



ADVOCACY UPDATE

EXCLUSIVE USE AND CO-LOCATION OF VISITING SPECIALISTS

Beginning last fall, the AHA began hearing from rural hospitals that were concerned about actions by the Centers for Medicare & Medicaid Services (CMS) to disallow visiting specialists in the hospital space because, 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. Here's an update on this issue.

We have heard from our rural members who are trying to provide their communities with needed access to specialty care that CMS's interpretation is highly problematic. Often, it is hard to convince specialists to come to a small town or rural community, but when they do, it dramatically improves access to needed care and management of chronic conditions and developing health issues. Further, knowing that specialists make periodic visits to small, rural communities can make it easier for primary care physicians to choose to settle in and serve a community.

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.

Congress is paying attention to this issue and how CMS is reinterpreting its rules governing such arrangements, particularly the impact on access to care in rural communities. In March, the South Dakota congressional delegation sent a letter, led by Sen. John Thune (R), to CMS expressing its concerns regarding CMS's new interpretation and its impact on access to and recruitment of specialty physicians in small and frontier hospital communities. Additionally, the Wisconsin congressional delegation is working on a similar letter, led by Reps. Ron Kind (D) and Reid Ribble (R). 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 and the rules and regulations governing shared space.

The AHA also is working directly with the CMS Office of Survey and Certification and the office that oversees provider-based payments. We have had productive conversations with CMS staff. For example, we facilitated a call this week that included some AHA small and rural hospital representatives and CMS staff. The hospital leaders spoke directly to CMS about why it was so important to be able to have specialists come to their communities. They discussed the improbability that these specialists could be accommodated in any other space in the town, and the distance and difficulty for community members if they had to travel to see specialists where the specialists maintain offices.

CMS staff found this information quite helpful and indicated at the end of the call that they understood why the community views having visiting specialists quite beneficial. They are thinking about ways in which this could be done in a manner that would be acceptable and not run afoul of existing laws, rules or regulations. Given the complexity of this issue, CMS is likely to take several months of work before providing hospitals with any further information.

That said, this issue does not just involve the conditions of participation, compliance and payment provisions; it involves the Stark and anti-kick-back laws and other rules. In other words, it is complicated. We will continue to work with CMS and Congress to urge resolution to this issue and will keep our rural and frontier members informed.

If you have further questions, please contact Evelyn Knolle, senior associate director of policy at eknolle@aha.org.



John T. Supplitt
Senior Director
American Hospital Association
Constituency Sections



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155 N. Wacker, Chicago, IL 60606