Craig Thomas Rural Hospital and Provider Equity (R-HoPE) Act of 2014

Section 1: Short Title; Table of Contents

Section 2: Sense of the Senate

The Sense of the Senate describes the unique challenges rural communities face when it comes to health, and the importance of ensuring that rural residents have access to affordable and quality health care. Federal health care policy must reflect these unique needs. The Sense of the Senate calls upon rural health stakeholders to work together to identify innovative improvements to federal rural health care policies. Instead of advocating temporary fixes each Congress, this section looks to stakeholders to work with each other and with policy makers to come up with sustainable solutions to rural health care challenges. Rural communities cannot be left behind.

Section 3: Equalize Medicare Disproportionate Share Hospital Payments

Hospitals serving a disproportionate share of Medicaid and low income Medicare beneficiaries receive additional payments from Medicare. Medicare's disproportionate share hospital (DSH) payments are capped at 12% for most rural hospitals. This provision would remove that limit to provide additional Medicare funding to rural hospitals serving large numbers of these low income patients.

Section 4: Reinstate the Hold Harmless for Rural Hospitals under the Outpatient Prospective Payment System

The Medicare outpatient prospective payment system (OPPS) went into effect on August 1, 2000. In 1999, the Balanced Budget Refinement Act (BBRA) included provisions that would hold harmless rural hospitals with less than 100 beds. Essentially, the BBRA allowed small rural hospitals to continue being reimbursed under pre-PPS rules. The BBRA mandated that Congress should receive recommendations on whether the hold harmless should be lifted, or made permanent. The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 extended the hold harmless provision for small, rural hospitals as well as Sole Community Hospitals located in rural areas through December 21, 2005.

The Deficit Reduction Act (DRA) of 2005 extended the hold harmless only for small rural hospitals having 100 or fewer beds that are not sole community hospitals. Additionally, the DRA mandated step-down payments to these rural hospitals paying 95 percent of the difference between the prior payment system and the hospital outpatient payment system. In 2007, that percentage fell to 90 percent, and in 2008 to 85 percent. This was not a MedPAC recommendation.

In fact, the March 2005 MedPAC report suggested extending hold harmless payments through calendar year 2006. This one year extension was to provide analysts time to better determine the reasons that some rural hospitals are not performing as well under Medicare. Once identified, policies would be developed to address the specific issues these hospitals face.

Most recently, the hold harmless provision was extended at 85% of the payment difference under the Medicare and Medicaid Extenders Act of 2010 for one year until December 31, 2011. The Middle Class Tax Relief and Job Creation Act of 2012 again extended this payment level through December 31, 2012. The program was *not* extended in the American Taxpayer Relief Act of 2012.

Given that data is not available to determine whether the hold harmless should be lifted, this section would reinstate the original hold harmless policy at 100% of the payment difference for small rural hospitals and sole community hospitals through January 1, 2015.

Section 5: Assistance for Low Volume Hospitals

Current inpatient payment rates do not account for the fact that most rural facilities cannot achieve the same economies of scale as large hospitals. To help address this, MedPAC recommended implementing a payment adjustment for certain small rural hospitals that serve a low-volume of patients. The MMA established a graduated adjustment/add-on payment for low volume hospitals. Eligible hospitals are those located more than 25 miles away from another hospital and have fewer than 800 discharges in a given year. The maximum total adjustment is 25 percent of the otherwise applicable prospective payment rate. The health care law further built on this policy by making eligible for FY11 and FY12 hospitals more than 15 miles from another hospital with fewer than 1600 discharges. ATRA extended the low volume adjustment through September 30, 2013, the Pathway for SGR Reform Act of 2013 extended it through April 1, 2014, and the Protecting Access to Medicare Act of 2014 extended it until April 1, 2015.

This section builds on the MMA provision as the payment adjustments are designed to decrease as the level of inpatient admissions rises, and would phase out completely for facilities that discharge more than 2,000 patients per year. This provision would help rural hospitals that are not included under the PPS system, and may have difficulties operating in the rural system, but are not appropriate candidates for Critical Access Hospital status.

In addition, this provision makes temporary improvements to the payment adjustment by maintaining the mileage limit at 15 miles and increasing the adjustment amount by a percentage determined by the Secretary. Approximately 600 rural facilities nationwide would be eligible for this assistance. This provision would extend the program through January 1, 2016.

Section 6: Continuation of Geographic Reclassification for Certain Hospitals in Sparsely Populated States

Under current law, hospitals can apply to re-classify their wage index to another area if they believe their labor costs are more reflective of another market. As part of this process, hospitals must be located in a county that is adjacent to the county in which they propose to re-classify. There are concerns that this criteria is unfair to many small urban and rural facilities, many of which compete for the same labor pool, but are not located as close to their competitors as facilities in large urban markets.

To address this problem, the MMA included an appeals process that allowed hospitals located in sparsely populated areas (states with fewer than 10 people per square mile) to re-classify if they are otherwise eligible for re-classification aside from not meeting the current proximity/adjacency requirement. This policy is set to expire September 30, 2011. This policy expired on March 31, 2012.This provision would reinstate the reclassification option through January 1, 2015.

Section 7: Reasonable Lab Costs Payment Extension for Rural Hospitals

This section would extend Section 416 of the MMA as amended by Section 107 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 which provided reasonable cost reimbursement for clinical diagnostic laboratory services provided by qualifying rural hospitals with fewer than 50 beds in certain states with low population density rural areas. These hospitals have relied on these additional Medicare payments, and would be hard pressed to continue necessary services without the funding. These payments expired on June 30, 2012. This provision would reinstate reasonable cost reimbursement for these services through January 1, 2015.

Section 8: Critical Access Hospital (CAH) Ambulance Payment Improvement

Under current law, CAHs only receive cost-based reimbursement for ambulance services if they are the only provider within a 35-mile drive. This provision would eliminate the 35-mile "isolation test" requirement, ensuring that CAHs are appropriately reimbursed for providing emergency medical services.

Section 9: Capital Infrastructure Loan Program

This program would make loans available to help rural facilities improve aging buildings and infrastructure. In addition, rural providers could apply to receive planning grants to help assess capital and infrastructure needs. This program would be authorized through January 1, 2015, and funding would be subject to the annual appropriations process.

Section 10: Extend the Medicare Incentive Payment Program

The Medicare Incentive Payment (MIP) Program provides 10 percent bonus payments to physicians practicing in Physician Scarcity Areas. The MMA built upon this program by requiring CMS to identify eligible rural providers and automatically provide the 10 percent add-on payment to all Medicare claims. This legislation would extend the MIP program until January 1, 2015.

Section 11: Extend the Physician Fee Schedule Work Geographic Adjustment

Medicare payments for physician services are based upon a fee schedule, intended to relate payments for a given service to the actual resources used in providing that service. There are three components of this fee schedule – liability, practice, and work. CMS defines "physician work" as the amount of time, skill, and intensity necessary to provide services. Each component of the fee schedule is multiplied by a geographic index designed to adjust for variations in cost. The geographic index as it relates to "physician work" is lower in rural areas than in urban areas. Thus, although rural physicians put in as much or even more time, skill, and intensity into their work as physicians in urban areas, rural physicians are paid less for their work. The MMA increased the work geographic index to a base of one over a two year period for any locality for which such index was below one. Those fee schedule areas that are currently at or above one are not affected.

Section 102 of the Tax Relief and Health Care Act of 2006 allowed this adjustment to continue through calendar year 2007. The Medicare, Medicaid and SCHIP extenders Act of 2007 extended the floor through June 30, 2008. The Medicare Improvement for Patients and Providers Act (MIPPA) continued the extension through December 31, 2009. The health care law extended this floor through December 31, 2010, the Medicare and Medicaid Extenders Act of 2010 through December 31, 2011. the Middle Class Tax Relief and Job Creation Act through December 31, 2012, ATRA extended it through December 31, 2013, the Pathway for SGR Reform Act of 2013 extended it through April 1, 2014, and the Protecting Access to Medicare Act of 2014 extended it through April 1, 2015. This section would extend current law until January 1, 2016, for rural physicians.

Section 12: Physician Assistants and Hospice Patients

Physician assistants (PAs) are a crucial part of the health care workforce in rural America. In some rural areas, PAs may be the only primary health care professional available. Currently, PAs are not permitted to order or provide hospice care for their patients. These restrictions limit PA's ability to offer needed services to patients at a time when they're most vulnerable, especially those living in rural and frontier areas. This section would allow physician assistants to order post-hospital extended care, and provide hospice care to their patients who elect Medicare's hospice benefit.

Section 13: Improving Care Planning for Home Health Patients

Under existing Medicare policy, physician assistants, nurse practitioners, and clinical nurse specialist are not allowed to directly prescribe home health services. These restrictions limit these provider groups' ability to offer needed services to patients, especially those living in rural and frontier areas. This section removes those restrictions for physician assistants, nurse practitioners, and clinical nurse specialists who have no financial relationship with a home health agency and are legally authorized to perform the services. These providers will be reimbursed by Medicare for these services at 85 percent of the physician fee schedule.

Section 14: Rural Health Clinic Reimbursement

Rural Health Clinics (RHCs) receive an all-inclusive payment rate that is capped at approximately $78. Various analyses have suggested that payment rate does not appropriately cover the cost of services for RHCs and that the cap should be raised to address the shortfall. This provision would raise the RHC cap to $101, bringing it closer to the payment rate for rural Federally Qualified Health Centers (FQHCs).

Section 15: Rural Home Health Add-On Payment

The Deficit Reduction Act extended a 5 percent add-on payment increasing reimbursements to home health agencies for services delivered in rural areas, which has expired and been extended temporarily. Section 15 would reinstate the 5 percent add-on payment through January 1, 2015. This 5 percent would supplant the 3 percent rate increase that was included in the health care law and began on April 1, 2010.

Section 16: Temporary Ground Ambulance Payment Extension

Ambulance service providers are closing their doors and scaling back their services due to inadequate Medicare reimbursement and inappropriate payment denials by Medicare claims processors. These funding difficulties often jeopardize the level of care that ambulance service providers can deliver, and ultimately may increase the time it takes to respond to patients. To help alleviate this situation, the Medicare Improvements for Patients and Providers Act (MIPPA) temporarily increased payments by 3 percent for rural ground ambulance services. The MIPPA provision has been extended by ATRA to January 1, 2014, the Pathway for SGR Reform Act of 2013 extended it through April 1, 2014, and the Protecting Access to Medicare Act of 2014 extended it until April 1, 2015. This section would increase add-on payment for rural ambulance service providers to 5%. The 5% increase is based on the findings of a recent Government Accountability Office report, which determined that ambulance service providers are reimbursed below their costs in providing services to Medicare patients. The section also extends through January 1, 2016, the bonus payment provision from the Medicare Modernization Act for transports originating in "super rural" areas.

Section 17: Mental Health Provider Reimbursement

The Medicare program permits only psychiatrists, psychologists, social workers, and clinical nurse specialists to bill for mental health services provided to Medicare beneficiaries. However, the vast majority of rural areas are designated as mental health professional shortage areas, and most rural counties do not have a psychiatrist or a psychologist. This section would increase the number of mental health providers available to seniors by allowing marriage and family therapists and licensed professional counselors to bill Medicare for their services and be paid the rate of social workers. These providers are much more likely to practice in a rural setting and are often the only mental health professional available in remote rural and frontier areas.

Section 18: Physician Pathology Services Extension

In 1999, the Centers for Medicare and Medicaid Services (CMS) made a regulatory change mandating that hospitals (not Medicare) pay independent laboratories for services provided to beneficiaries. This CMS regulation would have added a new financial burden on many small, rural independent laboratory facilities.

The Benefits Improvement and Protection Act (BIPA) of 2000 temporarily prohibited this payment change from taking place. BIPA allowed rural, independent laboratories to continue billing Medicare directly, but only for a few years. Congress extended this moratorium several more times in the 2003 MMA, the 2006 Tax Relief and Health Care Act, the 2007 Medicare, Medicaid, and SCHIP Extension Act, the 2008 MIPPA, the health care law, and the Medicare and Medicaid Extenders Act of 2010. . The moratorium expired on June 30, 2012, and this provision would restore it through January 1, 2015.

Section 19: Facilitating the Provision of Telehealth Services Across State Lines

Telehealth has helped to bring health care into rural areas that otherwise lack access to such services. Medicare has recognized the value of telehealth and provides reimbursement for certain providers and services. However, a problem exists when telehealth services are provided across state lines because of individual state licensure laws. This provision would direct the Secretary of HHS to work with stakeholders to adopt regulations to facilitate multistate practice acts.

Section 20: Improving Access to Anesthesiology Services

Medicare normally pays for anesthesia services under the Medicare Part B fee schedule. However, as a means of attracting anesthesia professionals to rural areas Congress has authorized rural hospitals to use a more generous Medicare Part A pass-through arrangement to pay for the services of anesthesiologist assistants and nurse anesthetists. However, there is still a shortfall of anesthesia providers in rural hospitals. This provision would expand the pass-through policy to include anesthesiologists. An estimated 638 rural hospitals would be eligible for this provision.

Section 21: Increase the Physician Fee Schedule Practice Expense Geographic Adjustment

Medicare payments for physician services are based upon a fee schedule, intended to relate payments for a given service to the actual resources used in providing that service. There are three components of this fee schedule – liability, practice expense, and work. Practice expenses include both the direct costs associated with a procedure (i.e.; non-physician personnel, equipment, and supplies) and the indirect costs (i.e.; office rent). Each component of the fee schedule is multiplied by a geographic index designed to adjust for variations in cost.

The methodology for calculating the practice expense geographic index has been criticized for being an inaccurate reflection of the actual cost of setting up a practice, and is lower for rural areas than in urban areas. This provision would establish a floor of 1.0 on the practice expense geographic index through January 1, 2015, to ensure that rural physicians are provided a bridge to any new payment system.

Section 22: Revisions to Standard for Designating Sole Community Hospitals

One of the criteria for gaining Sole Community Hospital status is that the hospital be more than 35 miles from a like hospital. This provision clarifies that the measurement for that mileage should be the most expeditious and accessible route as designated by law enforcement for emergency vehicle travel.

Section 23: Reimbursing CAHs for Certified Registered Nurse Anesthetists (CRNA) On-Call Services

Often times, CAHs rely on the services of CRNAs to deliver anesthesia services. Currently, CAHs are not reimbursed for the time they must pay CRNAs to be on-call, while they are reimbursed for on-call time of anesthesiologists. This provision would correct this inequity and ensure CAHs no longer have to absorb the cost of having these vital services available to their patients at all times.

Section 24: Reauthorizing Grants to States for Operation of Offices of Rural Health

In 1990, Congress authorized the Office of Rural Health Policy to make grants to States for the purpose of improving health care in rural areas through the operation of State offices of rural health. The program requires a state match, which increases as State Offices become more established. States have flexibility in using the grants to meet the unique needs of their communities, but they must meet minimum requirements including establishing an information clearinghouse; coordinating state and federal rural health programs throughout the state; providing technical assistance to improve participation in state and federal programs; and improving availability of health professionals in rural areas. This provision reauthorizes the program, which expired in 2002.

Section 25: Removing the Medicare 96-hour Physician Certification Requirement for Inpatient CAH Services

As a condition of reimbursement for Critical Access Hospital inpatient services, CMS requires a physician to certify that a beneficiary may reasonably be expected to be discharged or transferred to a hospital within 96 hours after admission to the CAH. While CMS has not previously enforced this requirement as a condition of payment, CMS recently published a guidance that indicates its intent to begin enforcing this requirement. Under current law, CAHs are already required to maintain an average inpatient time of 96 hours per patient, however they offer some medical services that have standard lengths of stay greater than 96 hours. This provision would allow CAHs to maintain this average of 96 hours per inpatient stay, while removing the duplicative requirement that a physician individually certify that each patient is expected to be discharged within 96 hours.