

# Small or Rural Update



Val Verde Regional Medical Center  
Del Rio, TX



Carilion Franklin Memorial Hospital  
Rocky Mount, VA

## Summer 2017

The American Hospital Association (AHA) is a tireless advocate working to ensure that the unique needs of our 2,000 plus rural hospital members are a national priority. This issue of the Small or Rural Update discusses Congress' activity around replacing and repealing the Affordable Care Act as well as reviews the federal budget, AHA representation and advocacy, rulemaking and regulatory policy.

### 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 offers 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 Aug. 11](#).

### HILL ACTION ON THE AFFORDABLE CARE ACT

From the onset of the debate to repeal and replace the Affordable Care Act, America's hospitals and health systems have been guided by a set of key principles that would protect coverage for Americans. Unfortunately, the House-passed [American Health Care Act](#) (AHCA) and the Senate's draft bill, the [Better Care Reconciliation Act](#) (BCRA), move in the opposite direction, particularly for our most vulnerable patients.

The BCRA would result in 22 million more people uninsured in 2026 and cut \$772 billion in federal spending from the Medicaid program from 2017-2026, according to an analysis by the Congressional Budget Office (CBO).

Rural communities will be especially hard hit. Because rural regions tend to have sicker patients and more costly care, the need for access to coverage – both Medicaid and availability through the marketplace – is especially important. This current plan does not provide the safety net that rural patients and hospitals need. Many rural hospitals have a higher-than-normal percentage of Medicaid patients and expected cuts to the program could adversely affect facilities – perhaps to the point of closure for some.

When rural hospitals close, the effects are felt throughout the community. Rural hospitals are often the community's largest employer, leading to job losses outside the hospital walls. Doctors, nurses, technicians and others are often forced to leave the area to look for jobs elsewhere.

Senate Republicans have decided against holding a procedural vote on the BCRA, opting instead to re-write the measure over the Fourth of July recess and get a new analysis from the CBO. AHA continues to urge senators to oppose the BCRA and go back to the drawing board to develop legislation that continues to provide coverage to all Americans who currently have it.

Please visit AHA's [special advocacy resource page](#) for a summary of the BCRA and [talking points](#), along with other resources. Hospital and health system CEOs also have received data analyses from AHA on how the BCRA would impact coverage in their communities. We also launched a special [webpage](#) hospital leaders can share with their employees and trustees to amplify our message on Capitol Hill. So far, thousands of messages have been sent to lawmakers urging them to protect coverage.

To support our grassroots efforts and lobbying on Capitol Hill, the [Coalition to Protect America's Health Care](#), of which the AHA is a founding member, is running TV, radio, and [digital advertising](#) reinforcing the need to protect coverage. The Coalition also has energized its online community of 1.4 million members and urged its supporters to reach out to their senators through a dedicated [email campaign](#).

## **THE FEDERAL BUDGET**

### **FY 2017 Budget**

On May 4, the Senate voted 79-18 to pass an [omnibus appropriations bill](#) providing discretionary funding for the federal government through Sept. 30, the end of the 2017 fiscal year (FY). The omnibus bill includes \$73.5 billion for the [Department of Health and Human Services](#), a \$2.8 billion increase from FY 2016. The National Institutes of Health would receive a \$2 billion increase, while the Health Resources and Services Administration (HRSA) would receive a \$6 million increase for rural health programs. Included in the bill are line items for:

- **Rural Health Outreach** – The budget agreement provides \$65.5 million for the Rural Health Outreach program. The agreement provides not more than \$12.5 million for Outreach Service Grants; not less than \$15 million for Rural Network Development Grants; not less than \$12 million for Delta States Network Grant Program; not less than \$2.2 million for Network Planning Grants; and not more than \$6.5 million for Small Healthcare Provider Quality Improvement Grants.
- **Delta States Rural Development Network Grant Program** – The budget agreement provides an additional \$2 million to support HRSA's collaboration with the Delta Regional Authority to develop a pilot program to help underserved rural communities identify and better address their health care needs and to help small rural hospitals improve their financial and operational performance.
- **Rural Hospital Flexibility Grant Program** – The budget agreement provides an additional \$2 million for a total \$43.6 million rural hospital flexibility grant program. With the additional funds, HRSA is directed to issue a new funding opportunity announcement. The agreement directs HRSA to give preference in grant awards to Critical Access Hospitals serving rural communities with high rates of poverty, unemployment, and substance abuse.
- **Telehealth** – The budget agreement provides an additional \$1.5 million for telehealth. The agreement directs HRSA to develop a plan to create a telehealth center of excellence to test the efficacy of telehealth services in both urban and rural geographic locations. The agreement allocates not less than \$7.3 million for the Telehealth Network Grant Program giving preference in grant awards to small hospitals serving communities with high rates of poverty, unemployment, and substance abuse.
- **National Diabetes Prevention Program** – The budget agreement includes \$22.5 million for the NDPP, an increase of \$2.5 million over FY 2016, and directs all new funds to support new program providers, including a focus on rural providers.
- **First Responder Training** – The budget agreement provides \$12 million for First Responder Training grants as authorized in the Comprehensive Addiction and Recovery Act of 2016, P.L. 114-198. Of this amount, \$6 million is set aside for rural communities with high rates of substance abuse.
- **Air Ambulance Services and Payment Structures** – The budget agreement directs the Government Accountability Office (GAO) to submit a report to the Committees on Appropriations of the House of Representatives and the Senate on fixed wing and helicopter air ambulance services, operational costs, and, as available, payment structures.
- **Critical Access Hospitals** – The budget agreement continues to note concerns about the proposal to eliminate Critical Access Hospitals (CAH) status from facilities located less than 10 miles from another hospital and reducing the reimbursement rate from 101 to 100 percent on the hospitals to properly provide care to local residents. CMS is directed to take steps to limit the negative impact of the proposed rate reduction on CAH.

### Federal Debt Ceiling

Recently, the Office of Management and Budget Director Mick Mulvaney told the House Budget Committee that tax receipts are coming in more slowly than expected and Treasury

Secretary Steven Mnuchin is urging Congress increase the debt ceiling before the August recess. The debt limit was reinstated in March, but the Treasury Department is using “extraordinary measures” to avoid a devastating government default.

### **FY 2018 Budget**

President Trump recently submitted to Congress his budget request for FY 2018. The budget request, which is not binding, proposes savings of \$627 billion over 10 years, of which \$610 billion is attributable to the request’s Medicaid reform proposal. The budget also assumes \$250 billion in savings from the repeal of the Affordable Care Act (ACA). The budget request would not make any direct reductions to Medicare funding. The budget request would extend CHIP funding through FY 2019, while calling for \$5.8 billion in additional savings from program funding over the two-year window.

The AHA is deeply disappointed that the president’s budget for FY18 eliminates funding for the National Health Service Corps and the graduate medical education (GME) payments to Teaching Health Centers. Failing to fund these important programs will further exacerbate the challenge of addressing workforce and physician shortages in rural communities. Additionally, we are disappointed to see reductions in funding for other rural health programs, including reduced funding for telehealth (\$17M in FY17 to \$10M in FY18) and the elimination of funding for Rural Hospital Flexibility Grants, which provides support for a range of activities focusing on critical access hospitals. Find more information on the White House’s budget request in [AHA Special Bulletin](#).

## **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 2017 advocacy agenda](#).

### **2017 Advocacy Agenda**

In 2017, AHA is working with Congress urging them to:

- Extend funding for the Children’s Health Insurance Program (CHIP), which covered roughly 5.6 million children as of February. Without an extension, states will start running out of federal funds in October, with the majority of states exhausting their money between January and March, according to the Medicaid and CHIP Payment and Access Commission.
- Reject reductions in Medicare funding for indirect medical education and direct Graduate Medical Education (GME) and pass the Resident Physician Shortage Reduction Act (S. 1301/H.R. 2267), which would increase the number of Medicare-funded residency positions.

- Pass the Standard Merger and Acquisition Reviews Through Equal Rules (SMARTER) Act (H.R. 659), 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 2017 rural advocacy agenda](#).

- Pass S. 1130, the Rural Emergency Acute Care Hospital (REACH) Act, which would allow CAHs and small rural hospitals with 50 or fewer beds to convert to rural emergency hospitals and continue providing necessary emergency and observation services (at enhanced reimbursement rates); but stop inpatient services. The legislation also provides enhanced reimbursement rates for the transportation of patients to acute care hospitals in neighboring communities.
- Pass the Rural Hospital Regulatory Relief Act of 2017 (S. 243/H.R. 741), to make permanent the enforcement moratorium on CMS’s “direct supervision” policy for outpatient therapeutic services provided in CAHs and small, rural hospitals.
- Pass the Rural Hospital Access Act of 2017 (S. 872/H.R. 1955), to permanently extend the Medicare-dependent hospitals and enhanced low-volume adjustment programs.
- Pass the Medicare Ambulance Access, Fraud Prevention, and Reform Act of 2017 (S. 967), to permanently extend the ambulance add-on payment adjustment.
- Pass the Medicare Access to Rehabilitation Services Act of 2017 (S. 253/H.R. 807), to repeal the outpatient rehabilitation therapy caps.
- Pass the Telehealth Innovation and Improvement Act (S. 787), to allow eligible hospitals to test offering telehealth services to Medicare patients and evaluate these services for cost, effectiveness and quality of care.
- Pass the Conrad State 30 and Physician Access Reauthorization Act (S. 898/H.R. 2141), which extends and expands the Conrad State 30 J-1 visa waiver program, which allows physicians holding J-1 visas to stay in the U.S. without having to return home if they agree to practice in a federally-designated underserved area for three years.

### **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

### Inpatient PPS Payment Update

CMS on April 14 issued its hospital IPPS proposed rule for FY 2018. The proposed rule would increase IPPS rates by 1.6 percent in FY 2018, after accounting for inflation and other adjustments required by law. The proposed rule outlines some promising proposals intended to reduce regulatory barriers for hospitals, health systems and the patients they serve, such as on the CAH 96-hour rule, electronic clinical quality measures (eCQMs) and the electronic health record (EHR) incentive program. It also includes a request for information soliciting feedback on how Medicare can contribute to making the delivery system less bureaucratic and complex, and how it can reduce burden for clinicians, providers and patients in a way that increases quality of care and decreases costs.

In a [statement](#) AHA identified some troubling elements, including CMS's intent to not restore last year's excess cut to reimbursement rates for hospital services and its proposal to begin to use the "Worksheet S-10" data to distribute disproportionate share hospital (DSH) payments without taking sufficient action to ensure the accuracy, consistency and completeness of these data prior to their use. A [Regulatory Advisory](#) is available for reference.

*RCH Demonstration.* In addition and as required under the 21<sup>st</sup> Century Cures Act, CMS proposed extending and expanding the Rural Community Hospital Demonstration (RCH) demonstration program and issued a [Request for Applications](#) on April 17 which includes eligibility requirements for participation, the application process, and logistics related to the application review process for new hospitals. The agency's goal is to finalize selections by June 2017.

An AHA-supported letter from Sen. Grassley and several other members of Congress to CMS urged the agency to implement the extension of the RCH Demonstration program according to Congressional intent. The IPPS proposed rule would implement the five-year extension in a manner that would result in a gap in reasonable cost payment for the existing RCH demo hospitals. The agency also discussed an alternative approach that would allow for a continuous extension (i.e., retroactive payments). The AHA believes that the extension should be continuous.

We submitted detailed [comments](#) to CMS on the proposed rule as well as its [response to the request for information](#) on CMS flexibilities and efficiencies.

### FCC Rural Health Care Program

The Federal Communication Commission should update its Rural Health Care Program to meet the growing demand for broadband telehealth services, the AHA said in [comments](#) submitted recently. Specifically, AHA recommends the program increase the Healthcare Connect Fund and HCF discount percentage; reduce administrative burden; support consortium administrative expenses and remote patient monitoring; and reconsider how it defines an eligible rural area. The comments were submitted in response to a public request

for comments on how to accelerate access to broadband-enabled health care solutions in rural and other underserved areas.

### MACRA Proposed Rule

On June 20 CMS issued a [proposed rule](#) updating the requirements of the quality payment program (QPP) for physicians and other eligible clinicians mandated by the Medicare Access and CHIP Reauthorization Act of 2015. The QPP includes two tracks – the default Merit-based Incentive Payment System and advanced alternative payment models. The rule proposes what eligible clinicians must report for the QPP's 2018 performance period, which will affect eligible clinicians' payment under the Medicare physician fee schedule in calendar year 2020. AHA is [encouraged](#) by CMS's proposal for a facility-based clinician reporting option, and applauds the agency's proposal to extend the use of modified stage 2 meaningful use requirements through 2018. AHA will encourage CMS to provide the same relief to hospitals. See the [AHA Special Bulletin](#) for highlights of the proposed rule.

### **Regulatory Guidance**

#### Guidance on Shared Space

CMS is working to finalize updated guidance related to co-location, which should clarify policies governing how hospitals can share space with other providers, the agency told the AHA recently. AHA has been urging CMS to provide more transparency about the agency's expectations for shared space and to allow for flexibility where needed and appropriate, especially for rural areas where hospitals may have visiting specialists. We continue to appreciate CMS's openness to hearing our concerns. We have asked CMS to make this guidance a priority and to align its policies as much as possible with the agency's broader mission to promote coordinated, patient-centered care across the continuum.

#### MIPS Participation Status Letter

CMS is reviewing claims and letting practices know which clinicians need to take part in the Merit-based Incentive Payment System (MIPS), an important part of the new Quality Payment Program. During the spring, physicians were sent a letter from their MAC providing the participation status of each MIPS clinician associated with their Taxpayer Identification Number (TIN). Clinicians should participate in MIPS in the 2017 transition year if they:

- Bill more than \$30,000 in Medicare Part B allowed charges a year and
- Provide care for more than 100 Part B-enrolled Medicare beneficiaries a year.

During this first year of the program, CMS is committed to working with physicians to streamline the process as much as possible. The agency's [Quality Payment Program](#) website has additional resources.

#### CAH 96-hour Certification Requirement

As a condition of payment for inpatient services provided at a CAH, the statute requires that a physician certify that an individual may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. In the IPPS proposed rule, CMS states that it reviewed the CAH 96-hour certification requirement to determine if

there are ways to reduce its burden on providers. As a result, the agency states that it will direct Quality Improvement Organizations (QIOs), Medicare Administrative Contractors (MACs), the Supplemental Medical Review Contractor (SMRC), and Recovery Audit Contractors (RACs) to make the requirement a low priority for medical record reviews conducted on or after Oct. 1, 2017. This means that absent concerns of probable fraud, waste or abuse of the coverage requirement, these contractors will *not* conduct medical record reviews to determine compliance with the CAH 96-hour certification requirement.

The AHA appreciates CMS's recognition that this condition of payment could stand in the way of promoting essential, and often lifesaving, health care services to rural America. We urge CMS to finalize this proposal on a permanent basis to provide CAHs with certainty that the agency will not begin to audit the 96-hour hour certification requirement in the future.

In addition, while this moratorium offers some comfort, it does not remove the 96-hour certification requirement from the statute, and the AHA remains concerned that CAHs may still be at risk for penalties. As a result, the AHA will continue to advocate for a legislative solution that permanently removes the 96-hour physician certification requirement as a condition of payment for CAHs and we urge CMS to work with us to support that effort.

#### Clinical Decision Support (CDS) Mandate under the Physician Fee Schedule

In the Protecting Access to Medicare Act of 2014, Congress included a mandate ordering providers to consult appropriate use criteria via electronic CDS when ordering outpatient advanced imaging exams for Medicare patients. Jan. 1, 2018 is the deadline for referring providers to begin consulting CDS when placing advanced outpatient imaging orders, and for furnishing providers to submit documentation of CDS use on Medicare claims for reimbursement.

### **Health Care Policy**

#### 340B Drug Pricing Program

The 340B Drug Pricing Program has been in the news recently, and we expect the attention placed on the program to increase over the coming months. The Trump Administration continues to discuss taking action on the issue of prescription drug costs, and it has been reported that the Administration is drafting an executive order on drug prices that could place harmful restrictions on the 340B program by reducing both the number of patients and hospitals eligible to benefit from the program. In addition, the Administration's 2018 budget request would direct the Department of Health and Human Services to work with Congress to reform the program. **Please [view the AHA Member Advisory](#) for key messages about the program that you can use when discussing it with your community, policymakers and the media.**

#### 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 urges CMS to cancel Stage 3 of meaningful use by removing the 2018 start date from the regulation, and gather input from stakeholders on ways to further reduce the burden of the meaningful use program requirements.

### 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.

### Access to Care in Vulnerable Communities

In 2016, an AHA task force released its report on Ensuring Access to Care in Vulnerable Communities, which offers hospital and health system leaders nine innovative ways to preserve access to essential health services in vulnerable communities. These nine strategies are:

1. Addressing the social determinants of health
2. Global budgets
3. Inpatient/outpatient transformation strategy
4. Emergency medical centers
5. Urgent care centers
6. Virtual care strategy
7. Frontier health system
8. Rural hospital-health clinic strategy
9. Indian health service strategy

Successful implementation of these emerging strategies by vulnerable communities is dependent on numerous public policy changes. As such, AHA is developing the specific legislative and regulatory changes that are necessary to enable their implementation. We are advocating that policy makers make such changes a priority so that hospitals and health systems can better ensure access to care in vulnerable urban and rural communities. Learn more at [www.aha.org/EnsuringAccess](http://www.aha.org/EnsuringAccess).

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](mailto:jsupplitt@aha.org).