amend title XVIII of the Social Security Act to protect and preserve access of Medicare beneficiaries in rural areas to health care providers under the Medicare program, and for other purposes.
IN THE SENATE OF THE UNITED STATES
MAY 20, 2014
Mr. FRANKEN (for himself, Mr. ROBERTS, Mr. HARKIN, and Mr. BARRASSO) introduced the following bill; which was read twice and referred to the Committee on Finance

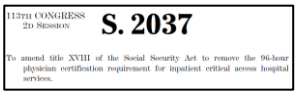
Rural Hospital and Provider Equity Act (R-HoPE) (S. 2359): R-HoPE is AHA-supported legislation that would extend critical rural provisions that have expired or are set to expire and implement new provisions that would benefit rural hospitals. Specifically, the bill would reinstate and extend the outpatient hold harmless, increase the low-volume payment adjustment to 2,000 discharges, extend cost-based reimbursement for rural outpatient labs, improve critical access hospital (CAH) ambulance payments, reinstate and extend the billing for the technical component of pathology services, and reimburse CAHs for certified registered nurse anesthetist (CRNA) on-call services.

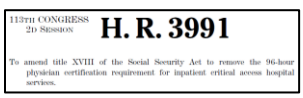
In addition, S. 2359 would remove the 96-hour physician certification requirement as a condition of payment and it would reinstate and extend through 2014 the enforcement moratorium on the CMS outpatient therapy "direct supervision" policy for CAHs and rural PPS hospitals with 100 or fewer beds.


113TH CONGRESS
1ST SESSION
S. 1143
To amend title XVIII of the Social Security Act with respect to physician supervision of therapeutic hospital outpatient services.


113TH CONGRESS
1ST SESSION
H. R. 2801
To amend title XVIII of the Social Security Act with respect to physician supervision of therapeutic hospital outpatient services.

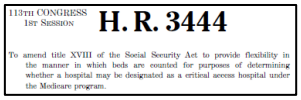
The Protecting Access to Rural Therapy Services Act: would protect access to outpatient therapeutic services by adopting a default standard of "general supervision" (rather than "direct supervision") for outpatient therapeutic services; creating a provider advisory panel to identify those outpatient services complex enough to require direct supervision; and holding hospitals and CAHs harmless from civil or criminal action regarding CMS's retroactive reinterpretation.


113TH CONGRESS
2D SESSION
S. 2037
To amend title XVIII of the Social Security Act to remove the 96-hour physician certification requirement for inpatient critical access hospital services.


113TH CONGRESS
2D SESSION
H. R. 3991
To amend title XVIII of the Social Security Act to remove the 96-hour physician certification requirement for inpatient critical access hospital services.

Critical Access Hospital Relief Act of 2014: would remove the 96-hour physician certification requirement as a condition of payment for CAHs, but leaves the condition of participation intact. A physician would not be required to state that the patient will be discharged or transferred in less than 96 hours in order for the CAH to be paid on that particular claim. CAHs would continue to need to meet the other

certification requirements that apply to all hospitals as well as the condition of participation requiring a 96-hour annual average length of stay.


113TH CONGRESS
1ST SESSION
H. R. 3444
To amend title XVIII of the Social Security Act to provide flexibility in the manner in which beds are counted for purposes of determining whether a hospital may be designated as a critical access hospital under the Medicare program.

Critical Access Flexibility Act: would give CAHs needed flexibility to accommodate fluctuations in patients through the option of meeting an average annual daily census of 20. This additional flexible option would allow for hospitals to appropriately accommodate daily and seasonal fluctuations.

REGULATORY PRIORITIES

CMS has published several final and proposed rules affecting rural hospitals including CAHs. Reviews of the major rules follow.

Inpatient PPS Proposed Rule

On April 30, CMS released its proposed rule for payment of inpatient hospital PPS. It would increase inpatient PPS rates by 1.3 percent in FY 2015 compared to FY 2014 and contains a mandated update of 2.1 percent to the national standardized amount for those hospitals that submit data on quality measures and were meaningful users of electronic health records (EHRs) in FY 2013. AHA has prepared a Regulatory Advisory on the IPPS proposed rule.

The IPPS proposed rule includes provisions for its two-midnight policy that was final in the FY 2014 inpatient PPS rule. Under this policy, CMS will generally consider hospital admissions spanning two midnights as appropriate for payment under the inpatient PPS. In contrast, hospital stays of less than two midnights will generally be considered outpatient cases, regardless of clinical severity. In this proposed rule, CMS:

- Solicits comments on an alternative payment methodology under the Medicare program for short inpatient stays.
- Reiterates that there may be rare and unusual circumstances that justify inpatient admission and payment absent an expectation of care spanning two midnights.
- Reiterates its 96-hour condition of payment, but now proposes to allow CAHs to complete this certification no later than one day before the date on which the claim for payment for the inpatient CAH service is submitted.
- Clarifies funding of graduate medical education for rural hospitals that are now classified as urban in the revised Core Based Statistical Areas.

Also, CMS proposes that, when an urban hospital and a rural hospital are participating in a program that is separately accredited as a rural track program and the rural hospital is redesignated as urban due to implementation of the new OMB labor market delineation, the hospital originally classified as urban will continue to be paid for the rural track during a two-year transition period.

Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction

On May 7, CMS issued a final rule to revise and clarify certain Conditions of Participation (CoPs) and Conditions for Coverage (CfCs). These requirements will take effect July 11 and

AHA prepared a Special Bulletin on the final rule. Among other changes, the rule responds to stakeholder concerns about current governance-related provisions for hospitals. Specifically, CMS will:

- Allow greater flexibility for hospital medical staff structures and will remove a regulation requiring that a hospital's governing board include a member of the medical staff;
- Allow qualified dieticians or qualified nutrition professionals to order patient diets, as authorized by the medical staff and state law, under the hospital CoPs;
- Allow CMS-approved accrediting organizations to assess compliance with "swing bed" requirements, thus potentially reducing the need for a separate state agency survey;
- Remove a requirement that CAHs consult with a non-staff member in developing patient care policies;
- Revise regulations for CAHs, rural health clinics and FQHCs to eliminate the requirement that a physician must be on site at least once in every two-week period. CMS also will adjust CAH requirements for medical review of outpatient records accordingly.

Direct Supervision of Hospital Outpatient Therapeutic Services (HOTS)
While the AHA continues to pursue a legislative solution, the end to the enforcement delay puts all hospitals not compliant with CMS's supervision regulations at risk for significant enforcement penalties, including payment recoupment, as of Jan. 1.

When the Advisory Panel on Hospital Outpatient Payment (HOP Panel) met on March 10 it recommended that CMS reduce the supervision level for 18 services to general supervision. However, CMS did not accept all of the HOP Panel's recommendations; instead it accepted the recommendation for only seven services, rejected the recommendation for three services and, as noted below, deferred its decision on the eight chemotherapy administration codes pending further discussion at the next HOP Panel meeting.

In a partial response to the HOP Panel's March recommendations, on June 5 CMS published a statement indicating that it is considering allowing chemotherapy administration to be furnished under "general supervision" after the first or initial administration of chemotherapy occurs. In the statement, CMS states that it is seeking hospital presentations at the upcoming HOP Panel meeting about the specific question of whether the supervision level should be direct for the initial administration (first administration in a series of administrations of the same drug) followed by general for subsequent administrations of the same drug.

The next meeting of the HOP Panel is Aug. 25-26. The Panel will again listen to testimony from clinical professionals on general supervision. Hospitals may request a change in supervision level for any HOTS that have not previously been considered by the HOP Panel. A list of all of the HOTS that have already been considered by the HOP Panel was posted on CMS's websites in June 2014. Please see AHA's June 18 Action Alert for more information on how to testify.

Presently CMS's website lists 56 services that, as of July 1, 2014 are either designated as non-surgical extended duration therapeutic services or may be furnished under general supervision in accordance with applicable Medicare regulations and policies. All other HOTS require a minimum of direct supervision. Additional resources are available on the AHA website for Rural Hospital Issues.

Meeting Meaningful Use in 2014: On May 20, CMS and Office of the National Coordinator for Health Information Technology released a proposed rule that would allow hospitals and eligible professionals multiple pathways to meet meaningful use in 2014, including using the 2011 Edition Certified Electronic Health Record Technology to meet the meaningful use requirements in place for 2013. CMS says that beginning in 2015, all eligible hospitals and professionals would be required to use the 2014 Edition CEHRT to report meaningful use. The rule also proposes beginning Stage 3 of meaningful use in fiscal year (FY) 2017. The proposed rule does not change any of the individual requirements for Stage 2. The AHA submitted comments on June 17, supporting the flexibility and urging CMS to issue a final rule as quickly as possible. Additional resources are available on the AHA website for Meaningful Use.

Fire Safety Requirements for Health Care Facilities

On April 16, CMS released a proposed rule that would adopt in full the 2012 edition of the Life Safety Code (LSC). AHA has prepared a Regulatory Advisory on the proposed rule. For hospitals and CAHs, for example, CMS would require the following:

- The LSC defines "health care occupancy" as providing medical or other treatment or care simultaneously to four or more patients on an inpatient basis. CMS states that it will not make an exception for facilities with fewer than four patients. CMS states that, "All health care occupancies that provide care to one or more patients would be required to comply with the relevant requirements of the 2012 edition of the LSC."
- CMS would continue its prohibition related to roller latches.
- When a sprinkler system is out of service for more than four hours in a 24-hour period, the facility would need to evacuate or partially evacuate the building or establish a fire watch until the system is back in service.
- Hospitals and CAHs would need to have supply and exhaust systems in windowless anesthetizing locations that vent and prevent recirculation of smoke.
- Except for newborn nurseries and rooms intended for occupancy for less than 24 hours, every sleeping room would need to have an outside window or outside door, with specific sill heights.

Inpatient Admission Order & Certification and the 2-Midnight Benchmark: To review, the FY 2014 Hospital IPPS Final Rule described two distinct, although related, medical review policies:

- 2-midnight benchmark, which serves as guidance for admitting practitioners to identify when an inpatient admission is generally appropriate for payment and
- 2-midnight presumption of medical necessity which instructs Medicare review contractors.

On April 1, 2014, the President signed the Protecting Access to Medicare Act of 2014. Section 111 of this law:

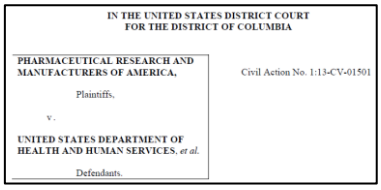
1. Permits CMS to continue medical review activities under the MAC Probe & Educate process through March 31, 2015, and
2. Prohibits CMS from allowing the Recovery Auditors to conduct inpatient hospital patient status reviews on claims with dates of admission October 1, 2013 through March 31, 2015.

CMS will continue the "Probe & Educate" process through March 31, 2015, and will continue to prohibit Recovery Auditor inpatient hospital patient status reviews for dates of admission occurring between October 1, 2013 and March 31, 2015. As of May 12, 2014, MACs have completed most first probe reviews, of 10 (or 25) claims, for providers within their jurisdiction, and are beginning to provide educational information related to the first probe period findings. AHA prepared a Special Bulletin on CMS guidance of its two-midnight policy.

Physician Certification of 96-hour Stay for CAHs: Also, as part of the FY 2014 Hospital IPPS Final Rule, Inpatient Admission Order and Certification, CMS clarified its guidance on physician certification of 96-hour stay for CAHs. As a condition of payment –a physician must certify that a beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission. If enforced, CAHs would be forced to eliminate services that would exceed 96 hours and beneficiaries would have to travel out of the community to access them. Additional information on physician certification of a 96-hour stay may be found on the AHA website.

Outpatient Therapy Caps: Medicare currently sets annual per beneficiary payment limits for outpatient therapy services PT, OT and speech provided by therapists and other eligible professionals. The law allows for an exceptions process to the cap if the therapy is deemed medically necessary. The SGR fix extended the therapy cap exceptions process through March 31, 2015. However, since January 1, 2014 the therapy cap applies to all Part B outpatient therapy settings including CAHs and hospital outpatient departments. This policy was reviewed in an AHA Regulatory Advisory.

LEGAL RESOURCES


IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

PHARMACEUTICAL RESEARCH AND MANUFACTURERS OF AMERICA,

Plaintiffs,

v.

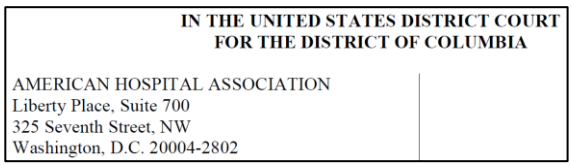
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*

Defendants.

Civil Action No. 1:13-CV-01501

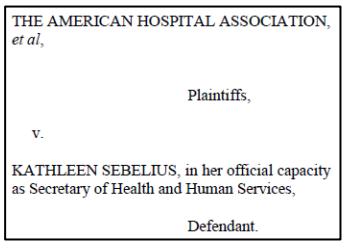
340B Drug Pricing Program: On May 27, the U.S. District Court for DC ruled against the HHS in a lawsuit brought by the Pharmaceutical Research and Manufacturers of America (PhRMA). HHS's 2013 final rule **allowed certain 340B hospitals to purchase orphan drugs** through the 340B program when they did not use the drugs to treat conditions for which the orphan drug designation was given. As a result of the court's ruling, **HHS's final rule is no longer in effect**. AHA supported HHS as a friend of the court because we believe that their interpretation in the rule was the only practical approach to preserve access for hospitals affected by the 340B Orphan Drug exclusion.

HHS and its Health Resources and Services Administration recently said on its website that it will continue to allow certain hospitals to purchase "orphan drugs" through the 340B Drug Pricing Program when the drugs are not used to treat the orphan condition. HRSA also posted updated orphan drug designation lists and an orphan drug selection file to assist 340B stakeholders in complying with HRSA's policy.


IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLUMBIA

AMERICAN HOSPITAL ASSOCIATION
Liberty Place, Suite 700
325 Seventh Street, NW
Washington, D.C. 20004-2802

On May 22, AHA filed a complaint in the U.S. District Court for DC, this time to compel HHS to meet statutory deadlines for timely review of Medicare claims denials. Medicare law requires an Administrative Law Judge (ALJ) to hold a hearing and **render a decision within 90 days** of the filing of the appeal request. HHS's Office of Medicare Hearings and Appeals imposed in December a moratorium on assigning new appeals to ALJs, **leaving 480,000 appeals** awaiting assignment to an ALJ as of Feb. 12. Under the moratorium, hospitals **could wait 3 years or more** for a hearing on newly filed appeals.


THE AMERICAN HOSPITAL ASSOCIATION, *et al*,

Plaintiffs,

v.

KATHLEEN SEBELIUS, in her official capacity as Secretary of Health and Human Services,

Defendant.

On March 10, in a supplemental brief filed in federal court, AHA and five hospital systems deny that policy changes last March or in the final inpatient prospective payment system rule for fiscal year 2014 make their legal challenge to the CMS rebilling policy moot. The lawsuit challenges CMS's attempt to evade responsibility for paying under Part B for significant numbers of previously denied claims that the agency said could not be rebilled when it applied a policy that it now admits was unlawful.

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 Jumel Ola, Section for Small or Rural Hospitals, at (312) 422-3345. Applications are due July 25.

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.