



Advancing Healthy Communities






South Dakota
Association of Healthcare Organizations

Federal Issues Brief

2017

South Dakota Association of Healthcare Organizations

Advancing healthy communities through a unified voice across the health care continuum.

Welcome to the Federal Issues Brief for 2017.

Every day, health care providers in South Dakota and across the nation face difficult challenges in ensuring that patients receive timely access to essential services, especially in medically underserved rural and frontier communities. Some of these challenges involve continually improving safety and quality integration, workforce shortages and reductions in provider reimbursements.

In addition, significant changes are being considered for the Medicaid and Medicare systems that will impact these vital programs.

To meet these challenges, providers are amplifying their focus on advancing healthy communities, improving affordability through innovative system delivery reforms and managing care across the health care continuum. Working together, we can achieve our vision of … "communities where all individuals achieve their highest level of health."

This brief identifies and outlines the association's public policy, advocacy and regulatory priorities, including:

BILL KEY

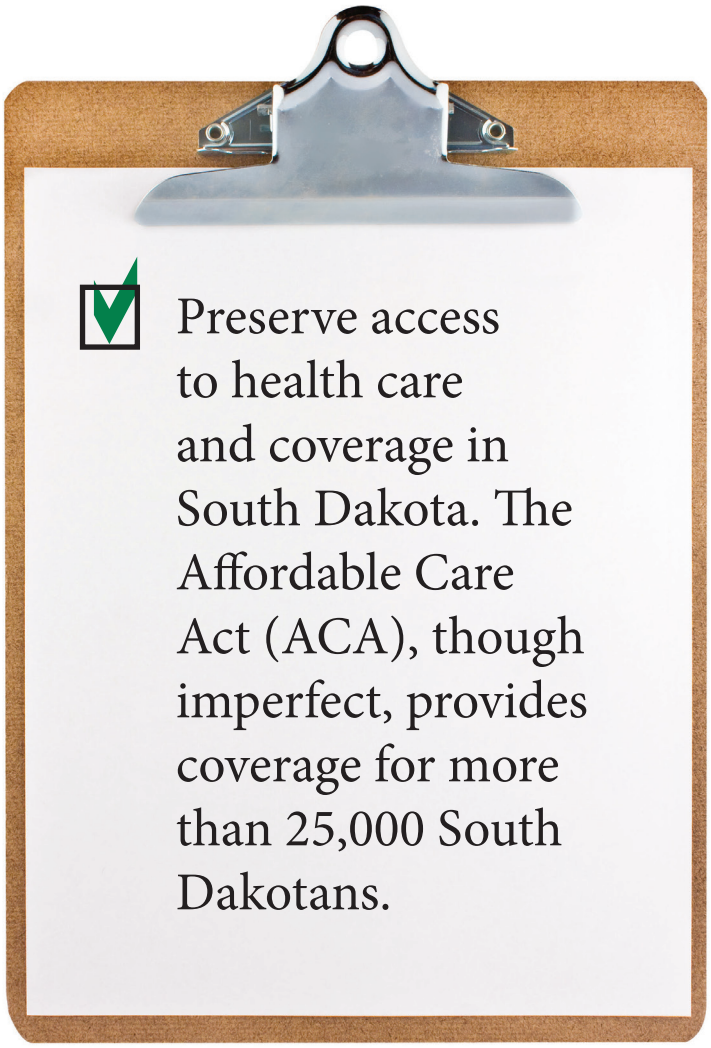
[T] Sponsored or co-sponsored by Sen. John Thune
[R] Sponsored or co-sponsored by Sen. Mike Rounds
[N] Sponsored or co-sponsored by Rep. Kristi Noem

Ensure coverage and access for those most in need of health care services by enacting legislation to improve flawed areas of the Affordable Care Act (ACA).

- Support a Medicaid replacement plan that addresses both age and income so costs don't shift to South Dakota seniors.
- Support the Restoration of Provider Cuts included in the Affordable Care Act if repealed. The cuts included in the ACA were balanced by an expectation of increased health care coverage. Continuing these cuts in the absence of the ACA will be detrimental to health care access across the state, as they already have had a negative impact of $1.7 billion (2010-2016).
- Preserve Medicaid funding by basing reimbursement on the cost of providing services.
- Promote Medicare structure reforms to make the program more sustainable while maintaining access to care.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

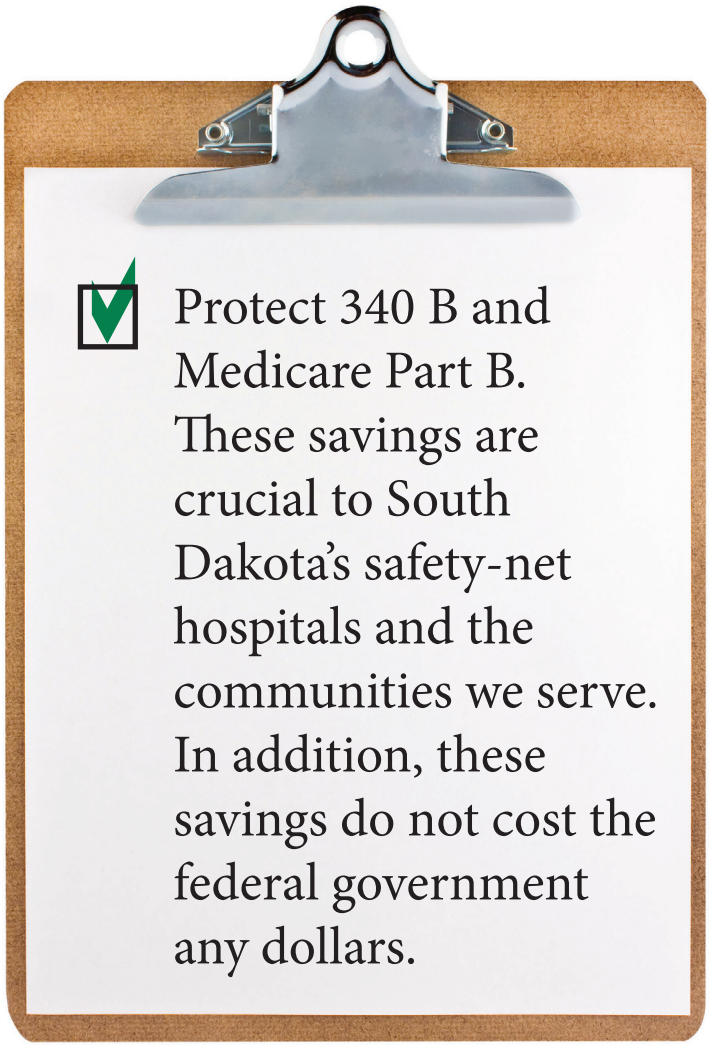
- Support repealing the annual fee on health insurance providers enacted by the ACA. (H.R. 246 [N])
- Support the Protecting Senior's Access to Medicare Act of 2017, which repeals the independent payment advisory board created with the ACA. (S.260 [T] [R], H.R. 849 [N])
- Support South Dakota's working poor and ensure they receive comparable benefits to those in Medicaid expansion states.



Redesign care and embrace alternative payment models that promote effective, efficient, coordinated and seamless care for patients.

- Reject site neutral payments. Reductions would negatively impact South Dakota health care providers by $463 million over 10 years.
- Preserve funding for the Children's Health Insurance Program (CHIP) and mental health services to ensure access for these vulnerable populations.
- Protect the Frontier Amendment, which is crucial to sustaining adequate access to health care in medically underserved areas across South Dakota and impacts South Dakota at $730.7 million over 10 years.
- Support Medicare Rural Payment Extensions, which make permanent the increased payments under the Medicare low-volume hospital program. (S. 872, H.R. 1955)

- Preserve coverage and funding that assists with South Dakota's long-term care rebalancing efforts and addresses the growing population.
- Continue support for innovative Medicaid programs that increase access to home- and community-based services, such as Money Follows the Person, Health Homes, and 1915(i) waivers.
- Preserve critical funding for the Older Americans Act to allow older adults the ability to remain at home and in their communities as long as possible.



- Support the Preserve Access to Medicare Rural Home Health Services Act, the rural add-on for home health services in rural areas, to extend through 2022. (S. 353)
- Support legislation to permanently extend the ambulance add-on payment.
- Support the Improving Transparency and Accuracy in Medicare Part D Spending Act which would prohibit Medicare Prescription Drug Plan sponsors from retroactively reducing payment on clean claims. (S. 413 [T], H.R. 1038)
- Rescind the category of observation stays by supporting the Improving Access to Medicare Coverage Act to count a period of observation services in a hospital toward satisfying the 3-day inpatient hospital requirement for coverage of skilled nursing facility services under Medicare. (S.568, H.R. 1421)
- Support the Medicare Access to Rehabilitation Services Act of 2017 to repeal the Medicare outpatient rehabilitation therapy caps. (H.R. 807, S. 253)
- Support a bill to amend Title XVIII of the Social Security Act to implement Medicare payment policies designed to improve management of chronic disease, streamline care coordination and improve quality outcomes without adding to the deficit. (S. 870 [T])
- Support the Lymphedema Treatment Act to cover lymphedema compression treatment items as durable medical equipment under Medicare. (H.R. 930 [N])

Proposed Medic

Accumulated Impact

South

This report shows annual impact estimates for all cuts in the analysis over the period of 2017-2026.

	2017	2018	2019	2020	2
Graduate Medical Education Funding:					
IME Reduced by 10%	($607,100)	($623,500)	($639,500)	($660,700)	($6
IME Payments based on a National Pool	$0	$0	($1,219,600)	($1,260,000)	($1,3
DGME Capped at 120% of U.S. Average Resident Salary	($1,271,900)	($1,298,300)	($1,325,300)	($1,352,700)	($1,3
Outpatient Payment Equalization:					
OPD/Physician Payment Equalization-E/M Services	($20,801,800)	($21,207,500)	($21,642,100)	($22,248,300)	($22,
OPD/Physician Payment Equalization-Targeted Services	($13,672,500)	($13,939,000)	($14,224,500)	($14,622,900)	($15,
OPD/ASC Payment Equalization-Targeted Services	($6,911,500)	($7,046,200)	($7,190,600)	($7,392,000)	($7,5
Rural Hospital Programs:					
SCH Program Elimination	($17,661,700)	($17,412,300)	($17,225,500)	($17,146,000)	($17,
CAH Payment Cut to 100% of Cost	($1,303,000)	($1,341,700)	($1,383,400)	($1,426,500)	($1,4
Elimination of CAH Status	($51,548,200)	($54,071,500)	($56,369,700)	($58,198,100)	($60,
Post-Acute Payment Proposals:					
Post-Acute Marketbasket Reduction	($572,800)	($620,900)	($1,151,700)	($1,573,600)	($2,0
IRF Site-Neutral Adjustment	($270,300)	($272,900)	($278,500)	($286,100)	($2
Wage Index Floor Adjustments:					
Repeal of Frontier Rural Floor	($64,943,600)	($66,168,000)	($67,677,100)	($69,729,700)	($71,
Medicare DSH Payments:					
Paul Ryan Medicare DSH Proposal	$0	$6,770,000	$4,599,800	($4,101,200)	($9,2
Tom Price Medicare DSH Proposal	$0	($1,251,400)	($2,631,300)	($4,101,200)	($4,2
Other Proposals:					
Reimbursable Bad Debt reduced to 25%	($270,700)	($553,000)	($850,100)	($876,300)	($9

Notes:
This analysis is intended for advocacy purposes only, not intended for budgeting purposes, and indicates how existing Medicare provider payments would be affected by additional cuts that Congress may consider to achieve Medicare payment policy and/or long-term deficit reduction goals. The impacts shown in this analysis include several of the major cuts proposed in recent years. Due to the lack of data, some proposals are not included in this analysis, and each proposal shown in this analysis is described below.

IME/DGME:

- IME Cuts (source: FFY 2017 Presidential Budget): This impact reflects the recommendation to reduce IME reimbursement by 10% for IPPS hospitals.
- IME Payments based on a National Pool (source: Proposal for the "Medicare IME Pool Act of 2015" introduced by Representative Kevin Brady of Texas): This impact reflects the proposal, beginning FFY 2019, to convert 100% of IME payments into a national pool that would be allocated to hospitals annually based on the national distribution of full-time resident positions.
- DGME Cuts (source: Simpson-Bowles Commission): This impact reflects the recommendation to limit teaching hospitals' Direct Graduate Medical Education (DGME) reimbursement to 120% of the national average salary paid to residents in 2010, updated annually thereafter.

Outpatient Payment Equalization:

- OPD/Physician Payment Equalization for E/M Services (source: H.R. 3630): This impact reflects the U.S. House-approved policy from 2011 to cap payment to hospitals for outpatient evaluation and management (E/M) services at the payment level provided to physicians under the Medicare physician fee schedule.
- OPD/Physician Payment Equalization for Targeted Services (source: MedPAC policy option): This impact reflects a MedPAC policy option from 2013 to cap payments to hospitals for certain outpatient services (66 APCs) at the payment level provided to physicians under the Medicare physician fee schedule.
- OPD/ASC Payment Equalization for Targeted Outpatient Services (source: MedPAC policy option): This impact reflects a MedPAC policy option from 2013 to cap payment to hospitals for certain outpatient services (12 APCs) at the payment level provided to Ambulatory Surgical Centers (ASCs) under the ASC payment system.

Rural Programs:

- SCH Program Elimination (source: Congressional Budget Office): This impact reflects the recommendation to eliminate special inpatient payment status for sole community hospitals (SCHs).
- CAH Payment Cuts (source: FFY 2014 Presidential Budget): This impact reflects a reduction in Medicare reasonable cost-based payments to Critical Access Hospitals (CAHs) from 101% to 100% for Inpatient, Outpatient and swing bed services.
- Elimination of CAH Status: This is the impact of including CAHs in the PPS programs for Inpatient, Outpatient and swing bed services, instead of paying at 101% of Medicare reasonable costs.

Post-Acute Care Programs:

care Cuts Analysis

of Medicare Proposals

Dakota

The values shown reflect annual impact estimates of proposals that have been put before Congress.

2021	2022	2023	2024	2025	2026	10 Year Estimate of Proposals 2017-2026
82,000)	($703,800)	($726,500)	($746,100)	($765,500)	($785,400)	**($6,940,100)**
300,500)	($1,342,300)	($1,385,400)	($1,422,900)	($1,459,800)	($1,497,800)	**($10,888,300)**
380,800)	($1,409,400)	($1,438,600)	($1,468,400)	($1,498,900)	($1,530,000)	**($13,974,300)**
848,900)	($23,466,100)	($24,099,500)	($24,750,400)	($25,393,700)	($26,054,100)	**($232,512,400)**
017,900)	($15,423,200)	($15,839,700)	($16,267,400)	($16,690,200)	($17,124,300)	**($152,821,600)**
591,600)	($7,796,500)	($8,007,000)	($8,223,100)	($8,437,000)	($8,656,400)	**($77,251,900)**
029,200)	($16,890,600)	($16,728,900)	($17,180,600)	($17,627,300)	($18,085,500)	**($172,987,600)**
469,600)	($1,513,300)	($1,558,800)	($1,605,100)	($1,651,900)	($1,699,600)	**($14,952,900)**
017,800)	($61,892,900)	($63,826,400)	($66,031,800)	($68,235,200)	($70,521,300)	**($610,712,900)**
014,000)	($2,470,800)	($2,947,000)	($3,438,500)	($3,826,800)	($4,570,100)	**($23,186,200)**
93,800)	($301,700)	($309,900)	($318,200)	($326,800)	($335,300)	**($2,993,500)**
774,900)	($73,880,800)	($76,049,100)	($78,102,300)	($80,133,100)	($82,216,600)	**($730,675,200)**
271,300)	($9,565,000)	($9,866,500)	($10,172,400)	($10,450,900)	($10,718,000)	**($52,775,500)**
229,300)	($4,353,300)	($4,477,000)	($4,708,600)	($4,870,200)	($4,983,400)	**($35,605,700)**
02,200)	($928,800)	($956,500)	($983,000)	($1,009,400)	($1,036,600)	**($8,366,600)**

- Post-Acute Marketbasket Reduction (source: FFY 2017 Presidential Budget): These impacts reflect reductions of 1.1 percent to the marketbasket updates for inpatient rehabilitation facilities, long-term care hospitals, and home health agencies. Skilled nursing facilities would receive a 2.5 percent reduction in 2017, 2.0 percent in 2019, 1.0 percent in each of 2020-2023, and 0.97 beginning 2024.
- IRF Site-Neutral Adjustment (source: MedPAC policy option): This impact reflects a MedPAC policy option from 2014 to cap inpatient rehabilitation payments for certain conditions to the amount that would have been paid in a skilled nursing facility.

Wage Index Floor Adjustments:

- Repeal of Frontier Rural Floor: Reflects the impact that a repeal of the Frontier Rural Floor (floor wage index of 1.0000, included in the ACA) would have on providers located in states designated as "frontier." Values include impacts to payments under both IPPS and OPPS and do not extend to other states as this provision is not budget neutral.
- Medicare DSH Payments:
  Paul Ryan Medicare DSH Proposal (source: "A Better Way"): Impacts reflect the estimated change in DSH payments made to hospitals were House Speaker Paul Ryan's proposal for distribution of the national uncompensated care payment (UCP) pool implemented, without a repeal of the ACA. This proposal would drop reductions to the pool for FFYs 2018 and 2019 and distribute based solely on charity care amounts found on Worksheet S-10 of the Medicare cost report. In addition, beginning with FFY 2021, Medicare DSH payments would change to be paid based entirely upon the UCC pool. Amounts incorporate projected changes to the national uninsured rate provided by the CBO..
  Tom Price Medicare DSH Proposal (source: Proposal for the "Empowering Patients First Act"): Impacts reflect the estimated change in DSH payments made to hospitals were Representative Tom Price's proposal for distribution of the national uncompensated care payment (UCP) pool implemented, without a repeal of the ACA. This proposal would distribute based solely on charity care amounts found on Worksheet S-10 of the Medicare cost report. Amounts incorporate projected changes to the national uninsured rate provided by the CBO.

Other Cuts Under Consideration:

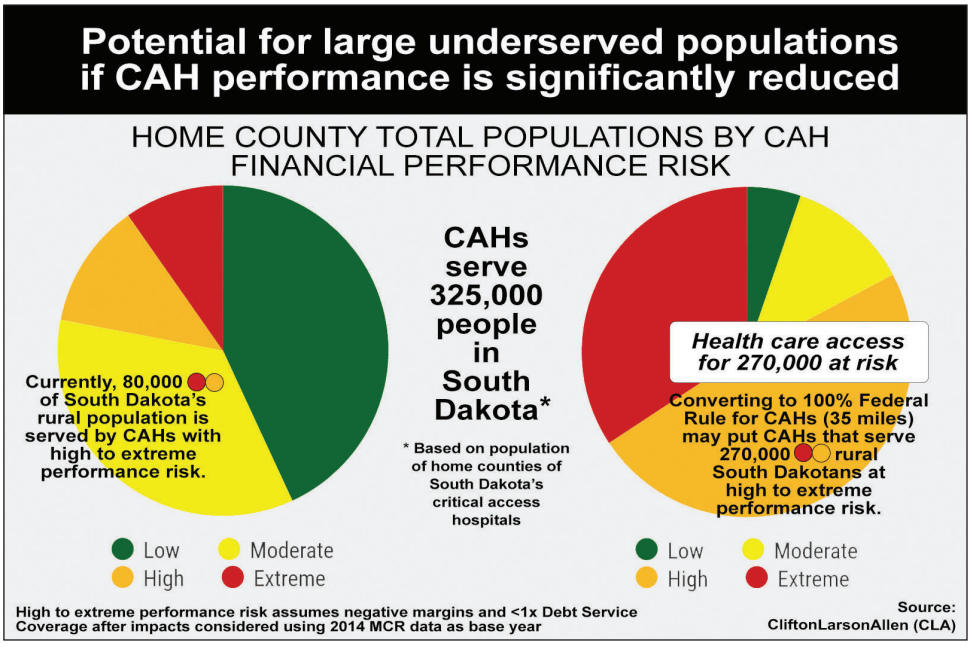
- Bad Debt Payment Cuts (source: FFY 2017 Presidential Budget): These impacts reflect the recommendation to reduce payments for reimbursable bad debts for all provider settings from 65% to 25%, over 3 years.

The date sources for Medicare payment data are the respective CMS payment rule Impact Files, Medicare Cost Reports (2012, 2013, 2014, and 2015), and/or Medicare Claims data (2013, 2014). All of the impacts in this analysis reflect Medicare FFS payments. Dollar impacts may differ from those provided by other organizations due to differences in source data and analytic methods. Dollar impacts have been rounded to the nearest hundred dollars; totals may not foot due to rounding; dollar amounts less than $50 will appear as zeros.

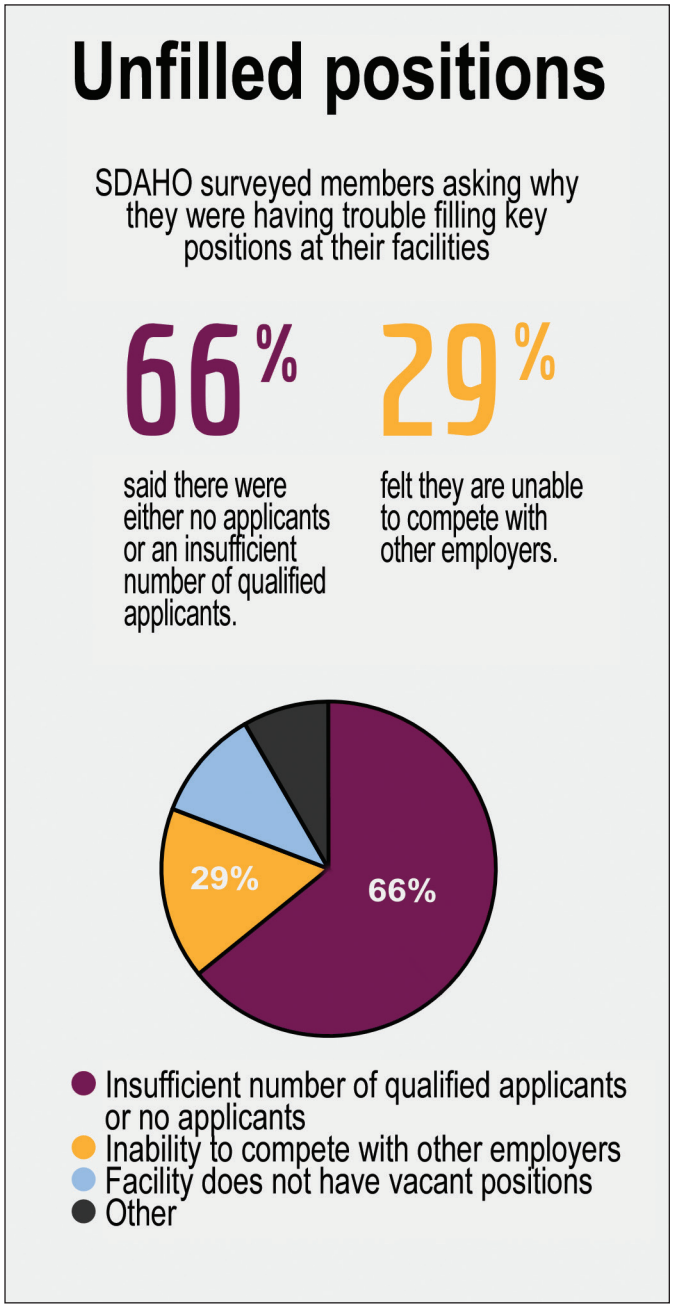
Quality the public can trust can be strengthened with legislative actions that empower innovation and improvements at the local and state levels. Legislation must consider unintended consequences that affect delivery of health care services.

Access

- Support Critical Access Hospitals (CAH) by removing the 96-hour physician certification requirement as a condition of payment.
- Reject elimination of the CAH provider status, which would result in a negative impact to South Dakota of $661 million over 10 years.
- Ensure adequate payment for care and protect individuals from excessive financial burden, such as combining Medicare Parts A and B, limiting Medigap coverage, further means-testing Medicare premiums and raising the Medicare eligibility age.
- Preserve existing, federal-subsidized housing funding. Quality housing is a social determinant of health. Housing plus services leads to increased access to care, better outcomes and decreased institutional care.
- Support the Affordable Housing Credit Improvement Act, which allows for low income tax credits for seniors in affordable housing properties. (S. 548)
- Support the Medicare Mental Health Access Act (S. 448 [R], H.R. 1173 [N]) to provide for the treatment of clinical psychologists as physicians for purposes of furnishing mental health services under the Medicare program.
- Support the State Veterans Home Adult Day Health Care Improvement Act, which allows for U.S. Department of Veterans Affairs (VA) payment for adult day services. (S. 324)
- Support the Medicare Patient Access to Hospice Act by providing for the recognition of attending physician assistants as attending physicians to serve hospice patients. (H.R. 1284)
- Support the Rural Access to Hospital Act, which allows rural health clinics (RHCs) and federally qualified health centers (FQHCs) to receive Medicare payment for attending physician services that treat terminal illnesses of patients on hospice care. (H.R.1828)



- Support the Improving Access to Affordable Prescription Drugs Act. (S. 771)
- Support amending Title XVIII of the Social Security Act to ensure equal access of Medicare beneficiaries to community pharmacies in underserved areas as network pharmacies under Medicare prescription drug coverage and for other purposes. (H.R. 1939)
- Support the Improving Access to Affordable Prescription Drugs Act. (H.R. 1776)
- Maintain the ban on Physician Self-Referral to Physician-Owned Hospitals. The Congressional Budget Office scored this policy as saving $500 million over 10 years; if the policy is reversed, these savings will be erased.
- Support a bill to require the Center for Medicare and Medicaid Innovation to test the effect of including telehealth services in Medicare health delivery reform models. (S. 787)
- Support the Furthering Access to Stroke Telemedicine Act to expand the use of telehealth for individuals treated for strokes. (S. 431 [T])
- Support the Home Health Care Planning Improvement Act by allowing payment for home health services to Medicare beneficiaries by a nurse practitioner, clinical nurse specialist or physician assistant. (S. 445, H.R. 1825)
- Support the Pharmacy and Medically Underserved Areas Enhancement Act. (S. 109 [T] [R])
- Support the Community-Based Independence for Seniors Act to allow for a demonstration program that would provide eligible Medicare beneficiaries adult day care services, homemaker services, home-delivered meals, transportation services, respite care and safety equipment. (S. 309)



Workforce

- Support workforce legislation that promotes funding options needed to provide critically needed positions.
- Amend Medicare and Medicaid statutes to repeal nursing homes' automatic loss of authority to train CNAs because of penalties imposed under the survey process.
- Reject reductions in Medicare funding for medical education support programs to ensure an adequate level for providers for high quality and safe care for patients.
- Promote the use of telehealth, remote patient monitoring and similar technologies by removing barriers to their use and expanding payments. (S. 787, S. 431)
- Support protections for sports medicine

professionals who provide services in a secondary state. (S. 808 [T] [R], S. 302)
- Support Title VIII of the Nursing Workforce Reauthorization Act, which extends through FY 2022 funding for nursing workforce programs and grants. (H.R. 959)
- Support the Palliative Care and Hospice Education and Training Act, which would promote education and research in palliative care and hospice. (S. 693, H.R. 1676)

Quality

- Streamline, prioritize and simplify quality reporting to identify and align meaningful measures that matter.
- Support the Independent Outside Audit of the Indian Health Service Act. (S. 431, S. 465 [R])
- Support the Rural Hospital Regulatory Relief Act, which permanently extends CMS instruction against the enforcement of direct physician supervision requirements for outpatient therapeutic services in critical access and small rural hospitals. (H.R. 741, S. 243 [T])
- Support Indian Health Service accountability and transparency to ensure South Dakota's tribal communities have access to care. (S. 109)
- Suspend the flawed hospital star rating system as it provides inaccurate and misleading information.
- Repeal Title VII of the Balanced Budget Act of 2015 on civil money penalties.
- Remove impediments and improve payment process and timelines for Veterans Choice Program. (S. 663 [T], S.304 [T] [R], and S. 544 [R])
- Support the Office of Information and Regulatory Affairs (OIRA) Insight, Reform and Accountability Act of 2017. (S. 676, H.R. 1009)

The regulatory burden faced by providers is substantial and unsustainable. We urge you to modify or eliminate duplicative, excessive and contradictory provider regulations.

- Preserve flexibility for providers related to treatment spaces for outreach specialists who provide services at rural hospitals.
- Oppose physician supervision of hospital outpatient therapy.
- Hold Medicare Recovery Audit Contractors (RACs) accountable.
- Suspend the Medicaid restrictions on coverage of home- and community-based services (HCBS) that have created obstacles for seniors living in campus-based settings. (HCBS final rule)
- Remove faulty hospital quality measures.
- End onerous home health agency pre-claim review.
- Eliminate unfair Long-term Care Hospital (LTCH) regulation.
- Preserve Medicaid supplemental payments in managed care.
- Delay and review the nursing home Requirements of Participation final rule. This comprehensive revision of the nursing home oversight structure affects every aspect of nursing homes' operation.
- Revise and simplify the payroll-based journal ("PBJ") reporting system, which nursing homes must use to report their staffing levels.
- Repeal Title VII of the Bipartisan Budget Act of 2015 that immediately doubled civil monetary penalties and other fines/penalties in all health care and employment regulations.
- Revisit the CMS nursing home 5-star rating system, especially by changing the current practice of "grading on a curve" to a system of performance benchmarks that would enable all nursing homes to achieve a five-star rating. This would result in a star rating system that would ensure the same level of quality from state to state by defining performance and holding providers accountable.
- Support family caregivers who provide a wide range of long-term care and services to seniors and people with disabilities by recommending the establishment of a domestic policy office of the presidency to address issues of caregiving and services.
- Allow states to pilot test alternative survey systems with federal oversight. Alternatives could include allowing high-performing nursing homes to be eligible for Medicare/Medicaid through deemed status via a respected private-sector accreditation entity like the Joint Committee. Another cost-effective alternative would be to permit longer intervals between surveys for high-performing nursing homes.
- Until a new system is in place, CMS should suspend using 3-star or higher status as a criterium for Accountable Care Organizations (ACOs), hospitals and health systems participating in bundled payment initiatives.
- Exempt health care providers from the Service Contract Act, ensuring that they will not be considered federal contractors subject to minimum wage, paid sick leave and other mandates created by executive order.
- Treat contracts with the Veterans Administration as provider agreements, like Medicare and Medicaid.

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