Rural Health Policy in the Post BBA Era

Congressional Staff Briefing

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What are BB's All About?

- BBA in 1997
- BBRA in 1999
- BIPA in 2000

Medicare Payment Policies = Savings, Give-backs

- Hospital Inpatient
- Hospital Outpatient
- Skilled Nursing
- Home Health
- Physician Payment

Hospital Inpatient Payment

- BBA limited the updates through FY 2002
- BBA reduced Disproportionate Share payments through FY 2002
- BBA limited inpatient payment if patients discharged to other institutions. Principle carries on – recent MedPAC recommendation

Hospital Inpatient Payment (2)

- BBRA reduced the reduction for DSH
- BBRA created PPS for psychiatric hospital and distinct-part units

Hospital Inpatient Payment (3)

- BIPA increased inpatient by full market basket for FY 2001 and spread remaining BBA reduction over two years
- BIPA added 1% to DSH payments in 2001 and 2002
- BIPA lowered threshold for DSH payment to 15% for all hospitals

Hospital Inpatient Payment (4)

- MedPAC recommendation for 2004 update is market basket minus 0.4

Hospital Outpatient

- Converted to PPS
- Conversion delayed to 1-1-04 for rural hospitals under 100 beds
- Annual decisions regarding updates
- MedPAC recommendation for 2004 update is market basket minus 0.9

Skilled Nursing

- BBA changed to PPS beginning in 1998, phased in by 2002
- BIPA: Secretary may establish process for geographic reclassification
- Consideration to increase nursing component of calculation by 16.6%
- MedPAC recommendation: no payment update in 2004

Home Health

- BBA phased in new PPS by 2000
  - Interim Payment System with sharp reductions in payment
  - 15% reduction with implementation of PPS
- BBRA and BIPA delayed implementation of the 15% reduction
- BIPA:
  - restored full market basket update in FY 201
  - payment for delivering services via telecommunications
  - Allows for use of technology as supervision of branch offices
  - 10% add-on payment for rural HHAs through April, 2003

Home Health (2)

- MedPAC recommendations:
  - No update in 2004
  - Rural HHAs get 5% add-on, less than the current 10% add-on

Physician Payment

- BBA:
  - Established single conversion factor instead of 3 separate updates
  - Calculate practice expenses with resource-based method instead of historical
- Pressing general issue now is the Sustained Growth Rate Calculation
- Rural perspective is the calculation of Geographic Practice Cost Index [RUPRI brief will explain]
- MedPAC recommendation: 2.5% increase in 2004 (vs. 4.5% reduction under current formula)

Other Important Rural-Oriented Provisions of BBA/BBRA/BIPA

- Medicare+Choice program experiment
- Critical Access Hospital Certification
- State Rural Hospital Flexibility Grant Program
- Small Rural Hospital Improvement Program

The Medicare+Choice Experiment

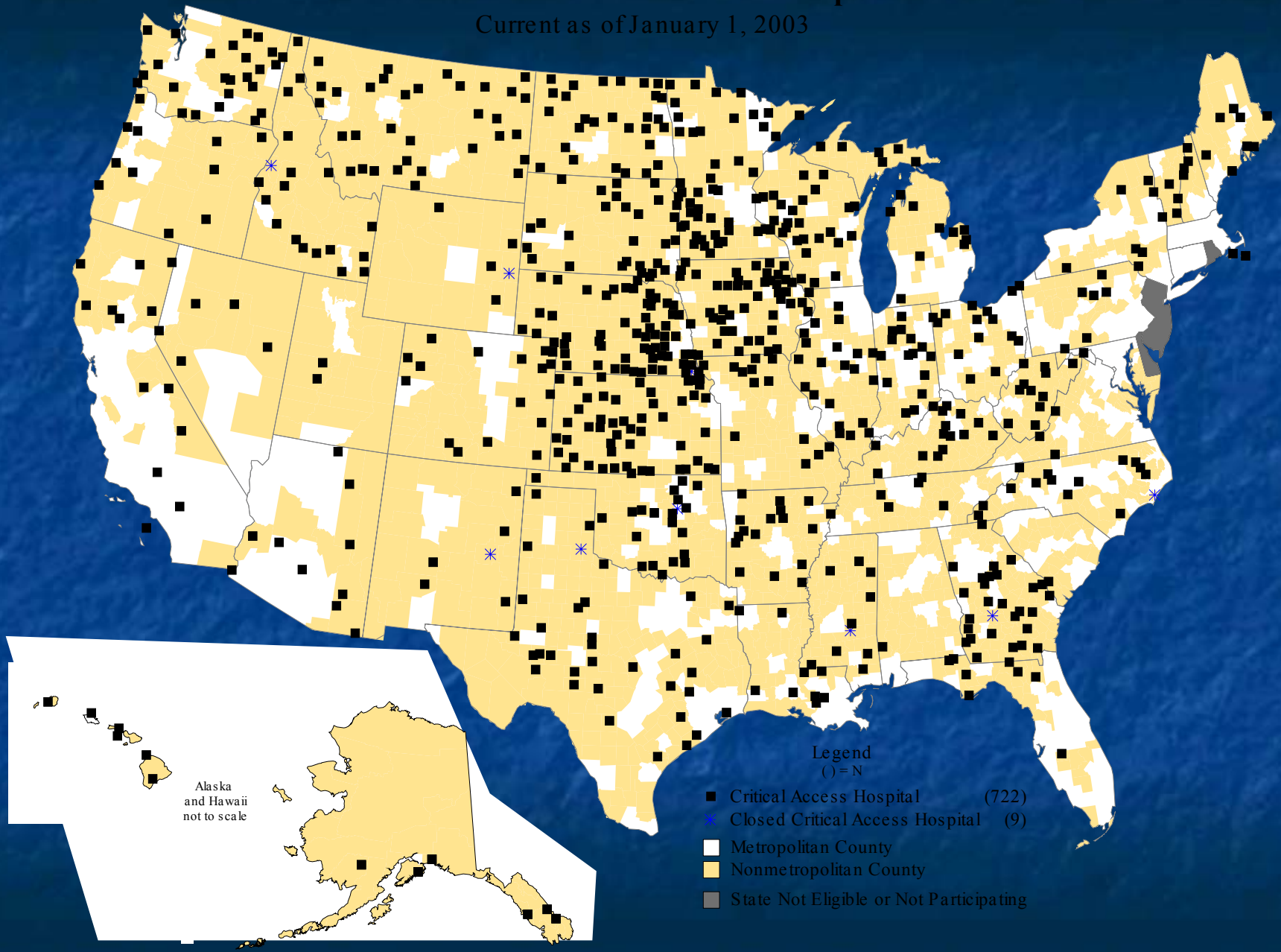
- Initial excitement because:
  - Floor payment
  - Provider-Sponsored Organizations
  - Other options including Fee-for-Service
- Very few takers: reality of all of the expenses network design set in
- Left with case examples of viable plans
- Growth in the FFS option
- New PPO demonstrations from CMS
- Pronounced failure by many, still uncertain by some, still supported by others

Critical Access Hospitals

- New designation in Medicare
- Meet certain requirements
  - 25 total beds; 15 acute
  - 96 hour average length of stay
  - 24 hour emergency room
- Payment is cost based
- 722 as of January 24, 2003, with 69 pending
- web sites:
  - www.rupri.org/rhfp-track
  - www.ruralresource.org/index.shtml

Location of Critical Access Hospitals

Current as of January 1, 2003



Sources: CMS and State Offices Coordinating with MRHFP, 2003.

Produced By: North Carolina Rural Health Research and Policy Analysis Center, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

State Rural Hospital Flexibility Grant Program

- New designation in Medicare
- Meet certain requirements
  - 25 total beds; 15 acute
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  - 24 hour emergency room
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State Rural Hospital Flexibility Grant Program

- Web sites:
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- Address broad goals
  - CAH certification
  - Quality Improvement
  - EMS
  - Network Development
- Has become a significant contribution to rural health services
- Needs reauthorization

Small Hospital Improvement Program

- Grants directly to hospital
- Purposes:
  - PPS systems
  - HIPAA preparedness
  - Quality Improvement
- Appropriations through the authority of the Flex Grant Program

And There is Medicare Change

- Redesign
- Outpatient Prescription Drug Benefit

Medicare Redesign

- Private Sector choices
- Government Option?
- Rural Concerns – RUPRI offers a briefing document, Walsh Center some conceptual work

Medicare Outpatient Prescription Drug Benefit

- Critical to rural beneficiaries
- Of concern to rural providers
- Seeing the policy field in the 2002 proposals through a set of rural criteria

Medicare Outpatient Prescription Drug Benefit (2)

Principle: Equity. The Medicare program should maintain equity vis à vis benefits and costs among its beneficiaries, who should be neither disadvantaged nor advantaged merely because of where they live.

Criterion	Provisions Consistent With The Criterion	Provisions Inconsistent With The Criterion
Rural beneficiaries should have opportunities to enroll in plans that include outpatient prescription drug benefits comparable to those available to urban beneficiaries.	• The same basic prescription drug benefit will be available to all beneficiaries. • A basic benefits plan must be guaranteed in all locations. • Plans shall provide beneficiaries with access to negotiated prices, regardless of whether they are covered with respect to those drugs.	• Coverage of all areas is not mandated if only incentives will be used to attract health plans to underserved areas. • The outpatient prescription drug benefit will take a market-based approach.

Medicare Outpatient Prescription Drug Benefit (3)

Principle: Access. The Medicare program should ensure that beneficiaries have reasonable access to all medical services, including having essential services within a reasonable distance/time of their residence and being able to afford medically necessary services.

Criteria	Provisions Consistent With The Criteria	Provisions Inconsistent With The Criteria
Rural beneficiaries must have access to at least one plan and preferably a choice of plans that offer actuarially comparable benefits to those offered in urban areas.	• Pharmacy benefit managers (PBMs) must cover service areas no smaller than a state. • Incentives can be provided to entice PBMs to expand service areas to smaller rural areas. • The Secretary must assure that there are at least two plans in each eligible beneficiary's area. • The Secretary must develop procedures to provide coverage for beneficiaries that reside in areas not covered by any contracts.	• The Secretary will develop procedures for providing a catastrophic coverage benefit in areas where prescription drug discount cards are not offered.
The Medicare outpatient prescription drug benefit should not undermine rural Medicare beneficiaries' access to local pharmacy services.	• PBMs should ensure that local pharmacies have a reasonable opportunity to participate as providers. • The Secretary shall give special attention to access, pharmacy counseling services, and delivery in rural and hard-to-serve areas through the use of incentives to pharmacists. • Contractors must take into account pharmacies' resources and time used in implementing the program when establishing pharmacy dispensing fees, so that rural pharmacies can afford to participate.	

Medicare Outpatient Prescription Drug Benefit (4)

Principle: Costs. The Medicare program should include mechanisms to make the costs affordable, both to beneficiaries and to the taxpayers financing the program.

Criteria	Provisions Consistent With The Criteria	Provisions Inconsistent With The Criteria
The benefit structure of the outpatient prescription drug program should be structured so that it simultaneously balances the goals of cost containment and affordability for the rural Medicare beneficiary. The goal of cost containment can be achieved by the judicious use of (a) deductibles, (b) coinsurance rates, and (c) premiums.	• Deductible, copayment, and premium provisions are included.	
Proposals should enact (d) reasonable out-of-pocket limits and (e) subsidize the premiums. These provisions are especially important to rural residents because a greater proportion of rural beneficiaries have lower heath status as compared to urban beneficiaries.	• Out-of-pocket costs for most Medicare beneficiaries will be lower relative to the status quo for the many beneficiaries who currently have either no prescription drug coverage or limited coverage. • Appropriate low-income subsidies are included.	• Some proposals have provisions that impose high out-of-pocket costs on Medicare beneficiaries.
Proposals should be structured to provide protection against rapid growth in prescription drug prices, necessary to meet the goals of cost containment for the program and affordability to the taxpayer.	• Formularies and negotiations are used to control prices.	

Medicare Outpatient Prescription Drug Benefit (5)

Principle: Quality. The Medicare program should promote the highest attainable quality of care for all beneficiaries, defined in terms of health outcomes for beneficiaries.

Criteria	Provisions Consistent With The Criteria	Provisions Inconsistent With The Criteria
The outpatient prescription drug benefit shall include quality standards and programs to improve rural health outcomes.	• Quality standards and quality assurance measures, including medication therapy management, will be established.	
Rural provider organizations should have access to resources and mechanisms for training personnel and implementing rural-appropriate quality assurance and improvement systems.	• Providers, pharmacies, and enrollees will be educated with regard to formulary and inappropriate prescribing.	
Rural provider organizations should have access to resources and mechanisms to acquire and develop information systems. Associated computer and telecommunications infrastructure requirements shall be appropriate for rural provider system size and scope.	• Specific funding is provided for information systems and infrastructure development to support quality improvement provisions.	• Information systems and infrastructure development are not supported with designated funding.
Advisory committees considering infrastructure issues shall include members sensitive to the rural challenges of implementing and operating a rural Medicare outpatient prescription drug benefit.	• Rural representatives are required on committees that advise quality improvement strategies.	• Advisory committees may be constituted without rural representatives.

Medicare Outpatient Prescription Drug Benefit (6)

Principle: Choices. The Medicare program should ensure that all beneficiaries have comparable choices available to them—among health care plans (e.g., benefits covered and out-of-pocket expenses potentially incurred) and among health care providers.

Criteria	Provisions Consistent With The Criteria	Provisions Inconsistent With The Criteria
If the outpatient prescription drug benefit proposal is predicated upon offering beneficiaries a choice of privately sponsored plans as a central principle of the proposal, then rural beneficiaries should have a choice of these plans available to them.	• See *Access* principle, first criteria.	• See *Access* principle, first criteria.
Choice of pharmacists should be assured. This will require offering at least one option in reasonable proximity to the beneficiary (in the closest community) and at least one option that is the low-cost choice available through the plan, which may include mail-order.	• Plans are required to contract with any provider willing to meet their conditions and must allow beneficiaries to obtain prescription drugs from any provider, sometimes paying extra for that choice (point-of-service).	• The point-of-service option alone does not constitute adequate choice.
Private plans applying to provide or manage the outpatient prescription drug benefit should be required to provide proof of long-term solvency, so that rural beneficiaries have consistent choices available to them.	• Plans must meet minimum solvency standards.	
Enrollment periods need to be of sufficient length to allow beneficiaries unfamiliar with choosing among alternative plans (disproportionately rural beneficiaries) to make informed decisions.	• Beneficiaries will have time to make an enrollment decision that is at least equivalent to the current Part B time line.	
Educational activities should allow for the unique characteristics of rural areas and permit education by those most familiar with these characteristics. Local civic groups and area agencies on aging are likely candidates to provide education to rural beneficiaries.	• Plans must provide beneficiaries with benefit information that the Medicare administrator specifies and that includes consumer satisfaction surveys.	• Beneficiaries have only one source of information through a single dissemination of printed material and a phone number for questions.

Viewing the BIG PICTURE in Rural Health

- Appropriate service delivery systems
- Serving the population through best possible access to highest quality services
- Can think in terms of places of greatest challenge – Vulnerable Places

Getting Help

- Rural Research Centers

Rural Policy Research Institute

www.rupri.org