Fourteen Needed CMS Regulatory Improvements

The following are proposals to the Centers for Medicare & Medicaid Services (CMS) from the Rural Wisconsin Health Cooperative (RWHC) in Sauk City, Wisconsin that we believe would enhance the ability of rural providers to serve their communities:

1. Non-enforcement of 96-Hour Rule Condition of Payment requirement.
2. Common-sense approach needed for “exclusive use” standard.
3. Prohibit the direct supervision requirements for outpatient therapy services.
4. CMS should make full use of flexibility already given by Congress regarding rural Graduate Medical Education (GME).
5. Sole Community Hospitals (SCH) and CAHs should be eligible for Indirect GME (IME).
6. Expand Medicare coverage of telehealth services.
8. Adjust rural readmission measures to reflect differences in sociodemographic factors.
10. Hold Medicare Recovery Audit Contractors (RACs) accountable.
11. More accurate price standardization of CAH swing bed claims is needed.
12. Performance comparisons should occur between equivalent cohorts in MIPS.
13. Implement appropriate validation survey rotations for CMS Validation Surveys.
14. Create a culture of consultation/education as part of CMS mandated surveys.

1. Non-enforcement of 96-Hour Rule Condition of Payment requirement.

The Centers for Medicare and Medicaid Services (CMS) has indicated it would begin enforcing a condition of payment for critical access hospitals (CAHs) that requires a physician to certify that a beneficiary may reasonably be expected to be discharged or transferred to another hospital within 96 hours of admission. While CAHs must maintain an annual average length of stay of 96 hours, they may offer some critical medical services that have standard lengths of stay greater than 96 hours. Enforcing the condition of payment will force CAHs to eliminate these “96-hour-plus” services. CMS should not enforce this provision and reduce unnecessary red tape in line with the congressional intent in the creation of the CAH program.

2. Common-sense approach needed for “exclusive use” standard.

The CMS enforcement in rural communities of the nonsensical “exclusive use” regulation is creating a chilling effect and exacerbating the specialty care shortage crisis that plagues rural America. The tremendously burdensome requirements of the regulation (such as exclusive entrance, waiting and
registration areas, permanent walls, and a distinct suite designation) do not make sense for small rural facilities and are often prohibitively expensive or not physically possible.

This is an access issue. In rural America, access to primary care is difficult; access to specialty care is daunting and often means several hours of travel. Visiting specialists provide a crucial service in rural communities and commonly provide access to cardiologists, oncologists and pediatric surgeons. 

Allowing visiting specialists to utilize any available space in a hospital is an effective way to allow this important type of access while not adding unnecessary burden or financial costs to the health care system.

3. Prohibit the direct supervision requirements for outpatient therapy services.

In the 2009 OPPS final rule, CMS mandated a new policy for “direct supervision” of outpatient therapeutic services that hospitals and physicians recognized as a burdensome and unnecessary policy change that could harm access to care in rural and underserved communities. Because CMS characterized the change as a “restatement and clarification” of existing policy in place since 2001, hospitals, particularly small and rural hospitals and CAHs, found themselves at increased risk of unwarranted enforcement actions. For CYs 2010-2013, in response to hospital concerns, the agency prohibited its contractors from enforcing the direct supervision policy. While Congress has extended this enforcement moratorium annually since 2014, this annual reconsideration of the misguided direct supervision policy places these hospitals in an uncertain and untenable position. RWHC urges the Administration to permanently prohibit its contractors from enforcing the direct supervision regulations in CAHs and small and rural hospitals and require only a general supervision requirement that will better protect patient safety and access.

4. CMS should make full use of flexibility already given by Congress regarding rural Graduate Medical Education (GME).

The Balanced Budget Act of 1997 (Sec. 4623: In calculating the FTE cap on residents, this provision gave the Secretary the authority to give special consideration to facilities that meet the needs of underserved rural areas). CMS should look to implement the Advancing Medical Resident Training in Community Hospitals Act (S.2671 / H.R.4732), which corrects a technical glitch in federal physician residency program rules that inappropriately caps the number of residency positions, in 3 ways:

- If a hospital has received a per resident amount (“PRA”) or cap of 1 FTE or less prior to October 1, 1997, that hospital could now expand that cap and set a new PRA and FTE Limitation (cap) with a new residency program.
- If a hospital received PRA or a cap of 3 or less after October 1, 1997, they would have an opportunity to expand that cap and set a new PRA with a new residency program.
- Going forward, retroactive to October 15, 2015, any hospital with a cap of less than 3 could expand their FTE cap and reset a PRA with a new residency program. And in no case going forward from October 15, 2015, would a hospital have a PRA set until they claimed at least 1 FTE, or FTE cap until they train more than 3.
5. **Sole Community Hospitals (SCH) and CAHs should be eligible for Indirect GME (IME).**

Physician rotation in rural resident programs in CAHs and other small hospitals in rural America has been proven to dramatically improve workforce shortages in rural locations. Unfortunately, an unintended consequence of the Affordable Care Act (ACA) restricts Medicare from covering the costs of training resident physicians at CAHs, and has restricted efforts to expand training medical professional in rural communities. This unintended consequence restricts CAHs by only allowing them to put direct GME on cost reports—which is roughly equivalent to about one-third of typical total GME payments. They are not eligible for reimbursement for the costs of IME. In addition, other hospitals cannot claim the residents’ time spent in a CAH, so there is no reimbursement for IME costs. SCHs are restricted from rebasing their hospital-specific rate to include IME when they start a new training program. CMS has the authority to allow a CAH to choose annually whether it wishes to be considered a hospital or a non-provider for GME purposes only, as well as, allow reimbursement for SCHs to include IME expenses, regardless of the mode of payment under which they are reimbursed. Further, **rural ambulatory sites eligible for GME reimbursement through Medicare should be broadly defined.** Urban or other teaching hospitals sponsoring rural training tracks (RTTs) should be allowed to recover costs through Medicare whenever they bear all or substantially all of the costs of resident education, including when residents are located at hospital sites that do not claim direct and/or indirect costs through Medicare.

6. **Expand Medicare coverage of telehealth services.**

Hospitals are embracing the use of telehealth technologies because they offer benefits such as virtual consultations with distant specialists, the ability to perform high-tech monitoring without requiring patients to leave their homes and less expensive and more convenient care options for patients. However, coverage and payment for telehealth services remain major obstacles for providers seeking to improve patient care. Medicare, in particular, lags far behind other payers due to its restrictive statutes and regulations. For example, CMS approves new telehealth services on a case-by-case basis, with the result that Medicare pays for only a small percentage of services when they are delivered via telehealth. **RWHC urges the Administration to expand Medicare coverage, such as by a presumption that Medicare-covered services also are covered when delivered via telehealth unless CMS determines on a case-by-case basis that such coverage is inappropriate.**

7. **Implement the National Quality Forum (NQF) Rural Metrics Report Recommendations.**

In the Fall of 2015, CMS received a Rural Metrics Report from NQF that CMS had requested as part of it’s annual contract with NQF, the country’s top arbitrator of healthcare metrics. The Report gives a series of recommendations from a Committee convened for the first time ever to address “performance measurement issues for rural small-practice and low-volume providers.” Without such measures, rural America will be left behind as CMS and insurers move into a new age of transparency and accountability.

The NQF Report suggests how “to mitigate challenges in payment incentive programs; identify which measures are most appropriate; and recommend how future development resources are best directed to address particular measurement gaps areas.” RWHC believes that CMS has not given the recommendations the full review they deserve—that once again rural health will
get the short end of the stick. **CMS needs to implement the recommendations of the 2015 Rural Metrics Report that they requested from the NQF.**

8. Adjust rural readmission measures to reflect differences in sociodemographic factors.

Hospital readmission measures and other outcome measures have been publicly reported and used to penalize poor performance. But because they lack appropriate adjustment for the impact of the community and other factors, those hospitals serving certain communities sustain larger penalties. RWHC has worked with the National Quality Forum (NQF) to develop rural relevant sociodemographic factors. **RWHC calls upon the Administration to immediately adjust rural readmission measures to account for sociodemographic factors beyond hospitals’ control.**


Despite objections from a majority of the Congress, CMS published a set of deeply flawed hospital star ratings on its website this Fall. The ratings were broadly criticized by quality experts and Congress as being inaccurate and misleading to consumers seeking to know which hospitals were more likely to provide safer, higher quality care. As stated, RWHC has long worked with the NQF, advancing that rural hospitals should report quality measurements that make sense and are relevant to the services that they provide. CMS has the authority and should create measurements tailored for rural hospitals and the unique patient volumes and services provided at rural hospitals. **RWHC calls on the Administration to suspend the faulty star ratings from the Hospital Compare website.**

10. Hold Medicare Recovery Audit Contractors (RACs) accountable.

Medicare RACs are paid a contingency fee that financially rewards them for denying payments to hospitals, even when their denials are found to be in error. **RWHC urges the Administration to revise the RAC contracts to incorporate a financial penalty for poor performance by RACs, as measured by Administrative Law Judge appeal overturn rates.**

11. More accurate price standardization of CAH swing bed claims is needed.

An unintended consequence of the ACA has allowed CMS to alter its price/payment standardization methodology, thereby treating CAH swing-bed claims differently and inequitably than it does CAH inpatient claims and CAH outpatient claims. The ramifications of this payment inequity will result in significant losses to CAHs and exacerbate the current escalation of rural hospital closures. The difference in payment limits Medicare’s ability to compare post-acute care expenditures between CAH and other providers. For larger, non-rural providers participating in bundled payment programs, inaccurate data on resource efficiency may limit their willingness to refer beneficiaries to CAHs for post-acute care. In addition, as CMS relies on the Medicare Spending Per Beneficiary (MSPB) measure to assess providers’ resource efficiency, inaccurate standardization may declare CAH swing beds more inefficient than is the actual case, again harming the rural hospital.
More accurate standardization can allow CAHs to participate in these programs with the added benefit of allowing rural patients to receive care close to home and family. CMS has the authority to revise the price standardization formula for CAH swing bed claims to improve price standardization and maintain rural patients access to care.

12. Performance comparisons should occur between equivalent cohorts in MIPS.

Actuarial estimates predict that the Merit-Based Incentive Payment System (MIPS) will penalize 87% of solo practitioners, 69.9% of practices with 2-9 eligible clinicians, and 59.4% of practices with 10-24 eligible clinicians (see table 64 on p. 28376 of CMS-5517-P; Vol. 81, No. 89). CMS has projected that the vast majority of clinicians who are likely to be penalized under MIPS will be those in small practices, especially those in practices with 15 or fewer clinicians. Many observers and leaders (including those in Congress) have expressed concern that this is CMS’ way of pressuring small and rural practices into joining large conglomerates or even getting out of medicine altogether.

RWHC believes this is not an exaggerated fear, but something that is likely to happen over time if significant changes aren’t made to create additional flexibilities for small practices without the resources to navigate the complexities and challenges of the proposed requirements. RWHC believes that this issue can be mitigated by implementing the following five changes:

- Reduce the reporting and administrative burdens for Eligible Clinicians (ECs) in practices with 15 or fewer clinicians.
- Reduce the level of penalty that ECs in practices with 15 or fewer clinicians are subject to.
- Ensure that socioeconomic risk adjustments are used so that quality outcomes beyond clinician control do not impact their quality scores.
- Significantly raise the $100 million currently allocated for technical assistance for small practices closer to what was provided for Stage 1 meaningful use, including continuing to fund many of the RECs that are in a position to do “boots-on-the-ground” work.
- Provide all ECs more time during which to prepare for the new requirements. If there is one thing that we have learned from the Meaningful Use program, a few months is not nearly enough time for ECs to digest and implement these types of complex requirements.

13. Implement appropriate validation survey rotations for CMS Validation Surveys.

CMS is empowered to survey an accredited provider to validate the accreditation process of the Accrediting Organization (AO), e.g. The Joint Commission, which survey hospitals every three years to maintain their accreditation. While all hospitals are subject to periodic accreditation surveys, the CMS validation surveys can be extremely rigorous and stressful. In many cases, hospital senior management may be singularly focused on the survey for a period of months. Further, there seems to be a disparity in the fact that rural deemed facilities are, according to CMS, receiving double the rate of validation surveys that urban and suburban deemed facilities. Within the last nine years three Wisconsin rural deemed facilities have received repeat validation surveys after consecutive AO surveys. CMS should create a prohibition on these repeat validation surveys, so that a rural deemed facility cannot have a repeat validation survey within a period of nine years. How random this is or isn’t may not be the question, but the
question is whether or not there is a way to reduce the odds of a hospital being chosen within nine years if it was already chosen once. After all, the purpose of the accreditation survey is to validate the accrediting process of the AO, not the performance of the hospital.

14. **Create a culture of consultation/education as part of CMS mandated surveys.**

Certain rural health care facilities must demonstrate compliance with the Medicare conditions of participation (CoPs) in order to be eligible to receive Medicare reimbursement. CMS allows health care facilities that are “provider entities” to demonstrate this compliance through accreditation by an AO. Whether surveys are conducted by AOs or state agencies, the surveys can be extremely rigorous and stressful for all involved, surveyors and facility staff. **CMS should aim to create a culture of consultation and education during the survey process across all CMS-approved surveyors.** Facilities are not looking to be out of compliance, and often times are not sure the best way to regain compliance and would benefit from a more positive consultative experience that seeks to educate facilities on best practices and maintaining compliance. RWHC member hospitals believe that this would lead to a more positive and productive relationship between facilities and surveyors.