31ST ANNUAL
AMERICAN HOSPITAL ASSOCIATION
RURAL HEALTH CARE
LEADERSHIP CONFERENCE

FEBRUARY 4–7, 2018
ARIZONA GRAND RESORT & SPA | PHOENIX, AZ

Federal Legislative & Regulatory Update
Overview

• Immediate Rural Priorities & Congressional Deadlines

• Other Issues on the “To-Do” List

• Regulatory Update

• Ensuring Access in Vulnerable Communities

• Advocacy Messages & Resources
### What’s at Stake?

- Due to inaction from Congress, critical programs that protect health care in rural communities have expired in 2017.
  - The Medicare-Dependent Hospital program expired Sept. 30.
  - The enhanced Low-Volume Adjustment program expired Sept. 30.
  - The ambulance add-on payment program expired Dec. 31.

### Why it’s Important?

- These programs have bipartisan support and are critical for rural hospitals and their ability to provide quality, accessible care in their communities.
  - Rural hospitals overall provide essential health care services to nearly 57 million people and are often the only source of care in the community.
  - Every dollar spent by a rural hospital produces another $2.29 of economic activity.
  - 830 rural hospitals across the country are negatively impacted by the expiration of these programs, threatening patient access to care.

### What’s the Solution?

- Urge your Members of Congress to protect these vital rural programs by cosponsoring:
  - The Rural Hospital Access Act of 2017 (S. 872/H.R. 1955) which would permanently extend the Medicare-Dependent Hospital and enhanced Low-Volume Adjustment programs; and
  - The Medicare Ambulance Access, Fraud Prevention, and Reform Act of 2017 (S. 967) and the Ambulance Medicare Budget and Operations Act of 2017 (H.R. 3236) which would extend the ambulance add-on payment adjustment.

And most importantly, urge your lawmakers to include straight extensions of these critical rural programs in any “must-pass” legislation moving through Congress in the coming weeks.

---

[Source: American Hospital Association](www.aha.org/ruralhealth)
AHA Message

Congress Monday passed another short-term spending bill to keep the government open through Feb. 8. House and Senate leaders are now working on a potentially larger spending deal to keep the government open through the end of the federal fiscal year (FY) on Sept. 30.

While we are pleased that this week’s spending bill extended funding for the Children’s Health Insurance Program, it is critical that Congress address some unfinished business from FY 2017 in the next spending bill, including:

- extending expired programs that support patient access to care in rural communities, and
- eliminating Medicaid cuts that would hit communities serving disproportionate numbers of vulnerable and low-income individuals particularly hard.

In addition, as Congress begins to set priorities for the remainder of the year, Medicare payments for hospital services remain at high risk for potential cuts to fund other congressional priorities. For example, some lawmakers have suggested cutting payments to hospitals when a hospital discharges a patient to hospice care early in their stay, similar to the Centers for Medicare & Medicaid Services’ post-acute care transfer policy. Specifically, the proposal would cut payments by $4.68 billion over 10 years. Additional site-neutral and rural payment changes also remain areas for concern of potential cuts.
Must-Pass Legislation

**Calendar-Deadlines**
- Current CR through Feb 8
- CR though March 23
- Increasing the caps
- Longer-term bill for FY18
- Raising the debt ceiling

**AHA Message**
- Protect Rural Programs
  - MDH Program
  - Enhanced LVA
  - Ambulance Add-on
  - Therapy Caps
- Delay Medicaid DSH Cuts
- No Hospital Cuts
CR Through March 23rd

What’s Included

- 2 year straight extension of LVA
- 2 year straight extension of MDH
- 5 year extension of Ambulance Add-on
- 2 year delay of Medicaid DSH cut
- Permanent repeal of therapy cap
- Meaningful Use flexibility
- Chronic Care Act
- Telehealth (stroke, diabetes)
- Hospice transfer policy
Up Ahead…?

- Infrastructure package
- Entitlement reform
- Graham-Cassidy 2.0
- Opioid funding/Behavioral Health
- 340B Program
- Ensuring Access
- Regulatory relief
Top Priorities:

• **Drug prices**

• **Medicaid Reform**
  – Block grants; work requirements

• **Make healthcare affordable**
  – Transparency & accountability

• **Pay for value**
  – Mandatory demos
  – Additional APMs
  – HIT/telehealth
Regulatory Burden Overwhelming Providers, Diverting Clinicians from Patient Care

Regulations are essential to ensure safety and accountability. However, the rapid increase in the scope and volume of mandatory requirements diverts resources from the patient-centered mission of health systems, hospitals and post-acute care providers.

$39 BILLION
Spent by health systems, hospitals, and post-acute care providers each year on non-clinical regulatory requirements

629 mandatory regulatory requirements
- Hospitals have to comply with 341 mandatory regulatory requirements.
- Post-acute care providers have an additional 288 requirements.

$7.6 MILLION
per community hospital spent annually to comply

- This figure rises to $9 million for those hospitals with post-acute care.
- For the largest hospitals, costs can exceed $19 million annually.
- The average hospital also spends almost $760,000 annually on the information technology investments needed for compliance.

Patients are affected by excessive regulatory burden through:
- Less time with their caregivers
- Unnecessary hurdles to receiving care
- Higher health care costs.

Percent & Number of Regulations, by Domain

- Billing & Coverage: 7
- Program Integrity: 8
- Health IT/ Meaningful Use: 26
- Post-acute Care: 288
- Hospital Conditions of Participation: 96
- Privacy & Security: 78
- Quality Reporting: 58
- Fraud & Abuse: 52
- New Models of Care: 16
Medicare conditions of participation; billing and coverage determinations are the most costly areas:

- The Medicare COPs are important to ensure that care is provided safely and meets standards.
- However, these requirements need to be evaluated carefully to ensure they actually improve safety.
- Existing guidance to simplify billing and coverage determinations should be adopted universally by payers and others to achieve savings.

Regulatory burden costs $1,200 every time a patient is admitted to a hospital.

FTEs Dedicated to Regulatory Burden per Hospital

- Legal
- Physician (MD, DO)
- Compliance
- Other Staff
- Health IT Professional
- Management
- Nursing Allied Health
- Other Administrative

Source: Data from the American Hospital Association Report: Regulatory Overload - Accessing Regulatory Burden on Health Systems, Hospitals and Post-acute Care Providers.

Reducing regulatory requirements will allow providers to focus on patients, not paperwork.
Centers for Medicare & Medicaid Services

2017

- Repeal & Replace
- Medicaid Reform
  - Waivers
- Regulatory Relief
  - Flexibility in HIT/MU
  - “Meaningful Measures”

2017 Progress

- CAH 96-hr rule
- Direct supervision
- Interpretive guidance
- MU stage 3
- Number of eCQMs
- Star ratings
- Flexibility in MACRA
- Part B drug demo
- Telehealth
- FCC
Protecting 340B

- Outpatient PPS Final Rule
- Energy & Commerce Committee Report
- Telling the 340B Story

**REVIEW OF THE 340B DRUG PRICING PROGRAM**
Task Force Report

Task Force on Ensuring Access in Vulnerable Communities

November 29, 2016

To learn more about the work of this AHA Task Force, please visit www.aha.org/ensuringaccess
Emerging Strategies

Virtual Care Strategies
Social Determinants
Inpatient/Outpatient Transformation
Urgent Care Center
Rural Hospital-Health Clinic
Emergency Medical Center
Global Budgets
Frontier Health System
Indian Health Services
2018 Rural Advocacy Agenda

- Direct Supervision
- 96 Hour Rule
- Rural Extenders
  - Medicare Dependent Hospital Program
  - Enhanced Low-volume Adjustment
  - Ambulance Add-On Payments
- 340B Program
- Workforce
- IT and Meaningful Use
- Behavioral Health
- Telehealth
- Care Coordination
- Vulnerable Community Models

Promote Regulatory Relief

- Direct supervision. Pass the Rural Hospital Regulatory Relief Act (S. 2440, H.R. 4580) to make permanent the transportation monorail on CMS’s “direct supervision” policy for inpatient therapeutic services provided in critical access hospitals (CAHs) and rural hospitals.
- 96-hour physician certification. Remove the 96-hour physician certification requirement as a condition of payment for CAHs. These hospitals would still be required to satisfy the condition of participation requiring a 96-hour annual average length of stay.
- Information technology and meaningful use. Improve interoperability of health information networks and strengthen cyber security. Urged CMS to cancel Stage 3 of meaningful use by continuing to allow reporting using modified Stage 2 measures in 2015, instituting a 90-day reporting period, and reducing the reporting burden of the program. Pass the Medicare Health Reform (MHR) Regulatory Relief Act (S. 2440, H.R. 4580), which would eliminate the “all or nothing” approach, establish a 30-day reporting period, and expand hardship exemptions.

Secure the Future of Critical Rural Programs & Policies

- 340B Low-volume coverage. Pass the Rural Hospital Access Act (S. 4580, H.R. 11025) to permanently extend the Medicare-dependent hospitals and enhanced low-volume adjustment programs.
- Ambulance aid-on-payment. Pass the Medicare Ambulance Access, Fraud Prevention, and Reform Act (S. 2440) and the Ambulance Medicare Budget and Operations Act (H.R. 3290) to extend the ambulance aid-on-payment program.
- Telecare. Exempt CAHs from the cap on outpatient therapy services. Extend the outpatient therapy exception process and oppose the expansion of the cap to services provided in the outpatient departments of hospitals and CAHs. Pass the Medicare Access to Rehabilitation Services Act (S. 2440, H.R. 11025) to protect the outpatient rehabilitation therapy caps.
Rural Advocacy Resources

- Rural Advocacy Agenda
- Rural Infographics
- Advocacy Alliances
- www.aha.org/RuralAdvocacy
31ST ANNUAL
AMERICAN HOSPITAL ASSOCIATION
RURAL HEALTH CARE LEADERSHIP CONFERENCE

FEBRUARY 4–7, 2018
ARIZONA GRAND RESORT & SPA | PHOENIX, AZ

Federal Legislative & Regulatory Update