Benefits Improvement And Protection Act Provisions: Where Do We Go From Here?

Congressional Staff Meeting

January 16, 2001

Washington, DC

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Table I.A. Medicare Payment for Acute Care: Hospital Payment

Concerns	Legislation	Next Steps
Rural hospitals suffering under multiple reductions in Medicare funding, exacerbating and perpetuating unstable financial condition.	Restoration of some portions of cuts in: inpatient payment, outpatient payment, and payment for bad debt.	Need to develop system for outpatient payment for small rural hospitals. Consider low volume adjustment.
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.	Requires use of occupational mix adjustment. Allows wage area reclassification to apply for 3 years.	Monitor impact of occupational mix adjustment. Reconsider percent of DRG to which wage index is applied.
High percentage of hospitals with negative margins among the special categories (sole community, Medicare-dependent, under 50 beds).	Fiscal relief for sole community hospitals, extension of Medicare-dependent hospital program with some recalculation.	Monitor impact of additional payment based on use of new services or technologies.
Inequity in use of disproportionate share funds.	Establish a floor (percent of patient days for which payment is low) of 15% DSH for all hospitals, with additional payment capped at 5.25% for small rural hospitals.	Analyze the effects of increasing the cap.

Table I.B. 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, effective October 1, 2000.	Monitor the decisions to pay retroactively for the difference in what was paid and what is now required; monitor any necessary payment to beneficiaries.
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 CAHs provide a host of services, and perhaps more payments should be based on cost.	Establishes cost-based payment for swing beds and hospital-owned ambulance services. Provides payment for on-call physicians.	Assess ambulance payment provision (conference report stated owned or operated; legislation is owned and operated). Monitor access for services of CAHs that are not reimbursed based on cost. Monitor access to services where there is no CAH, but where the state rural hospital flexibility grant program may be helpful.

Table I.C. Medicare Payment for Acute Care: Payment for Safety Net Providers (Including Medicaid Payments)

Concerns	Legislation	Next Steps
The Balanced Budget Act allowed for phasing out cost-based payment to rural health clinics (RHCs) and federally qualified health centers (FQHCs), but without any alternative payment system.	A prospective payment system (PPS) is developed for RHCs and FQHCs, using the cost-based payment amounts of FY 1999 and FY 2000 as the base.	Monitor the development of the new system.

Table I.D. Medicare Payment for Acute Care: Changes in Payment for Other Services

Concerns	Legislation	Next Steps
Enhance reimbursement for services delivered via telehealth in the amount of payment, eligibility for payment, and requirements for professional presentation of patients that increases cost.	Eligibility is now beneficiaries in any non-metropolitan county. Services expanded to include psychiatric services. Payment of a facility fee to the rural site.	Assess the efficacy of services delivered through telehealth, drawing on experiences of demonstration sites.
The new ambulance payment system (fee schedule) is likely to create financial difficulties for rural providers, who have requested a delay in implementation.	The consumer price index is used to increase ambulance payment in 2001 additional payment based on miles traveled. GAO study of payment problems.	Consider provisions to hold rural providers harmless to payment changes until the Secretary responds to the GAO report. Consider adjustments for low volume providers.

Table I.E. Medicare Payment for Acute Care: Beneficiary Copayments and Additional Benefits

Concerns	Legislation	Next Steps
Increases in Medicare cost-sharing have disproportionate impact on rural beneficiaries.	Reduction of beneficiary copayment for outpatient services, 20%, is certain by 2004. Payment based on assignment lowers beneficiary financial liability for prescription medications.	Consider beneficiary liability in any further changes to the Medicare program.

Table II.A. Medicare Payment for Post-Acute Care: Home Health Services

Concerns	Legislation	Next Steps
Rural agencies especially vulnerable to changes in payment. Compensation needed for travel costs.	Additional 10% payment for home health services delivered to rural beneficiaries, until April 2003. One-year delay in 15% reduction, and study to see if it is needed.	Objective analysis of costs borne by rural home health agencies, including costs in remote, isolated agencies. Be sure any further reduction in payment occurs only after further study justifies the cut. Examine any disproportionate impacts of proposed cuts.
Delivering services in remote areas a particular problem. Costs of supervision in remote site.	Definition of branch office changed, including using technology to provide supervision. Payment for services delivered using telehealth.	Assess response of home health agencies.

Table II.B. Medicare Payment for Post-Acute Care: Skilled Nursing Facility Services and Hospice Care

Concerns	Legislation	Next Steps
Wage index used to adjust for regional differences is the hospital inpatient payment wage index.	Secretary *may* establish procedure for reclassification after data are collected to establish an area wage index based on wage data from SNFs.	Before any geographic reclassification, Secretary should complete analysis on following: consideration of ingredients of the wage index; implications of using the hospital wage index vs. a separate index for SNFs; and effects on rural SNFs and the patients they serve.
The trade association recommends adjusting the update factor, having a one-time upward adjustment, delaying implementation of new rules until deficiencies are corrected, and updating the SNF benefit.	Full market basket increase in FY 2001 for SNF and Hospice services increases the nursing component of the federal PPS.	Ongoing assessment of the impact of new payments system on rural SNFs.

Table III.A. Medicare+Choice Policies: Monthly Per Member Payment

Concerns	Legislation	Next Steps
Using counties as basis for payment is inequitable and unattractive to plans seeking regional presence.	None specific to this concern. New floor payment affects so many counties that it will become a regional rate.	Continue to assess the need to change rates from county-specific to a different region.
Payment in rural areas inadequate to induce offering of plans and enrollment into them.	New floor of $475 in rural areas. Update in 2001 will be 103% phase-in of risk adjustment.	Analysis needed of the minimum rate that would induce increased use of the program in rural areas. Objective of the M+C program needs clarity (offering plans with additional benefits and/or saving money for the program).

Table III.B. Medicare+Choice Policies: Additional Provisions

Concerns	Legislation	Next Steps
Plans are not entering rural markets. Plans are withdrawing from rural markets at rates greater than withdrawals from urban markets	Bonus payments for entering markets where there were no plans previously, including where plans withdrew. Allows expansion of service areas during a contract year.	Assess the effects of the bonus payments.
Plans are burdened with unnecessary and/or unrealistic regulations.	No new regulations during a calendar year.	Continued assessment.

Demonstrations and Studies of Particular Note

MedPAC

1. Report on Access To, and Use Of, Hospice Benefit
2. Study on Medicare Reimbursement for Services Provided by: certified nurse-midwife, physician assistant, nurse practitioner, clinical nurse specialist
3. Study on Medicare Coverage of Services Provided by: surgical technologist, marriage counselor, marriage and family therapist, pastoral care counselor, and licensed professional counselor of mental health
4. Study on Low-volume, Isolated Rural Health Care Providers
5. Study on Consumer Coalitions

GAO

1. Study on Costs of Emergency and Medical Transportation Services
2. Study of Inclusion of Distinct Part Rehab and Psych Units as Separate Units within CAHs
3. Study of Costs of Providing Ambulance Services in Rural Areas
4. Study of Effects of EMTALA on Hospital Emergency Departments