# SMALL OR RURAL HOSPITAL UPDATE

## Spring 2018

American Hospital Association
Section for Small or Rural Hospitals

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** reviews the AHA rural advocacy agenda, federal rule making, national policy priorities and tools and resources for rural hospitals.

## RURAL ADVOCACY


Senate Hearing Examines Rural Health Care: The Senate Finance Committee May 24 held a hearing on "Rural Health Care in America: Challenges and Opportunities." In a statement submitted for the record, AHA recommended legislative and regulatory actions to maintain access to health care in rural communities – from enacting alternative payment models such as the rural emergency medical center to providing regulatory relief and expanding access to telehealth services. Hospital and health system witnesses at the hearing included Konnie Martin, CEO of San Luis Valley Health in Alamosa, CO. "Federal payment systems and delivery models must...be updated to meet the realities and challenges of how health care is delivered today and in the future....In a country as great as ours, where you live should not determine if you live." Senators Wyden and Hatch expressed support for advancing bipartisan legislation this year to help address some of the challenges of providing care in rural areas.

Rural Emergency Medical Center Act of 2018 (H.R. 5678): Reps. Lynn Jenkins (R-KS), Ron Kind (D-WI) and Terri Sewell (D-AL) May 7 introduced AHA-supported legislation that would create a new Medicare facility designation to help rural communities maintain access to essential emergency and outpatient services for patients. The legislation aligns with the emergency medical services model recommended by the AHA's Task Force on Ensuring Access in Vulnerable Communities in 2016. **Please urge your representative cosponsor H.R. 5678.** See the AHA Action Alert for more details.

Critical Access Hospital Relief Act of 2018 (H.R.5507): This legislation would remove the 96-hour physician certification requirement as a condition of payment for critical access hospitals (CAHs). A physician would not be required to state that the patient will be discharged or transferred in less than 96 hours in order for the CAH to be paid on that particular claim. CAHs would continue to need to meet the other certification requirements that apply to all hospitals as well as the condition of participation requiring a 96-hour *annual* average length of stay.

CMS Rural Health Strategy published: CMS May 8 released the agency's Rural Health Strategy to promote high-quality health care for all rural Americans, address the unique economics of providing rural health care, and bring a rural focus to CMS health care

delivery and payment reforms. AHA is pleased CMS put forward thoughtful recommendations to address the unique challenges of providing care to patients in rural communities," said Joanna Hiatt Kim, AHA vice president of payment and policy. "We look forward to working with CMS and Congress to take meaningful action to stabilize access in rural communities, such as creating new alternative payment models, expanding coverage of telemedicine and access to broadband, and reducing regulatory burden."

# OPIOIDS


House, Senate opioid bills: The AHA and more than 40 health care organizations April 23 urged the House Energy and Commerce Committee to report legislation to align 42 CFR Part 2 with HIPAA. Applying the same requirements to all patient information, whether behavioral or medical, would support the appropriate information sharing essential for clinical care coordination and population health improvement, while safeguarding patient information from unwarranted disclosure. The House Energy and Commerce Health Subcommittee May 8 held a hearing on draft legislation that would align 42 CFR Part 2 regulations on confidentiality of substance use disorder records with the HIPAA privacy rule. In a statement on May 8, AHA expresses strong support for legislation before the House Committee on Commerce: Improving the Coordination and Quality of Substance Use Disorder Treatment

The Senate Judiciary Committee May 24 approved five bills to address the opioid crisis, which include provisions aimed at increasing participation in drug take-back programs, strengthening Drug Enforcement Administration discretion in setting opioid quotas, and reducing demand for illicit narcotics. The House Energy and Commerce and Ways and Means committees and the Senate Health, Education, Labor and Pensions Committee also have advanced legislation to address the opioid crisis, and the Senate Finance Committee yesterday introduced 22 opioid-related bills.

AHA's opioid issue brief outlines a list of priorities to address the opioid crisis. To help hospitals and health systems address the opioid epidemic in their communities, visit www.aha.org/opioids for our Stem the Tide toolkit among other resources.

# 340B


Legal Action to Reverse/Delay 340B Cuts: The AHA and others April 2 urged a federal appeals court to find they are entitled to a preliminary injunction in their lawsuit to prevent a nearly 30% Medicare payment reduction for many hospitals in the 340B drug savings

program. The injunction would direct HHS to set outpatient prospective payment system payment rates for calendar year 2019 without the nearly 30% reduction and at the level needed to correct the past effects of the reduction.

Oral arguments began May 4 however, questions from the judges implied the court seemed most interested in whether the Medicare statute expressly precludes judicial review of HHS actions. The AHA hopes for a ruling from the court sometime this summer.

Delay for 340B Drug Ceiling Price Rule: HHS May 4 proposed delaying to July 1, 2019 the effective date of its final rule on 340B drug ceiling prices and civil monetary penalties for manufacturers. In the proposal, HHS says it is in the process of developing policies to address drug pricing in government programs, including the 340B program. In a statement, AHA expressed disappointment in this proposed delay of the 340B ceiling price and civil monetary penalties rule, especially considering that HRSA began rulemaking on this issue more than seven years ago.

Reporting requirements for 340B hospitals: Rep. Earl "Buddy" Carter (R-GA) April 24 introduced a bill that would require hospitals participating in the 340B drug savings program to report their low-income utilization rate for outpatient services. In a statement, AHA expressed concern that the bill would impose new overly burdensome reporting requirements on hospitals requesting data that is not accessible in nature. Such reporting requirements would not provide meaningful transparency nor tell the real story of the value of the 340B program.

Senate HELP Committee hearing examines 340B program: In a May 15 statement submitted for the hearing, AHA and its member hospitals and health systems support program integrity efforts to ensure that the 340B program meets the objective set by Congress: "to stretch scarce Federal resources as far as possible, reaching more eligible patients and providing more comprehensive services." We continue to work with the Health Resources and Services Administration (HRSA) and its partners on these efforts.

AHA, AAMC Leaders Respond to Flawed 340B Study in NEJM: In a letter to the editor of the New England Journal of Medicine, AHA Senior Vice President and Chief Medical Officer Jay Bhatt and AAMC Chief Health Officer Janis Orlowski say "methodologic flaws and errors undermine the findings" of a study on the 340B drug savings program. Read more.

Resources for Preserving Hospitals' Rights to Appeal Medicare Payment Cuts for 340B Claims: AHA is providing additional resources regarding how to preserve hospital rights to appeal Medicare cuts for 340B claims. Please see the memo, prepared for AHA by outside counsel Bill Schulz with Zuckerman Spaeder, which specifically addresses questions raised by hospitals as to whether they can bundle Medicare claims for redetermination. For further questions about this issue, please contact AHA's Lawrence Hughes at lhughes@aha.org.

# REGULATORY RELIEF


AHA Testimony to House Health Panel: On April 11, an AHA representative told the House Ways and Means Health Subcommittee that reforming the Medicare conditions of participation and modernizing the Stark Law are key to regulatory relief and the transition to value. Hospitals, health systems and post-acute care providers spend nearly $39 billion a year on administrative activities related to regulatory compliance, according to a study released last October by the AHA. In a letter to the subcommittee last year, AHA laid out actions that Congress could take immediately to reduce the regulatory burden on hospitals, health systems and the patients they serve.

# TELEHEALTH


FCC funding of the Rural Health Care (RHC) telehealth program: The AHA April 24 urged the FCC to reverse the "large and unexpected" funding cuts to RHC program participants in FY 2017 and permanently adjust the program's funding cap to prevent similar cuts in the future. The $400 million annual cap has been unchanged for more than 20 years. Eight months into FY 2017, the program announced funding cuts for individuals and consortia of 15% and 25%, respectively These cuts not only affect the ability of these rural health care providers to maintain strong broadband connections but also could force tough decisions affecting funding for essential health care services. For the April 24 letter of support, see "Letters" under Press Center at www.aha.org.

The House Appropriations Subcommittee on Financial Services and General Government April 26 held a hearing on the FCC's budget request for fiscal year 2019. During the hearing, Rep. Kevin Yoder (R-KS) questioned FCC Chairman Ajit Pai about FY 2017 cuts to the RHC Program. In his response, Pai said "Our staff is evaluating the comments we've received and we hope to make a judgment at some point in the near future."

Telehealth coverage and payment: CMS plans to continue periodic post-payment reviews and provider education to ensure Medicare claims for telehealth services meet program requirements, and to ensure Medicare contractors implement all planned claims edits, according to a report released by the HHS Office of the Inspector General. AHA supports

expanding access to telehealth services for Medicare beneficiaries, including for patients in non-rural settings and for a broader set of services and technologies.

# INPATIENT PROSPECTIVE PAYMENT SYSTEM


CMS April 24 released its fiscal year (FY) 2019 proposed rule for the hospital inpatient prospective payment system (IPPS). Highlights from an AHA Regulatory Advisory of the proposals affecting rural hospitals are summarized below. Comments on the proposed rule are due to CMS by June 25. The final rule will be published on or around Aug. 1 and take effect Oct. 1

Inpatient prospective payment system (PPS) updates: The rule contains several key proposals that would help deliver on CMS's promise to ease regulatory barriers and allow America's hospitals and health systems to better provide high-quality, efficient patient care. CMS proposes an increase to inpatient PPS payments by 1.75 percent in FY 2019.

An April 26 notice from CMS offers guidance to the payment adjustment for low-volume hospitals and to the Medicare-dependent Hospital (MDH) Program under the hospital inpatient prospective payment systems (IPPS) for FY 2018 in accordance with the Bipartisan Budget Act of 2018 (BiBA). Overall, IPPS hospitals are projected to experience an increase in estimated payments of $468 million as a result of the changes made by sections 50204 for the low-volume adjustment and 50205 for MDH of the BiBA.

Low-volume Hospitals (Section 50204): The BiBA retroactively extended the enhanced low-volume payment adjustment. CMS proposes to implement this change for FY 2018 and, for FY 2019. For FY 2018, low-volume hospitals will continue to be defined as those that are more than 15 road miles from another comparable hospital and that have up to 1,600 Medicare discharges. In order to receive the enhanced payments for FY 2018, a hospital must notify its Medicare Administrative Contractor (MAC) that it qualifies by May 24, per the instructions outlined in the notice. For FYs 2019 through 2022, the discharge thresholds would be modified to 500 total discharges and 3,800 total discharges. To receive the enhanced payments for FY 2019, a hospital must notify its MAC that it qualifies by Sept. 1, per the instructions outlined in the rule.

Medicare Dependent Hospitals (Section 50205): The BiBA also retroactively extended the MDH program through FY 2022. CMS states that a provider that was classified as an MDH as of Sept. 30, 2017 was automatically reinstated as an MDH effective Oct. 1, 2017, with no need to reapply for MDH classification. However, as outlined in detail in its April 26 notice, if the MDH had classified as a sole community hospital or cancelled its rural classification effective on or after Oct. 1, 2017, the effective date of MDH status may not be retroactive to Oct. 1, 2017.

The Rural Community Hospital Demonstration program: By law, the RCH Demonstration is required to be budget neutral. In the proposed rule, CMS provides a summary of the

final policies for implementation of the extension period authorized by the 21st Century Cures Act. They also describe the budget neutrality methodology finalized in accordance with these policies, and identify the amount of the proposed adjustment to the IPPS rates for FY 2019.

Frontier Community Health Integration Project (FCHIP) Demonstration: Ten CAHs are participating in the FCHIP Demonstration, which aims to test new models of health care delivery in the most sparsely populated rural counties with the goal of improving health outcomes and reducing Medicare expenditures. This demonstration is for three years and it began on August 1, 2016. In the FY 2019 proposed rule, CMS reiterates its previously announced policy to address the budget neutrality requirement for the demonstration in the event the demonstration is found not to have been budget neutral.

## PROPOSED POST-ACUTE CARE PAYMENT RULES FOR 2019

CMS also recently released proposed rules for FY 2019 payment for the:

- Long-term Care Hospital PPS
- Inpatient Rehabilitation Facility PPS
- Skilled Nursing Facility PPS

Please click on the links above to download a detailed AHA summary of each proposed rule. Each summary contains key takeaways for hospital and health system leaders, as well as information on how to register for upcoming member calls on each rule.

## NATIONAL INSTITUTES OF HEALTH "ALL OF US"


The National Institutes of Health on May 1 opened enrollment for the All of Us Research Program online and at community events in Birmingham, AL; Chicago; Detroit; Kansas City, MO; Nashville, TN; New York City; and Pasco, WA. The 21st Century Cures Act of 2016 authorized $1.5 billion for the program. It aims to enroll at least 1 million volunteers from diverse communities to share health and lifestyle information over time in a secure and private way for research in precision medicine, an emerging approach to disease treatment and prevention that considers differences in people's lifestyles, environments and biological makeup. The public will be able to enroll online or through participating health care providers.

Precision medicine is health care that is based on you as an individual. It takes into account factors like where you live, what you do, and your family health history. By participating, rural Americans can help precision medicine bring about advances in medical science and health care that work for them. AHA is a partner organization. See the All of Us fact sheet for additional information.

# TOOLS AND RESOURCES

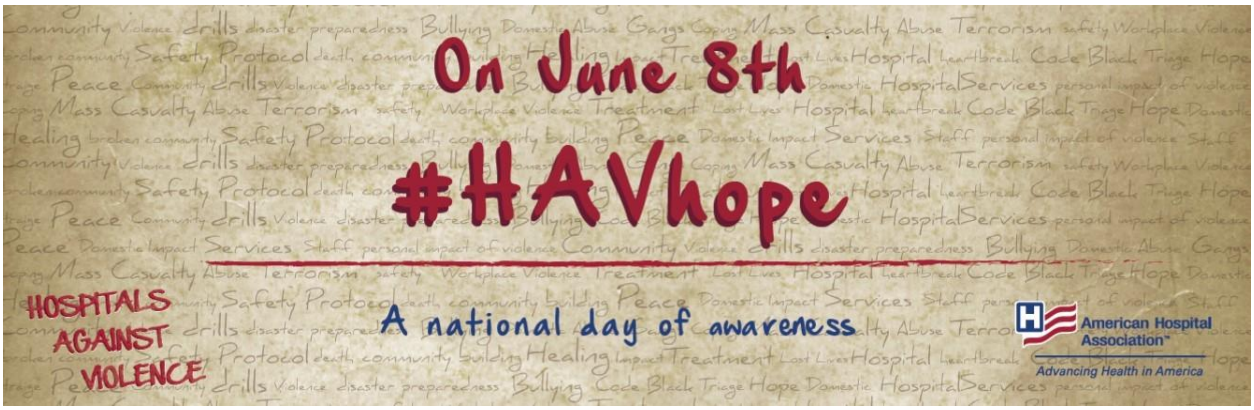
The Value Initiative: AHA's *The Value Initiative* provides members with the education, resources and tools that they need to advance affordable health care and promote value within their communities. We also gather the data, stories and hospital experiences necessary to develop and support federal policy solutions that could, for example, reduce drug prices and other input costs or reduce the regulatory burden associated with delivering health care. In addition, *The Value Initiative* serves as a platform for the AHA to engage in dialogue and foster change on this important issue with key stakeholders, policy makers, think tanks and advocacy groups. Visit www.aha.org/valueinitiative to learn more.


AHA innovation challenge and award: The AHA recently launched the 2018 Innovation Challenge to source and spread new ideas and novel approaches for integrated care delivery and financing models designed for specific high-need, high-cost populations. Teams from AHA member hospitals and health systems are invited to submit proposals by May 30 for novel approaches to drive better health outcomes, improve the care experience and reduce the total cost of care. For more information, go to https://innovationchallenge.aha.org.


Health care disruptive innovation resources: The AHA is working to collect, synthesize and communicate market intelligence around emerging trends and disruptors in health care to create awareness, assess impact and to provide assistance to our members. A new webpage is a hub for the latest on disruptive innovation in health care and the opportunities and challenges that lie ahead for hospitals and health systems. AHA also offers a number of new hands-on educational programs designed to help spark innovation within your organization to help you turn today's

challenges into tomorrow's opportunities. For more information, please visit www.aha.org/disruption.

Coding for social determinants of health: The AHA offers a new resource that members can use to educate caregivers and coding professionals about the importance of collecting data on the social determinants of health. AHA successfully advocated changing the requirement for these codes to be based on information documented by all clinicians involved in the patient's care instead of physician documentation only. This resource, "Issue Briefs and Data Resources" at www.aha.org/value-initiative is relevant for physicians, advanced practice clinicians and coding professionals.




Join Us for #HAVhope Day of Awareness on June 8: With care and compassion, hospitals, health systems and their caregivers work every day to end all forms of violence in our communities. Join the AHA on June 8 as we recognize your efforts through a digital Day of Awareness. We invite you to share photos of your anti-violence programs and staff on social media using #HAVhope. You can find additional information, including a printable HAVhope sign here. Let's stand together to combat violence in our workplaces and communities. For more information and resources about the Hospitals Against Violence initiative, go to www.aha.org/HAVhope.

Standard for active shooter, hostile event response: The National Fire Protection Association has published NFPA 3000: Standards for an Active Shooter/Hostile Event Response Program. According to an AHA Regulatory Advisory, the new standard provides communities with a tool to develop a coordinated response to community active shooter and hostile events.

AHA Health Equity Survey: The AHA's Health Research & Educational Trust and Institute for Diversity and Health Equity have launched the 2018 Population Health, Equity and Diversity Survey. Sent to AHA-member CEOs, the survey is designed to inform the field about hospitals' and health systems' ongoing efforts to address population health, health equity and diversity in the communities they serve. Aggregate findings from the survey will be shared in various forms, including whitepapers, presentations and educational forums. For more information, contact AHA survey support at surveysupport@aha.org or 800-530-9092.