

Small or Rural Update



Greene County Hospital
Eutaw, AL



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Los Alamos, NM

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Approximately 51 million Americans live in rural areas and depend on the hospital serving their community as an important source of care. These hospitals face a unique set of challenges because of their remote geographic location, small size, limited workforce, physician shortages and constrained financial resources with limited access to capital.

The American Hospital Association (AHA) is a tireless advocate working to ensure that the unique needs of our 2,125 rural hospital members are a national priority. This issue of the Small or Rural Update reviews the federal budget, AHA representation and advocacy, rulemaking and regulatory policy, and the Section for Small or Rural Hospital's Rural Hospital Leadership Award.

THE FEDERAL BUDGET

In March, the House Budget Committee voted 20-16 to approve a Republican [budget plan](#) for fiscal year 2017, which would reduce Medicare spending by \$449 billion and Medicaid and other health care spending by \$1.03 trillion over 10 years. All Democrats, joined by two Republicans, voted against the resolution. The plan would reduce the deficit by \$7 trillion over 10 years through \$6.5 trillion in savings coupled with economic growth to balance the federal budget, and require legislation this year to achieve at least \$30 billion in near-term mandatory savings.

With respect to health care, the plan would repeal the ACA; 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; and reform medical liability laws to curb frivolous lawsuits. It also would repeal Medicaid expansion under the ACA and create a block grant program that gives states the option to tailor a program to their communities. AHA members received a [Special Bulletin](#) with more information.

To date, the budget has not advanced to the full House Floor for consideration, nor has a budget been produced by the Senate. The appropriations process is moving forward in the absence of a budget agreement.

AHA REPRESENTATION AND ADVOCACY

Hospitals are transforming the way health care is delivered in their communities, working with other providers and community leaders to build a continuum of care to make sure every individual gets the right care at the right time in the right setting. In order to continue this transformation, and to provide patients with the access to care they need and expect, hospitals need a supportive and modernized public policy environment. Below are some of the key areas of focus for AHA's [2016 advocacy agenda](#).

2016 Advocacy Agenda

In 2016, AHA is working with Congress urging them to:

- Reject reductions in Medicare funding for indirect medical education and direct Graduate Medical Education (GME) and pass the Resident Physician Shortage Reduction Act (S. 1148, H.R. 2124), which would increase the number of Medicare-funded residency positions.
- Reject options that limit states' ability to partially fund their Medicaid programs using provider assessments, such as recent legislation (H.R. 4725) passed by the House Energy and Commerce Committee that would reduce the maximum allowable assessment percentage from 6.0 to 5.5 percent.
- Pass the Establishing Beneficiary Equity in the Hospital Readmission Program Act (S. 688, H.R. 1343), which would address the need for a sociodemographic adjustment in the Hospital Readmissions Reduction Program. AHA also will evaluate the need to similarly adjust other outcome measures. AHA will press the administration to appropriately adjust outcome measures for sociodemographic factors.
- Pass the Medicare Audit Improvement Act (H.R. 2156), which would, among other measures, eliminate the Recovery Audit Contractor (RAC) contingency fee structure and instead direct CMS to pay RACs a flat fee, as every other Medicare contractor is paid. It also would rationalize payments to RACs by lowering payments for poor RAC performance due to high rates of incorrect denials.
- Pass the Standard Merger and Acquisition Reviews Through Equal Rules (SMARTER) Act (S. 2102), already passed by the House, which would help rebalance the merger review process.

Rural Hospital Advocacy 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. Key areas of focus for rural hospitals and CAHs are included in the [AHA's 2016 rural advocacy agenda](#).

Medicare Rural Payment Extensions. Medicare rules include a number of important payment policies that ensure financial stability for hospitals that primarily treat Medicare patients, account for low patient volumes and address the high costs of providing ambulance services in rural areas. Without legislative action, these programs will expire in 2017:

- Medicare-dependent hospitals (MDH);
- Enhanced low-volume adjustment; and
- Add-on payments for ambulance services in rural areas.

AHA urges Congress to make these important programs permanent and extend regulatory relief by passing the:

- Rural Hospital Access Act (S. 332, H.R. 663), which would make the MDH program and low-volume adjustment programs permanent.
- Medicare Ambulance Access, Fraud Prevention, and Reform Act (S. 377, H.R. 745), which would make the ambulance add-on payments permanent.

CAH Payment Policies. Some policymakers are calling for dramatic reductions to the CAH program, including the elimination of CAH designation based on mileage between CAHs and other hospitals, and removal of CAH “necessary provider” exemptions from the distance requirement. In addition, CMS has indicated it will enforce the 96-hour condition of payment going forward.

AHA urges Congress to reject misguided proposals to change the CAH program and support the Critical Access Hospital Relief Act (S. 258, H.R. 169), which would remove the 96-hour piece of the physician certification requirement as a condition of payment.

Supervision of outpatient therapeutic services. In the 2009 outpatient prospective payment system (PPS) final rule, CMS mandated a new policy for “direct supervision” of outpatient therapeutic services that hospitals and physicians recognized as a burdensome and unnecessary policy change. At the urging of AHA and others, CMS has since adopted several positive changes including delaying enforcement of the policy through 2015 for CAHs and small and rural PPS hospitals. Since Jan. 1, 2016, CMS has permitted its contractors to enforce the direct supervision policy in all hospitals and CAHs.

New bipartisan legislation introduced in the House would permanently extend the enforcement moratorium on CMS' “direct supervision” policy for CAHs and small, rural hospitals. The AHA-supported “Rural Hospital Regulatory Relief Act of 2016,” (H.R. 5164) was introduced by Reps. Lynn Jenkins (R-KS) and Dave Loebsack (D-IA). AHA continues to urge Congress to pass the Protecting Access to Rural Therapy Services (PARTS) Act (S. 257, H.R. 1611), which would protect access to outpatient therapeutic services among other provisions.

Rural Community Hospital Demonstration. Sen. Charles Grassley (R-IA), Michael Bennet (D-CO), Jerry Moran (R-KS) and Lisa Murkowski (R-AK) recently introduced [AHA-supported](#) legislation (S. 607) which would extend for five years the Rural Community Hospital (RCH) Demonstration. The program enables rural hospitals with fewer than 51 acute-care beds to test the

feasibility of cost-based reimbursement. A companion bill (H.R. 672) was introduced in the House by Rep. Don Young (R-AK).

The AHA will work with hospitals to secure support for both S. 607 and H.R. 672. Please contact your legislators and urge them to cosponsor the Rural Community Hospital Demonstration Extension Act of 2015.

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. Recent policy changes are reviewed for their impact on the delivery of care in rural communities.

Rulemaking

CMS Releases Inpatient PPS Proposed Rule. CMS April 18 issued its hospital inpatient prospective payment system (PPS) and long-term care hospital (LTCH) PPS [proposed rule](#) for fiscal year (FY) 2017. Select highlights of the proposed rule related to the inpatient PPS are covered in a [Special Bulletin](#). Highlights of the proposed rule related to the LTCH PPS are covered in a separate [Special Bulletin](#). Comments will be accepted through June 17, 2016.

The proposed rule would increase inpatient PPS rates by 0.85 percent in FY 2017, after accounting for inflation and other adjustments required by law. Specifically, the update includes a proposed market-basket increase to the standardized amount of 2.8 percent. CMS proposes a 0.5 percentage point reduction to this update for productivity, as well as an additional 0.75 percentage point reduction, as mandated by the Affordable Care Act (ACA).

In addition, CMS proposes a 0.8 percent positive adjustment related to two-midnight policy. This proposed change represents an important, hard-fought victory for hospitals and health systems in reversing the unlawful 0.2 percent payment reduction for inpatient services. The AHA successfully challenged CMS's implementation of this cut in federal court and convinced CMS to restore the resources that hospitals are lawfully due.

CMS also proposes a cut of 1.5 percentage points in response to the American Taxpayer Relief Act of 2012 (ATRA). Although a cut to hospital payments was mandated by ATRA, CMS's proposal is significantly larger than Congress indicated and the hospital field anticipated. The AHA will urge CMS to reduce the amount of this cut in the inpatient PPS final rule for FY 2017.

Implementing the Medicare Access & CHIP Reauthorization Act (MACRA) Physician Payment Proposed Rule. MACRA of 2015 repeals the flawed Medicare physician Sustainable Growth Rate (SGR) formula and calls for CMS to implement a new two-track payment system for physicians and other eligible professionals that will take effect in 2019. This rule is reviewed in an [AHA Special Bulletin](#). [The proposed rule](#) describes several key policy issues such as:

- The default track is the Merit-Based Incentive Payment System (MIPS), which consolidates previously separate physician quality programs into a single program with up to 9 percent of payment at risk for performance; and

- The Alternative Payment Model (APM) track, which will award bonuses (from 2019 – 2024) to physicians who receive a sufficient amount of payment from APMs such as ACOs or medical homes.
- Other key issues for consideration:
 - Starting in 2019, MIPS Eligible Professionals (EPs) would include physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified registered nurse anesthetists. Other professionals may be added in later.
 - EPs below the low-volume threshold would be excluded from MIPS. The proposal defines the threshold as having Medicare billing charges less than or equal to \$10,000 and providing care for 100 or fewer Part B-enrolled Medicare beneficiaries.
 - The MIPS adjustment would apply to EPs who have assigned their billing rights to a CAH (i.e. Method II CAH billing).
 - Currently, Rural Health Clinics and Federally Qualified Health Centers are excluded from reporting to MIPS since they are paid differently under Medicare. CMS is asking for comment on whether these safety net providers should have the option to voluntarily report on applicable measures and activities with no penalty in order to remain in alignment with broader efforts under delivery system reform.
 - Only certain APMs are considered as qualifying for receipt of incentive payments and exclusion from MIPS payment adjustments.

Life-Safety Code Update. On May 4, 2016, [CMS issued a final rule](#) adopting the National Fire Protection Association’s (NFPA) 2012 Life Safety Code (LSC) with minor amendments and most chapters of its 2012 Health Care Facilities Code (HCFC) for hospitals, CAH and certain other facilities that participate in the Medicare and Medicaid programs. [The final rule](#) takes effect July 5. The LSC includes general requirements for all new and existing buildings. The HCFC contains more detailed provisions for health care building systems and equipment. The AHA’s American Society for Healthcare Engineering affiliate provided input to NFPA as it developed the revisions and encourages its members to comment on the draft 2018 editions of the codes available at www.nfpa.org/101next and www.nfpa.org/99next. AHA will continue to urge the agency to keep the fire-safety standards more current going forward, as there is already a 2015 edition of the LSC.

Regulatory Guidance

CMS Certification of Necessary Providers. On March 25, 2016, CMS published Transmittal 153 with [revisions to the State Operations Manual](#) (SOM) including procedures for recertification survey of CAHs. Prior to a survey by the state agency, Regional Offices (RO) must follow the guidance in SOM Section 2256A for determining:

- Rural status (If the CAH is not located in an area that is considered rural, a termination enforcement action must be undertaken.),
- CAH is a necessary provider (NP), and
- Distance and location.

The RO is provided a [recertification checklist for CAH](#) rural and distance or necessary provider designation which becomes part of their records. If there is insufficient evidence or documentation of NP status, a CAH may request a review and submit supplementary evidence to the CMS RO for consideration. Transmittal 153 offers several examples of potentially qualifying evidence.

Exclusive Use and Co-Location of Visiting Specialists. Beginning last fall, the AHA began hearing from rural hospitals that were concerned about CMS actions to disallow visiting specialists in the hospital space. The agency said such arrangements were contrary to the Medicare Conditions of Participation and ran afoul of the provider-based payment rules or other regulations. CMS's interpretation has caused rural hospitals across the country to consider whether they will need to unwind relationships with specialists who provide care in their rural communities, and the negative impact this would have on the patients they serve. This issue involves the conditions of participation, compliance and payment provisions as well as Stark, anti-kick-back laws and other rules. The AHA also is working directly with the CMS Office of Survey and Certification and the office that oversees provider-based payments.

Congress also is paying attention to this issue and how CMS is reinterpreting its rules governing such arrangements with particular focus on access to care in rural communities. The South Dakota Congressional delegation, led by Senator John Thune, sent a letter to CMS expressing concern regarding the impact the issue has on rural communities. The AHA will continue to educate Congress about the unique circumstances of ensuring access to health care in small and rural health communities including access to specialty physicians traveling to rural or frontier hospitals on an as-needed basis as well as the rules and regulations governing shared space.

Computed Radiography (CR) Standards. The Consolidated Appropriations Act of 2016 contained provisions that will cut payments to providers enrolled in the Outpatient Prospective Payment System (OPPS) or Medicare Physician Fee Schedule (MPFS) for diagnostic radiology performed on equipment that is not fully digital. Beginning in 2018, claims for x-rays performed using CR technology will be reduced by 7 percent. The cuts will increase to 10 percent beginning in 2023. In 2017, 20 percent cuts for analog begin. This is covered under [Medicare Claims Processing Manual Chapter 13](#). These provisions apply to only OPPS and the Medicare Physician Fee Schedule (MPFS), not CAHs.

Computed Tomography (CT) Diagnostic Imaging Services. The Protecting Access to Medicare Act (PAMA) of 2014 required providers that offer CT scanning services to comply with the National Electrical Manufacturers Association (NEMA) XR-29 standard attributes on CT equipment related to dose optimization and management. Effective January 1, 2016, a [payment reduction](#) of 5 percent applies to the technical component of CT procedures billed in hospital outpatient settings. The payment reduction increases to 15 percent in 2017. These provisions apply to only OPPS and MPFS, not CAHs.

Rural Health Clinic (RHC) Qualified Visits. A RHC claim must include one of the services listed on the [RHC Qualifying Visit List](#), which was recently updated with additional medically-necessary billable visits, effective April 1, 2016. The newly added codes are not payable through the claim system if reported as the only billable qualifying visit code on the claim until October 1, 2016, when the Medicare claims system will be updated to accept the new codes. As such, RHCs would need to hold any such claims with April 1, 2016 date of service forward until Fiscal Intermediary Standard System Guide is updated in the fall. However, if a new code is billed together on the same claim with another stand-alone billable qualifying visit code, the RHC claim may be submitted for services on or after April 1, 2016.

Health Care Policy

Telehealth. Current coverage, payment and other policy issues prevent full use of telehealth, remote patient monitoring and similar technologies. Medicare policy is particularly challenging as it limits the geographic and practice settings where beneficiaries may receive services as well as the types of services that may be provided via telehealth and the types of technology that may be used. Access to broadband services and state-level policy issues, such as licensure, also limit the ability to use telehealth. AHA continues to urge Congress to expand Medicare coverage and payment for telehealth. AHA also will work with the administration to include telehealth waivers in all new care models and adopt a more flexible approach to adding new telehealth services to Medicare. AHA will continue to work with the state hospital associations to address state-level issues including licensure and reimbursement for telehealth services. Visit the [AHA Telehealth](#) web page for additional resources.

Access to Care in Vulnerable Communities. The AHA Board of Trustees has commissioned a task force to confirm the characteristics of vulnerable communities and identify strategies and federal policies to help ensure access to care in these areas. The 30-member task force consists of two subcommittees that are examining the issue from the rural and urban perspectives. Its work is ongoing — it began in fall 2015 and is anticipated to conclude this fall. AHA continues to work with the task force to identify appropriate policies to ensure access to care in vulnerable communities and will advocate for those changes with Congress and the administration.

Site-Neutral Payments. Section 603 of the Bipartisan Budget Act of 2015 includes so-called “site-neutral” payment reductions for new off-campus hospital outpatient departments (HOPDs) which are defined as an off-campus department that started billing for Medicare outpatient services under OPPS on or after Nov. 2, 2015. Some, including the Medicare Payment Advisory Commission (MedPAC), have advocated for even greater use of such “site-neutral” payments. These proposals neglect the real difference between the care provided in each setting and the patients treated. AHA will continue to urge Congress to protect HOPDs under development and reject calls for any additional site-neutral payment policies. AHA is also urging CMS to implement the existing policy in the most favorable and flexible manner possible.

340B Drug Pricing Program. For nearly 20 years, the 340B program has provided help to safety-net hospitals by allowing them to stretch limited federal resources to reduce the price of outpatient pharmaceuticals for patients and expand health services. However, some want to scale it back or significantly reduce the benefits of the program. In 2015, the Health Resources and Services Administration (HRSA) proposed guidance that would reduce the volume of drugs eligible for 340B pricing. In early 2016, MedPAC recommended to Congress that Medicare payments to 340B hospitals be reduced. AHA will continue to urge Congress to oppose cuts to the 340B program and work with HRSA to protect patient access as it revises the rules for this program.

Quality Measurement. While the field is committed to quality improvement and transparency, complying with data requests is burdensome for providers. Consumers can be confused by the volume of information. Data collection and reporting activities would be more valuable if federal agencies and others asking for data agreed on a manageable list of high-priority aspects of care on

which providers would be asked to make meaningful improvement, and then to use a small and critically important set of measures to track and report on progress toward improving the care delivered as well as the outcomes for patients. AHA is working with the administration to prioritize and simplify quality reporting and improve the transition to required reporting of electronic measures. The Institute of Medicine (now National Academy of Medicine) has proposed a list of high-priority topics from which this work would begin.

EHR Incentive Program. CMS recently finalized rules making some needed changes to the program to increase flexibility in the short term. Unfortunately at the same time, it also finalized rules raising the bar on meaningful use requirements yet again with Stage 3 requirements that are required in 2018. These rules contain provisions that are challenging, if not impossible, to meet and require use of immature technology standards. AHA continues to urge CMS to modify the Stage 3 rules to be more flexible and feasible. CMS also should delay implementation to no sooner than 2019. AHA will continue to urge Congress to monitor CMS action and step in where appropriate.

Reducing Rx Drug Prices. The high cost of prescription drugs is putting a strain on Medicare, Medicaid and the entire health care system including patients. The AHA has been working with a number of stakeholders including the [Campaign for Sustainable Rx Pricing](#), to raise awareness of and develop policy solutions to combat the problems caused by drug price increases.

AHA RURAL HOSPITAL LEADERSHIP AWARD

The [AHA Rural Hospital Leadership Award](#) is sponsored by the Section for Small or Rural Hospitals. The 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 Rural Hospital Leadership Award applications are due on August 12, 2016.](#)

AHA RURAL HOSPITAL POLICY FORUM

The challenges facing rural hospitals become more urgent every day. The AHA is committed to ensuring access to care in the communities you serve. Your voice is needed to highlight the challenges with policymakers and your legislators. **Plan to attend the AHA's Rural Hospital Policy Forum on Capitol Hill June 23 in Washington, D.C. to learn the latest federal action on rural health policies and to weigh in on important rural hospital issues. See the [notice](#) for more details.**

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

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