

Rural Implications of BIPA 2000

National Flex/CAH Conference for the
Medicare Rural Hospital Flexibility Program
June 25, 2001

Keith J. Mueller, Ph.D.

Director

RUPRI Center for Rural Health

Policy Analysis



Ways of Considering BIPA

- Specific “fixes” to previous legislation
- Incremental improvements in payment
- Changes in the Medicare program
- Building blocks for rural health care delivery

What Do We In Rural Health Want?

- Lots of \$\$\$\$\$
- Lots of freedom
- Status quo
- Improve and sustain delivery systems

What Did We Get in BIPA?

- \$32 billion in total returned savings
- Regulatory relief/change for M+C plans, home health, telemedicine, CAH lab payment
- Payment changes that help existing institutions
- Opportunities for change

Some Specifics

Medicare Payment for Acute Care: Hospital Payment

Concerns	Legislation	Next Steps
<ul style="list-style-type: none">! Rural hospitals suffering under multiple reductions in Medicare funding, exacerbating and perpetuating unstable financial condition.	<ul style="list-style-type: none">! Restoration of some portions of cuts in the growth of: inpatient payment, outpatient payment, and payment for bad debt.! Some MDH and SCH issues addressed.	<ul style="list-style-type: none">! Need to develop a system for outpatient payment for small rural hospitals.! Consider low volume adjustment.
<ul style="list-style-type: none">! Rural hospital wage index adjustment results in lower payment, thought to be due to occupational mix and percent of DRG to which it is applied.	<ul style="list-style-type: none">! Requires use of an occupational mix adjustment.! Allows wage area reclassification to apply for three years.	<ul style="list-style-type: none">! Monitor the impact of occupational mix adjustment.! Reconsider the percent of DRG to which the wage index is applied.

Some Specifics

Medicare Payment for Acute Care: Hospital Payment

Concerns	Legislation	Next Steps
! Inequity in the use of disproportionate share funds.	! Lowers the threshold for receiving DSH payments to a consistent 15% level, payment capped at 5.25% for many small rural hospitals.	! Analyze the effects of increasing the cap.

Some Specifics

Medicare Payment for Acute Care: Payment for Critical Access Hospitals

Concerns	Legislation	Next Steps
! The all-inclusive payment provision of the Balanced Budget Refinement Act paid for professional services with a fee schedule, not based on cost.	! Establishes payment based on 115% of the fee schedule.	! Monitor the impact.

Some Specifics

Medicare Payment for Acute Care: Payment for Critical Access Hospitals

Concerns	Legislation	Next Steps
! Some CAHs provide an array of non-acute inpatient services, and perhaps more payments should be based on cost.	! Establishes cost-based payment for swing beds and hospital-owned ambulance services (if no others within 35 miles). ! Provides payment for on-call E.R. physicians.	! Assess the ambulance payment provision (conference report stated <u>owned or</u> operated; legislation is owned <u>and</u> operated). ! Monitor access to services of CAHs that are not reimbursed based on cost.

Some Specifics

Medicare Payment for Acute Care: Payment for Critical Access Hospitals

Concerns	Legislation	Next Steps
! Reimbursement for outpatient clinical diagnostic laboratory services was to be by a fee schedule, due to a drafting error in previous legislation.	! Requires that payment be cost-based, with no beneficiary liability, retroactive to 11/29/99.	! Monitor the decisions to pay retroactively for the difference in what was paid and what is now required; monitor any necessary payment to beneficiaries.

Some Specifics

Medicare Payment for Acute Care: Changes in Payment for Other Services

Concerns	Legislation	Next Steps
<p>! The new ambulance payment system (fee schedule) is likely to create financial difficulties for rural providers, who have requested a delay in implementation.</p>	<p>! The consumer price index is used to increase ambulance payment in 2001.</p> <p>! Additional payment based on miles traveled.</p> <p>! GAO study of payment problems.</p>	<p>! Consider provisions to hold rural providers harmless to payment changes until the Secretary responds to the GAO report.</p> <p>! Consider adjustments for low-volume providers.</p>

Some Specifics

Medicare Payment for Post-Acute Care: Home Health Services

Concerns	Legislation	Next Steps
<ul style="list-style-type: none">! Rural agencies especially vulnerable to changes in payment.! Compensation needed for travel costs.	<ul style="list-style-type: none">! Additional 10% payment for home health services delivered to rural beneficiaries, until April 2003.! One-year delay in the 15% reduction, and a study to see if it is needed.	<ul style="list-style-type: none">! Objective analysis of costs borne by rural home health agencies, including costs in remote, isolated agencies.! Be sure that any further reduction in payment occurs only after further study justifies the cut.! Examine any disproportionate impacts of proposed cuts.

Some Specifics

Medicare Payment for Post-Acute Care: Home Health Services

Concerns	Legislation	Next Steps
<ul style="list-style-type: none">! Delivering services in remote areas a particular problem.! Costs of supervision in remote site.	<ul style="list-style-type: none">! Definition of branch office is changed, including using technology to provide supervision.! Payment for services delivered using telehealth.	<ul style="list-style-type: none">! Assess the response of home health agencies.

CAH Reimbursement

- The outpatient diagnostic lab mess
 - BBA
 - ❖ Paid at cost - subject to deductibles and coinsurance
 - BBRA
 - ❖ Tried to exempt from deductibles and coinsurance
 - ❖ Result - exempt from deductibles and coinsurance, paid on a fee schedule, both effective 11/29/99

CAH Reimbursement

– BIPA

- ❖ Fixed (sort of)
- ❖ Paid at cost
- ❖ Exempt from deductibles and coinsurance
- ❖ Effective 11/29/99

CAH Reimbursement

- Problems remaining
 - ❖ Need to adjust any fee schedule reimbursements to cost (easy to do through the cost report, see transmittal A-01-68).
 - ❖ Need to refund any deductibles and coinsurance collected after 11/29/99
 - ❖ Problem with secondary payors paying on EOBs known to be wrong

CAH Reimbursement

- Financial implications of converting to a critical access hospital
 - Outpatient reimbursement will improve.
 - Inpatient reimbursement may or may not improve. It may even decrease, significantly. Many hospitals have a positive margin on inpatient services.

Case Study

■ Reimbursement benefit

- Critical access hospitals are paid costs for services to Medicare patients

- ❖ Example: Sole community hospital with average census of 10

Case Study

Inpatient:

Current Medicare

reimbursement

\$2,000,000

**Worksheet E, Part
A, Line 16**

Total Medicare

costs

2,050,000

**Worksheet D-1,
Part II, Line 49**

Net I/P benefit of

CAH status

\$ 50,000

Case Study

Outpatient:

Current Medicare

reimbursement

\$1,400,000

**Sum of E, Part B,
C, D, E**

Total Medicare

costs

1,470,000

**Sum of D, Part V
costs**

Net O/P benefit of

CAH status

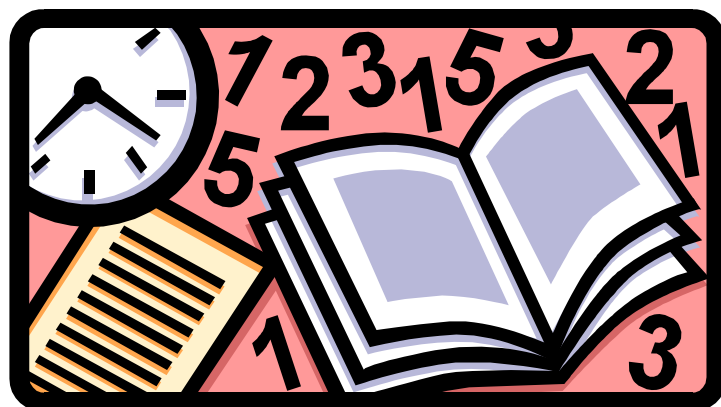
\$ 70,000

Case Study

DLT lab reimbursement	\$100,000	
DLT lab costs	<u>250,000</u>	Using lab cost to charge ratio
Benefit due to BIPA change	<u><u>\$150,000</u></u>	
Total benefit	<u><u>\$270,000</u></u>	

Critical Access Hospitals

- Having an accurately prepared cost report is vitally important



Where Do We Go From Here? (1)

- Resolving specifics of interpretation?
- Expanding services paid through cost-based?
- Expanding eligibility for CAH?
- Issues about fiscal intermediaries?
- Stand pat?

Where Do We Go From Here? (2)

- Still some real \$\$ needs in rural health delivery—addressed with REACH?
- Is the safety net secure?
- Do we stay with the status quo?

The Broader Medicare Context

- Push to redesign?
- In the year 2029...

The Broader Rural Context

- Security for the system
- Future for the system
- Investment in rural health

**RUPRI Center for
Rural Health Policy Analysis
www.rupri.org/healthpolicy**