

## Small or Rural Update

September 2018

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

### RURAL HOSPITALS

**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 creating 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, Colo., who told the committee, "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." During the hearing, Sens. Ron Wyden (D-Ore) and Orrin Hatch (R-Utah) expressed support for releasing bipartisan recommendations this year to help address some of the challenges of providing care in rural areas.



*Konnie Martin, CEO, San Luis Valley Health, Alamosa, CO.*

**Rural Emergency Medical Center (REMC) Act of 2018 (H.R. 5678):** Reps. Lynn Jenkins (R-Kan.), Ron Kind (D-Wis.) and Terri Sewell (D-Ala.) on May 7 introduced AHA-supported legislation that would create a new rural emergency medical center designation under the Medicare Program to allow certain existing hospitals to maintain access to essential emergency and outpatient services. 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.

### 340B DRUG PRICING PROGRAM

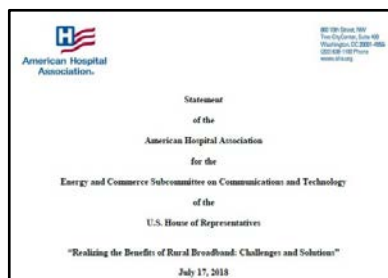
**Bipartisan letter urges effective administration of 340B program:** House Energy and Commerce Committee Chairman Greg Walden (R-Ore.), Energy and Commerce Committee Ranking Member Frank Pallone Jr. (D-N.J.), Senate Health, Education, Labor, and Pensions Committee Chairman Lamar Alexander (R-Tenn.), and Senate HELP Committee Ranking Member Patty Murray (D-Wash.), Aug. 27 sent [a letter](#) to the Health Resources and Services Administration urging the agency to use its existing rulemaking authority to implement regulations to better administer the 340B drug savings program. "The [D.C. District] court ruling made clear that HRSA does have regulatory authority that includes (1) establishing and implementing a binding Administrative Dispute Resolution process for the resolution of certain disputes relating to compliance with 340B Program requirements, (2) providing for the imposition of civil monetary penalties against manufacturers that knowingly and intentionally overcharge a covered entity for a 340B drug, and (3) issuing precisely defined standards of methodology for calculation of 340B ceiling prices," the leaders wrote.

**Hospital groups refile lawsuit to reverse 340B payment cuts:** The AHA, Association of American Medical Colleges, America's Essential Hospitals, and three hospital plaintiffs Sept. 5 refiled a [lawsuit](#) in federal district court seeking expedited relief from Medicare payment cuts for many hospitals in the 340B Drug Pricing Program. An appeals court in July delayed a ruling on the merits of the case because no claims had been filed when the lawsuit was brought to prevent the cuts. After the cuts took effect, the hospital plaintiffs filed claims that have progressed through the appeals process. The lawsuit argues that the 340B provisions of the Centers for Medicare & Medicaid Services' calendar year 2018 outpatient prospective payment system final rule, which reduced Medicare payments to certain hospitals for outpatient drugs purchased under the 340B program by \$1.6 billion a year, violate the Administrative Procedure Act and exceed the agency's statutory authority. "We look forward to receiving a prompt resolution on the merits of our case," the hospital associations [said](#) today. "For over 25

years 340B program drug discounts have played a critical role in helping hospitals expand access to care for vulnerable patients and communities at no cost to the federal government."

**AHA: NY Times article gives a 'thoroughly inaccurate and misleading' view of 340B program.** For more than 25 years, the 340B Drug Pricing Program has been critical in helping hospitals expand access to lifesaving prescription drugs and comprehensive health services to vulnerable patients and communities, AHA wrote in response to a recent article in The New York Times that portrayed the program inaccurately. [Read more.](#)

## TELEHEALTH



**House Subcommittee Hearing Examines Rural Broadband and Telehealth:** The House Energy and Commerce Subcommittee on Communications and Technology held a [hearing](#) examining challenges and solutions related to the issue of rural broadband. In a [statement](#) submitted for the hearing, AHA told the subcommittee it appreciates its "focus on the importance of expanding broadband connectivity and

removing barriers to improved access to health care through technology and telehealth." Specifically, AHA expressed support for the Federal Communications Commission's (FCC) recent vote to increase the Rural Health Care Program's annual cap to \$571 million after the cap remained static at \$400 million for more than 20 years. AHA also shared recommendations for modifications to streamline and greater incentivize program participation

**AHA supports FCC proposal for new telehealth pilot program:** The AHA [voiced support](#) for a FCC proposal to create a \$100 million pilot program to support telehealth for low-income Americans, calling the Connected Care Pilot Program "a critical next step towards delivering affordable telehealth services to those Americans who need it the most." In particular, AHA said the agency "should explore how the Connected Care Pilot Program can support costs for remote patient monitoring, including the cost of equipment, as an eligible expense," citing the potential for improved outcomes and decreased costs. AHA also said the program should not impose unnecessary administrative burdens and barriers to participation; use realistic metrics to measure success; receive adequate funding; and incentivize community-focused projects.

## PROPOSED AND FINAL RULES FOR HOSPITALS



## INPATIENT PPS: THE FINAL RULE FOR FY 2019

The Centers for Medicare & Medicaid Services (CMS) Aug. 2 issued its hospital inpatient prospective payment system (IPPS) and long-term care hospital (LTCH) PPS final rule for fiscal year (FY) 2019. The rule affects inpatient PPS hospitals, CAHs, LTCHs and PPS-exempt cancer hospitals. Provisions of the final rule will take effect Oct. 1. Please see the [AHA Regulatory Advisory](#) on the FY 2019 IPPS final rule for a detailed summary.

Highlights of the provisions relevant to rural inpatient PPS hospitals and CAHs follow. CMS finalized policies to:

- Increase inpatient PPS payments by 1.85 percent in FY 2019;
- Continue the transition to Worksheet S-10 to distribute uncompensated care disproportionate share hospital payments;
- Implement audits of Worksheet S-10 data;
- Approve a number of reclassification requests and allow the wage index imputed rural floor to expire;
- Implement the Promoting Interoperability program, with a new scoring approach that provides more flexibility to meet program requirements;
  - For more information related to the penalties described above for failure to either meet meaningful use or qualify for hardship exemption, including those that apply to CAHs, please review the Aug. 13, 2010 AHA Regulatory Advisory on meaningful use.
- Remove 18 measures and de-duplicate 21 measures in the Inpatient Quality Reporting program;
- Require hospitals to publicly post their charges via the Internet in a machine readable format;
  - AHA is developing a FAQ document and seeking further clarification from CMS on this provision.
- Retroactively reinstate the low-volume adjustment (LVA) and Medicare-dependent hospital (MDH) program;
  - For FY 2018, eligibility criteria for the LVA includes 1) being more than 15 road miles from another comparable hospital (i.e., IPPS hospital), and 2) fewer than **1,600 Medicare discharges**.
    - Transmittal 4046 describes how low-volume payments for FY 2018 will be made.
  - For FYs 2019-2022, eligibility criteria for the LVA includes 1) being more than 15 road miles from another comparable hospital (i.e., IPPS hospital), and 2) fewer than **3,800 total discharges** (Medicare and non-Medicare);
    - Payment adjustments will be made on a sliding scale.
  - The Bipartisan Budget Act (BiBA) also permits a hospital in an all-urban state to qualify for MDH status if it meets MDH classification criteria and meets one of the four criteria for rural reclassification.

CMS finalizes the requirement that all eligible hospitals, CAHs and eligible professionals must use the 2015 Edition certified EHR beginning in CY 2019. The AHA remains concerned about this requirement because not all vendors have certified products

available and the process of implementing upgrades, modifying workflows and ensuring that new systems are safe for patients takes considerable time to accomplish.

CMS acknowledged that CAHs participating in the Promoting Interoperability programs have the same eCQM reporting requirements and facilitating quality improvement for rural hospitals, small hospitals and CAHs can present unique challenges. CMS is exploring opportunities to develop more relevant measures and less burdensome methods to collect quality measure data for use by small and rural hospitals.

## HOSPITAL OUTPATIENT PPS/ASC PROPOSED RULE FOR CY 2019

On July 25, CMS issued its calendar year (CY) 2019 outpatient prospective payment system (OPPS)/ambulatory surgical center (ASC) proposed rule. In addition to standard updates, the rule would substantially expand Medicare site-neutral payment policies in several areas and make changes to the payment policies for drugs, including 340B-acquired drugs. AHA's

Aug. 9 [Regulatory Advisory](#) has a detailed analysis. Comments on the proposed rule are due to CMS by Sept. 24. The final rule is expected around Nov. 1, and would take effect Jan. 1, 2019.

Highlights of the provisions relevant to rural outpatient PPS hospitals and CAHs follow. CMS proposes to:

- Update OPPS payment rates by 1.25 percent in CY 2019;
- Reduce payments for clinic visit services in excepted off-campus provider-based departments (PBDs) to 40 percent of the OPPS rate;
  - [CMS](#) estimates greater payment reductions for rural hospitals (-1.3%) compared to urban hospitals (-1.2%), primarily due to the reduction for rural sole community hospitals (SCHs) (-1.5%) where a large number of clinic visits are held at off-campus PBDs.
- Reduce payments for new families of services furnished in excepted off-campus PBDs to 40 percent of the OPPS rate;
- Reduce payments for 340B-acquired drugs in non-excepted off-campus PBDs to average sales price (ASP) minus 22.5 percent, excludes CAHs and rural SCHs;
- Reduces payment for 340B Drug Discount Program by non-excepted off-campus PBDs to ASP minus 22.5 percent, excludes CAHs and rural SCHs;
- Maintains two rural-specific payment adjustments for CY 2019:
  - Increases payment for rural SCHs by 7.1% for OPPS services and procedures, and
  - Increases hospital wage index to at least 1.00 in frontier states (i.e., the “frontier floor”), per the Affordable Care Act.
- CMS announces that effective Jan. 1, 2019, it will create a new Healthcare Common Procedure Coding System (HCPCS) modifier that will be reported with every claim line for outpatient hospital services furnished in an off-campus ED. CAHs are excluded;
- Remove the Communication about Pain questions from the inpatient HCAHPS survey.

The AHA believes that this proposed policy misinterprets Congressional intent by proposing to reduce payment for services in “excepted” off-campus PBDs that Congress explicitly protected from site-neutral cuts in Section 603. The AHA is disappointed that CMS has resurrected the expansion of services proposal, which the agency had previously rejected. This policy would penalize hospital outpatient departments that expand the types of critical services they offer to their communities and prevent them from caring for the changing needs of their patients.

## MEDICARE PHYSICIAN FEE SCHEDULE: PROPOSED RULE FOR CY 2019

On July 12 CMS issued a proposed rule that would update physician fee schedule (PFS) payments for CY 2019 as well as several proposals to implement year three of the quality payment program (QPP). AHA’s Aug. 6 [Regulatory Advisory](#) offers a detailed analysis. Comments on the proposed rule are due to CMS by Sept.10, and changes are generally effective Jan. 1, 2019.

Highlights of the provisions relevant to rural outpatient PPS hospitals and CAHs follow. CMS proposes to:

- Increase PFS payments by 0.13 percent in CY 2019;
- Recognize the use of communication technology for remote provider-patient check-ins and remote evaluation of “store and forward” videos or images;
- Streamline documentation requirements and collapse payment rates for level two through five E/M visits into a single rate for new patients and another for established patients;
- Align the promoting interoperability requirements for MIPS-eligible clinicians with those proposed for hospitals and CAHs in the FY 2019 IPPS proposed rule;
- Continue to pay for non-excepted services in certain new off-campus PBDs at 40 percent of the OPPS amount;
- Reduce payment for new Part B drugs to 103 percent of wholesale acquisition cost;
- Automatically apply MIPS facility-based measurement to eligible clinicians / groups that meet the definition;
- Adding Codes for Virtual Care through Communication Technologies;
  - CMS is proposing to add new codes to allow providers to bill for additional patient-facing virtual services: (1) Brief Communication Technology-based Services (virtual check-in) and (2) Remote Evaluation of Pre-Recorded Patient Information (evaluation of patient-submitted photos). CMS is proposing to allow rural health clinics (RHCs) and federally qualified health centers (FQHCs) to bill for these services under a bundled code. CMS is also proposing new codes for Interprofessional Consultation via the Internet.
- Expanding Medicare-covered Telehealth Services to Include Prolonged Preventive Services;
  - CMS is proposing to add two codes to the telehealth list for CY 2019 for prolonged preventive services (HCPCS codes G0513 and G0514). As of CY 2018, CMS has 96 distinct codes that qualify as Medicare telehealth services under section 1834(m) of the Act.

The rule implements the BiBA’s extensions for rural areas to the existing 3 percent add-on payments for ground ambulance services, as well as the “super rural” ambulance add-on through Dec. 31, 2022. These provisions are retroactive to Jan. 1, 2012.

CMS proposes payment to RHCs and FQHCs for use of communication technology for brief “check-ins” and remote evaluation of patient-transmitted and recorded “store and forward” videos or images. RHCs and FQHCs would bill newly created G-codes to signify the delivery of these services. CMS also proposes to waive the RHC and FQHC face-to-face requirements when these services are furnished to an RHC or FQHC patient. CMS states its belief that these services could be particularly useful for beneficiaries who live in rural areas where the availability of transportation and certain services is limited.

CMS proposes to decrease the level of physician supervision required for diagnostic tests typically furnished by a radiologist assistant. Current regulations require “personal supervision,” which means a physician must be in the room during the performance of the procedure. CMS proposes to instead require “direct supervision,” which requires a physician to be immediately available to provide assistance or direction during the procedure.

CMS proposes to allow non-excepted PBDs to continue to bill for non-excepted services on the institutional claim using a “PN” modifier and would maintain payment for non-excepted services at 40 percent of the OPPS amount for CY 2019. The agency also proposes to maintain the same policies as 2018 related to supervision, beneficiary cost sharing, geographic payment adjustments and partial hospitalization services.

## POST-ACUTE CARE PAYMENT FINAL RULES FOR FY 2019

CMS also recently released final 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 final rule. Each Regulatory Advisory contains key takeaways for hospital and health system leaders. You also can listen to [playback recordings](#) of member calls on each rule, hosted by AHA policy staff.

## TOOLS AND RESOURCES



In an effort to further advance health in America, the AHA recently launched the AHA Center for Health Innovation to guide hospitals and health systems as they respond to the change around them. The AHA Center for Health Innovation's work will focus on providing forward-looking market insights, novel partnerships within and outside of the health care field, unique leadership development opportunities, and enhanced capabilities to spread leading practices at-scale.

The Center is one part of the AHA's larger agenda for innovation and transformation. In addition, the AHA is expanding its public policy agenda to develop new public policy ideas that better reflect the new directions in which its members are heading and to identify and offer fresh solutions to long-term challenges, as well as taking steps to strengthen its field engagement with new and innovative ways to engage the membership in the life of the association.

A new AHA Center for Health Innovation online resource provides easy access to a dynamic community of forward-thinking health care experts, and the knowledge and tools needed to successfully innovate and transform. For more information, visit [AHA.org/Center](http://AHA.org/Center).



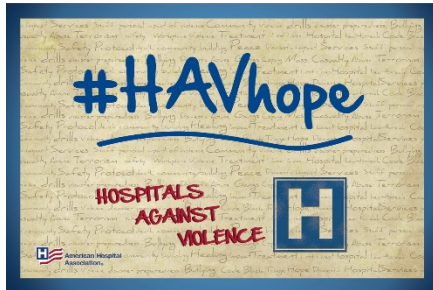
In [FutureScan 2018–2023](#), a panel of thought leaders addresses eight issues transforming the future of health care and provides strategic actions you can take to position your organization for future success. In the annual guide published by the American Society for Healthcare Strategy & Market Development, experts point out that providers are increasingly taking action to improve patient and staff safety. Other trends include the growing demand for medical facilities to withstand earthquakes, floods, and other catastrophes and the increasing need for hospital and outpatient pharmacies to increase drug security to guard against theft. AHA offers members a downloadable [PowerPoint presentation](#) with key findings from the *FutureScan* report to use with their stakeholders.



**AHA Data Products:** AHA Data represents information that is directly provided by more than 6,300 hospitals and 400 health care systems. Our data warehouse covers an array of data points, including demographics, operations, service line, staffing, C-suite information, expenses, physician organization structures, beds, utilization and more. Historical data sets are available for many of these tools.

- [AHA Annual Survey Database™](#): A comprehensive census providing access to an unparalleled resource for hospital market research and health care field analysis.
- [AHA Guide®](#): A comprehensive directory of hospital profiles including physician arrangements, hospital organization structure, utilization data, primary service data, approval code/accreditations, Medicare Provider Identification and more.
- [AHA Hospital Statistics™](#): A reference source that features aggregated data for analysis and comparison of hospital trends in utilization, personnel and finances in U.S. hospitals since 1946.





[AHA Members in Action](#): Case studies that showcase what members are doing to prevent violence in the workplace may be found at our Hospitals Against Violence [webpage](#).

[Human Trafficking](#): For the first time, 29 new ICD-10 codes will be available on Oct. 1 to allow providers to identify and assist victims of human trafficking and coding professionals to translate that information into data that will provide greater insights into the problem. The AHA's Hospitals Against Violence initiative, in collaboration with Catholic Health Initiatives and Massachusetts General Hospital's Human Trafficking Initiative and Freedom Clinic, along with support from other hospital and health system members, advocated for the codes. Working together, the focus is now to educate providers, clinicians, coding professionals and others in the hospital likely to encounter victims on this important issue, including through a new [webpage](#) with dedicated resources on this topic.



The American Hospital Association's 2019 Rural Health Care Leadership Conference, February 3-6, Phoenix, AZ, brings together top practitioners and thinkers to share strategies and resources for accelerating the shift to a more integrated and sustainable rural health system. We'll examine the most significant operational, financial and environmental challenges and present innovative approaches that will enable you to transform your organization's care delivery model and business practices. Registration for the 2019 AHA Rural Health Care Leadership Conference will open in October 2018. **For more information, visit the [AHA Rural Health Care Leadership Conference homepage](#).**