CAH UPDATE

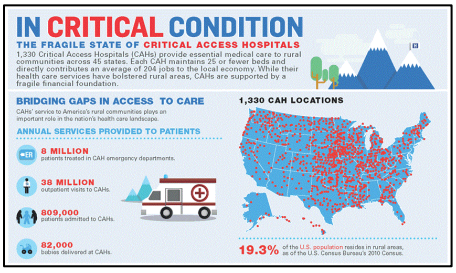
Chadron Community Hospital
Chadron, NE

Boone County Hospital
Boone, IA

Spring 2015

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). This issue of *CAH Update* reviews the fragile state of CAHs and the policy emerging from the Centers for Medicare & Medicaid Services (CMS), the Health Resources and Services Administration (HRSA) and the Office of Inspector General (OIG). It also reviews AHA's main concern for advocacy, federal policy and rulemaking.

THE FRAGILE STATE OF CAHS



The **fragile state of CAHs** is illustrated in an AHA infographic and well-documented in other resources. Proposed budget cuts by the President and Congress, as well as recommendations included in reports published by the Health and Human Services (HHS) Office of Inspector General (OIG), if implemented through legislation, would challenge the continued viability of many CAHs and threaten beneficiaries' access to care in rural America.

OIG Report on Swing-Bed Reimbursement Rates

Recently the OIG recommended CMS seek legislation to reduce swing-bed reimbursement rates for CAHs from 101% of reasonable costs to the daily rates paid under the skilled nursing facility (SNF) prospective payment system (PPS). The OIG report estimates that Medicare could have saved $4.1 billion between 2005 and 2010 if CAHs were paid for swing-bed services using SNF PPS rates.

In comments included in the report, CMS disagreed with the recommendation, stating the OIG finding "overestimates savings by failing to incorporate important factors such as the level of care

needed by swing-bed patients, transportation fees to alternative facilities, and the use of point-to-point mileage distances instead of road miles." The agency also expressed concerns with the methodology used to determine the findings on availability of skilled nursing services at nearby alternative facilities and the calculation of cost savings.

AHA commented that the report demonstrates an unfortunate lack of understanding of how health care is delivered in rural communities and inappropriately focuses on potential Medicare savings, instead of ensuring Americans in rural areas have access to the right care, at the right time, and in the right place. The AHA continues to strongly advocate for maintaining the CAH program as it is currently.

CMS Letters on Location and Distance Requirements

In addition, AHA is aware of **letters sent by CMS to CAHs** requesting hospitals respond within 15 days of notification by providing documentation regarding compliance with the location and distance requirements prior to a facility's recertification survey. Although the letters were quickly rescinded, this act signals that future licensure surveys may require evidence that a CAH is a necessary provider or otherwise meets the requirements for location and distance.

FISCAL CLIFFS

SGR Fix

Last year's temporary fix to a scheduled cut to Medicare physician payments ends March 31. As that deadline approaches, House leaders are considering a bipartisan package that would eliminate the sustainable growth rate (SGR) and extend funding for two years for the Children's Health Insurance Program (CHIP), which is set to expire in September. The bipartisan agreement represents a compromise for both parties. Republicans are agreeing to not paying for a large portion of the bill in exchange for structural reforms to the Medicare Program. Democrats are able to permanently address the flawed SGR system without having to fully offset the bill. Without another short-term remedy or the passage of a replacement plan, physicians would see a 21 percent cut in Medicare payments on April 1.Watch for AHA Special Bulletins and Countdown emails for the latest updates on SGR fixes.

FY 2016 Federal Budget

Budget season is underway with the President submitting his request to Congress on Feb. 2. The House and Senate are scheduled to complete their respective budget resolutions by April 15.

President's Budget Request

President Obama requested $431.3 billion in reductions to Medicare, of which $349.8 billion would come from providers and $83.8 billion would come from structural reforms.

Among other Medicare-related changes, the plan would:

- Substitute savings for the Budget Control Act's sequestration
- Reduce bad debt payments to providers by $31.1 billion
- Implement site-neutral payments to providers saves $29.5 billion
- Reduce Medicare GME payments by $16.3 billion
- Reduce CAH payments from 101 to 100 percent by $1.73 billion
- Eliminate CAHs within 10 miles for savings of $770 million.
- Implement bundled post-acute care payments saving $9.3 billion
- Expand Medicare Independent Payment Advisory Board (IPAB) for savings of $20.9 billion

The president's plan would increase Medicaid funding overall by $7.7 billion over 10 years. The proposal also reinstates the Affordable Care Act's (ACA) Medicaid pay bump for primary care physicians. Extending the pay increase through 2016 and including additional providers, as the budget proposes, would add roughly $6.3 billion to the deficit between 2016 and 2025. However, the budget also includes reductions to Medicaid, including reducing Medicaid disproportionate share hospital payments in FY 2025 for savings of $3.29 billion.

The president's budget request for HHS follows:

- Health Centers - $809 million in mandatory funding; total program $4.2 billion
- National Health Service Corps – $287 million in discretionary; $235 million in mandatory; total program $810 million
- Rural Health Outreach Grants - same as last year - $59 million
- Rural Health Research - roughly the same $9 million
- Rural FLEX (CAH) grants - down from $41.6 to $26 million
- State Offices of Rural Health - roughly the same $9.5 to $10 million
- Rural Access to Emergency device - from $4.5 million to $0
- Telehealth - same as last year -- $15 million

House Budget Resolution

House Budget Committee Chairman Tom Price (R-GA) released the committee's budget plan for FY 2016, which would reduce Medicare spending by $148 billion and Medicaid and other health care spending by $913 billion over 10 years. Overall, the plan would reduce spending by $5.5 trillion over the next 10 years to balance the federal budget. With respect to health care, the plan would repeal the ACA, including IPAB. It also would create and implement a "premium support" Medicare model, allowing beneficiaries to remain in "traditional Medicare" or transition to the new model; combine Medicare Parts A and B to create a single deductible for seniors; make reforms to medical liability laws to curb frivolous lawsuits; and repeal the Medicare physician SGR formula. In addition, the House proposal would repeal Medicaid expansion under the ACA and create a block grant program that gives states flexibility to tailor a program to their communities; and unify Medicaid and the State CHIP into a single program.

Senate Budget Resolution

Senate Budget Committee Chairman Mike Enzi (R-WY) released a draft budget for FY 2016, which would repeal the ACA and adopt the president's overall Medicare reductions of nearly $431 billion over 10 years. As drafted, the Senate Budget Resolution:

- Balances the budget in 10 years
- Repeals and replaces the ACA with "reserve funds" for legislation that "strengthens the doctor- patient relationship, expands choice, and lowers health care costs"
- Supports the total amount of proposed net Medicare savings in the president's budget, but directs congressional committees to work to achieve the savings
- Directs the Senate Finance and Health, Education, Labor and Pension committees to report by July 31 changes in laws within their jurisdictions to achieve savings in FY 2016
- Repeals the IPAB
- Calls for modernization of Medicaid based on CHIP by increasing state flexibility in designing benefits and administering its programs

LEGISLATION AND ADVOCACY

The AHA has created three goals for rural hospital advocacy action this Congress.

1. Secure the Future of Critical Rural Programs and Policies
2. Relieve Regulatory Burden
3. Protect Essential Resources

These goals are supported by 19 objectives which can be found on our website at http://www.aha.org/content/15/ruraladvocacygoals.pdf. Already, nine bills have been introduced in Congress addressing many of our advocacy priorities. A summary follows:

Rural Hospital Advocacy Agenda

Congress has introduced several bills that identify AHA advocacy priorities for rural hospitals including:

1. **The Critical Access Hospital Relief Act** (S. 258/H.R. 169) would remove the 96-hour condition of payment but leave the condition of participation intact.
2. **The Protecting Access to Rural Therapy Services (PARTS) Act** (S. 257) would allow general supervision by a physician or non-physician practitioner for many outpatient therapeutic services, adopt a default setting of general supervision, and create an advisory panel to establish an exceptions process. The legislation also would create a special rule for CAHs that recognizes their unique size and Medicare conditions of participation, and 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.
3. **The Rural Hospital Access Act** (S. 332/H.R. 663) would permanently extend the Medicare-dependent Hospital program and the enhanced low-volume Medicare adjustment for small rural PPS hospitals.
4. **The Rural Community Hospital (RCH) Demonstration Extension Act** (S. 607/ H.R. 672) would extend the program for five years. The program enables small rural hospitals with fewer than 51 acute care beds to test the feasibility of cost-based reimbursement.
5. **The Medicare Ambulance Access, Fraud Prevention, and Reform Act** (S. 377/H.R. 745), would extend permanently add-on payments for ambulance services in rural areas and direct the Secretary to study how the additional payments should be modified for the costs of providing ambulance services in urban, rural, and super-rural areas. Also, the bill directs the Secretary to establish a process for preauthorization of ambulance services for patients with end stage renal disease.

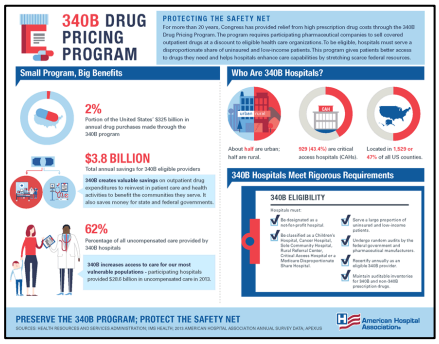
The Flexibility in Health IT Reporting (Flex-IT) Act (H.R. 270) would give hospitals and eligible professionals more flexibility in meeting meaningful use requirements for electronic health records (EHRs) in FY 2015. Specifically, the legislation would shorten the 2015 reporting period to 90 days from the current 365 days for Medicare and Medicaid EHR Incentive Program participants using the 2014 Edition Certified EHR. Without this change, a vast majority of hospitals are required to meet all Stage 2 requirements starting on Oct 1, 2014, and maintain compliance through Sept. 30, 2015.

RULEMAKING AND PUBLIC POLICY

The AHA works to ensure vital funding and equitable treatment of hospitals that care for the 51 million Americans that live in rural areas. Public policy and rulemaking from various agencies influence the security of access and coverage. CAHs are implicated in a host of rules and public policy concerns that are reviewed below.

340 B Drug Discount Pricing Program

On Nov. 13, 2014, the HRSA Office of Pharmacy Affairs confirmed that it will withdraw its proposed "mega rule" for the 340B Drug Pricing Program from review at the OMB. Instead, HRSA will issue guidance on certain areas of the program beginning in 2015 allowing an opportunity for the public to comment on the guidance it issues.



- Hospital eligibility
- Patient definition
- Contract pharmacy
- Drug diversion
- GPO exclusion

Despite the 340 B drug discount 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. In addition, AHA has created a 340B advocacy toolkit with sample resources that you can work with your communications staff to customize to show how your hospital uses the 340B program to benefit your patients and communities. We continue to support HRSA's efforts to improve the 340B program for eligible hospitals and clinics and look forward to engaging them on the guidance.

Meaningful Use of EHRs

We have transitioned from incentives to penalties for meaningful use of EHRs. Eligible hospitals and CAHs that can participate in either of the Medicare or Medicaid EHR Incentive Programs will be subject to *payment adjustments* unless they are meaningful users under one of the EHR Incentive Programs.

CAHs that are not meaningful users will be subject to a payment adjustment for FY 2015. This payment adjustment is applicable to a CAH's Medicare reimbursement for inpatient services during the cost reporting period in which they failed to demonstrate meaningful use. If a CAH has not demonstrated meaningful use for an applicable reporting period, then for a cost reporting period that begins in FY 2015, its reimbursement would be reduced from 101 percent of its reasonable costs to 100.66 percent. Further reductions will occur until the penalty reduces payment from 101 percent to 100 percent of costs.

CAHs are required to submit their attestations or hardship exceptions on Nov. 30 of the fiscal year of their reporting period. For example, if a CAH is attesting to meaningful use for 2015, then the attestation or hardship exception must be submitted no later than Nov. 30, 2015 to avoid payment adjustments. Hardship exceptions are considered for the following categories:

- Infrastructure — A CAH must demonstrate that they are in an area without sufficient internet access or face insurmountable barriers to obtaining infrastructure (e.g., lack of broadband).
- Unforeseen Circumstances — including an unforeseeable barrier, such as a natural disaster.

Important to note:

CAHs must apply for a hardship exception every year

CAHs will only be granted a hardship exception for up to five years

CMS **plans to shorten the 2015 Medicare Meaningful Use reporting period** to 90 days through rulemaking this spring. This is the result of concerns raised by providers about their ability to deploy 2014 Edition Certified EHR Technology. CMS is also planning to realign hospital reporting periods to the calendar year, and to modify other aspects of Meaningful Use to match long-term goals, reduce complexity, and lessen providers' reporting burden. These changes are being proposed separately from the Meaningful Use stage 3 proposed rule, which is also being developed and will address the program framework in 2017 and beyond.

PQRS Payment Adjustments for CAHs

CMS recently published Guidance on the Physician Quality Reporting System (PQRS) 2013 Reporting Year and 2015 Payment Adjustment for Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and CAHs in MedLearn Matters. This article is intended those who submit claims to Medicare Administrative Contractors (MACs) for services furnished to Medicare beneficiaries.

The guidance clarifies that An eligible provider (EP) who furnishes Medicare Part B services at a CAH and the CAH is paid under Method II is not eligible for the 2013 PQRS incentive payment or for the 2015 PQRS negative payment adjustment if he or she has not satisfactorily reported 2013 PQRS quality measures. However, a CAH provider paid under Method II is required to report the rendering NPI at the line level if it is different than the rendering NPI at the claim level.

Accountable Care Organizations

Recently CMS introduced the ACO Investment Model, an initiative designed for organizations participating as ACOs in the Medicare Shared Savings Program (MSSP). The ACO Investment Model is a model of pre-paid shared savings that builds on the experience with the Advance Payment Model to encourage new ACOs to form in rural and underserved areas and current MSSP ACOs to transition to arrangements with greater financial risk. The ACO Investment Model will target new ACOs serving rural areas and areas of low-ACO penetration and existing ACOs committed to moving to higher risk tracks. CMS will also give preference to ACOs that provide high quality of care, achieve their financial benchmark, demonstrate exceptional financial need, and submit compelling proposals for how they will invest both their own funds and CMS's funds. Applications will be available this summer from CMS for ACOs that started in 2014 or will start in 2016.

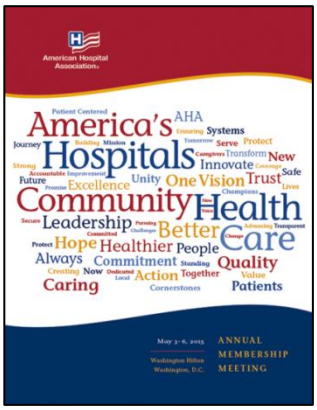
An ACO staple is the Advance Payment Model, which was designed for physician-based and rural providers who have come together voluntarily to give coordinated high quality care to the Medicare patients they serve. Through the Advance Payment ACO Model, participants that were selected

received upfront and monthly payments, which they can use to make important investments in their care coordination infrastructure. ACOs participating in the model received three types of payments:

1. An upfront, fixed payment
2. An upfront, variable payment based on the number of the ACO's preliminarily prospectively-assigned beneficiaries
3. A monthly payment of varying amount depending on the size of the ACO based on the number of its preliminarily prospectively-assigned beneficiaries.

The structure of these payments addresses both the fixed and variable costs associated with forming an ACO. CMS recoups Advance Payments through offset of an ACO's earned shared savings. ACOs selected to receive advance payments entered into an agreement with CMS that details the obligation to repay advance payments. If the ACO did not generate sufficient savings to repay the advance payments as of the first settlement for the MSSP, CMS will continue to offset shared savings in subsequent performance years and any future agreement periods, or pursue recoupment where appropriate.

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. Honorees receive a **$1,500 stipend** to offset the cost of attending an AHA educational program. The 2015 Application can be found **HERE.** Contact Jumel Ola 312-422-3345 for additional information.



2015 AHA ANNUAL MEMBERSHIP MEETING

2015 will bring about even more changes for health care, and you'll be part of the action. Please join the country's foremost political, policy, opinion and health care leaders at the 2015 AHA Annual Membership Meeting as we forge paths in the new terrain. Register now at www.aha.org.

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

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