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The Rural Access to Hospice Act (H.R. 2594/ S.1190)

Background

Hospice is a person-centered model that works to meet the unique needs of patients and families facing serious illness at the end of life. One way to increase access to hospice is to address a statutory barrier related to payment for services through Rural Health Centers (RHC) and Federally Qualified Health Centers (FQHC), also known as Community Health Centers. RHCs and FQHCs were created in 1977 and 1991, respectively, as a response to a shortage of physicians serving Medicare patients in disadvantaged communities and parts of rural America. They are a part of the healthcare “safety net” and provide primary care to over 27 million Americans.¹ For many people, RHCs and FQHCs are their only source for primary care.

RHCs/FQHCs and Hospice

Despite recent growth in hospice utilization, traditionally underserved minority and rural communities continue to lag behind more suburban affluent communities in hospice access and utilization. The goal of the Rural Access to Hospice Act, along with other legislative and regulatory initiatives, is to help close this gap in access and utilization of hospice care.

One reason for this disparity in utilization of hospice is a statutory barrier that inhibits access to hospice in communities served by RHCs and FQHCs. When patients enroll in hospice, they select a physician or nurse practitioner to serve as their attending physician. The attending physician collaborates with the hospice in the development of the care plan and is kept informed of the patient’s care. Typically, the attending physician is reimbursed for these services under Medicare Part B. In general, RHCs are currently paid a single All-Inclusive Rate (AIR) for all the services furnished during an RHC visit in a day, regardless of whether one service or multiple services are actually furnished in the visit. FQHCs are paid the lesser of the actual charges or a single FQHC prospective payment system (PPS) rate covering all the services that may be furnished during an FQHC visit in a day. Hospice attending physician services are not included in either the AIR or the PPS rates.

This oversight keeps patients who may have been receiving services from their same primary care physician serve, some for over 20 years, from choosing that physician as their hospice attending physician. This loss of a trusted provider at a critical time poses a huge burden to patients and their families. The National Advisory Committee on Rural Health and Human Services notes that when rural patients discover that their primary care provider is unable to serve as their attending physician, patients choose to dis-enroll from hospice, or not to enroll at all.² The Medicare Hospice Benefit guarantees the patient the right to choose their own physician, however current law prohibits patients of RHCs and FQHCs from exercising that right.

The Solution

Skilled nursing facilities (SNFs) faced a similar prohibition from RHC physicians providing services to SNF residents until 2003, when Congress passed legislation that allowed RHC and FQHC physicians to bill Medicare separately for their services in a SNF. The Rural Access to Hospice Act takes a similar approach and would allow RHCs and FQHCs to receive payment for serving as the hospice attending physician. NHPCO urges all members of Congress to pass this common-sense legislation to ensure that terminally ill beneficiaries in underserved and rural communities can access the hospice benefit and the attending physician of their choice.

The Rural Access to Hospice Act was reintroduced in the Senate by Senators Shelley Moore Capito (R-WV) and Jeanne Shaheen (D-NH) and in the House by Congressman Ron Kind (D-WI) and Congresswoman Jackie Walorski (R-IN). It has technical assistance from CMS, and a CBO score of \$5 million over ten years.

For more information on this legislation, contact NHPCO’s Hospice Action Network Team at info@nhpcohan.org.

¹ National Association of Community Health Centers. About Our Health Centers: <http://www.nachc.org/about-our-health-centers/>

² HRSA. Office of Rural Health Policy. National Advisory Committee on Rural Health and Human Services Policy. “Rural Implications of Changes to the Medicare Hospice Benefit.” August 2013. <http://www.hrsa.gov/advisorycommittees/rural/publications/nacrhhshospicebrief.pdf>.