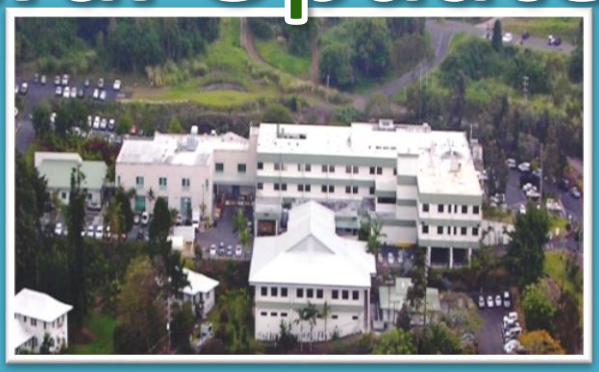
Small or Rural Update

St. James Parish Hospital
Lutcher, LA



Kona Community Hospital
Kealakekua, HI

Summer 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). *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. Information on the Shirley Ann Munroe Leadership Award also is included.

THE FY 2016 BUDGET

In February, President Obama released his FY 2016 budget; he requested $431.3 billion in reductions to Medicare, of which $349.8 billion would come from providers including CAHs and $83.8 billion would come from structural reforms. His budget proposes $128 million for rural health programs, including $59 million for rural health outreach grants, $26 million for rural hospital FLEX grants and $14.9 million for telehealth.

In June, the House Appropriations Committee voted 30-21 to approve legislation that would provide $153 billion in discretionary funding for the departments of Labor, Health and Human Services, Education and related agencies in FY 2016, $3.7 billion less than this year. The bill would provide $71.3 billion for HHS programs, an increase of $298 million from FY 2015. Funding levels include more than $6 billion for the Health Resources and Services Administration (HRSA).

In June the Senate Appropriations Committee voted 16-14 to approve legislation that would provide $153.2 billion in discretionary funding for the departments of Labor, HHS, Education and related agencies in fiscal year 2016, $3.6 billion less than this year. According to the committee, the legislation eliminates discretionary funding for the Affordable Care Act and Independent Payment Advisory Board, and would prevent using discretionary funds to

support state-based health insurance exchange operations and the ACA Risk Corridor program. The bill would provide $70.4 billion for HHS programs, $646 million less than in FY 2015. Among other provisions, the HHS funding includes $150.6 million for rural health programs.

Health Resources and Services Administration
FY 2016 House and Senate Bills All Purpose Table
(dollars in thousands)

Program	FY 2015 Enacted	FY 2016 Request		
		President	House	Senate
RURAL HEALTH				
Rural Health Policy Development	9,351	9,351	9,351	9,351
Rural Health Outreach Grants	59,000	59,000	59,000	63,500
Rural & Community AED	4,500	-	4,500	-
Rural Hospital Flex Grants	41,609	26,200	41,609	41,609
State Offices of Rural Health	9,511	9,511	9,511	9,511
Radiation Exposure Screening and Education	1,834	1,834	1,834	1,834
Black Lung	6,766	6,766	6,766	6,766
Telehealth	14,900	14,900	14,900	18,000
Subtotal, Office of Rural Health Policy	**147,471**	**127,562**	**147,471**	**150,571**
OTHER				
Nat. Health Service Corps Loan Repayment	**1,190**	**1,190**	**1,190**	**1,190**
Rural Physicians Training Grants	**-**	**4,000**	**-**	**-**
Nurse Corp Scholarship & Loan Repayment	**81,785**	**81,785**	**81,785**	**79,785**
Health Centers	**5,000,533**	**5,091,522**	**5,091,522**	**5,091,522-**

HOSPITAL ADVOCACY AGENDA

Medicare Access and CHIP Reauthorization Act of 2015: On April 16, President Obama signed into law the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The bill represents a historic bipartisan, bicameral effort to repeal the Medicare physician sustainable growth rate (SGR) formula after 18 years and 17 temporary "patches." The legislation provides payment updates for physicians over a decade and encourages the adoption of "alternative payment mechanisms" (APMs).

MACRA repeals the SGR formula, halting a 21% cut to Medicare payments to physicians and other health care professionals effective April 1. In place of the SGR, the bill provides a 0.5% update from July 2015 through 2019 for physicians and other health care professionals paid under the physician fee schedule. In addition, beginning in 2019, the bill incorporates a Merit-based Incentive Payment System (MIPS) that will assess professionals' performance in four specific performance areas: quality, resource use, clinical practice improvement activities and meaningful use of EHRs. It will then translate that performance into a payment adjustment. Qualifying APM participants are exempt from the MIPS, as well as most EHR meaningful use requirements. From 2019 through 2024, they will receive an annual lump-sum payment incentive equal to 5% of their covered services from the previous year.

MACRA provisions of importance to hospitals include:

- Extension of the Children's Health Insurance Program through Sept. 30, 2017.
- Delay of enforcement of two-midnight policy through Sept. 30, 2015
- Delay of Medicaid DSH cuts until 2018
- HHS report to Congress on barriers to more widespread adoption of telemedicine and remote patient monitoring
- Rural Medicare extenders
    - Medicare-dependent hospital (MDH) program (through Sept. 30, 2017)
    - Enhanced low-volume adjustment (LVA) (through Sept. 30, 2017)
    - Ambulance add-on payment (through Dec. 31, 2017)
    - Outpatient therapy caps (through Dec. 31, 2017)
    - Home health rural add-on (through Dec. 31, 2017)
    - Physician work geographic cost index (GPCI) floor (though Dec. 31, 2017)

See the AHA Legislative Advisory on MACRA for additional information.

New proposals have been introduced in this Congress that have implications for all hospitals including rural. They include:

21st Century Cures Act (H.R. 6) is designed to accelerate the discovery of breakthrough devices and pharmaceuticals. It passed the House July 10, but not after considerable debate. The bill does not cut payments to hospitals as an offset or include changes to the 340B program, which it once did. The bill does contain challenging provisions on interoperability referenced in a letter from AHA. The Senate will consider similar legislation later this year.

Promoting Access, Competition, and Equity Act of 2015 (H.R. 2513) would loosen the current restrictions on the growth of physician-owned hospitals. It is bad policy that would result in additional gaming of the Medicare program, jeopardize patient access to emergency care, potentially harm sicker and lower-income patients, and damage the safety-net provided by full-service hospitals.

Hospital Agenda for 114th Congress: The advocacy agenda for hospitals addresses priorities introduced as legislation in Congress for all hospitals, including rural, such as:

- Establishing Beneficiary Equity in the Hospital Readmissions Program Act (S 688/HR 1343) requires the Secretary to make a risk adjustment based on a hospital's proportion of inpatients who are full-benefit dual eligible individuals and the socioeconomic status of patients served by the hospital. It is budget neutral.
- Medicare Audit Improvement Act (HR 2156) would eliminate the RAC contingency fee structure, establish limits on medical record requests and allow denied inpatient claims to be billed as outpatient claims.
- Two-midnight Short Stay Payment Policy; not yet introduced in this Congress, proposals would require CMS to implement a new payment methodology for short inpatient stays

RURAL HOSPITAL ADVOCACY AND REPRESENTATION

The AHA continues to advocate for rural and critical access hospitals and stands committed to maintaining a health care presence in rural communities.

Maintaining a Health Care Presence in Rural Communities: On May 7, AHA before the Committee on Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies of the United States Senate offered a statement on "Rural Health." The AHA recommended Congress take action on behalf of rural hospitals to provide relief from harmful federal regulations and policies and protect important programs.

Congressional Staff Briefing: To help educate Capitol Hill staffs about the unique circumstances and the vital role of rural hospitals, the AHA organized a June 9 briefing. Panelists for the program include:

- Christina Campos, administrator for Guadalupe County Hospital – a 10-bed general acute care facility in Santa Rosa, New Mexico. The next closest hospital is 50 miles.
- Susan Starling, CEO of Marcum & Wallace Memorial Hospital – a CAH serving several counties surrounding Irvine, Kentucky. Many patients travel over 30 miles to seek care at the hospital.
- Dick Brown, president & CEO of the Montana Hospital Association, which has been active in helping to develop alternative reimbursement options for rural health care.

Video replay of the briefing and discussions are available. Click on the links to hear the discussion.

- What is Rural?
- 96-hour Rule
- Direct Supervision of Outpatient Therapeutic Services
- State Profile in Innovation
- Interoperability / EHR
- Grants and Affiliations
- Questions & Answers Session

Advising the Senate Rural Health Caucus: On June 16, the AHA participated in a bipartisan Capitol Hill briefing hosted by the Senate Rural Health Caucus to educate congressional staff on the unique circumstances and needs impacting health care delivery in rural communities. The AHA highlighted the importance of continuing vital rural programs, such as the MDH and enhanced low-volume adjustment programs; and passing key rural legislation such as S. 607/H.R. 672 to extend the Rural Community Hospital Demonstration program.

AHA Advocacy Agenda for Rural Hospitals: The AHA supports policies and legislation that enable rural hospitals to care for their communities. Below are key areas of focus for our 2015 advocacy agenda.

- MDH and low-volume adjustment. The Rural Hospital Access Act (S. 332/H.R. 663) would permanently extend the Medicare-dependent hospitals and enhanced low-volume adjustment programs.
- Ambulance add-on payment. The Medicare Ambulance Access, Fraud Prevention and Reform Act (S. 377/H.R. 745) would permanently extend the ambulance add-on payment adjustment.
- RCH demo. The Rural Community Hospital (RCH) Demonstration Extension Act (S. 607/H.R. 672) would extend the program for five years. The RCH program enables rural hospitals with fewer than 51 acute care beds to test the feasibility of cost-based reimbursement.
- Exempt CAHs from the cap on outpatient therapy services (H.R. 775/S. 539) and extend the outpatient therapy exception process and oppose the expansion of the cap to services provided in the outpatient departments of hospitals and CAHs.
- Direct supervision. The Protecting Access to Rural Therapy Services (PARTS) Act (S. 257/ H.R.1611) would ensure that CMS appropriately addresses the issue of direct supervision for outpatient therapeutic services for rural hospitals and CAHs. Recently 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.
- 96-hour physician certification. The Critical Access Hospital Relief Act (S. 258/H.R. 169) would remove the 96-hour physician certification requirement as a condition of payment for CAHs. These hospitals would still be required to satisfy the condition of participation requiring a 96-hour annual average length of stay.

On June 24, the Senate Finance Committee approved AHA-backed bills – S. 1461 and S. 607 – to support access to hospital services in rural communities.
S. 1461 would delay through December enforcement of direct supervision requirements for outpatient therapeutic services provided in CAH and certain small, rural hospitals. S. 607 would extend for five years the Rural Community Hospital Demonstration Program, which enables rural hospitals with 50 or fewer acute-care beds to test the feasibility of cost-based reimbursement. The bill would extend the demonstration only for those hospitals participating in the program as of Dec. 30, 2014, and require the Secretary of Health and Human Services (HHS) to report to Congress on the effectiveness of the program by Aug. 1, 2018.

Rural Emergency Acute Care Hospital: Sen. Charles Grassley, R-Iowa, on June 23 introduced the Rural Emergency Acute Care Hospital Act (S. 1648), which 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. They would receive enhanced reimbursement rates of 110% of reasonable costs to transport patients to acute-care hospitals in neighboring communities.

In a letter to the senator, AHA Executive Vice President Rick Pollack called the legislation "a good first step toward ensuring access to health care services in some rural communities," and said the AHA looks "forward to working with you to further develop this and other

alternative payment models to ensure the continued access to health care services in rural communities."

REGULATORY AND POLICY PRIORITIES

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

Hospital Outpatient Prospective Payment Proposed Rule: On July 1, CMS issued a proposed rule for CY 2016 for the hospital outpatient prospective payment (OPPS) and ambulatory surgical center (ASC) payment systems. Under the rule, there would be a net decrease in OPPS payments of 0.2% for all hospitals, with rural hospitals expected to see a net decrease of -0.3%. This net decrease largely results from a proposed 2.0 percentage point cut intended to account for CMS's overestimation of the amount of packaged laboratory payments under the OPPS for laboratory tests that were previously paid under the Clinical Laboratory Fee Schedule.

AHA Executive Vice President Rick Pollack expressed disappointment with the negative update, saying AHA was "dismayed that miscalculations by the actuaries are resulting in penalties to hospitals and the patients they care for" and urged CMS to reevaluate the actuaries' estimates.

In addition, CMS proposes to alter its two-midnight policy so that certain hospital inpatient services that do not cross two midnights may be appropriate for payment under Medicare Part A if a physician determines and documents in the patient's medical record that the patient requires reasonable and necessary admission to the hospital as an inpatient. CMS does not propose any changes for stays that are expected to last more than two midnights.

The agency also proposes changes to the related enforcement requirements, proposing to use Quality Improvement Organizations to conduct first-line medical reviews of the majority of patient status claims rather than Medicare Administrative Contractors or Recovery Audit Contractors, which would focus only on those hospitals with consistently high denial rates. However, CMS does not propose to reverse the 0.2% payment cut associated with the two-midnight policy.

Pollack called the proposals a "good first step," saying hospitals "appreciate today's proposal to maintain the certainty that patient stays of two midnights or longer are appropriate as inpatient cases." The rule is summarized in an AHA Special Bulletin.

2016 Medicare Physician Fee Schedule: On July 8, CMS placed the 2016 Medicare Physician Fee Schedule on display for public inspection in the Federal Register. This proposed rule makes several policy changes related to Medicare Part B payment. Among changes important to rural providers, the rule seeks to:

- Extend payment add-ons for ambulance transportation services in rural areas;
- Authorize Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) to provide chronic care management services;

- Require RHCs to report all services using standardized coding systems, such as level I and level II of the HCPCS; and
- Create an exception to the Stark law that would permit payment from a hospital, FQHC, or RHC to a physician to assist the physician in employing a non-physician practitioner within the same geographic region.

Through this proposed rule, CMS is also seeking input on provisions included in the MACRA such as an appropriate low-volume threshold for excluding professionals from the Merit-based Incentive Payment System (MIPS). Comments are due September 8, 2015.

CMS Transmittal 138, Appendix W, State Operations Manual for CAHs: On April 7, through CMS Transmittal 138, Appendix W, Survey Protocol, Regulations and Interpretive Guidance for Critical Access Hospitals (CAHs) and Swing Beds in CAHs, was revised to reflect recent regulation changes. CMS also uses this transmittal to make clarifications and updates to existing guidance. Revisions and updates address several sections of the rule such as:

- Bed counts
- Physician chart review of NPP
- Guidance for physician supervision
- Pharmacy operations in a CAH
- Infection control
- Nutritional requirements
- ALOS of 96 hours
- Services provided under agreement
- Nurse staffing and Rx administration
- Nursing care plan

Transmittal 138 also references the revised mountainous terrain definition from 2013:

- Travel route must be located in a mountain range
- Must have either of the following characteristics:
  - Steep grades (i.e., greater than 5 percent), continuous abrupt and frequent changes in elevation or direction, or cause heavy vehicles to operate at crawl speeds for significant distances or at frequent intervals; or
  - Roads on the travel route are considered by the State Transportation or Highway agency to be located in mountainous terrain based on necessary construction techniques
  - If mountainous terrain claim is based on either of these, a letter from the State Transportation or Highway agency is required

Transmittal 138 also references the revised Office of Management & Budget (OMB) Metropolitan Statistical Area (MSA) delineations to which CAHs are accountable:

- §485.610(b)(5) – The 2010 census revised the OMB MSA delineations that CMS Regional Offices must refer to when reassessing an existing CAH's rural location status. These are adopted by CMS and in effect.
- Provides a two-year grace period during which CAH status may be retained to existing CAHs that were previously determined to be located in a rural area based on prior OMB MSA delineations, but which are no longer rural based on the most recent OMB MSA delineations adopted by CMS and in effect.
- CAHs must comply with the location and distance requirements at the time of initial certification as well as during each subsequent recertification

- 35-mile distance requirement
- 15-mile distance requirement
- Necessary provider designation (designated by the State prior to January 1, 2006)

A CMS memorandum (S&C 145-CAH) from the Survey & Certification Group to the State Survey Agency Directors dated June 26 provides additional clarification of CAH rural status, location and distance requirements. All parties are being reminded that S&C-13-20, issued March 15, 2013, updated the interpretive guidelines for §485.610 and §485.610(c) to clarify that *a CAH must meet the location and distance requirements not only at the time of initial conversion to CAH status, but at all times the facility participates as a CAH*. The CAH's compliance with these requirements must be reassessed at the time of each recertification. The guidance provides several detailed examples of how a CMS Regional Office is to make rural location determinations.

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.

Eligible hospitals and CAHs participating in meaningful use for the first time this year may attest to a 90-day reporting period for fiscal year 2015, and a number of hospitals have indicated to the AHA and CMS that they are ready to do so. CMS has recently reversed a policy decision that would have made these hospitals wait until early 2016 to attest. Under a temporary solution that will be implemented on a case-by-case basis attestation can now be made this summer. More information is available in an AHA Special Bulletin.

Stage 2 2015 modifications rule includes some important flexibility in two requirements. First, it proposes a 90-day reporting period for 2015. Second for the portal, a hospital would have to show that at least one patient used the portal, rather than having to reach the 5% mark. The rule also proposes to add flexibility to the requirements on sharing information during transitions of care. We expect a final rule in August.

The Stage 3 rule continues to pursue aspirations without much thought to feasibility, and raises the bar yet again. There are some promising new directions in health IT such as patient-generated data or devices as part of an EHR. Vendors and others are making progress in allowing use of third-party apps to access and use data stored in an EHR. In Stage 3 CMS proposes to require these things even while they are still being developed and tested.

Given the track record of meaningful use, the AHA believes the wiser course of action is to hold off on finalizing Stage 3 so that we can learn from Stage 2 and test these promising new approaches. There is also a considerable amount of activity underway to improve interoperability, or the ability of EHRs to actually share data. We believe it is time to prioritize that work over new meaningful use requirements. More can be found in the AHA Regulatory Advisory.

340B Drug Pricing Program: On June 16, HRSA released a proposed rule on drug ceiling prices and civil monetary penalties for manufacturers in the 340B Drug Pricing Program. Required by the Affordable Care Act, the rule would amend Section 340B of the Public Health Service Act to impose monetary sanctions (not to exceed $5,000 per instance) on drug manufacturers who intentionally charge a 340B hospital or covered entity more than the ceiling price established under the procedures of the 340B program. The proposed rule also would require greater transparency in calculating the 340B ceiling drug prices to ensure that drug manufacturers are not overcharging 340B covered entities. Section 340B of the Public Health Service Act requires pharmaceutical manufacturers participating in Medicaid to sell outpatient drugs at discounted prices to health care organizations that care for many uninsured and low-income patients.

Also in June, the AHA responded to a report that is the "latest in a series of attempts to misrepresent" the 340B Drug Pricing Program and the benefits it helps bring to poor patients and vulnerable communities. "Given the increasingly high cost of pharmaceuticals, the 340B program provides critical support to help hospitals' efforts to build healthy communities," writes AHA Senior Vice President of Public Policy Analysis and Development Linda Fishman. "It is important for policymakers and the public to see through the attempt by the pharmaceutical industry to disparage a program that helps provide access to care for vulnerable communities."

A July 6 Government Accountability Office (GAO) report examining Medicare Part B spending at hospitals participating in the 340B Drug Pricing Program draws unsubstantiated conclusions about a program that has a proven track record of improving access to care for poor patients and vulnerable communities.The AHA, along with HHS, has expressed concerns about the methodology GAO used to conclude that financial incentives were driving 340B Medicare DSH to prescribe more drugs or more expensive drugs to treat Medicare Part B patients. We also believe that the report does not appropriately account for certain differentiating factors and characteristics of 340B DSH hospitals.

When Congress created the 340B program more than 20 years ago, it stated the purpose of the program was to permit providers that care for a high number of low-income and uninsured patients "to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." Given the increasingly high-cost of pharmaceuticals, the 340B program is crucial to helping provide low-cost pharmacy services to vulnerable patients, and it remains a critical component of helping safety-net health care providers create healthier communities.

Find more facts on how the 340B program helps communities on the AHA website.

The House Energy and Commerce Committee is expected to engage on 340B this fall, likely after the HRSA releases its long-awaited guidance on the program. The committee is

seeking feedback on the legislative proposal that was circulated as part of the 21st Century Cures discussion. We'll be convening members and providing input.

Hospital Compare: CMS anticipates that the July update to the Hospital Compare website will include performance data reported voluntarily byCAHs, the agency told AHA, quickly responding to an AHA letter expressing "deep disappointment" that the website's April update failed to include most of the CAH data. "The fact that so many CAHs are engaged in voluntary quality reporting demonstrates their commitment to sharing information with the communities they serve, and to identifying opportunities to improve care," wrote Nancy Foster, AHA vice president of quality and patient safety policy. "Moreover, many payers – including some Medicaid programs and private insurers – use Hospital Compare data reported by CAHs in their pay-for-performance programs. For these reasons, it is critical that CMS post voluntarily reported data in a timely fashion." CMS said it regrets that the data were not posted in April and is taking steps to help ensure future updates of the data are timely.

SHIRLEY ANN MUNROE LEADERSHIP AWARD

The Shirley Ann Munroe Leadership Award recognizes small or rural hospital chief executives and administrators who have achieved improvements in local health delivery and health status through their leadership and direction. The Award is designed to provide professional development and educational opportunities to outstanding small or rural hospital chief executives and includes a **$1,500 stipend** to offset the cost of attending an AHA educational program. The application is due Aug. 21. Please contact Jumel Ola, staff specialist, at jola@aha.org or 312-422-3345 for information on the award and completing the application.

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.