Small or Rural Update

Yuma District Hospital, Yuma, CO

Winona Health, Winona, MN

Winter 2014-15

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). *Small or Rural Update* gives our members news on legislative and regulatory activities, as well as updates on Section programs and services. This issue of *Small or Rural Update* reviews the federal budget, legislative advocacy and regulatory policy, and examines proposed rules for Medicare payment, and more.

ADVOCACY AND THE FEDERAL BUDGET

2015 Fiscal Year Federal Budget: Congressional leaders agreed on a $1.01 trillion spending bill, the Consolidated and Further Continuing Appropriations Act, which funds most federal agencies through Sept. 30, 2015. Now signed into law, this measure provides full funding for 11 of the 12 individual annual spending bills; it extends funding for the Department of Homeland Security only through early 2015.

The law provides a total of $5.4 billion in emergency funding to combat Ebola internationally and domestically. It allocates funding for a number of efforts that hospitals are undertaking to prepare for and respond to Ebola. Access our special Ebola Preparedness Resources for up-to-date guidance from the CDC and other authorities, AHA advisories and additional helpful resources.

The appropriations measure provides $147.5 million for rural health. Among other areas, the measure provides $59 million in rural outreach grants, $41.6 million for rural hospital flexibility grants and $14.9 million for telehealth. The law requires the Health Resources and Services Administration (HRSA) to report to the Appropriations committees by March 3, 2015, on its progress in making 340B ceiling prices available to covered entities through a website. In addition, the law directs HRSA to work with covered entities to better understand the way these entities support direct patient benefits from 340B discounted sales.

For more on the bill and the provisions important to hospitals, see the AHA Special Bulletin for members.

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. The fix is paid for in part by ensuring accuracy under the physician fee schedule and by extending the sequester through 2024 by doubling the cuts in the first six months of 2024 to 4 percent, but eliminating it in the last six months of that year.

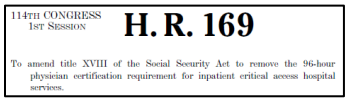
ACA Medicaid Parity Sunset December 31: Under the ACA, state Medicaid programs must pay primary care physicians Medicare rates for primary care services. Federal funding for the two-year payment enhancement expired at the end of 2014. While some state Medicaid programs are planning to extend the enhanced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

Ways and Means FY 2016 Budget Discussion Draft: In late 2014, the House Committee on Ways and Means Subcommittee on Health Chairman Kevin Brady (R-TX) released a draft bill "Hospital Improvements for Payment Act of 2014," which includes items such as HR 3769, HR 3991 and HR 4781, as well as language on Medicare's recovery audit contractor program, "two-midnight" policy and short inpatient stays; the CMS's 96-hour physician certification requirement for CAHs; adjustments to the Hospital Readmissions Reduction Program; and physician self-referral to hospitals in which they have an ownership interest, among other topics. Although the bill was not brought to the floor of the house for consideration, it serves as a discussion draft for future legislation.

In our comments, AHA expressed appreciation for the committee's attempt to offer a solution to issues related to patient status determinations, the two-midnight policy and the overwhelming number of claims in the appeals process, but noted the proposal "is complex, confusing and administratively burdensome." In addition, AHA said many of the RAC-related proposals "fall far short of what will be necessary to reduce excessive and inappropriate denials by RACs and alleviate the administrative and financial burden the RAC program imposes on hospitals and the administrative appeals process." AHA urged the committee to consider additional fundamental RAC program reforms. AHA also voiced strong opposition to any changes in the Affordable Care Act to the limits on physician self-referral to hospitals in which they have an ownership interest.

LEGISLATIVE ADVOCACY

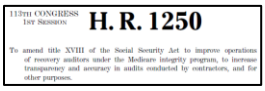
New Business: The advocacy agenda for rural hospitals targets unfinished business from the 113th Congress. Also, it includes new legislation that was recently introduced in the 114th Congress.

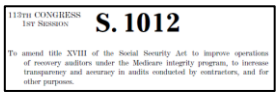

114TH CONGRESS
1ST SESSION
H. R. 169
To amend title XVIII of the Social Security Act to remove the 96-hour physician certification requirement for inpatient critical access hospital services.

Critical Access Hospital Relief Act (H.R.169) would remove the 96-hour physician certification requirement as a condition of payment for CAHs. Specifically, H.R. 169 would remove the condition of payment but leave 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. AHA shared its support for the recently introduced legislation in a letter to Rep. Adrian Smith (R-KS).

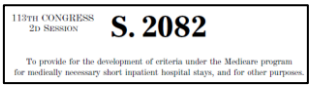
Flexibility in Health IT Reporting (Flex-IT) Act of 2015 (H.R. 270) requires CMS to make a necessary adjustment to how it implements the Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs. The Flex-IT Act reduces the reporting period to one quarter of FY 2015 (rather than an entire year), whereby hospitals must report to CMS that they are using a 2014 Edition Certified EHR and meeting many more regulatory performance requirements. AHA shared its support for the recently introduced legislation in a letter to Rep. Renee Ellmers (R-NC).

Unfinished Business: The advocacy agenda for hospitals addresses bills introduced but not acted upon in the 113th Congress, but need to be fixed permanently. Advocacy priorities include legislation that has been introduced in Congress for all hospitals, including rural, such as:

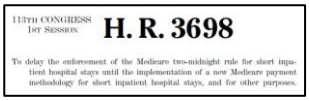

113TH CONGRESS
1ST SESSION
H. R. 1250
To amend title XVIII of the Social Security Act to improve operations of recovery auditors under the Medicare integrity program, to increase transparency and accuracy in audits conducted by contractors, and for other purposes.


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.

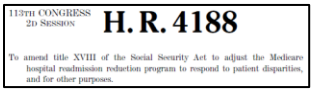
Medicare Audit Improvement Act (H.R. 1250/S. 1012) would establish a consolidated limit for medical record requests, impose financial penalties on RACs that fail to comply with program requirements, make RAC performance evaluations publicly available and allow denied inpatient claims to be billed as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

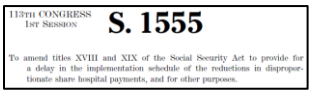
Two-Midnight Rule Coordination and Improvement Act (S. 2082) would require CMS to implement a new payment methodology for short inpatient stays in FY 2015.

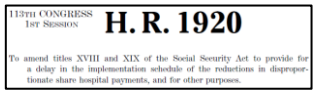

113TH CONGRESS
1ST SESSION
H. R. 3698
To delay the enforcement of the Medicare two-midnight rule for short inpatient hospital stays until the implementation of a new Medicare payment methodology for short inpatient hospital stays, and for other purposes.

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
2D SESSION
H. R. 4188
To amend title XVIII of the Social Security Act to adjust the Medicare hospital readmission reduction program to respond to patient disparities, and for other purposes.

Establishing Beneficiary Equity in the Hospital Readmission Program Act of 2014 (H.R. 4188) would adjust the Medicare Hospital Readmissions Reduction Program to account for certain socioeconomic and health factors that can increase the risk of a patient's readmission, such as being eligible as a dual-eligible under Medicaid as well as Medicare.

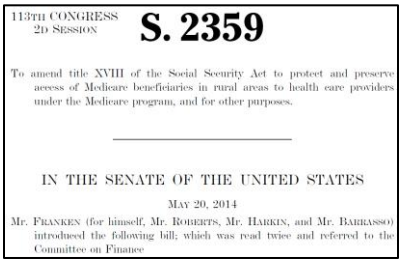

113TH CONGRESS
1ST SESSION
S. 1555
To amend titles XVIII and XIX of the Social Security Act to provide for a delay in the implementation schedule of the reductions in disproportionate share hospital payments, and for other purposes.


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.

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

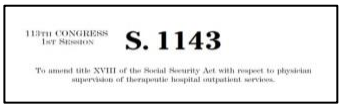
MAY 20, 2014

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) 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.

Extension of Moratorium on Enforcement of Direct Supervision: The president signed into law H.R. 4067, AHA-supported legislation that extended to all of calendar year 2014 the enforcement moratorium on the outpatient therapeutic services "direct supervision" policy for critical access hospitals and rural prospective payment system hospitals with 100 or fewer beds. CMS's direct supervision policy requires a supervising physician or non-physician practitioner to be immediately available whenever a Medicare patient receives outpatient therapeutic services; general supervision allows the service to be performed under the overall direction and control of a physician or non-physician practitioner without them being present.


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 AHA also supports passage of the **Protecting Access to Rural Therapy Services Act (H.R. 2801/S. 1143),** legislation that would allow general supervision by a physician or non-physician practitioner for many outpatient therapy services, ensuring rural residents can continue to receive a range of outpatient services in their communities.

REGULATORY AND POLICY PRIORITIES

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

Implementing the Veteran's Choice Act: In August, Congress enacted the Veterans Choice Act, which enables veterans to see a local, non-VA provider if they reside farther than 40 miles from a VA site of care or if they face an appointment wait time of longer than 30 days. Coverage through the new Choice program began **November 5**. Veterans who live at least 40 miles from a VA facility, those who are currently waiting for an appointment longer than 30 days from their preferred date or the date deemed medically necessary by their referring physician, and those veterans enrolled in VA health care who may be eligible for the Choice Program in the future **have already been mailed a Veterans Choice Program card and may come to you for their care**. However, before providers can be reimbursed for providing care to eligible veterans, they must sign a participation agreement. More information is forthcoming, but in the meantime, if you have questions please visit the Veterans Choice web site at: www.va.gov/opa/choiceact/ or call the VA at 866-606-8198.

ICD-10 Delays: In a letter to congressional leaders, the AHA and six other organizations representing hospitals voiced their strong support for the Oct. 1, 2015, transition to the ICD-10 coding system and urged Congress to avoid any further delays in the implementation date. Recent ICD-10 implementation delays have been disruptive and costly for hospitals and health systems, as well as to health care delivery innovation, payment reform, public health and health care payment. ICD-9 is outdated and ICD-10 is needed to keep up with advances in medicine and ensure accurate payment. To view the letter, see "Letters" under Advocacy Issues at www.aha.org.

340B Drug Pricing Program: In September, AHA sponsored a briefing on Capitol Hill to educate congressional staff about the many benefits the 340B Drug Pricing Program provides to low-income patients and communities. The 340B program has faced increased criticism from some drug manufacturers and certain interest groups, and oftentimes, many of the program's important benefits are overlooked.

Despite the program's proven track record of decreasing government spending and expanding patient access to medical services, some policymakers and interest groups want to scale it back or significantly reduce its benefits. In addition, some groups continue to spread misinformation about the program. "Setting the Record Straight on 340B" attempts to separate fact versus fiction on the 340B program.

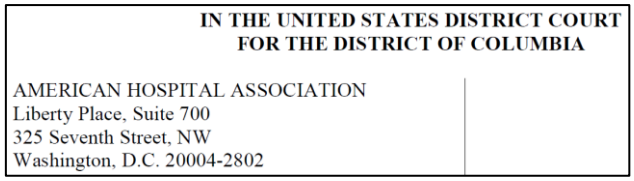
340B 'Mega Rule' Withdrawn, Guidance Coming: The Health Resources and Services Administration (HRSA) has withdrawn a proposed "mega rule" for the 340B Drug Pricing Program, and instead plans to issue guidance on key policy issues beginning in 2015, the agency announced. HRSA said there will be an opportunity for the public to comment on the guidance it issues. The 340B Drug Pricing Program is vital to so many vulnerable patients and communities. We look forward to engaging with HRSA when it issues the interpretative guidance.

ACA Health Insurance Marketplace Enrollment: The Federal Office of Rural Health Policy (FORHP) has posted new outreach and enrollment resources on its website, including a

Best Practices Guide In Rural Outreach and Enrollment. Drawing on information from grantee experiences during the first period of Open Enrollment, this Best Practices Guide chronicles best practices and common challenges that affect outreach and enrollment activities in rural communities. The strategies in this Best Practices Guide echo the findings published by the North Carolina Rural Health Research Program's recent brief, "Best Practices for Health Insurance Marketplace Outreach and Enrollment in Rural Areas" and complements the research presented in the University of Minnesota Rural Health Research Center's brief, "Successful Health Insurance Outreach, Education, and Enrollment Strategies for Rural Hospitals," which delved more specifically into hospital engagement in outreach and enrollment. Open Enrollment in the Marketplace began November 15, 2014, and runs through February 15, 2015. Consumers should visit HealthCare.gov to review and compare health plan options.

ACA Enrollment data from the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) now includes a rural-urban data cut, which shows that 18 percent of those individuals selecting 2015 Marketplace plans on Healthcare.gov live in rural areas. The December Enrollment Report also notes that the majority of individuals selecting 2015 Marketplace plans on Healthcare.gov selected silver plans (68 percent).

LEGAL RESOURCES


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

Delays in Medicare Hearings and Appeals: The District of Columbia federal district court Dec. 18 dismissed a lawsuit brought by the AHA and several hospitals to compel the department to meet the statutory deadline of reviewing Medicare claims denials within 90 days at the third level of appeals. The AHA is poised to appeal the court's opinion. The AHA sued HHS over the backlog last May. Hospitals contend that it can take up to five years to appeal claims denials.

Payment Obligations Under the Medicaid Act: The AHA and Federation of American Hospitals a friend-of-the-court brief urged the Supreme Court to affirm a 9th Circuit Court of Appeals decision upholding the right of health care providers to take states to court when they fail to live up to their payment obligations under the Medicaid Act. In 2012, the cost of providing care to Medicaid beneficiaries exceeded reimbursements by $13.7 billion, up from $11.3 billion in 2009. The appeal was filed by Idaho Medicaid officials.

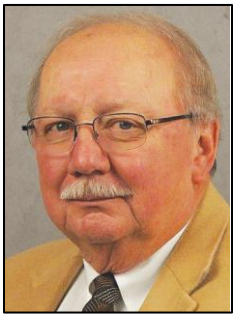
RURAL HEALTH WORKFORCE

Rural areas often lack adequate numbers of health care providers and thus are nationally identified through designations such as Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUAs/MUPs). These designations are important in determining eligibility for a variety of programs, such as the National Health Service Corps. To streamline the designation process, HRSA's Bureau of Health Workforce has created the Shortage Designation Management System (SDMS). The SDMS uses a number of federal data sources such as Census information, CDC data and National Provider

Identifier (NPI) Standard data to facilitate a more coordinated approach to shortage designation. The Bureau of Health Workforce will provide information on the revised process.

Workforce continues to be an important policy issue for rural communities. The HRSA Workforce Simulation Model (HWSM), a new resource from the National Center for Health Workforce Analysis, includes projections on health care provider supply. This includes findings related to pharmacists, occupational and physical therapists, and vision occupations.

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. As CEO of Chadron (Neb.) Community Hospital & Health Services, Harold Krueger has harnessed the power of broadband communications to reshape rural health care in western Nebraska, eastern Wyoming and southern South Dakota, while extending his hospital's reach deep into the rural communities it serves. That commitment to enhancing care and communication through information technology (IT) and building healthier communities through outreach has helped earn Krueger the AHA's 2014 Shirley Ann Munroe Leadership Award.

28TH ANNUAL RURAL HEALTH CARE LEADERSHIP CONFERENCE

The 2015 Rural Health Care Leadership Conference brings together top practitioners and thinkers to share strategies and resources for accelerating the shift to a more integrated, high performing and sustainable rural health care system. Visit **http://www.aha-slhq.org/** to learn more.

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

For more information, contact John Supplitt, senior director, AHA Section for Small or Rural Hospitals, at (312) 422-3306 or jsupplitt@aha.org.