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THE RURAL COMMUNITY HOSPITAL DEMONSTRATION EXTENSION ACT OF 2015

JULY 30, 2015.—Ordered to be printed

Mr. HATCH, from the Committee on Finance, submitted the following

R E P O R T

[To accompany S. 607]

The Committee on Finance, to which was referred the bill (S. 607) to amend title XVIII of the Social Security Act to provide for a five-year extension of the rural community hospital demonstration program, and for other purposes, having considered the same, reports favorably thereon with an amendment and an amendment to the title and recommends that the bill, as amended, do pass.

I. LEGISLATIVE BACKGROUND

The Committee on Finance, to which was referred the bill (S. 607) to amend title XVIII of the Social Security Act to provide for a five-year extension of the rural community hospital demonstration program, and for other purposes, having considered the same, reports favorably thereon with an amendment and an amendment to the title and recommends that the bill, as amended do pass.

Background and need for legislative action

The Centers for Medicare and Medicaid Services (CMS) is conducting the Rural Community Hospital Demonstration Program which started as a five year program authorized in section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. The demonstration was expanded and extended for an additional five year period in sections 3123 and 10313 of the Patient Protection and Affordable Care Act (PPACA) of 2010.

Congress established this demonstration in response to the financial concerns of certain small, rural hospitals. The demonstration is intended to test the feasibility and advisability of cost-based re-

imbursement for rural hospitals that are too small to remain financially viable under Medicare's inpatient hospital prospective payment system, but are too large to convert to Critical Access Hospital (CAH) status.

In order for CMS to consider a hospital eligible to participate in the demonstration program, the following requirements, as specified by the authorizing legislation, had to be met:

- Facility is located in a rural area [as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)) or treated as being so located pursuant to section 1886(d)(8)(E) of the Act (42 U.S.C. 1395ww(d)(8)(E))];
- Facility has fewer than 51 acute care inpatient beds, as reported in its most recent cost report (excluding beds in a distinct psychiatric or rehabilitation unit of the hospital);
- Facility provides 24-hour emergency care services; and
- Facility is not designated, or deemed eligible for designation, as a CAH under section 1820 of the Social Security Act.

Additionally, section 410A of the MMA required the demonstration be conducted in 10 states with low population densities. Using data from the U.S. Census Bureau, CMS identified the following states to participate in the initial demonstration: Alaska, Idaho, Montana, Nebraska, Nevada, New Mexico, North Dakota, South Dakota, Utah, and Wyoming. Sections 3123 and 10313 of the PPACA expanded the demonstration's eligibility to 20 states, but retained the same criteria and data as the initial facility solicitation. Using data from the U.S. Census Bureau, CMS revised the participating states to be: Alaska, Arizona, Arkansas, Colorado, Idaho, Iowa, Kansas, Maine, Minnesota, Mississippi, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, and Wyoming.

There are currently 22 hospitals participating in the rural community hospital demonstration. As publicly reported by CMS in July of 2013, the participating hospitals' names and locations are as follows:

Central Peninsula Hospital	Soldotna, Alaska
Bartlett Regional Hospital	Juneau, Alaska
Columbus Community Hospital	Columbus, Nebraska
Banner Churchill Community Hospital	Fallon, Nevada
Garfield Memorial Hospital	Panguitch, Utah
Mt. Edgecumbe Hospital	Sitka, Alaska
Brookings Health Center	Brookings, South Dakota
Delta County Memorial Hospital	Delta, Colorado
Yampa Valley Medical Center	Steamboat Springs, Colorado
Sterling Regional Medical Center	Sterling, Colorado
St. Anthony Regional Hospital	Carroll, Iowa
Grinnell Regional Medical Center	Grinnell, Iowa
Skiff Medical Center	Newton, Iowa
Lakes Regional Healthcare	Spirit Lake, Iowa
Mercy Hospital	Fort Scott, Kansas
Mercy Hospital	Independence, Kansas
Geary Community Hospital	Junction City, Kansas
Bob Wilson Memorial Hospital	Ulysses, Kansas
Maine Coast Memorial Hospital	Ellsworth, Maine
Inland Hospital	Waterville, Maine
Marion General Hospital	Columbia, Mississippi
San Miguel Hospital Corporation	Las Vegas, New Mexico

S. 607, as reported by the Committee on Finance, would extend the Rural Community Hospital Demonstration Program for an additional five years with three modifications. First, only those hospitals that were participating in the demonstration as of December 30, 2014 would be eligible to remain in the program. Second, the Secretary of Health and Human Services would not have the authority to select any additional hospitals to participate in the demonstration. Finally, the Secretary of Health and Human Services would be required to submit a report to Congress, no later than August 1, 2018, evaluating the demonstration's financial and operational impact on participating hospitals. It is expected that this report to Congress will contain both case study and financial impact analyses.

II. EXPLANATION OF THE BILL

A. Amend section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. #108–173; 42 U.S.C. 1395ww note), as amended by sections 3123 and 10313 of the Patient Protection and Affordable Care Act (P.L. 111–148), providing for a five-year extension of the Medicare Rural Community Hospital Demonstration Program.

PRESENT LAW

Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108–173) established the Rural Community Hospital (RCH) Demonstration Program beginning no later than January 1, 2005 for no more than 15 rural community hospitals. Section 410A defines a rural community hospital as a hospital that is located or treated as being located in a rural area, has fewer than 51 acute care inpatient beds, makes 24-hour emergency care services available, and is not eligible or not designated as a critical access hospital. This demonstration tests the feasibility and advisability of establishing "rural community hospitals" to furnish covered inpatient hospital services to Medicare beneficiaries in states with low population densities over a five-year period. Under the demonstration, participating hospitals are paid under a reasonable cost-based methodology for furnishing inpatient hospital services (excluding psychiatric or rehabilitation care) and extended care services to Medicare beneficiaries, rather than receive payment under Medicare's prospective payment systems. Payments to the participating hospitals in their first cost reporting periods of the demonstration equal their reasonable costs of furnishing such services. Payments to the participating hospitals in each of their subsequent cost reporting periods will be the lesser amount of the reasonable costs of furnishing such services in that cost reporting period or a target amount applicable to that cost reporting period. The target amount for each participating hospital's second cost reporting period is equal to the reasonable costs of a participating hospital's first cost reporting period under the demonstration, increased by the applicable percentage increase in the inpatient hospital market basket update for that particular cost reporting period. Subsequent target amounts would be equal to the prior cost reporting period's target amount increased by the applicable percentage increase in the inpatient hospital market basket

Medicare payments under this demonstration are required to be budget neutral compared to what Medicare would have spent in the absence of this demonstration. Additionally, the Secretary is required to submit a report to Congress on the demonstration, including recommendations for legislative and administration action, no later than six months after the completion of the demonstration. The RCH demonstration is ongoing and no report has been submitted.

Section 3123 of the ACA extended the duration of the RCH demonstration for an additional five years. This provision also required the Secretary to expand participation from hospitals in states with the lowest population densities (as determined by the Secretary) from 10 states to 20 states. The ACA additionally increased the number of hospitals able to participate in the demonstration during the extension period to no more than 30 rural community hospitals. Hospitals participating in the demonstration as of the last day of their initial five-year periods were grandfathered into the extension period. Finally, the ACA rebased the reasonable costs used to determine payments and target amounts for participating hospitals under the five-year extension period to be the reasonable costs of a hospital's first cost reporting period under the five-year extension period. This five-year extension period would end by September 30, 2015 for the hospitals that were initial participants in the demonstration.

EXPLANATION OF PROVISION

S. 607, as modified, would extend the RCH demonstration for an additional five years only for those hospitals that were participating in the demonstration as of December 30, 2014. The reasonable costs used to determine payments and target amounts for hospitals participating under the RCH demonstration for the second five-year extension period would be rebased to be the reasonable costs of a hospital's first cost reporting period under the second five-year extension period. The demonstration would end December 31, 2021. Further, the Secretary's report to Congress would be required to be submitted no later than August 1, 2018.

EFFECTIVE DATE

The provision becomes effective upon the date of enactment.

III. BUDGET EFFECTS OF THE BILL

A. COMMITTEE ESTIMATES

The Committee adopts as its own the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

B. BUDGET AUTHORITY

In compliance with section 308(a)(1) of the Congressional Budget and Impoundment Control Act of 1974 (P.L. 93–344), the Committee states that no provisions of the bill as reported involve new or increased budget authority.

C. CONSULTATION WITH CONGRESSIONAL BUDGET OFFICE

In accordance with section 403 of the Congressional Budget and Impoundment Control Act of 1974 (P.L. 93–344), the Committee advises that the Congressional Budget Office has submitted a statement on the bill. The following is the cost estimate provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, July 17, 2015.

Hon. ORRIN G. HATCH,
Chairman, Committee on Finance,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 607, the Rural Community Hospital Demonstration Extension Act of 2015.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Jamease Kowalcyzk and Kevin McNellis, who can be reached at 226–9010.

Sincerely,

ROBERT A. SUNSHINE
(For Keith Hall).

Enclosure.

S. 607—Rural Community Hospital Demonstration Act

Summary: S. 607 would extend the Rural Community Hospital (RCH) demonstration program for an additional five years, through the end of calendar year 2021. Under the demonstration program, Medicare pays certain hospitals in rural areas on the basis of the reasonable costs they incur instead of using the payment rates determined by Medicare's Acute Inpatient Prospective Payment System (IPPS). CBO estimates that enacting S. 607 would increase direct spending by $27 million in fiscal year 2016 but that this additional spending would be offset in future years. Therefore, the bill, on net, would have no significant effect on direct spending over the 2016–2025 period. Pay-as-you-go procedures apply because enacting the legislation would affect direct spending. Enacting the legislation would not affect revenues.

S. 607 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary effect of S. 607 is shown in the following table. The costs of this legislation fall within budget function 570 (Medicare).

	By fiscal year, in millions of dollars—											
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016–2020	2016–2025
CHANGES IN DIRECT SPENDING												
Estimated Budget Authority ..	27	−23	−4	0	0	0	0	0	0	0	0	0
Estimated Outlays	27	−23	−4	0	0	0	0	0	0	0	0	0

Basis of estimate: S. 607 would allow the 22 hospitals participating in the Rural Community Hospital (RCH) demonstration program as of December 30, 2014, to continue in the program for an

additional five years. The term of participation in the current round of the demonstration program is limited to five years. Under current law, seven of the 22 hospitals will complete their term of participation by the end of fiscal year 2015, 11 will complete their participation during fiscal year 2016, and the remaining four will do so early in fiscal year 2017.

Medicare pays each hospital in the demonstration program its reasonable costs for inpatient services. Reasonable costs are defined as the hospital's actual cost per discharge during a year, subject to the limitation that reasonable costs cannot increase more quickly than the percentage adjustment that was used to update Medicare's IPPS payment rates for the current year.

Hospitals participating in the demonstration program generally receive payments that are higher than payments calculated using Medicare's IPPS rates. However, the demonstration is designed to be budget neutral. The Centers for Medicare & Medicaid Services (CMS) accomplishes this by reducing IPPS payments to non-participating hospitals by an amount the Secretary estimates will offset the cost of the demonstration for the upcoming year—that is, the expected difference between payments to RCH participants for the upcoming year and what they would be paid using IPPS payment rates.

By August 2, 2015, CMS will issue a final rule for the IPPS in fiscal year 2016 that will include an adjustment to payment rates that reflects the expected cost of the demonstration for the 15 hospitals that will continue to participate under current law for part or all of fiscal year 2016. That adjustment will not reflect the cost of including the seven hospitals that will complete their terms of participation by the end of fiscal year 2015 under current law, nor will it include the cost of extending the participation of hospitals that will complete their participation during fiscal year 2016.

Based on the adjustments made in recent years ($47 million and $54 million for 2014 and 2015, respectively), as well as the preliminary estimate of the adjustment included in the proposed rule for the IPPS for fiscal year 2016 ($26 million), CBO estimates that net direct spending would increase in fiscal year 2016 by $27 million because all 22 hospitals would participate for the full year, whereas the budget-neutrality adjustment would account for only part of that participation.

Based on information provided by CMS, CBO expects that CMS would make an adjustment to IPPS payment rates for services furnished during fiscal year 2017 that would offset both the expected cost of the demonstration in that year and the estimated costs from 2016 that were not offset by that year's adjustment. As a result, CBO estimates that spending for services furnished during fiscal year 2017 would decline by an additional $27 million. (Because Medicare payments are made after services are furnished, CBO estimates that $4 million of that reduction would be realized in fiscal year 2018.) In total, CBO estimates that enacting S. 607 would not have a significant effect on direct spending over the 2016–2025 period.

Pay-As-You-Go considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net

changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table.

CBO ESTIMATE OF PAY-AS-YOU-GO EFFECTS FOR S. 607, THE RURAL COMMUNITY DEMONSTRATION ACT OF 2015, AS ORDERED REPORTED BY THE SENATE COMMITTEE ON FINANCE ON JUNE 24, 2015

	By fiscal year, in millions of dollars—												
	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2015–2020	2015–2025
	NET INCREASE OR DECREASE (−) IN THE DEFICIT												
Statutory Pay-As-You-Go Impact	0	27	−23	−4	0	0	0	0	0	0	0	0	0

Intergovernmental and private-sector impact: S. 607 contains no intergovernmental or private-sector mandates as defined in UMRA and would impose no costs on state, local, or tribal governments.

Estimate prepared by: Federal costs: Jamease Kowalczyk and Kevin McNellis; Impact on state, local, and tribal governments: J'nell Blanco Suchy; Impact on the private sector: Amy Petz.

Estimate approved by: Holly Harvey, Deputy Assistant Director for Budget Analysis.

IV. VOTES OF THE COMMITTEE

In compliance with paragraph 7(b) of rule XXVI of the Standing Rules of the Senate, the Committee states that, with a majority present, the "Rural Community Hospital Demonstration Extension Act of 2015" as modified was ordered favorably reported by voice vote on June 24, 2015.

V. REGULATORY IMPACT AND OTHER MATTERS

A. Regulatory Impact

Pursuant to paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee makes the following statement concerning the regulatory impact that might be incurred in carrying out the provisions of the bill.

Impact on individuals and businesses, personal privacy and paperwork

In carrying out the provisions of the bill, there is no expected imposition of additional administrative requirements or regulatory burdens on individuals or businesses. The provisions of the bill do not impact personal privacy.

B. Unfunded Mandates Statement

The Committee adopts as its own the estimate of federal mandates prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act of 1995 (P.L. 104–4). The Congressional Budget Office estimates the bill would not impose intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act and would impose no costs on state, local, or tribal governments.

VI. CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In the opinion of the Committee, it is necessary in order to expedite the business of the Senate, to dispense with the requirements of paragraph 12 of rule XXVI of the Standing Rules of the Senate (relating to the showing of changes in existing law made by the bill as reported by the Committee).

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