



Advancing Health in America
Section for Small or Rural Hospitals

HOSPITAL UPDATE

Summer 2019

As the summer months approach, here's what you need to know about rural health advocacy, policy and field resources. We've compiled the most relevant news items to help you continue to serve your rural communities and share updates and opportunities. As always, please feel free to reach out to us with tips, stories, or policy priorities to flag at jsupplitt@aha.org

LEGISLATION TO WATCH



House advances FY 2020 Labor-HHS-Education appropriations bill

On April 30, the House Appropriations Subcommittee on Labor, Health and Human Services, and Education approved [legislation](#) that would provide \$189.8 billion in discretionary funding for the departments of Labor, HHS and Education and related agencies in fiscal year 2020.

According to a committee [summary](#), the bill would provide \$99 billion for HHS, \$8.5 billion more than this year and \$20.9 billion more than the president's budget request. Specific increases include \$2 billion more for the National Institutes of Health; \$475 million more for the Health Resources and Services Administration; \$315 million more for the Centers for Medicare & Medicaid Services; \$115 million more for the Substance Abuse and Mental Health Services Administration; and \$35 million more for Hospital Preparedness Program grants. The bill also includes \$50 million for research to prevent firearm injury and death. It next moves to the full committee.

House Judiciary Committee supports action on anticompetitive delays for generics

On April 30, the House Judiciary Committee approved by voice vote the Creating and Restoring Equal Access to Equivalent Samples Act (H.R. 965), AHA-supported legislation that would allow generic drug manufacturers facing certain anticompetitive delay tactics to bring an action in federal court for injunctive relief. Previously passed by the Energy and Commerce Committee, the bill could next move to the floor.

Federal Trade Commission's ability to challenge anticompetitive pay-for-delay

Also on April 30, the Judiciary Committee approved bipartisan bills to strengthen the Federal Trade Commission's ability to challenge anticompetitive pay-for-delay agreements in court (H.R. 2375); reduce incentives for brand name drug makers to interfere with the regulatory approval of generics and biosimilars (H.R. 2374); and require the FTC to study competition in the drug supply chain (H.R. 2376).

REGULATORY POLICY AND RULEMAKING OF NOTE

DEPARTMENT OF HEALTH AND
HUMAN SERVICES

45 CFR Part 160

Notification of Enforcement Discretion
Regarding HIPAA Civil Money
Penalties

AGENCY: Office of the Secretary, HHS.

ACTION: Enforcement Discretion.

HHS reduces maximum penalties for HIPAA violations

The Department of Health and Human Services recently issued a [notice](#) on April 30 reducing the maximum civil monetary penalty for all but the most serious violations of the Health Insurance Portability and Accountability Act. A 2013 rule applied a maximum penalty of \$1.5 million for all four penalty tiers under the HITECH Act of 2009. Based on further review of the statute by the HHS Office of the General Counsel, the notice reduces the maximum penalty for three of the four tiers, the exception being violations due

to willful neglect that are not corrected in a timely manner.



CMS issues draft guidance on hospital space-sharing arrangements

The Centers for Medicare & Medicaid Services recently released [draft guidance](#) for state survey agencies on hospitals that share space, staff or services with another hospital or health care entity. The guidance seeks to

clarify how CMS and state surveyors will evaluate these arrangements for compliance with the Medicare conditions of participation. Prior sub-regulatory interpretations prohibited co-location of hospitals with other health care entities. CMS intends for this guidance to ensure safety and accountability without being overly prescriptive. For example, the guidance clarifies that the entities can share public areas, such as waiting rooms and main hallways, but not clinical space. Comments on the draft guidance are due July 2. See the [AHA Regulatory Advisory](#) for additional information.

CMS issues draft ligature risk guidance for psychiatric hospitals, units

The Centers for Medicare & Medicaid Services recently released [draft revised guidance](#) to clarify its ligature risk policy, which pertains to environmental safeguards for patients at risk of harm to self or others. The draft guidance updates 2017 guidance to clarify what constitutes a ligature risk and the agency's expectation for locked, as well as unlocked psychiatric units. Locked psychiatric units within psychiatric hospitals and acute-care hospitals, as well as emergency departments with dedicated psychiatric beds within a locked unit, are required to achieve a ligature-resistant environment. Unlocked psychiatric units and general acute-care beds designated for the treatment of physical diseases and disorders do not have to meet the ligature resistant standard. CMS will accept comments on the draft guidance through June 17. See the [AHA Regulatory Advisory](#) for additional information.

CMS Releases Hospital Inpatient PPS Proposed Rule for Fiscal Year 2020

The Centers for Medicare & Medicaid Services (CMS) April 23 issued its hospital inpatient prospective payment system (PPS) and long-term care hospital (LTCH) PPS proposed rule for fiscal year (FY) 2020. In addition to proposing a 3.2 percent increase in inpatient PPS payments for 2020, the rule makes changes to Disproportionate Share Hospital payments, new technology payments, the area wage index and quality incentive programs, among other policies.

CMS proposes policies to:

- **Increase inpatient PPS payments by 3.2 percent** in FY 2020.

- Use a single year of uncompensated care data from Worksheet S-10 to determine the **distribution of Disproportionate Share Hospital** uncompensated care payments for FY 2020.
- Increase the **new technology add-on payment** from 50 percent to 65 percent of the marginal cost of the case.
- **Modify the wage index** values for those hospitals with a wage index below the 25th percentile and those hospitals with a wage index above the 75th percentile.
- No longer include wage index data from urban hospitals that reclassify as rural when **calculating each state's rural floor**.
- Implement a reporting period of a minimum of **any continuous 90 days** for the calendar year 2021 reporting period for the Promoting Interoperability Programs.
- Replace the claims-only hospital-wide readmission measure in the Inpatient Quality Reporting program with a hybrid **hospital-wide all-cause readmissions** measure.
- Beginning in FY 2020, CAHs are reimbursed for ambulance services at 101 percent of costs if the CAH is the only supplier of ambulance services located within a 35 mile drive of the CAH and **excludes out of state ambulances** not legally authorized to deliver patients to the CAH.
- CMS proposes that a **hospital may include residents training in a CAH** in its FTE count as long as the non-provider setting requirements are met. The proposal does not affect those CAHs that currently operate their own residency programs.

AHA is pleased that CMS has increased the new technology add-on payment rate. In addition, we are strongly supportive of the proposed 90-day reporting period for attestation for the Promoting Interoperability Programs, a move that will reduce regulatory burden on hospitals. The AHA appreciates CMS's recognition of the wage index's shortcomings. At the same time, improving wage index values for some hospitals – while much needed – by cutting payments to other hospitals, particularly when Medicare already pays far less than the cost of care, is problematic. See the [AHA Regulatory Advisory](#) for additional information.

CMS proposed rule for patient access to health information and information blocking and certification of health IT

The Centers for Medicare & Medicaid Services (CMS) and the Office of the National Coordinator for Health Information Technology (ONC) Feb. 11 issued proposed rules that would promote patient access to health information in Medicare, Medicaid, the Children's Health Insurance Program (CHIP), and federally facilitated exchange plans, as well as address information blocking and certification of health IT. We cannot support including electronic event notification as a condition of participation for Medicare and Medicaid.

The rule will:

- Require electronic notification of inpatient admission, discharge and transfer as a hospital condition of participation in Medicare and Medicaid, affecting acute, long-term care, rehabilitation, psychiatric, children's, cancer and critical access hospitals.
- Require payers and plans participating in Medicare, Medicaid, CHIP and federally facilitated exchanges to provide access to enrollee claims and other information through APIs by 2020.
- The rule also includes several requests for information on patient matching, interoperability in CMMI models, sharing information across the continuum of care, and enabling information sharing between payers and providers through APIs.
- ONC's rule proposes policies to:

- Establish seven exceptions to the prohibition on information blocking by providers, vendors, and exchange networks, including, among others, privacy, security, and responding to requests that are infeasible.
- Adopt the HL7 FHIR standard for APIs and set guidelines for fees that may be charged by API technology suppliers and data suppliers (including providers).
- Promulgate additional conditions of certification and maintenance of certification requirements for health IT developers.



Other CMS Proposed Rules for Fiscal Year 2020

- ✓ **Long-term Care Hospital and Skilled Nursing Facility PPS:** As finalized in last year's rulemaking, a redesigned SNF PPS payment model will be implemented in FY 2020, bringing transformational change to the field. This rule proposes additional policy changes, which are more limited in scope. See the [AHA Regulatory Advisory](#) for details.
- ✓ **Inpatient Rehabilitation Facility PPS:** We are appreciative that the agency has provided a description of the data and methodologies it used in modifying the IRF PPS for FY 2020, as well as sharing provider-specific impacts. See the [AHA Regulatory Advisory](#) for details.
- ✓ **Inpatient Psychiatric Facilities:** CMS April 18 issued a proposed rule to update the payment rates for inpatient psychiatric facilities for fiscal year 2020. CMS proposes a net payment increase of 1.7 percent, or \$75 million, compared to FY 2019. See the [AHA Regulatory Advisory](#) for details.
- ✓ **Hospice:** CMS April 19 issued a proposed rule to update the payment rates for hospices for fiscal year 2020. CMS proposes a net increase to payments of \$540 million, compared to FY 2019. See the [AHA Regulatory Advisory](#) for details.

PILOTS, NEW MODELS OF CARE

CMS announces new value-based payment models for primary care

The Centers for Medicare & Medicaid Services' Innovation Center has [announced](#) the Primary Care Initiative, which will provide primary care practices and other providers with five new payment model options under two paths – Primary Care First and Direct Contracting.

The PCF model options are focused on individual primary care practice sites, while the DC model options aim to engage a wider variety of organizations that have experience taking on financial risk and serving larger patient populations, such as accountable care organizations, Medicare Advantage plans and Medicaid managed care organizations.

The PCF options will be tested for five years beginning in January 2020 and incent providers to reduce hospital use and total cost of care through performance-based payment adjustments. The DC model options focus on care for patients with complex, chronic needs and serious illness and provide prospective model participants a range of financial risk arrangements, CMS said. All of the payment model options are expected to qualify in 2021 as Advanced Alternative Payment Models under Medicare's Quality Payment Program for clinicians.

CMS Blog: Rethinking Rural Health Strategy into Action



CMS is developing a new innovative model specifically for rural communities that will come out later this year that will offer a pathway for stakeholder coalitions comprised of providers, purchasers, and payers to invest collectively in increasing access and improving rural healthcare delivery. The model will offer support and resources so that participating communities will be able to design a customized model that reflects the aligned priorities and needs of their own community. Ultimately, the goal is to improve the quality of care delivered in rural communities; enhance patient access to care; modernize the community's delivery system, including expanding access to innovative technologies; and transition rural providers to value-based payment models that promote provider stability and financial sustainability.

CMMI Announces Emergency Triage, Treat, and Transport (ET3) Model

The Center for Medicare and Medicaid Innovation (CMMI) Feb. 14 announced a new voluntary payment model called the Emergency Triage, Treat, and Transport (ET3) Model, which would change the delivery and payment of emergency medical transportation. The model is designed to provide greater flexibility to ambulance suppliers and providers to address the emergency health care needs of Medicare beneficiaries that access 911 services.

- The model will provide payment for new care settings to which ambulances can transport patients and for treatment in place, in addition to payment for ambulance transport to destinations covered in current regulations (such as hospital EDs).
- Medicare-enrolled ambulance service suppliers and hospital-owned ambulance providers will be eligible to participate in the model.
- CMMI also will encourage participation by local governments and other relevant entities in a supporting role.

AHA TOOLS AND RESOURCES

AHA Rural Report Podcast Series



AHA published a rural report, "[*Challenges Facing Rural Communities and the Roadmap to Ensure Local Access and High-quality, Affordable Care.*](#)"

It is a call to action to address the persistent, recent and emergent challenges facing rural hospitals and the communities they serve. This podcast series is built around the **Rural Report**. Meaning, it highlights a rural health challenge and shows how the field has met this call to action at least locally. On our first podcast we examine the challenge of behavioral health services for rural Americans. Our experts will share an [evidence-based model](#) to increase access to mental health services, as well as an [evidence-based practice](#) to integrate behavioral health services into primary care clinics.



AHA Tools and Resources on Ligature Risks

The American Society for Health Care Engineering of the American Hospital Association (ASHE) developed multiple tools and resources on ligature risks in the physical environment to help hospitals and other health care facilities understand and implement CMS guidance and Joint Commission recommendations related to establishing a policy to perform an environmental-risk assessment when an at-risk patient is present. The tools are available free of charge to ASHE

members. Information about the tools can be found on the ASHE News and Resources web page: <http://www.ashe.org/resources/preventing-self-harm-and-ligaturerisks.shtml>

AHA Community Health Worker Toolkit



American Hospital Association (AHA) formed a strategic alliance with the National Urban League (NUL) to advance health equity as well as diversity in health care leadership in communities across the United States. [*Building A Community Health Worker Program: The Key to Better Care, Better Outcomes, & Lower Costs*](#) toolkit. This resource is intended to help administrative and clinical leaders implement successful and sustainable CHW programs and includes rural

perspectives. This CHW toolkit will cover what CHW programs are and what is suggested to implement a program on your own as well as the benefits to your organization, your patients and your community. Using the information within the toolkit, you will be able to design and implement a CHW program to serve the patients within your community and achieve better patient experience, improve health and increase affordability.

OPPORTUNITIES

HRSA announces funding to expand rural medication-assisted treatment

Eligible hospitals, clinics and other organizations may apply through June 10 for up to \$725,000 per entity to expand access to medication-assisted treatment for opioid and other substance use disorders in high-risk rural communities, the Health Resources and Services Administration has [announced](#). HRSA expects to award about \$8 million in fiscal year 2019 through the [funding opportunity](#).

VA Mental Health Environment of Care Checklist

The US Department of Veteran Affairs (VA) developed the Mental Health Environment of Care Checklist (MHEOCC) for VA Hospitals to review inpatient mental health units for environmental hazards. The purpose is to identify and abate environmental hazards that could increase the chance of patient suicide or self-harm. The checklist has been used in all VA mental health units since October 2007. Contact <mailto:Peter.Mills@va.gov> for more information.



AHA Rural Hospital Leadership Team Award

The [AHA Rural Hospital Leadership Team Award](#) from the [AHA Section for Small or Rural Hospitals](#) honors the **leadership team** who have guided their hospital and community through transformational change on the road to health care reform. The team will have displayed outstanding leadership and responsiveness to the community's health needs and demonstrated a collaborative community process that has led to measureable outcomes. The team will receive a **stipend for 2019 of \$1,500** to attend the AHA Rural Leadership Conference in Phoenix or the AHA Annual Meeting in Washington, DC. For an [application](#) and additional information visit our [website](#) or contact Jumel Ola at 312-422-3345.