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DISCOVERY HEALTHCARE
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Major Rural Hospital Federal Issues

- Medicare Cutbacks and Unfunded/Underfunded Mandates
- 1115 Waiver Extension/Renewal
- RAC Audits
- Outpatient Therapy Cap for Non-CAH Rural Hospitals
- Therapy Supervision Rule for Rural Hospitals is Off-Base
- Technical Correction Needed for CAH 96-Hour Stay Rule

Major Rural Hospital Federal Issues (cont.)

- Low Volume Adjustment (LVA)
- Medicare Dependent Hospital (MDH)
- Two Midnight Rule
- Medicare SNF Qualification Criteria
- Readmission Penalties
- Rural Ground Ambulance Payment Adjustment
- Critical Access Hospitals (CAH)
- 340B Drug Program
- Medicaid DSH Reductions

Medicare Cutbacks

(Using Texas as an example)

Medicare Payment Cutbacks ->
Heavy Financial Stress->
Reduced Payments of 171 Texas Rural Hospitals estimated more than $50 million loss over the past 4 years

2% Sequestration	$25,000,000	(all 171 hospitals)
Bad debt allowance reduction	$2,150,000	(all 171 hospitals)
Value Based quality penalty	$13,500,000	(104 hospitals)
Readmission penalty	$673,000	(9 hospitals)
Loss of Outpatient Hold Harmless	$10,200,000	(52 hospitals)

Source: Texas Organization of Rural and Community Hospitals

Medicare Cutbacks (Cont.)

(Using Texas as an example)

Medicare cutbacks are a contributing factor to:

- Closure of 13 inpatient rural hospitals since early 2013
- Conversion to the ICD-10 medical coding system
- Electronic Medical Records conversion cost well below Medicare payment offsets

Source: Texas Organization of Rural and Community Hospitals

1115 Waiver Extension/Renewal

- Critical for 1115 waiver supplemental payment program to be renewed or extended when it expires in 2016
- Funds from this program provide as much as 1/3 of their payments for many rural hospitals
- If CMS is not prepared to grant Texas another 5 year period with modifications requested by State, then a 2 year extension of current system is vital
- Purpose: allows Texas to provide managed insurance plans for Medicaid recipients (rather than fee-for service)
- Continue system where hospitals receive federal dollars to offset some of their uncompensated care cost and gain extra federal dollars for new programs

Recovery Audit Contractor (RAC) Audits

- Unfair treatment under RAC program
- Branded as a tool to seek out Medicare fraud, and created a “bounty hunter” environment
- Hospitals pay back dollars for services because cost of fighting audit decisions is too high
- Questioning billing for up to 5 years vs. ability to bill within one year

Outpatient Therapy CAP

- Capping payments for therapy services, excludes CAH
- Patients do not receive complete service or the hospital takes a loss
- Exemption from CAP for CAH expires January 1, 2018
- CAP needs to be repealed

Therapy Supervision Rule for Rural Hospitals is Off-Base

- CMS attempts to increase on-site physician supervision for therapy services in CAH and rural hospitals
- Physicians and Hospitals plead its unnecessary
- Because of this rule:
  - Scheduling services is frustrating for patients
  - And limits access to these services

Technical Correction Needed for 96-hour Stays

- CAH patients (on average) must be discharged within 96 hours
- Conflicts occur when patient stay exceed 96 hours
- In FY 2014, Medicare rules emphasize the need of a certification on each patient in order for hospitals to be paid
- Resulting in CAHs may be denied payment for patient stays exceeding 96 hour limit

Low Volume Adjustment (LVA)

- LVA add-on payments keep hospitals open
- Designed to help larger hospitals with low patient volumes
- Renewal for short intervals ranging from a few months to a year at a time
- LVA currently extended until October 1, 2017, but needs to be made permanent

Medicare Dependent Hospital (MDH)

- MDH for larger rural hospitals too big to be CAH and with low patient volume + high percentage Medicare
- Eligibility: Rural with under 100 beds with at least 60% of its days or discharges covered by Medicare Part A and not designated as a Sole Community Hospital (SCH)
- MDH extended through October 1, 2017 and should be made permanent

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Two Midnight Rule

- CMS to define “inpatient” stay vs. an “outpatient” stay
- Impacts how much the hospital is paid
- Not in the best interest of elderly Medicare patients
- Imposes added cost to those declared outpatients
- Congress ordered delayed until September 30, 2015

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Medicare SNF Qualification Criteria

- Similar policy issues to “two midnight” rule
- A Medicare patient must be in a hospital as an “inpatient” for three-days to be eligible for SNF services
- Overnight stay that spans less than two midnights is presumed to be outpatient and the hospital is paid the lower outpatient rates
- Three-day minimum needs to be abolished or modified with medical necessity being the primary determinant

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Readmission Penalties

- Most hospitals with higher than expected Medicare patient readmission rates are now dealing with reduced Medicare Payments
- Payment penalties began Oct 1, 2012 for readmission within 30 days of discharge
- Reduction of up to 2% in all Medicare payments made to a Hospital, not just for the cases involving readmission
- Discriminate against rural hospitals because of their higher levels of Medicare patients and wide swings in utilization

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Rural Ground Ambulance Payment Adjustment

- Add-on payment from base Medicare payment rates for ground ambulance
  - 3% add-on for rural areas
  - 2% add-on for urban areas
- Designed to help ambulance services remain financially viable
- Because of lower volume, this payment bump is especially critical to keeping rural ambulance service
- Currently extended until January 1, 2018

Critical Access Hospitals

- No changes for CAH
- Pertinent for hospitals to stay open
- In August 2013, OIG suggested that mileage waiver should be eliminated and a hard 35-mile separation requirement
- Enactment would remove CAH status – leaving them in a financial bind and facing most certain closure

340B Drug Program

- There is a handful of hospitals “profiting” from this Program
- The Program has proved very helpful in allowing rural hospitals to provide services for the underserved
- Requires drug manufacturers to provide outpatient drugs to eligible groups at significantly reduced prices

340B Drug Program (Cont.)

- The policy question comes down to whether the program is designed to provide access to drugs for uninsured safety net patients and/or to provide hospitals and their other entities with increased revenue to enhance access to health services
- Elimination of Program would be financially troubling for small rural hospitals

DSH Reductions

- Federal Disproportionate Share Hospital (DSH) payments to states will begin to reduce in 2018 through 2025, which will shrink a major funding source for many rural hospitals
- Affordable Care Act assumed states would expand Medicaid thus reducing the number of uninsured entering hospitals, in turn reducing DSH payments
- State such as Texas that opted to not expand Medicaid, will not gain the benefit of more people being insured, yet their DSH payment will decline

DSH Reductions (cont.)

- CMS projected a 5+% cut in year one of the reductions and then growing each year after that
- Congress should give consideration to legislation to limit any future DSH reductions in states that did not expand Medicaid, as federal government will save money in those states by not bearing the cost of Medicaid expansion
- Loss of DSH dollars to hospitals in a state with continuing high uninsured (such as Texas) could be financially devastating to many of those hospitals

Continuum of Care

Positioning for the Future

- Accountable Care Organizations (ACO)

- Medicare shared savings program
- Coordinated High Quality Patient Care
- Three year commitment to network
- Joint Accountability among Providers
- Providers seamlessly share information
- Cost savings through cooperation and avoiding unnecessary tests and procedures

Continuum of Care

Positioning for the Future

- **Population Health Initiative**
- Initiative to track health outcomes within a group of patients
- The health outcomes of a group of patients
- Improving population health by improving access
- Embrace prevention measures among populations

- **Telemedicine**
- Initiative in Radiology and Behavioral Health Care
- Modern Technology in Telemedicine Equipment
- Community Reception
- Will most likely move into ER and possibly Routine areas

New Legislation
Rural Emergency Acute Care Hospital Act

A bill was filed recently by Iowa Senator Chuck Grassley to create a new type of rural hospital which is similar to a free standing emergency room.

- S. 1648 calls for the Centers for Medicare and Medicaid Services (CMS) to create a program where Critical Access Hospitals and other rural hospitals of 50 beds and less have an option to drop inpatient services but continue with their emergency room and outpatient services, plus receive 110% of allowable cost on Medicare.

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New Legislation
Rural Emergency Acute Care Hospital Act

- Patients could stay overnight as long as the average annual patient stay does not exceed 24 hours. Should a Medicare patient need to be transferred to another hospital as the 24 hour limit approaches, Medicare would also pay the ambulance service 110%. The concept is to give financially struggling rural hospitals an option rather than complete closure leaving a community with no care.
- As the bill was just filed, it is too early to gauge support.

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HR 3225–Save Rural Hospitals Act

Critical Elements of the Bill:

- Reverse Bad Debts reimbursement reductions to CAHs.
- Extend Low-Volume payments to hospitals and MDH status permanently.
- Reinstating Revised DRG payments for MDHs and SCHs permanently.
- Reinstating TOPS payments for OP services for SCHs permanently.
- Delaying application of penalties for failure to be Meaningful Electronic Health Record user.

HR 3225–Save Rural Hospitals Act

- Elimination of Rural Medicare and Medicaid DSH payment reductions.
- Make permanent increased Medicare Payments for ground Ambulance services in rural areas.
- Equalizing beneficiary copayments for services furnished to CAHs.
- Elimination of 96-hour physician certification requirement for IP CAH services.
- Reforming RAC audits under Medicare.

Questions

Please call or email with any questions

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Thanks for your attendance!