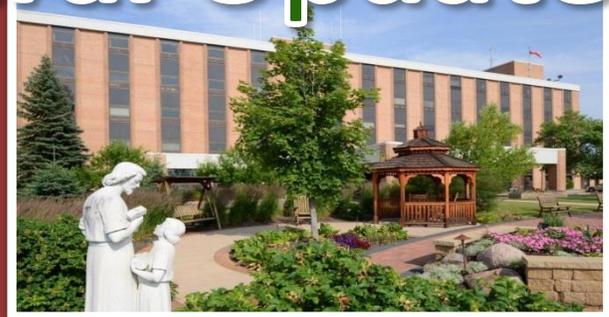


Small or Rural Update



**Spearfish Regional Hospital
Spearfish, SD**



**St. Joseph's Hospital
Chippewa Falls, WI**

Fall 2015

The AHA and its Section for Small or Rural Hospitals represents and advocates on behalf of more than 1,700 rural hospitals, including 1008 critical access hospitals (CAHs). This issue of **Small or Rural Update** reviews the federal budget, legislative advocacy and regulatory policy, and examines final and proposed rules for Medicare outpatient payments, physician fee schedule, 340 B drug pricing, discharge planning for post-acute services, and grants. There is special attention paid to CMS survey and certification of CAHs and the distance and location documentation requirements for necessary providers. Information on the 29th annual Rural Health Care Leadership Conference is included.

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 some seniors. The cost is offset in part by implementing site-neutral payments for new off-campus provider-based hospital outpatient departments – 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 bill also extends the 2% Medicare sequester for an additional year.

The provisions in Section 603, "Treatment of New Off-Campus Outpatient Departments," enacts site-neutral payment reductions for Medicare services that are furnished in new off-campus provider-based (PB) hospital outpatient departments (HOPDs) that are not dedicated emergency departments. The bill defines off-campus PB HOPDs as departments that are not on the main campus of a hospital and are located more than 250 yards from the main campus. The section defines a "new" PB HOPD as an entity that started billing for

Medicare outpatient services under the Medicare OPPS on or after the Act's date of enactment, but is not a dedicated emergency department. New off-campus PB HOPDs would not be eligible for reimbursements from the Centers for Medicare & Medicaid Services' (CMS) OPPS beginning Jan. 1, 2017. Instead, as of that date, these new off-campus PB HOPDs would be eligible for reimbursements from other Medicare Part B payment systems, including the Medicare physician fee schedule (PFS), the ambulatory surgery center (ASC) payment system, or the clinical laboratory fee schedule (CLFS), as appropriate.

For more details on the legislation, see the AHA's factsheet on [Site-neutral HOPD Technical Corrections](#).

TASK FORCE ON ENSURING ACCESS IN VULNERABLE COMMUNITIES

The AHA Board created a 30-member task force that will work 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. The Task Force on Ensuring Access in Vulnerable Communities consists of two subcommittees that will examine the issue from the rural and inner-city perspective. The task force will hold four meetings and several conference calls over time and expects to conclude in April 2016. Task force activities include conducting field hearings for broader member input, and the state associations will be engaged through its own process.

AHA ADVOCACY AGENDA

As the first session of the 114th Congress winds to a close, there remains some unfinished business on our advocacy agenda for hospitals. Our priorities are described below.

General Agenda

Equity in Readmissions. While addressing unnecessary readmissions is an important way to improve patient care, there are many factors that influence the likelihood a patient will be readmitted. AHA has long advocated that the CMS amend the measures used in its public reporting and for the Readmissions Reduction Program to recognize that many of the factors influencing patient readmissions are related to sociodemographic and other factors outside the control of hospitals. [An article](#) providing important evidence for this assertion was published September 2015 in the *Journal of the American Medical Association (JAMA) Internal Medicine*. CMS has disregarded AHA's request for the program to include a risk adjustment factor for sociodemographic factors outside of a hospital's control. That is why we support the **Establishing Beneficiary Equity in the Hospital Readmission Program Act (S. 688/H.R. 1343)** bipartisan, bicameral legislation to improve the fairness of the readmission program, ensuring hospital performance is compared equally.

Inpatient Claims Audit and Payment. While Recovery Audit Contractors were established to ensure the accuracy of Medicare and Medicaid payments, the faulty design of the program instead imposes significant administrative and financial burden on hospitals. AHA

strongly supports H.R. 2156, the **Medicare Audit Improvement Act of 2015** that would make significant, fundamental changes to the Recovery Audit Contractor (RAC) program. Among other measures, the bill would:

- Eliminate the RAC contingency fee structure. Instead, the bill would direct the Centers for Medicare & Medicaid Services (CMS) to pay RACs a flat fee, as every other Medicare contractor is paid, to reduce the financial incentive for overzealous auditing practices;
- Establish a consistent and transparent methodology to calculate RACs' total appeals overturn rates;
- Rationalize payments to RACs by lowering payments for poor RAC performance due to high rates of incorrect denials;
- Fix CMS's unfair rebilling rules by allowing hospitals to rebill claims when appropriate; and
- Require RACs to make their inpatient claims decisions using the same information the physician had when treating the patient.

Physician Training. The current freeze on the number of physician training positions that Medicare funds has severely limited hospitals' ability to train the next generation of physicians. It has also contributed to a shortage of physicians, especially in behavioral health, primary care and general surgery. The AHA strongly supports the **Resident Physician Shortage Reduction Act (S. 1148/H.R. 2124)**, which would add 3,000 Medicare-funded residency slots each fiscal year from 2017 through 2021, at least half of which must be used for a shortage specialty residency program. The number of available physician slots at teaching hospitals has been frozen for the last 18 years.

Rural Hospital Agenda

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.

- **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.
- **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. Also introduced, [S. 1461](#) and [H.R. 2878](#) would extend through CY 2015 the enforcement delay on direct supervision requirements for outpatient therapeutic services provided in CAHs and rural PPS hospitals with 100 or fewer beds.
- **The 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.
- **The Medicare Ambulance Access, Fraud Prevention, and Reform Act of 2015** (S. 377/HR 745) 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 the following 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 CY 2016 for the hospital outpatient and ambulatory surgical center payment systems. Under the rule, there is a net decrease in OPSS payments of 0.4%. CMS did not reverse the 0.2% payment cut associated with the two-midnight policy.

Also in 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 OPPS 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.

For more, see the Nov. 18 [AHA Regulatory Advisory](#) on the final rules for both the hospital outpatient/ASC payment systems. Join the AHA policy staff for a webinar Nov. 23 at 2 p.m. ET. Members can register [here](#).

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.

Other proposals finalized in the rule include the use of star ratings on Physician Compare and the application of the value-based payment modifier to groups consisting of only non-physician eligible professionals, such as physician assistants. CMS did not finalize its proposal to require reporting of the Consumer Assessment of Healthcare Providers and Systems survey by group practices of 25-99 eligible providers (EPs), though it will require reporting by group practices of 100 or more EPs.

CMS is extending the Chronic Care Management (CCM) benefit to rural health clinics (RHCs). Beginning on Jan. 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. The proposed rate for the CCM services will be based off the national average non facility payment rate for CPT code 99490 which was \$42.91 per beneficiary per month in the first quarter of 2015. 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. The proposal requires an HCPCS (CPT) code to be reported along with the standard Medicare revenue code for each service furnished by an RHC to a Medicare patient.

CMS approved new CPT codes 99497 (initial 30 minutes) and 99498 (subsequent 30 minutes) for explanation, discussion and completion of Advanced Directive forms for Medicare beneficiaries. The estimates of payment are \$86 in an office setting and \$80 in an inpatient setting. While this can now be part of the Annual Wellness Visit or a physician visit, and does qualify as an RHC visit, it cannot be billed in an RHC in addition to the All-Inclusive Rate.

For more, see the Nov. 2 AHA [Special Bulletin](#) on the final rules for both the hospital outpatient/ASC payment systems and PFS..

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](#).

340B Orphan Drug Litigation. A lawsuit brought by the Pharmaceutical Research and Manufacturers of America challenged HHS’s 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 the Department of Health and Human Services (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.

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](#) on the proposed rule for those seeking additional information. Comments are due Jan. 4, 2016.

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. **The AHA has long advocated for this shorter reporting period and appreciates this change.** CMS 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. CMS states that the reduction in the number of objectives for Stage 3 is to focus on advanced use objectives that support clinical effectiveness, patient safety, patient engagement and care coordination.

To meet the objectives of Stage 3 in 2018, CMS finalizes 21 measures that raise the modified Stage 2 thresholds and introduce new requirements and functionality, such as an application program interface (API) to facilitate providing the patient with access to his or her health information through a third-party application. CMS finalizes the change for EHs and CAHs to align the eCQM reporting period with the calendar year EHR reporting period. CMS also finalizes the continued requirement that in 2015 through 2017, EHs and CAHs report 16 eCQMs across at least three National Quality Strategy (NQS) domains and EPs report nine eCQMs across at least three NQS domains.

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.

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. In January, HHS Secretary Burwell announced the goals and timeline for moving the Medicare program toward paying providers for the value, rather than the volume of care they give patients. Specifically:

1. HHS set a goal of tying 30% of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50% of payments to these models by the end of 2018.
2. HHS also set a goal of tying 85% of all traditional Medicare payments to quality or value by 2016 and 90% by 2018 through programs such as the Hospital Value Based Purchasing program and the Hospital Readmissions Reduction Program.

In July, CMS proposed a new payment model that would bundle payment to acute care hospitals for hip and knee replacement surgeries. As proposed, the Comprehensive Care for Joint Replacement (CCJR) model would be mandatory for most hospitals located in 75 geographic areas across the country. It would be a five year demo, starting Jan. 1, 2016. Hospitals would be held accountable for the quality and costs of the entire hip/knee replacement surgery through 90-days post discharge. This includes all Medicare Part A and B services. [AHA commented to CMS in a letter](#) and hospitals generally are supportive however, the HHS Secretary must issue waivers to the applicable fraud and abuse laws that restrict care coordination. This includes both the Stark (physician self-referral) law and Anti-kickback statute that dictate the financial arrangements formed by hospitals participating in this new model.

Rural hospitals including CAHs 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.

CMS SURVEY AND CERTIFICATION OF CAHS

Tom Nickels, AHA EVP, on Nov. 17, [in a letter](#) to Andrew Slavitt, Acting Administrator, CMS, expressed concern that CMS's recently expressed requirements around the documentation necessary to support a critical access hospital's (CAH) necessary provider (NP) designation (see below) are inappropriate and unnecessarily limited. 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. AHA looks forward to working with CMS to develop a reasonable solution that will ensure that those CAHs that have rightfully obtained NP designation may continue to participate in the CAH program. If you have any questions, please contact Priya Bathija, senior associate director, AHA Policy, at (202) 626-2678 or 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.

NP 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 (CAH) 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. Health care networks can be an effective strategy to help smaller rural health care providers and health care service organizations align resources and strategies, achieve economies of scale and efficiency, and address challenges more effectively as a group than as single providers.

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 will hold a **technical assistance webinar on Dec. 2 at 2 p.m. ET**. 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.



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

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