

# CAH Update



Lucas County Health Center  
Chariton, IA



SLV Health—Conejos County  
La Jara, CO

## FALL 2016

Rural hospitals are community anchors and the nation needs them. The American Hospital Association (AHA) works to assure their place in the delivery system and ensure access to health care service in rural communities. As outlined in an [AHA infographic](#):

- Approximately 51 million individuals reside in rural America – that represents approximately 18% of the population and **84% of the geographic area of the USA.**
- There are **1,855 rural community hospitals** that support nearly **2 million jobs.**
- Every dollar spent by a rural hospital produces another **\$2.29 of economic activity.**
- A typical critical access hospital (CAH) employs **213 community members.**
- Rural hospitals handle more than **21.5 million emergency visits.**

The AHA is a tireless advocate working to ensure that the unique needs of our 2,030 small or rural hospital members and 992 CAH 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 30<sup>th</sup> annual [AHA/Health Forum Rural Health Care Leadership Conference](#).

### THE FEDERAL BUDGET

**Continuing Resolution.** At the 11<sup>th</sup> hour Congress passed a continuing budget resolution (H.R. 5325) to fund the federal government until Dec. 9, 2016. When Congress returns after the election, it will need to complete work on fiscal year (FY) 2017 appropriations bills or take other action to fund the government. Lawmakers could craft an omnibus bill or pass several smaller spending packages (this "mini-bus" option is currently preferred by House Speaker Paul Ryan and Senate Majority Leader Mitch McConnell), or they could pass another continuing resolution to fund the government into the next administration.

### 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 receives 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 key areas of focus for CAHs in [AHA's 2016 advocacy agenda](#).

## 2016 Advocacy Agenda

**340B Orphan Drugs Exclusion.** On Sept. 29, the AHA expressed support for H.R. 6174, the [Closing Loopholes for Orphan Drugs Act](#), bipartisan legislation that would limit the “orphan drug” exclusion for 340B drug pricing programs’ rural and cancer hospitals. This bill would allow 340B hospitals subject to the exclusion to purchase orphan drugs through the 340B program when the drugs are used to treat an illness other than the rare conditions for which the orphan drug designation was given.

**Delay Release of CMS Star Ratings for One Year.** The [Hospital Quality Rating Transparency Act of 2016](#) (H.R. 5927) would delay the release of the hospital star ratings until no earlier than July 31, 2017 and require CMS to accept comments for 60 days on its methodology and the data used. In addition, it asks that the methodology and data be validated by a third party. The bill also would require the agency to remove the star ratings from the Hospital Compare website if they are posted prior to the bill’s enactment.

**Workforce.** AHA continues to urge Congress to pass 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.

## 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 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](#) and recent action by Congress is promising.

**Senators Introduce Bill to Bolster Rural Health Care.** Sens. Pat Roberts (R-KS), John Barrasso (R-WY), Heidi Heitkamp (D-ND) and Al Franken (D-MN) Sept. 28 introduced the [Rural Hospital and Provider Equity Act](#) (R-HoPE), AHA-supported legislation that would extend critical rural provisions that have expired or are set to expire and implement new provisions that would benefit rural hospitals. The bipartisan bill (S. 3435) would remove the 96-hour physician certification requirement as a condition of payment for CAHs, and extend the enforcement moratorium on the CMS direct supervision policy for outpatient therapeutic services provided in CAHs and certain small, rural hospitals.

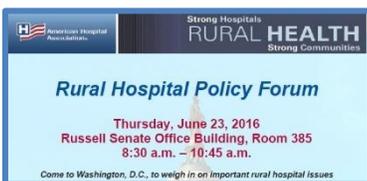
**House Passes Bill to Extend Direct Supervision Moratorium.** The House of Representatives recently passed the Continuing Access to Hospitals Act of 2016 (H.R. 5613) to extend through calendar year (CY) 2016 the enforcement delay on direct supervision requirements for outpatient therapeutic services provided in critical access hospitals and rural

prospective payment system hospitals with 100 or fewer beds. The bill was referred to the Senate Finance Committee for consideration.

AHA also urges Congress to pass S. 3129 to extend for [CY 2016 the enforcement moratorium](#) on CMS's "direct supervision" policy on outpatient therapeutic services provided in CAHs and small, rural hospitals. In addition, Congress should pass the [Rural Hospital Regulatory Relief Act](#) (H.R. 5164) to *permanently* extend the enforcement moratorium for CAHs and small rural hospitals. The 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.

In addition, AHA continues working with Congress urging them to pass 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. CAHs would still be required to satisfy the condition of participation requiring a 96-hour annual average length of stay.
- [Rural Hospital Access Act](#) (S. 332/H.R. 663), which would permanently extend the MDH and enhanced low-volume adjustment programs.
- [Medicare Ambulance Access, Fraud Prevention and Reform Act](#) (S. 377/H.R. 745), which would permanently extend the ambulance add-on payment adjustment.
- [RCH Demonstration](#) bill (S. 607/H.R. 672), which would extend the demonstration five years to allow rural hospitals with fewer than 51 acute-care beds to test the feasibility of cost-based reimbursement. In addition, Section 103 of the [Helping Hospitals Improve Patient Care Act](#) of 2016 (H.R. 5273), would extend the Rural Community Hospital Demonstration Program for five years and expand the program to rural areas in all states.



**AHA Rural Hospital Policy Forum.** This summer, AHA organized a Rural Hospital Policy Forum in Washington, DC that was attended by over 100 rural hospital leaders. AHA Executive Vice President Tom Nickels moderated a congressional panel and leaders received an update on the AHA Task Force on Ensuring Access in Vulnerable Communities. A [video](#) featuring rural hospital employees was unveiled and promoted on social media.

Speakers included Sens. Ron Wyden (D-OR), Pat Roberts (R-KS) and Jon Tester (D-MT), as well as staff from the Senate Finance and House Ways & Means committees.



**Celebrate National Rural Health Day.** Nov. 17 marks National Rural Health Day, an opportunity to "Celebrate the Power of Rural" by honoring the selfless, community-minded, "can do" spirit of that prevails in rural America. It also is an opportunity to highlight the unique health care challenges that rural citizens

face – and showcase the efforts of rural providers, State Offices of Rural Health and other rural stakeholders to address those challenges. The AHA Section for Small or Rural Hospitals invites you to join us in promoting National Rural Health Day.

## RULEMAKING AND REGULATORY POLICY

Medicare policy changes and payment adjustments often have significant and sometimes 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.

### Regulations

**CMS Releases Inpatient PPS Final Rule.** CMS published its final rule on Aug. 2, which is reviewed in an [AHA Regulatory Advisory](#). Specifically, the agency increases rates by 0.95% compared to FY 2016. This represents a major victory for hospitals because it finalizes a permanent adjustment of approximately 0.2% to remove the cut instituted when the agency implemented the two-midnight policy as well as a one-time adjustment of 0.6% to address the retroactive cut for FYs 2014-2016.

As part of the Notice of Observation Treatment and Implication for Care Eligibility (NOTICE) Act, CMS created the Medicare Outpatient Observation Notice (MOON). The act requires hospitals and CAHs to provide Medicare beneficiaries receiving observation services for more than 24 hours a written notice (in the form of the MOON) and an oral explanation of their status as an outpatient under observation, and not as an inpatient. Further, the notice must explain the reasons for their status and the implications of that status, such as the implications on cost-sharing and subsequent eligibility for skilled nursing facility (SNF) services.

The AHA believes that hospitals and practitioners should communicate clearly with Medicare beneficiaries and their families about their status in the hospital. As such, we believe that the MOON, properly written and formatted, will ensure improved beneficiary understanding of their outpatient observation status and its implications. [In our comments](#) we offer several suggestions to make the notice clearer, easier to understand and more aligned with Congress's intent in enacting the NOTICE Act.

**CMS Outpatient PPS Proposed Rule Includes Changes to the EHR Incentive Program.** In the rule released on July 6, CMS proposes:

1. changes to the EHR Incentive Program objectives and measures for eligible hospitals (EHs) and CAHs for Modified Stage 2 and Stage 3, starting with the EHR reporting periods in CY 2017;
2. changes to the EHR reporting period in CY 2016 for EHs, CAHs and eligible professionals (EPs);
3. to revise the reporting period for EHs, CAHs and EPs that are new program participants in CY 2017;
4. to clarify the policy on measure calculations for actions outside the EHR reporting period; and
5. a one-time significant hardship exception from the 2018 payment adjustment for new EPs in the EHR Incentive Program in CY 2017 that are transitioning to the Merit-based Incentive Payment System (MIPS) in CY 2017.

The proposals to remove objectives and measures or change measure thresholds would not apply to EHs and CAHs attesting under the Medicaid EHR Incentive Program. CMS states its concern that states would incur additional cost and time burdens in updating their technology

and reporting systems within a short period of time if the proposed changes to the objectives and measures were applicable to the Medicaid EHR Incentive Program.

The AHA is pleased with CMS's proposal to suspend the HCAHPS survey pain-management questions in the VBP program scoring methodology while the agency field tests new questions. Further, the AHA is pleased that CMS proposes a 90-day EHR reporting period for 2016, additional flexibility in the reported measures and the reduced threshold for some Stage 3 requirements. However, we are disappointed that CMS proposes to retain several unrealistic Stage 3 requirements, such as the required use of application program interfaces. The proposed rule is reviewed in an [AHA Regulatory Advisory](#). A final rule is expected Nov. 1.

**Physician Fee Schedule Proposed Rule.** On July 7, CMS released its proposed rule for CY 2017 with changes to the Medicare PFS and other revisions under Medicare Part B. The proposed rule is reviewed in an [AHA Regulatory Advisory](#). In addition to the standard update to PFS payment weights and rates, the rule would:

- Expand payment for telehealth services to include certain end-stage renal disease-related services and advanced care planning and it allows for critical care consultations.
- Provide an arrangement for point of service (POS) payments for telehealth that is when the telehealth POS code is used, the practitioner providing telehealth services would be paid the facility rate for those services.

The PFS also includes flexibility for supervision of auxiliary personnel providing chronic care management (CCM) or transitional care management (TCM) services in a RHC or FQHC. Currently, auxiliary staff – including nurses, medical assistants and other clinical staff who work under the direct supervision of a RHC or FQHC practitioner – may furnish these services incident to a RHC or FQHC visit. CMS proposes to allow these services to be furnished under general supervision of RHC or FQHC practitioners. This would apply only to auxiliary personnel furnishing CCM or TCM incident to services, and would not apply to other RHC or FQHC services.

**Emergency Preparedness.** On Sept. 16 CMS published a [final rule](#) establishing new emergency preparedness requirements for Medicare and Medicaid-participating health care facilities. The regulations apply to 17 different provider types, including hospitals, CAHs, ambulatory surgical centers, long-term care facilities (LTCs), intermediate care facilities for individuals with intellectual disabilities, and rural health clinics. **All organizations will need to conduct a thorough evaluation of their existing emergency preparedness programs to determine necessary changes and additions needed to comply with the final rule.** See the AHA [Regulatory Advisory](#) for details.

The final standards require health care facilities to conduct risk assessments using an all-hazards approach; develop emergency preparedness plans, policies, and procedures, including distinct communications plans; and establish training and testing programs. Hospitals, CAHs and LTC facilities will also be required to have emergency and standby power systems that reflect their emergency plans. The AHA was successful in convincing CMS to provide flexibility with regard to the location and testing of generators. The new requirements have an implementation date of Nov. 15, 2017.

**Hospital Compare Star Ratings.** On July 27, CMS released the performance data. The rating approach is quite complex and [AHA is very concerned](#). CMS constructs the star ratings using a subset of measures – about 60 in total – from the hospital inpatient and outpatient quality reporting programs. Legislators are responding to hospitals' concerns; 60 senators and 225

members of the House of Representatives signed “Dear Colleague” letters urging CMS to delay releasing the star ratings. In addition, the Hospital Quality Rating Transparency Act (H.R. 5297) was introduced in the House.

**Medicare Conditions of Participation.** On June 16, CMS proposed a rule to update select Conditions of Participation (CoPs) that hospitals and CAHs must meet to participate in Medicare and Medicaid. CMS believes the changes are necessary to align the Medicare requirements with current practice standards, improve quality and reduce barriers to care. See the [AHA Regulatory Advisory](#), but among the proposed changes, CMS would:

- Require hospitals and CAHs to implement antibiotic stewardship programs that adhere to nationally recognized guidelines and best practices;
- Augment infection prevention and control regulations for both hospitals and CAHs;
- Update quality assessment and performance improvement (QAPI) requirements, including the establishment of robust, ongoing, data-driven QAPI programs for CAHs; MBQIP potentially meets this requirement for CAHs;
- Make several changes related to the content of hospital medical records;
- Allow qualified dietitians/nutrition professionals in CAHs to order patient diets, as authorized by the medical staff and state law; and
- Require hospitals and CAHs to implement written policies to prohibit discrimination on the basis of race, color, religion, national origin, sex (including gender identity), sexual orientation, age or disability, and to inform patients of their right to be free from discrimination.

**Implementing the Medicare Access & CHIP Reauthorization Act (MACRA) Physician Payment Final Rule.** MACRA of 2015 repeals the flawed Medicare sustainable growth rate methodology for updates to the physician fee schedule and requires CMS to establish a new physician quality and value-based payment program – the [Quality Payment Program](#) (QPP) – that starts in CY 2019. Eligible clinicians will participate in one of two tracks – the default Merit-based Incentive Payment System (MIPS) or alternative payment models (APMs) – and their 2019 payments will be tied to performance during 2017. The rule finalizes most of the key policies for the 2019 QPP. The rule also finalizes policies related to blocking of health information and EHR surveillance that apply to all hospitals, critical access hospitals and physicians.

AHA is disappointed that CMS continues to narrowly define advanced APMs, which means that less than 10 percent of clinicians will be rewarded for their care transformation efforts. However, we are encouraged that CMS is exploring a new option that would expand the available advanced APMs that qualify for incentives. In addition, we are pleased that CMS has provided clinicians with increased flexibility to meet MACRA’s aggressive timelines and reporting requirements by allowing them to “pick their pace.” See the [AHA Special Bulletin](#) for details.

The final rule includes descriptions of key policy issues such as:

- The MIPS adjustment would apply to EPs who have assigned their billing rights to a CAH (i.e., Method II CAH billing).
- Currently, RHCs and FQHCs are excluded from reporting to MIPS since they are paid differently under Medicare.
- CMS also raises the low-volume threshold above which clinicians are required to participate in the MIPS. Specifically, clinicians billing \$30,000 or less of Medicare charges, or that see 100 or fewer Medicare patients, will **not** be required to participate in the MIPS.

With the Quality Payment Program set to begin on Jan. 1, 2017, CMS offers some flexibility by providing clinicians with three options for MIPS participation during CY 2017:

**1. Report “some” data to avoid a penalty, but receive no incentive payments.**

Specifically, clinicians that report any of the following will avoid a penalty:

- At least one measure in the quality category;
- One clinical practice improvement activity (CPIA); or
- The measures required under the advancing care information (ACI) category.

**2. Report data MIPS categories for a continuous 90 days to avoid a penalty and be potentially eligible for small positive MIPS adjustments.** Specifically, clinicians will be expected to report:

- More than one measure in the quality category;
- More than one CPIA; or
- More than the measures required in the ACI category.

**3. Report all required data in all MIPS categories for at least 90 continuous days, and be eligible for larger positive MIPS incentives.** Additional details on the finalized reporting requirements for each category are provided later in this bulletin.



Additional resources on the new physician payment system can be found on the AHA [MACRA webpage](#) complete with resources and tools. Watch for details about educational videos, MACRA Minutes, and a Nov. 3 webinar.

**Rural Health Clinic Qualifying Visits.** Effective Oct. 1, 2016, RHCs shall add modifier CG to the line with all the charges subject to coinsurance and deductible, which includes all charges subject to coinsurance and deductible for the visit for select billable visits on the RHC Qualifying Visit List. For RHCs, the coinsurance is 20 percent of the charges. Therefore, coinsurance and deductible will be based on the charges reported on the revenue code. RHCs will continue to be paid an all-inclusive rate (AIR) per visit.

## HEALTH CARE POLICY

**Federal Court Denies Request to Delay Medicare Appeals Backlog.** A District of Columbia federal court trial judge Sept. 19 denied the government’s request to delay further proceedings in a case brought by the AHA and three hospital organizations to compel HHS to meet its congressionally mandated deadlines for reviewing Medicare claims denials.

The [AHA praised the court’s decision](#), saying that it rightly recognizes that HHS has neither developed nor even offered any realistic plan for resolving the backlog of appeals and that only a court order will ensure that it takes the immediate, concrete and feasible steps necessary to come into compliance with the mandatory deadlines.

**QIOs Resume Two-Midnight Reviews.** Quality Improvement Organizations recently resumed claim audits under the two-midnight inpatient admissions policy, CMS [announced](#). CMS temporarily [paused](#) the patient status reviews in May to improve standardization after AHA shared with the agency hospitals’ concerns about the review process. CMS said it was lifting the pause in reviews because the Beneficiary and Family Centered Care QIOs have

completed re-training on the two-midnight policy; re-reviewed claims that were previously formally denied; performed provider outreach on claims affected by the temporary suspension; and initiated provider outreach and education regarding the two-midnight policy.

In addition, CMS said it examined and validated the BFCC-QIOs' peer review activities related to short-stay reviews and will continue to review a sample of completed claim reviews each month, monitor provider education calls, and respond to individual provider inquiries and concerns. Questions and comments about the reviews may be submitted to CMS at [ODF@cms.hhs.gov](mailto:ODF@cms.hhs.gov).

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

#### Save the Date!

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.

---

---

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).