

# Small or Rural Update



Alliance Health - Woodward  
Woodward, OK



Mercy Medical Center - Clinton  
Clinton, IA

## WINTER 2016

The AHA advocates to ensure that the unique needs of our 2,125 rural hospital and 992 CAH members are a national priority. This year-end edition of the **Small or Rural Update** reviews AHA activities around the presidential transition and new Congress; the federal budget; rulemaking and regulatory policy; recommendations from the AHA Board Task Force on Ensuring Access in Vulnerable Communities; the recipient of the AHA Rural Hospital Leadership Award; and information on the 30<sup>th</sup> annual [AHA/Health Forum Rural Health Care Leadership Conference](#).

## TRANSITION 2017

As President-elect Trump's administration begins to take shape, the AHA has developed new members-only resources to keep you informed on how the new administration and new Congress' efforts are likely to impact hospitals and health systems. Visit our webpage, "[Transition 2017](#)," to keep up-to-date on the latest developments, including our recent three letters to President-elect Trump. You'll also find details on the key players, our advocacy agenda and messages moving forward, links to health policy proposals from Congressional leaders, policy makers and thought leaders from across the political spectrum. We'll add resources hospital leaders can use with their own staffs and in their communities, such as slide decks and infographics. AHA's regular webcasts will continue (the next one is Dec. 15 at 4 p.m. ET) and we've added special transition news and updates to AHA News Now and Weekly Update.

In a Nov. 30 [letter](#) to President-elect Trump, the AHA detailed five objectives to help modernize the public policy environment to enhance providers' ability to improve quality and affordability of care:

1. Reduce the regulatory burden;
2. Enhance affordability and value;
3. Continue to promote quality and patient safety;
4. Ensure access to care and coverage; and
5. Continue to advance health system transformation and innovation.

The letter concludes by urging the new Administration to ensure that any repeal of portions of the ACA simultaneously include a replacement plan that continues to provide a mechanism for individuals to obtain affordable insurance coverage. In addition, it requests that providers' payments that were reduced significantly to fund coverage expansion be reexamined.

## **IMPACT OF REPEALING THE AFFORDABLE CARE ACT ON HOSPITALS**

The AHA and the Federation of American Hospitals (FAH) recently sent letters to President-elect Trump and Congressional leaders highlighting a new [report](#) that details the impact a potential repeal of the Affordable Care Act (ACA) would have on hospitals and health systems as they strive to care for their communities. The report, which was commissioned by the AHA and FAH, was prepared by the health care economics firm Dobson | DaVanzo.

The report finds that, under the most recent repeal without replacement bill, H.R. 3762, hospitals would face a net negative impact of \$165.8 billion from 2018-2026 after accounting for the restoration of the Medicaid Disproportionate Share Hospital (DSH) cuts that H.R. 3762 contemplates. It also found that hospitals would suffer a loss of \$289.5 billion in Medicare inflation updates if the payment reductions in the ACA are not restored. Finally, the study authors calculate that the impact of retaining the Medicare and Medicaid DSH reductions would amount to \$102.9 billion. Estimates show that the cumulative federal payment reductions to hospital services that have been imposed through other Congressional and Executive Branch actions subsequent to and independent of the ACA total another \$148 billion from 2010 – 2026, and come on top of the ACA reductions.

The AHA strongly believes that any repeal legislation must be accompanied by provisions that protect the coverage for those currently receiving such protection. However, if that is not the legislative path to be pursued, then it is vital that such legislation provide a true clean slate and also include repeal of the reductions in payments for hospital services embedded in the ACA – specifically the substantial reductions to hospitals' annual inflation updates and the cuts to Medicare and Medicaid DSH payments. If the coverage associated with the ACA disappears, the importance of these payments would be heightened – they are vital in helping defray the costs of treating our most vulnerable patients.

## **HOUSE AND SENATE PASS 21<sup>ST</sup> CENTURY CURES ACT**

On Dec. 7, the Senate passed the 21st Century Cures Act, and President Obama is expected to sign the bill, which passed the House Dec. 1, into law. This bill is primarily designed to advance the development of medical treatments and cures through investments in research and updates to how new therapies are developed and approved. The major components of the bill fund new initiatives at the National Institutes of Health (NIH) and the Food and Drug Administration (FDA). Specifically, the bill authorizes \$4.8 billion for the NIH to fund new initiatives around precision medicine, cancer, neuroscience, and regenerative medicine. The bill also provides \$500 million over 10 years to the FDA to facilitate the development of new drugs and devices, as well as modernizing clinical trials and the development of evidence.

In addition, the law contains several important hospital-related provisions, including:

- exceptions from the outpatient prospective payment system (OPPS) site-neutral payments for certain off-campus hospital outpatient departments that were under construction at the time the site-neutral statutory provisions were passed in November 2015;
- changes to health information technology (IT) policy, such as introducing penalties for “information blocking,” taking steps to advance interoperability, adding new certification and

transparency requirements for developers of health IT, and taking steps to improve patient access to health records;

- adjustments to the Hospital Readmissions Reduction Program to account for socioeconomic status;
- providing for an additional 12 months of relief from the long-term care hospital 25% Rule;
- prohibitions on enforcement of the “direct supervision” regulations for 2016 for outpatient therapeutic services provided in CAHs and certain small, rural hospitals;
- reforms to the mental health system, including provisions related to mental health parity, integration with physical health services, workforce development, and privacy provisions, among others;
- providing \$1 billion in grants to states to help address the opioid epidemic; and
- extending the Rural Community Hospital Demonstration Program for five years.

In total, the act authorizes approximately \$6.3 billion in new spending, which will be paid for from a \$3.5 billion reduction in the Prevention and Public Health Fund, along with other savings and anticipated revenue. See the [AHA Legislative Advisory](#) for details on the Act.

## THE FEDERAL BUDGET

The Congress passed and President Obama signed into law a [continuing resolution](#) (H.R. 2028) that will fund federal programs until April 28, 2017 and provide \$872 million in funding for the 21<sup>st</sup> Century Cures Act, among other provisions. The CR provides \$872 million for fiscal year (FY) 2017 Cures activities that includes \$352 million for NIH, most of which will go toward the cancer moonshot, and \$500 million for states to respond to the opioid abuse crisis. It also includes \$20 million for FDA to carry out the law. All of the money is fully offset.

## REGULATORY POLICY

As the calendar year concludes, the AHA has identified actions for regulatory relief while CMS has posted final rules for outpatient observation and announced new patient engagement models. These are described below.

### Reducing the Regulatory Burden on Hospitals

In a Dec. 2 [letter](#) the AHA thanked President-elect Trump for his interest and commitment to addressing regulatory reform, and suggested 33 actions the incoming administration could take immediately to reduce the regulatory burdens on hospitals and the patients they serve. The letter includes examples of actions that can be taken by CMS, other agencies within HHS and other departments of the federal government including several that are important specifically to rural hospitals such as:

- Expanding Medicare coverage of telehealth services;
- Prohibiting enforcement of direct supervision requirements;
- Prohibiting enforcement of the condition of payment that requires a physician to certify a 96-hour stay or less for a Medicare beneficiary admitted to a CAH; and
- Stop categorically disallowing visiting specialist leased space arrangements or co-location simply because they do not have separate spaces, entrances and/or waiting areas.

These and many other actions are outlined in detail in our letter to the President-elect.

## **CMS posts final hospital MOON for implementation by March 8**

CMS [posted](#) its updated version of the Medicare Outpatient Observation Notice, a standard notice that all hospitals and CAHs must provide effective March 8, 2017 to all Medicare beneficiaries who receive outpatient observation services for more than 24 hours. Under the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, hospitals must provide oral and written notice to beneficiaries within 36 hours after observation services are initiated, or sooner if the individual is transferred, discharged or admitted as an inpatient. The notice informs them that they are an outpatient receiving observation services, not an inpatient, and the associated implications for cost-sharing and eligibility for Medicare coverage of skilled nursing facility services. CMS issued the final policies for implementing the NOTICE Act in August with the inpatient prospective payment system final rule, but delayed implementation until 90 days after the updated MOON was posted on its website. The CMS website includes a [downloadable copy](#) of the MOON. CMS notes that manual instructions will be made available in the coming weeks.

## **CMS announces two new patient engagement models**

The CMS Innovation Center announced two [Beneficiary Engagement and Incentives Models](#) that will test different approaches to shared decision making regarding treatment options. The [Shared Decision Making Model](#) will test a specific approach to integrate a four-step decision making process into the clinical practice of practitioners who are participating accountable care organizations. The [Direct Decision Support Model](#) will test an approach to shared decision making provided outside of the clinical delivery system by an organization that provides health management and decision support services. ACOs that are currently in the Medicare Shared Savings Program or Next Generation ACO Model and interested in participating in the SDM Model must submit a Letter of Intent for consideration for participation in the DDS and SDM Models by March 5. Decision Support Organizations that are interested in participating in the DDS Model must submit a Letter of Intent for consideration for participation in the DDS and SDM Models by March 5.

## **AHA TASK FORCE ON ENSURING ACCESS TO CARE FOR VULNERABLE COMMUNITIES**

Fifteen months ago, the AHA Board of Trustees created a task force to provide a path forward for the preservation of health care services in our nation's vulnerable rural and urban areas. Task force members spoke with hospital and community leaders across the country to identify ways hospitals and health systems can partner with their communities to best adjust to and meet patient and community needs. The result: a menu of specific options and strategies that will allow communities, and the hospitals that serve them, to protect access to essential health care services.

The task force defined a vulnerable community as a population that, due to their individual circumstances, is much more likely to be in poor health and have disabling conditions. They then worked to identify the characteristics and parameters that would identify such vulnerable rural and urban communities. In doing so, they relied upon personal experiences, as well as an analysis of financial data and other information from qualitative sources related to vulnerable rural and urban communities. A [Rural Chartbook](#) developed by the Task Force contains metrics related to rural communities and the hospitals.

The range of health care services needed and the ability of individuals to obtain access to health care services varies widely in each community. The task force determined, however, that access to a baseline of high-quality, safe and effective services must be preserved.

The task force also outlined nine “emerging strategies” designed to serve as a menu of potential options for communities to meet their specific health care needs:

- Addressing the social determinants of health
- Global budgets
- Inpatient/outpatient transformation strategy
- Emergency medical center
- Urgent care center
- Virtual care strategies
- Frontier health system
- Rural hospital-health clinic strategy
- Indian Health Services strategies

Explanations of the nine emerging strategies can be read in the [full report](#).

As hospitals and health systems continue to transform care delivery, we encourage AHA members to view the report. It provides new ideas and options to address vulnerable communities’ challenges, needs and support structures. The report also includes real-world case examples. In addition, the AHA will continue to use the Task Force’s policy recommendations to advocate with the new Congress and Administration. To learn more about this initiative, please visit [AHA.org/EnsuringAccess](http://AHA.org/EnsuringAccess).

## **RURAL HEALTH NETWORK DEVELOPMENT PLANNING GRANT**

HRSA is accepting applications for the [Rural Health Network Development Planning Grant Program](#). As many as 24 rural community health networks will each receive up to \$100,000 per year to expand local capacity and coordinate care. Successful applicants are rural nonprofit or rural public entities representing a consortium/network of three or more health care providers. The program promotes the planning and development of healthcare networks in order to: (i) achieve efficiencies; (ii) expand access to, coordinate, and improve the quality of essential health care services; and (iii) strengthen the rural health care system as a whole. The program will support one year of planning with the primary goal of helping networks create a foundation for their infrastructure and focusing member efforts to address important regional or local community health needs.

On Tuesday, Dec. 13 at 2 pm ET, HRSA will host a [technical assistance webinar to assist with applications](#). No pre-registration is required, but you must dial into the conference line (877-918-1352, passcode: 1557034) to hear the audio. Please e-mail Meriam Mikre at [mmikre@hrsa.gov](mailto:mmikre@hrsa.gov) if you have questions.

## **ROD NELSON RECEIVES THE 2016 AHA RURAL HOSPITAL LEADERSHIP AWARD**

After careful consideration and a thorough vetting of the dozens of applications received for the AHA Rural Hospital Leadership Award it was announced that Rod Nelson, CEO, Mackinac

Straits Health System, Inc., St. Ignace, MI is the recipient of the 2016 Rural Hospital Leadership Award.

Among other things, Mr. Nelson and his team established a joint venture between Mackinac Straits Hospital Authority and the Sault Ste. Marie Tribe of Chippewa Indians Health Services to create the Mackinac Straits Health System (MSHS). MSHS is a result of numerous collaborations with Sault Ste. Marie Tribe of Chippewa Indians, local leaders as well as county, state and federal officials. The Sault Tribe of Chippewa Indians donated 16 acres of land for the construction for new health care services campus, including Tribal Health Service (medical, dental, optical, behavioral health, pharmacy) and a 15 bed Critical Access Hospital, a five-physician Rural Health Clinic, a six-bed oncology infusion center, and a 48 private room nursing home. To address the mental health/addiction needs, the hospital created a community task force to include Hiawatha Behavioral Health, local law enforcement and city, county and state officials to create St. Ignace Shores, an eight-bed facility designed to integrate social detox with a mental health crisis unit. The outcome of this and other efforts is a state of the art health care campus serving tribal and non-tribal members in the region.

The Leadership Award review committee also recognized two finalists for their exceptional contribution to rural health care delivery. They are:

- Warren West, CEO, Littleton Regional Hospital (LRH), Littleton, NH: Mr. West provided the leadership necessary for LRH to remain a sustainable small and rural hospital by taking actions to accelerate the hospital on the road to reform. He also serves as CEO of North Country Healthcare, a group of four hospitals that have united to form a hospital system while preserving independence for each of its members.
- Lon Butikofer CEO, Regional Medical Center (RMC), Manchester, IA. Mr. Butikofer manages what is today an independent, sustainable CAH that provides access to a wide variety of critical health care services. Under his leadership, RMC participates in community outreach and expanded programs to include a walk-in clinic, robotic surgery and many patient-centered initiatives for a service area that spans four counties.

### 30<sup>TH</sup> ANNUAL AHA RURAL HEALTH CARE LEADERSHIP CONFERENCE

#### Plan now to attend!

February 5-8, 2017

Arizona Grand Resort & Spa

Phoenix, AZ



Since 1987, the [AHA/Health Forum Rural Health Care Leadership Conference](#) has been the educational event of choice for rural leaders who want to learn from top researchers, strategists and practitioners who can stimulate their thinking and provide the tools and approaches they need to transform the rural organization for a sustainable future.

This conference is designed for health care leaders from rural hospitals, health care systems with a strong presence in rural communities, rural health clinic, and community health organizations. Participants include administrators, trustees, physician executives, nursing administrators, public health officials and community leaders. Join us for a unique focus on innovative ideas, thoughtful insights and tested strategies for improving rural health care and developing the thoughtful leadership that can produce results.

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Visit the Section for Small or Rural Hospitals website 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).