United States Senate
Committee on Finance

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Grassley Introduces *Medicare Rural Health Access Improvement Act*

WASHINGTON – Sen. Chuck Grassley has introduced legislation to improve Medicare policies and funding formulas to preserve and add access to high quality health care in rural communities in Iowa and other states.

"It's challenging for rural communities to maintain access to their health care," Grassley said. "Medicare policies should help them keep and improve their access. Those policies should help keep small hospitals open for business and pay community doctors fairly so they can continue to serve rural areas well and even relocate to fill shortages in those areas. Congress has done a lot of good over the years to address Medicare needs in rural areas. Iowans have helped me identify those needs and refine the policies. This legislation builds on our successes. I hope to get this legislation enacted as soon as possible."

Grassley introduced the *Medicare Rural Health Access Improvement Act of 2008* late Thursday. He is ranking member of the Committee on Finance, with Senate jurisdiction over Medicare. Following are: (1) his floor statement of introduction and (2) a summary of the bill.

Statement of Senator Charles E. Grassley
Before the United States Senate
Introduction of the Medicare Rural Health Access Improvement Act of 2008
March 13, 2008

Mr. President, I am pleased to introduce the Medicare Rural Health Access Improvement Act of 2008. The purpose of this legislation is to continue ongoing efforts to ensure that Americans in rural areas have access to health care services. Much has been done in the past to improve access to rural providers such as hospitals and doctors. Much more still needs to be done.

Mr. President, I hold town meetings in each of the 99 counties in the great state of Iowa every year. As many know, Iowa is largely a rural state, and a significant concern that I consistently hear during these meetings is the difficulty my constituents experience in accessing health care services. As the

former Chairman and currently the Ranking Member of the Finance Committee, it has therefore been a priority for me to improve the availability of health care in rural areas.

In Iowa, as in many rural areas across the country, hospitals are often not only the sole provider of health care in rural areas, but also employers and purchasers in the community. Moreover, the presence of a hospital is essential for purposes of economic development because businesses check to see if a hospital is in the community in which they might set up shop. As you can see, it is vital that these institutions are able to keep their doors open.

In previous legislation, Congress has been able to improve the financial viability of rural hospitals. For instance, the creation and subsequent improvements to the Critical Access Hospital designation has greatly improved the financial health of certain small rural hospitals and ensured that community residents have access to health care.

However, there are still a group of rural hospitals that need help. I am referring to what are known as "tweener" hospitals, which are too large to be Critical Access Hospitals, but too small to be financially viable under the Medicare hospital prospective payment systems. These facilities are struggling to stay afloat despite their tireless efforts. Like in many communities in across the country, the staff of tweener hospitals and their community residents take great pride in the quality of care at these facilities. I have heard countless stories of the exemplary work tweener hospitals in Iowa perform not only as providers of essential health care, but also as responsible members of their communities. It is for this reason that many provisions in this bill are intended to improve the financial health of tweener hospitals and ensure that people have access to health care.

Mr. President, most tweener hospital are currently designated as Medicare Dependent Hospitals and Sole Community Hospitals under the Medicare program. There are provisions, both temporary and permanent, included in this bill that would improve Medicare payments for both types of hospitals. This includes improvements to the payment methodologies so that inpatient payments to these facilities would better reflect the costs they incur in providing care. Improvements are also proposed in this bill to Medicare hospital outpatient payments for both Medicare Dependent Hospitals and Sole Community Hospitals so they would both share the benefit of hold harmless payments and add-on payments.

Also, a major driver of the financial difficulties that tweener hospitals face is the fact that many have relatively low volumes of inpatient admissions. This bill would improve the existing low-volume add-on payment for hospitals so that more rural facilities with low volumes would receive the assistance they desperately need.

Over the years, many have commented that it is simply unfair for many rural hospitals to receive only a limited amount of Medicare Disproportionate Share Hospital, or DSH, payments while many urban hospitals are not subject to such a cap. This bill would eliminate the cap for DSH payments for those rural hospitals for a two-year period.

There are also other provisions that would continue to help rural hospitals. The rural flexibility program would be extended for an additional year. Certain rural hospitals that are paid on a cost basis for the outpatient laboratory services they provide would continue to do so on a permanent

basis. And Critical Access Hospitals that provide outpatient laboratory services would be paid 101 percent of their costs regardless of whether the specimen was collected from a patient of the CAH or whether the specimen was collected in a skilled nursing facility or clinic associated with the CAH.

This legislation also seeks to improve incentives for physicians located in rural areas and increase beneficiaries' access to rural health care providers. It includes provisions designed to reduce inequitable disparities in physician payment resulting from the Geographic Practice Cost Indices, or adjusters, known as GPCIs. Medicare payment for physician services varies from one area to another based on the geographic adjustments for a particular area. Geographic adjustments are intended to reflect cost differences in a given area compared to a national average of 1.0 so that an area with costs above the national average would have an index greater than 1.0, and an area below the national average would have an index less than 1.0. There are currently three geographic adjustments: for physician work, practice expense, and malpractice expense.

Unfortunately, the existing geographic adjusters result in significant disparities in physician reimbursement which penalize, rather than equalize, physician payment in Iowa and other rural states. These geographic disparities in payment lead to rural states experiencing significant difficulties in recruiting and retaining physicians and other health care professionals due to their significantly lower reimbursement rates.

These disparities have perverse effects when it comes to realigning Medicare payment to reward quality of care. Let me put that into context. Iowa is widely recognized as providing some of the highest quality health care in the country yet Iowa physicians receive some of the lowest Medicare reimbursement due to these inequitable geographic adjustments. Medicare reimbursement for some procedures is at least 30 percent lower in Iowa than payment for those very procedures in other parts of the country. That is a significant disincentive for Iowa physicians who are providing some of the best quality care in the country, and it is fundamentally unfair. Congress needs to reduce these disparities in payment and focus on rewarding physicians who provide high quality care.

The inequitable geographic payment formulas have also exacerbated the problems that rural areas face in terms of access to health care. Rural America today has far fewer physicians per capita than urban areas. The GPCI formulas are a dismal failure in promoting an adequate supply of physicians in states like Iowa, and more severe physician shortages in rural areas are predicted in the future.

The legislation I am introducing today makes changes in the GPCI formulas for work and practice expense to reverse this trend. It establishes a 1.0 floor for the physician work and practice expense adjustments. It also revises the calculation of the work and practice expense formulas to reduce payment differences and more accurately compensate physicians in rural areas for their true practice costs. We must act now to help rural states recruit and retain more physicians so that beneficiaries will continue to have access to needed health care.

Congress has previously enacted a number of other provisions to improve Medicare payment for health care professionals and providers in rural areas that will expire soon. This bill extends the five percent incentive payments for primary care and specialty physicians in scarcity areas through

December 2009. It also extends the existing payment arrangements which allow independent laboratories to bill Medicare directly for certain physician pathology services.

The bill includes several new provisions to improve beneficiary access to health care services. It increases rural ambulance payments by five percent for the next eighteen months. It permanently increases the payment limits for rural health clinics. It allows hospital-based renal dialysis centers and skilled nursing facilities to provide telehealth services. It also allows physician assistants to order post-hospital extended care services and to serve hospice patients.

Finally, the bill would protect rural areas from being adversely affected by the new Medicare competitive bidding program for durable medical equipment. It would ensure that home medical equipment suppliers who provide equipment and services in rural areas and small metropolitan statistical areas (MSAs) with a population of 600,000 or less can continue to serve the Medicare program by exempting these areas from competitive bidding. We must ensure that rural areas continue to have medical equipment suppliers available to serve beneficiaries in these areas.

Mr. President, as you can see, we still have much to do when it comes to ensuring access to health care in rural America. I look forward to working with my colleagues on this important matter.

Thank you, Mr. President. I yield the floor.

Medicare Rural Health Access Improvement Act of 2008

Title I – Provisions Relating to Medicare Part A

Section 101. Extension of Medicare FLEX Program.
The provision would extend the Medicare Rural Hospital Flexibility Grant Program through FY2009.

Section 102. Improvements to the Medicare Dependent Hospital (MDH) Program.
Starting for discharges on October 1, 2008, until October 1, 2011, MDH payments would not be adjusted for area wages unless it would result in improved payments, and MDHs would have their payments based on 85 percent of their hospital specific costs instead of 75 percent.

Section 103. Rebasing for Sole Community Hospitals (SCHs).
Starting for discharges on October 1, 2008, SCHs would be able to elect payment based on their FY2002 hospital-specific payment amount per discharge.

Section 104. Temporary Improvements to the Medicare Inpatient Hospital Payment Adjustment for Low-volume Hospitals.
In FY2009 and FY2010 hospitals that are located more than 15 road miles from another comparable hospital and have 2,000 discharges of individuals entitled to or enrolled for Medicare Part A benefits would receive a low-volume payment adjustment for Medicare inpatient hospital services. The Secretary would determine the applicable percentage increase using a linear sliding scale ranging from 25% for low-volume hospitals below a certain threshold to no adjustment for hospitals with greater than 2,000 discharges of individuals with Medicare Part A benefits.

Section 105. Temporarily Lifting the Disproportionate (DSH) Adjustment Cap for Rural Hospitals.
The provision would eliminate the DSH adjustment cap for rural hospitals for discharges occurring in FY2009 and FY2010.

Title II – Provisions Relating to Medicare Part B

Section 201. Extension and Expansion of the Medicare Hospital Outpatient Department Hold Harmless Provision for Small Rural Hospitals.
The provision would establish that in CY 2009 and CY 2010, small rural hospitals, including Medicare Dependent Hospitals and Sole Community Hospitals, would receive 100% of the difference between payments made under the Medicare Hospital Outpatient Prospective Payment System and those made under the prior reimbursement system.

Section 202. Expansion of the Medicare Hospital Outpatient Department Add-on Payment for Rural Sole Community Hospitals (SCHs).
Both SCHs and Medicare Dependent Hospitals (MDHs) in rural areas would receive a 7.1% increase in payments for covered hospital outpatient services starting January 1, 2009. The Secretary would be able to revise this percentage starting for services furnished after January 1, 2010 through promulgation of a regulation. The increased payments as they relate to SCHs and MDHs would not be implemented in a budget-neutral manner.

Section 203. Permanent Treatment of Medicare Reasonable Costs Payments for Certain Clinical Diagnostic Laboratory Tests Furnished to Hospital Patients in Certain Rural Areas.
This provision would make reasonable cost reimbursement for laboratory services provided by qualified rural hospitals permanent starting July 1, 2008.

Section 204. Clarification of Payment for Clinical Laboratory Tests Furnished by Critical Access Hospitals (CAHs).
Under this provision, clinical diagnostic laboratory services furnished by a CAH starting in January 1, 2009 would be reimbursed at 101% of costs as outpatient hospital services without regard to whether the specimen was collected from a patient of the CAH or whether the specimen was collected in a skilled nursing facility or clinic that is owned by or co-located with the CAH.

Section 205. Extension of Medicare Incentive Payment Program for Physician Scarcity Areas.
The provision would extend the 5% bonus payment to physicians practicing in physician scarcity areas through December 31, 2009.

Section 206. Revisions to the Work Geographic Adjustment Under the Medicare Physician Fee Schedule.
The provision would extend the 1.0 work floor through December 31, 2009. It would eliminate the work adjustment and establish a national value of 1.0, effective January 1, 2010.

Section 207. Revisions to the Practice Expense Geographic Adjustment Under the Medicare Physician Fee Schedule.
The provision would establish a practice expense floor of 1.0 for 2009. It would reduce the geographic adjustment for practice expense to 50 percent of the current adjustment, effective January 1, 2010.

Section 208. Extension of Treatment of Certain Physician Pathology Services Under Medicare.

The provision extends for eighteen months the provision that allows independent laboratories to continue to bill Medicare directly for the technical component of certain physician pathology services provided to hospitals as authorized by the Balanced Budget Act of 1997 through December 31, 2009

Section 209. Extension of Increased Medicare Payments for Rural Ground Ambulance Services.
The provision would provide for an increase in the rates otherwise established for ground ambulance services of 5 % in rural areas for the period July 1, 2008 – December 31, 2009.

Sec. 210. Adding Hospital-Based Renal Dialysis Centers (Including Satellites) As Originating Sites for Payment of Telehealth Services.
The provision would permit a hospital-based or critical access hospital-based renal dialysis center (including satellites) to serve as a telemedicine site, effective January 1, 2009.

Section 211. Expansion of Telehealth Services to Skilled Nursing Facilities.
The provision would permit otherwise qualifying skilled nursing facilities to be the originating site for the provision of covered telehealth services, effective January 1, 2009.

Section 212. Rural Health Clinic Improvements.
The provision would establish the RHC upper payment limit at $92 per visit in 2009. The limit would be increased in subsequent years by the percentage increase in the MEI applicable to primary care services.

Section 213. Exemption for suppliers in small MSAs and rural areas.
The provision would require the Secretary to exempt rural areas and small MSAs with a population of 600,000 or less from the Medicare competitive bidding program. Competitively bid prices would not apply to rural and small MSAs exempted under this section. The provision would be effective as if included in the MMA, other than for contracts entered into pursuant to implementation of competitive bidding prior to September 1, 2008.

Section 214. Permitting Physician Assistants to Order Post-Hospital Extended Care Services and to Provide for Recognition of Attending Physician Assistants as Attending Physicians to Serve Hospice Patients.
The provision would allow a physician assistant who does not have a direct or indirect employment relationship with a SNF, but who is working in collaboration with a physician, to order post-hospital extended care services. For purposes of a hospice written plan of care, the provision would

recognize attending physician assistants as attending physicians to serve hospice patients. It would continue to exclude physician assistants from the authority to certify an individual as terminally ill. The provisions would apply to items and services furnished on or after January 1, 2009.