HHS Regulatory and Policy Changes Focus on Supporting Rural Health Care

The Department of Health and Human Services (HHS) has taken a number of regulatory and policy actions in 2012 to assist rural hospitals, clinics and clinicians who play a key role in ensuring access to high-quality health services in Rural America.

The changes are part of an effort to take into account the unique challenges of rural health care delivery. These actions are also part of HHS' ongoing efforts to support the work of the White House Rural Council, which seeks to streamline and improve the effectiveness of Federal programs serving rural America and engaging rural stakeholders in that process.

The actions taken include a number of new proposals announced January 31st aimed at reducing the regulatory burden faced by rural hospitals, clinics and clinicians. They also include a number of changes that were part of the 2013 Medicare payment updates as well as other regulation and policy changes implemented over the past year.

I. Summary of Provisions from the May 16th Burden Reduction Regulation (CMS-3244-F) *(PDF – 304 KB, http //www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Downloads/CMS-3244-F.pdf)* ***That Benefit Rural Providers:***

- The regulation eliminated the requirement that Critical Access Hospitals (CAHs) must furnish diagnostic and therapeutic services, laboratory services, radiology services, and emergency procedures directly by CAH staff. This allows CAHs to provide such services through a contract. This change better enables CAHs to address staffing challenges, provide high quality care to their patients, and provide CAH patients better access to care.

- Another change will allow hospitals to determine the best ways to oversee and manage outpatients by removing the unnecessary requirement for a single Director of Outpatient Services. This change benefits smaller, low-volume rural hospitals with limited staff resources.

II. Summary of Proposals Included in Part II Burden Reduction Regulation (CMS-3267-P) That Benefit Rural Providers:

Proposal: Allow CAHs to Use Existing Staff to Develop Patient Care Policies
CAHs are typically required to develop patient care policies by working with a group that includes one representative who is not part of the hospital staff. Under the proposed rule, CAHs would not have to meet this requirement and could use their own staff to meet the standard.

Proposal: Provide Flexibility for On-Site Physician Supervision Requirements
HHS is proposing to revise the CAH, Rural Health Clinics (RHC) and Federally-Qualified Health Centers (FQHC) regulations to replace the requirement that an MD or DO must be onsite at least once in a two-week period (except in extraordinary circumstances) to provide medical direction, consultation, and supervision to Physician Assistants (PAs) and Nurse Practitioners (NPs). The proposed change would

remove a rigid requirement and provides CAHs, RHCs and FQHCs with the flexibility to address their specific circumstances and needs, thus enhancing access to care in rural and remote areas. Some providers in extremely remote areas or areas that have geographic barriers have indicated that they find it difficult to comply with the precise biweekly schedule requirement.

Proposal: Allow Dieticians to Order Patient Diets
Registered dieticians (in addition to other practitioners responsible for the care of the patient) can now order patient diets. This eases the burden on rural physicians and other clinicians to make these orders on behalf of the dieticians.

Proposal: Allow Flexibility in Outpatient Service Orders
Practitioners who are not on a hospital's medical staff may now order hospital outpatient services for their patients when authorized by the medical staff and allowed by State law. Not all clinicians in rural areas, particularly traveling specialists, are necessarily on the medical staff of a small rural hospital. This will allow these clinicians to order services directly.

Proposal: Align Survey Requirements for Swing Beds and Hospitals
Rural hospitals with swing beds will now be surveyed only when the hospital is surveyed rather than surveyed separately. Previously, the swing beds were subject to a separate survey. Given the small size of these facilities, allowing a single survey will reduce the burden on the hospital.

Seek Comment on Additional Flexibility for Rural Health Clinics
The proposed regulations seek comment from RHC providers about additional regulatory or other requirements that could reduce barriers to the provision of telehealth, hospice or home health services. There are over 3700 RHCs that provide access to health care services for rural residents. RHCs must also be located in a health professional shortage or medically underserved area. Many RHCs are also located in areas with shortages of mental health services and home health and hospice providers. This proposed regulation offers the public an opportunity to provide comments on potential changes to RHC policies that would allow these clinics to furnish distant site telehealth, home health and hospices services.

III. Summary of 2013 Payment Update Provisions That Benefit Rural Communities:

New primary care management code:
In the Final Calendar Year (CY) 2013 Medicare Physician Fee Schedule (MPFS) (PDF – 13 MB, http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf), HHS created a new service codes to cover care management and coordinating services. These codes would describe all non-face-to-face services related to the transitional care management furnished by the community physician or qualified non-physician practitioner within 30 calendar days following the date of discharge from an inpatient hospital, psychiatric hospital, long-term care hospital, skilled nursing facility, and inpatient rehabilitation facility; hospital outpatient for observation services or partial hospitalization services; and a partial hospitalization program at a community mental health center to community-based care. These codes will allow rural primary care providers to better coordinate the care furnished to their patients who often time are discharged back to rural communities from urban hospitals and skilled nursing facilities.

New telehealth covered services:
Telehealth is an important tool to improve access to a broader range of health care services in rural and frontier communities. In the final CY 2013 MFPS (PDF – 13 MB, http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf) HHS added the following services to the list of those eligible for telehealth reimbursement in CY 2013:

- Alcohol and/or substance (other than tobacco) abuse structured assessment,

- Screening and behavioral counseling interventions in primary care to reduce alcohol misuse,
- Screening for depression in adults,
- Screening for sexually transmitted infections (STIs) and high-intensity behavioral counseling (HIBC) to prevent STIs,
- Intensive behavioral therapy for cardiovascular disease, and
- Intensive behavioral therapy for obesity.

Ordering of Portable X-Ray

In the final CY 2013 MFPS (PDF – 13 MB, http://www.gpo.gov/fdsys/pkg/FR-2012-11-16/pdf/2012-26900.pdf) HHS amended the Conditions for Coverage (CfC) regulations to permit all physicians and certain non-physician practitioners (NPs, PAs, CNSs, CNMs, CPs, and CSWs) to order portable x-ray services, within the scope of their Medicare benefit and scope of practice. Previously, only MDs and DOs were permitted to do so. Rural clinics and hospitals rely heavily on non-physician practitioners and this proposal will allow for greater access to these services in rural communities that may not always have a physician available.

2013 Meaningful Use Stage II Final Rule

In the final rule for Meaningful Use Stage II (PDF – 1 MB, http://www.gpo.gov/fdsys/pkg/FR-2012-09-04/pdf/2012-21050.pdf), HHS allows for a three-month attestation rather than a full year of reporting. This change was supported by rural providers and eases the reporting burden for small rural providers while also ensuring that all providers are meeting the quality reporting requirements needed to show that they are on track for meeting the full range of meaningful use of electronic health record requirements.

Electronic Health Record Incentive Payments and Critical Access Hospitals

HHS announced in July 2012, through Frequently Asked Questions (FAQs) #3387 (https://questions.cms.gov/faq.php?isDept=0&search=3387+&searchType=faqId&submitSearch=1&id=5005) that it would allow CAHs to include capital lease costs for the purpose of determining electronic health record (EHR) incentive payments. Previously, CMS had excluded capital leases from inclusion in eligible EHR costs. A number of CAHs use capital leases to acquire EHRs and other technology and equipment, because of favorable financing terms or an inability to secure traditional loans for those purchases.

Special Project on Quality Improvement in Rural Hospitals

Over the past several months, HHS has increased the level of technical assistance provided to CAHs so that a greater percentage of facilities are now able to voluntarily report quality data for public reporting. HHS is now proposing to build on this effort with a new project in which Quality Improvement Organizations will work with CAHs intended to understand and improve the care delivered by CAHs by focusing on transfer communication from the CAH emergency department to acute care receiving facilities. This is a key role for small rural hospitals and is a growing area of focus in national discussions around patient safety and health care quality.