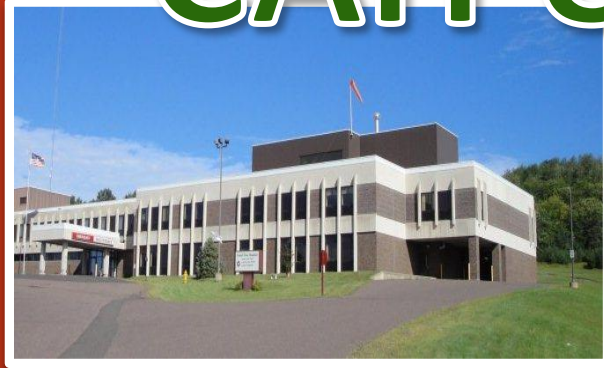


# CAH Update



**Aspirus Grand View Hospital  
Ironwood, MI**



**Caro Community Hospital  
Caro, MI**

## December 2015

### THE FEDERAL BUDGET

The president Nov. 2 signed into law the Bipartisan Budget Act to raise the nation's debt limit and set spending targets for the federal budget for the next two fiscal years. The law extends the debt ceiling to March 2017 and raises the discretionary spending caps imposed in 2011 under sequestration by \$80 billion above current levels, split evenly between defense and non-defense spending. It also staves off an impending increase in Medicare Part B premiums for millions of seniors. The cost is offset in part by extending the 2% Medicare sequester for an additional year. An equally troubling offset is the implementation of site-neutral payments for new off-campus provider-based (PB) hospital outpatient departments (HOPDs) – those that started to bill Medicare under the outpatient prospective payment system (OPPS) on or after the date of enactment of the bill. This provision was strongly opposed by the AHA.

The AHA is urging legislators to make technical corrections to the Bipartisan Budget Act to allow PB HOPDs already under development to qualify as grandfathered facilities. We also seek to clarify that changes in ownership of a facility do not impact the grandfathered status of a PB HOPD and that grandfathered HOPDs may relocate when they meet criteria determined by the Secretary of Health and Human Services. Visit AHA's [Action Center](#) for the latest alert, factsheet and FAQs on this issue.

### TASK FORCE ON ENSURING ACCESS IN VULNERABLE COMMUNITIES

AHA's Task Force on Ensuring Access in Vulnerable Communities is working to confirm the characteristics of vulnerable rural and urban communities and identify strategies and federal policies to help ensure access to care in these areas. A 30-member task force consists of two subcommittees that are examining the issue from the rural and inner-city perspective. For a complete list of task force members, click [here](#).

The AHA will be holding three field hearings across the country to gather member feedback related to the items that are being examined by the task force. The dates and locations for the first two field hearings have been confirmed:

- Wednesday, January 27, 2016 at the Hilton Chicago O'Hare Airport from 2:30 pm to 5 pm.
- Tuesday, February 9, 2016 at the Arizona Grand Hotel in Phoenix, AZ from 1:30 to 4:15 pm (this hearing will be held during the AHA Health Forum's Rural Leadership Conference).

The third field hearing will be held in March in Atlanta, Georgia. More details related to that field hearing as well as the general format and structure of the field hearings will be released on this website in the near future. If you are interested in participating in any of these field hearings, please click [here](#) to register.

### **AHA ADVOCACY AGENDA FOR RURAL HOSPITALS**

Medicare and other federal programs must account for the special circumstances of rural communities. The AHA works to ensure they do so by focusing on protecting vital funding, securing the future of existing special rural payment programs – including the critical access hospital (CAH), sole community hospital (SCH), Medicare-dependent hospital (MDH) and rural referral center (RRC) programs – and relieving regulatory burden. AHA's advocacy agenda for rural hospitals targets several priorities.

- **Critical Access Hospital Relief Act** (S. 258/H.R. 169), this legislation would remove the 96-hour condition of payment but leave the condition of participation intact.
- **The Protecting Access to Rural Therapy Services (PARTS) Act** (S. 257/HR 1611), would adopt a default standard of “general supervision” for most outpatient therapeutic services, among other provisions. The legislation would also hold hospitals and CAHs harmless from civil or criminal action regarding CMS's retroactive reinterpretation of “direct supervision” requirements for the period 2001 through 2015. Recently, the House of Representatives passed by unanimous consent AHA-supported legislation (S. 1461) that would delay through December 2015 enforcement of direct supervision requirements for outpatient therapeutic services provided in critical access hospitals and certain small, rural hospitals. The bill cleared the Senate in September and now goes to President Obama for his signature.
- **Rural Community Hospital Demonstration Extension Act** (S. 607/H.R. 672) would extend for five years the demo program, which enables small rural hospitals with fewer than 51 acute care beds to test the feasibility of cost-based reimbursement.
- **The Rural Hospital Access Act of 2015** (S. 332/H.R. 663) would make permanent both the Medicare-dependent Hospital program and the enhanced low-volume Medicare adjustment for small rural PPS hospitals.
- **Medicare Ambulance Access, Fraud Prevention, and Reform Act of 2015** (S. 377/HR 745) is legislation that would permanently extend add-on payments for ambulance services in rural areas and directs the Secretary HHS to study how the additional payments should be modified to account for the costs of providing ambulance services in urban, rural, and super-rural areas.

Legislation introduced in Congress this session draws our attention to the need for new strategies for payment and models of delivery to serve rural communities. AHA agrees conceptually that more must be done and this legislation is a good starting point for discussion.

- **Rural Emergency Acute Care Hospital Act** would allow CAHs and PPS hospitals with 50 or fewer beds to convert to Rural Emergency Hospitals (REH). REHs would provide emergency and outpatient services, but not inpatient care at enhanced reimbursement rates of 110% of reasonable costs.
- **Save Rural Hospitals Act** addresses beneficiary equity for outpatient services, regulatory relief, a new model for delivery of emergency care, and several Medicare extenders.

## **RULEMAKING AND REGULATORY POLICY**

Medicare policy changes and payment adjustments often have significant and problematic consequences for rural providers. AHA is sensitive to the administrative burden and cost created by rules that fail to consider the unique circumstances of small or rural community hospitals.

**Outpatient Prospective Payment System.** In late October, CMS issued a [final rule](#) for calendar year 2016 for the hospital OPSS and ambulatory surgical center payment system. Under the rule, CMS finalized its proposal to alter its “two-midnight” policy so that certain hospital inpatient services that do not cross two midnights may be considered appropriate for payment under Medicare Part A if a physician determines and documents in the patient’s medical record that the patient required reasonable and necessary admission to the hospital. CMS makes no changes for stays that last at least two midnights. CMS delayed enforcement of two-midnight policy through Dec 31 to align with the OPSS final rule. Nevertheless, AHA is pushing CMS to further extend this delay until March 31 to give hospitals and contractors time to implement policies that were finalized on Oct. 30.

The agency also restates the changes it announced to its medical review strategy in the OPSS proposed rule – namely, CMS now requires Quality Improvement Organizations to conduct first-line medical reviews of the majority of patient status claims rather than the Medicare Administrative Contractors or RACs, which will focus only on those hospitals with consistently high denial rates.

AHA has a [Regulatory Advisory](#) for CY 2016 that is both the hospital outpatient/ASC payment systems and the physician fee schedule for those seeking more information. The rule is effective Jan. 1, 2016.

**Physician Fee Schedule.** In late October, CMS [finalized](#) a payment increase of 0.5% for the physician fee schedule for calendar year 2016, as required by the Medicare Access and CHIP Reauthorization Act of 2015. The rule also finalizes CMS’s proposal to pay for advanced care planning services, which include explanation and discussion of advance directives by a physician or other qualified health professional.

CMS is extending the Chronic Care Management (CCM) benefit to rural health clinics (RHCs). Beginning on January 1, 2016 RHCs who furnish a minimum of 20 minutes per month of CCM services to qualifying patients may begin billing for these services. RHCs would also be subject to all the other requirements of providing CCM services such as having up-to-date EHR software,

maintaining an electronic beneficiary care plan, and beneficiary consent. CMS proposes to waive the face-to-face requirement in order to allow CCM services to be billed as part of the RHC benefit.

CMS requires that all RHCs must report all services furnished during an encounter using standardized coding systems beginning April 1, 2016.

AHA has a [Regulatory Advisory](#) for the Medicare physician fee schedule final rule. Changes generally will be effective Jan. 1, 2016.

**Discharge Planning Requirements for Transfers and Post-acute Services.** CMS issued a [proposed rule](#) revising discharge planning requirements for hospitals including long-term care hospitals and inpatient rehabilitation facilities, psychiatric hospitals, critical access hospitals and home health agencies that participate in the Medicare and Medicaid programs. The rule revises current discharge planning requirements and implements discharge-related provisions of the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014.

The proposed rule would require hospitals and CAHs to create discharge plans for all inpatients, as well as some outpatients, including observation patients; same-day patients receiving anesthesia or moderate sedation; emergency department patients whom a practitioner identifies as needing a discharge plan; and other categories of outpatients recommended by the medical staff and specified in the hospital's discharge planning policies approved by the governing board. The discharge planning process would need to focus on the patient's goals and preferences and prepare patients and their caregivers to be active partners in post-discharge care.

Hospitals and CAHs would need to establish a post-discharge follow-up process for at least some patients discharged to home, although CMS does not specify the mechanism or timing of follow-up programs. Instead, the agency emphasizes the importance of ensuring that hospitals follow up "with their most vulnerable patients, including those with behavioral health conditions." When transferring patients, hospitals, CAHs and home health agencies would be required to provide specific medical information to the receiving facility.

AHA has a [Regulatory Advisory](#) for those seeking additional information. Comments are due January 4, 2016.

**340B Omnibus Guidance.** HRSA's long awaited "Mega Guidance" on 340B was published on Aug. 28. AHA filed its comments with the agency in an Oct. 27 [letter](#).

AHA contends that the omnibus guidance as proposed would jeopardize hospitals' ability to serve vulnerable populations, including low-income and uninsured individuals and patients receiving cancer treatments. Strong objections were raised to many of the agency's proposals related to defining patient eligibility for the program. The AHA opposed HRSA's proposal to exclude from 340B pricing outpatient drugs that are reimbursed as part of a bundled Medicaid payment. Among other changes, AHA urged HRSA to withdraw a proposal so that patients receiving infusion services provided at 340B hospitals or their outpatient sites continue to qualify for 340B drug discount pricing. For more information, visit AHA's [340B Advocacy Alliance](#) and [www.aha.org/Protect340B](http://www.aha.org/Protect340B), our public site.

**340B Orphan Drug Litigation.** A lawsuit brought by the Pharmaceutical Research and Manufacturers of America challenged the Department of Health and Human Services' (HHS) 2014 interpretative rule that continued to allow hospitals subject to the orphan drug exclusion to purchase orphan drugs through the 340B program when the drugs are not used to treat the rare conditions for which the orphan drug designation was given. The U.S. District Court for the District of Columbia Oct. 14 ruled against HHS, and AHA expressed disappointment with the court ruling because it would deny rural and cancer hospitals access to these 340B discounts and reduce access to critical services and treatments for some of the most vulnerable patients in society. The AHA filed two [friend-of-the-court briefs](#) in support of HHS.

**Electronic Health Record (EHR) Incentive Program.** CMS on Oct. 16 published a final rule with comment for the Electronic Health Record (EHR) Incentive Program that makes modifications to meaningful use requirements in 2015 through 2017 and sets the start date for Stage 3 of the program as Jan. 1, 2018. AHA has a [Regulatory Advisory](#) that outlines the modifications and criteria in detail.

CMS finalizes numerous changes to the meaningful use requirements with the intent to streamline the program and better align it with Stage 3. CMS finalizes a 90-day reporting period for all providers in 2015, as proposed and also finalizes a change to the reporting period for EHs and CAHs from the fiscal year to the calendar year, aligning it with the reporting period for physicians and other EPs. Other items of particular interest to hospitals, address the e-prescribing, health information exchange, patient portal, summary of care and public health reporting requirements.

CMS finalizes that Stage 3 be optional for providers in CY 2017 and required for all providers beginning in 2018. CMS finalizes a set of eight objectives for all providers for Stage 3 in 2018. Limited variation would be permissible among the measures required of all EHs, CAHs and EPs.

AHA believes the goals as established by CMS are unrealistic and unattainable. More than 60% of hospitals and about 90% of physicians have yet to attest to Stage 2. The Stage 3 rule is too much too soon. Additional information on the [Medicare and Medicaid EHR Incentive Programs](#) is available at [www.aha.org](http://www.aha.org).

**Veterans Choice Program.** The Department of Veterans Affairs issued a [final rule](#) in late October for the Veterans Choice Program, which continues to use driving distance to determine the distance between a veteran's residence and the nearest VA medical facility. The Veterans Access, Choice and Accountability Act of 2014 requires the VA to enter into agreements with eligible non-VA entities or providers to furnish hospital care and medical services to eligible veterans who elect to receive care under the program. Eligibility criteria include living more than 40 miles from the nearest VA facility.

In the final rule, VA said it plans to publish a separate rulemaking announcing the criteria it will use to determine veteran eligibility based on the Construction Authorization and Choice Improvement Act of 2015, which allows the secretary to determine criteria for an unusual or excessive burden in traveling to a VA medical facility.

**ICD-10.** AHA has been working with CMS to ensure a smooth transition and continues to provide member resources, such as the recent "[ICD-10 Homestretch](#)" checklist, and a [Member Advisory](#) on post-transition issues. CMS reports that "claims are processing normally" and released data from Oct. 1 through Oct. 27 for Medicare fee-for-service claims that were submitted, rejected and denied, and

the results are consistent with data prior to ICD-10. We continue to monitor closely, however, as most claims submitted in early Oct. will be paid in the coming weeks.

**Payment Bundle Goals and Programs.** CMS on Nov. 16 finalized a new payment model that will bundle payment to acute care hospitals for hip and knee replacement surgery. Under this [Comprehensive Care for Joint Replacement](#) (CJR) model, the hospital in which the lower extremity joint replacement takes place will be held financially accountable for quality and costs for the entire episode of care, from the date of admission through 90 days post-discharge. According to CMS, the model will be implemented in 67 geographic areas across the country and mandatory for most hospitals in those areas. CMS delayed the start date of the CJR model from Jan. 1, 2016 to April 1, 2016. While CAHs are excluded from the CJR model, they are implicated in the program. For example, post-acute care services and CAH swing bed services will be bundled with the referring hospital – notwithstanding patient choice. The motivation will be on becoming the best value provider.

AHA has a [Regulatory Advisory](#) for those seeking additional information.

### **CMS SURVEY AND CERTIFICATION OF CAHS**

In a Nov. 17 [letter](#) to Andrew Slavitt, CMS's acting administrator, the AHA expressed concern that the agency's recently expressed requirements around the documentation necessary to support a CAH's necessary provider (NP) designation are inappropriate and unnecessarily limited (see discussion below on CMS's recent transmittals). In fact, we believe they may very well have the dire consequence of causing many CAHs to lose the designation that they rightfully obtained prior to 2006. We have urged CMS to immediately remedy this issue by revising its requirements to allow alternative methods of documentation. If you have any questions, please contact Priya Bathija, senior associate director, AHA Policy, at (202) 626-2678 or [pbathija@aha.org](mailto:pbathija@aha.org).

**CMS Transmittal 138, Appendix W, State Operations Manual for CAHs:** On April 7, guidance was revised to reflect recent regulation changes. CMS also uses this transmittal to make clarifications and updates to existing guidance for patient care policies like staffing and drugs and patient services including lab, radiology, emergency, and nursing.

**Clarification of CAH Rural Status, Location and Distance Requirements:** A CMS memorandum ([S&C 15-45-CAH](#)) from the Survey & Certification (S&C) Group to the State Survey Agency Directors dated June 26, 2015 reminds all parties that [S&C-13-20](#), issued March 15, 2013, updated the interpretive guidelines to clarify that a CAH must meet the location and distance requirements not only at the time of its initial conversion to CAH status, but at all times thereafter. It also reviews the definition of primary roads and mountainous terrain referenced in [S&C 13-26](#) sent to states on April 19, 2013.

**CMS Transmittal 143, Revisions to State Operations Manual (SOM) Chapter 2, The Certification Process and Interpretive Guidelines for CAHs:** In [Transmittal 143](#), CMS is informing State Survey Agencies (SAs) that revisions are being made to rules concerning loss of rural status due to adoption of the latest OMB MSA delineations. In addition, CMS explains that additional revisions are needed to clarify existing guidance related to requirements concerning CAH location

requirements relative to other CAHs or hospitals. CMS is careful to explain that only the RO makes the determination whether a CAH applicant or existing CAH meets the rural location requirement. However, SAs may wish to make informal assessments prior to conducting a survey, following the guidance provided in Section 2256A of the SOM.

Necessary provider CAHs that were designated prior to January 1, 2006 are grandfathered by statute, subject to certain conditions if they relocate. According to Transmittal 143, “ROs and SAs should have the documentation related to a CAH’s original designation as a necessary provider in the file on each CAH.” If they do not, SAs may ask the CAH to supply copies of the original necessary provider designation documents.

**CMS Transmittal 145, Revisions to State Operations Manual**, New Exhibit 356 added to Chapter 9, Critical Access Hospital Recertification Checklist: Rural and Distance or Necessary Provider Verification. This document describes the process used by the RO to determine compliance with distance and location requirements for a CAH and the documentation requested from the SA to help them with this determination.

**CMS Transmittal 148, Revisions to State Operations Manual, Model Termination Letter:** Includes the model correspondence CMS will use to terminate CAHs that are not eligible due to distance and location or for other purposes.

## GRANTS

The Federal Office of Rural Health Policy (FORHP) is currently accepting applications for the [Rural Health Network Development Planning Program](#). The purpose of the Network Planning program is to assist in the development of an integrated healthcare network, if the network participants do not have a history of formal collaborative efforts.

Previously funded projects supported workforce retention and recruitment, behavioral health, telehealth, care coordination and health information technology. FORHP specifically mentions that communities with emergency medical services and a hospital that has closed or is at risk of closing are encouraged to apply.

The deadline to apply is Jan.8, 2016. To answer questions and assist applicants, FORHP recently held a **technical assistance webinar**. To access materials shared, enter as a guest at <https://hrsa.connectsolutions.com/networkplanningtawebinar/>; conference line (for audio): 800-593-0693, passcode: 2922383. For more information, contact Amber Berrian at [aberrian@hrsa.gov](mailto:aberrian@hrsa.gov).



The **Rural Health Care Leadership Conference** continues to bring a unique focus on innovation, thoughtful insights, and tested strategies for improving rural health care and developing the thoughtful leadership that can produce results. Please [join us](#) in Phoenix, Feb. 7 – 10.

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](mailto:jsupplitt@aha.org).

