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Grassley works to strengthen rural health care system with equity, extensions and exemptions

WASHINGTON --- Senator Chuck Grassley introduced legislation this week to strengthen the health care delivery system in rural America.

Grassley's *Medicare Rural Health Access Improvement Act of 2009* would improve Medicare payments to rural doctors, ambulances and mid-size hospitals. The bill also works to protect access for rural residents to home medical equipment and supplies, to continue to lend support to rural hospitals such as critical access hospitals, and to provide additional authority for physician assistants who provide valuable extended care and hospice services.

"The policy changes in this legislation go directly to the special challenges facing the health care system in rural America," Grassley said. "They recognize the high quality of health care delivered by rural providers, embrace common sense solutions, and seek equitable treatment from payment systems."

Grassley's legislation would give what are known as 'tweener hospitals in Spencer, Spirit Lake, Fort Madison, Muscatine, Carroll, Grinnell, Newton and Keokuk, Iowa better treatment by the Medicare program and put them in a stronger position to provide health care services to people in their communities and local areas. 'Tweener hospitals are too large to be designated as critical access hospitals but too small to be financially viable under the Medicare hospital prospective payment system which is designed for larger operations.

"These hospitals are part of the backbone of the rural health care system and local rural economies. There's no justification for Medicare not recognizing their unique situation and vital role," Grassley said. "I'm committed to doing everything I can to make sure they're treated fairly and not left in a perilous situation."

Grassley is a long-time leader in expanding access to health care in rural America. He was the principal sponsor of the legislation that was enacted in 2003 to create the prescription drug benefit in Medicare, and the comprehensive proposal contained major improvements for the rural health care delivery network. Two years later, he won passage of major improvements for Medicare Dependent Hospitals in legislation that was enacted to reduce the deficit. Grassley has repeatedly worked to extend temporary provisions for rural health care, including geographic adjusters to improve physician pay and help keep doctors in rural areas. Last year, he helped win passage of a measure to protect rural health clinics from having to close by reconciling inconsistent time frames from the Department of Health and Human Services for certification requirements. Grassley is the Ranking Member of the Senate Committee on Finance, which is responsible for Medicare and Medicaid. He has been a member of the Senate's Rural Health Caucus for many years

A summary of the new Grassley legislation is below, along with the text of his floor statement marking introduction of the bill and a description of the bill by title.

Summary of the *Medicare Rural Health Access Improvement Act of 2009*

While the bill would benefit different types of rural hospitals, it would especially benefit tweener hospitals.

Tweener Hospital Improvements

- Most tweener hospitals currently are designated under the Medicare program as Medicare Dependent Hospitals (MDHs) and Sole Community Hospitals (SCHs)

- The bill would provide temporary and permanent improvements so that payments to these hospitals would better reflect the cost of providing inpatient and outpatient services

- Provisions assisting tweeners include:
    - Improving the ways MDHs are paid for inpatient services
    - Temporarily improving the hospital inpatient low-volume adjustment so that more rural hospitals benefit
    - Enabling both MDHs and SCHs to benefit from the same outpatient payment hold harmless protection and add-on payments
    - Temporarily lifting the disproportionate share hospital payment cap for rural hospitals
- Many of these provisions were recommended by tweener hospitals in Iowa and are supported by the Iowa Hospital Association and American Hospital Association

Critical Access Hospital Provisions

- For Critical Access Hospitals (CAHs), the Medicare Rural Hospital Flexibility Grant Program would be extended for a year,

Physician Payment Incentives and Improvements

- The bill would reduce disparities in physician payment that adversely affect physicians in Iowa and other rural states known as geographic adjustments or GPCIs (“GYPSEES”).

- Iowa physicians provide some of the highest quality health care yet they also receive some of the lowest Medicare reimbursement due to the GPCI adjustments.

- This is a significant disincentive for physicians who practice in Iowa, and it is fundamentally unfair.

- I share the goal of Iowa physicians and the Iowa Medical Society to reduce geographic disparities and establish more equity in Medicare payment.

- Physicians deserve equal pay for equal work, regardless of where they practice.

- The bill makes fundamental changes in the work and practice expense GPCIs to reduce geographic payment disparities.

- It would eliminate the work GPCI in 2010 by creating a national value of 1.0.

- It would also establish a practice expense floor of 1.0 and reduce the practice expense GPCI adjustment by 50 percent, as of 2010.

- Iowa physicians deserve fair treatment, and I will continue working to achieve that goal.

Rural Extensions:

- The bill would extend the existing payment arrangements which allow independent laboratories to bill Medicare directly for certain physician pathology services through 2010.

- The bill would extend and increase rural ambulance payments by five percent for 2010.

Improve beneficiary access to health care services.

- It would permanently increase the payment limits for rural health clinics.

- It would also allow physician assistants to order post-hospital extended care services and to serve hospice patients.

Rural Exemption from Competitive Bidding

- The bill would protect rural areas from being adversely affected by the new Medicare competitive bidding program for durable medical equipment. Rural areas and metropolitan statistical areas (MSAs) with a population of 600,000 or less would be exempt from competitive bidding.

- We must ensure that beneficiaries in rural areas continue to have access to necessary home medical equipment and supplies.

Statement of Senator Charles E. Grassley
Before the United States Senate
Introduction of the Medicare Rural Health Access Improvement Act of 2009
January 26, 2009

Mr. President, I am pleased to introduce the Medicare Rural Health Access Improvement Act of 2009.

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. And it is even more important in light of the economic challenges we face.

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 have 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 Medicare Dependent Hospitals 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. This essential program provides valuable resources for rural hospitals.

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 recognizes the equality of physician work in all geographic areas and establishes a national value of 1.0 for the physician work adjustment. It establishes a practice expense floor of 1.0 floor and revises the calculation of the practice expense formula to reduce payment differences and more accurately compensate physicians in rural areas for their true practice costs. These changes are needed to help rural states recruit and retain more physicians so that beneficiaries will continue to have access to needed health care.

Last year Congress enacted a number of other provisions to improve Medicare payment for health care professionals and providers in rural areas that will expire at the end of 2009. This bill extends the existing payment arrangements which allow independent laboratories to bill Medicare directly for certain physician pathology services through 2010. It extends and improves the rural ambulance payments enacted in the Medicare Improvements for Providers and Patients Act of 2008 by increasing payments from three to five percent and extending them an additional year, through 2010. The bill also includes several new provisions to improve beneficiary access to health care services. It permanently increases the payment limits for rural health clinics. 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 2009

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 FY2011.

Section 102. Improvements to the Medicare Dependent Hospital (MDH) Program.
Starting for discharges on October 1, 2009 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. Temporary Improvements to the Medicare Inpatient Hospital Payment Adjustment for Low-volume Hospitals.
In FY2010 and FY2011 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 104. 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 FY2010 and FY2011.

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 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, 2010. The Secretary would be able to revise this percentage starting for services furnished after January 1, 2011 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. Revisions to the Work Geographic Adjustment Under the Medicare Physician Fee Schedule.
The provision would eliminate the work adjustment and establish a national value of 1.0, effective January 1, 2010.

Section 204. Revisions to the Practice Expense Geographic Adjustment Under the Medicare Physician Fee Schedule.
The provision would establish a practice expense floor of 1.0 and reduce the geographic adjustment for practice expense to 50 percent of the current adjustment, effective January 1, 2010.

Section 205. Extension of Treatment of Certain Physician Pathology Services Under Medicare.
The provision extends for an additional year 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, 2010

Section 206. 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 2010.

Section 207. Rural Health Clinic Improvements.
The provision would establish the RHC upper payment limit at $92 per visit in 2010. The limit would be increased in subsequent years by the percentage increase in the MEI applicable to primary care services.

Section 208. 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 209. 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, 2010.