Mandated Report: Rural Payment Adjustments

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MEDPAC

Mandated topics in the rural report – due June 2012

- Access to services (February presentation)
- Payment adjustments (today's presentation)
- Quality of care (future presentation)
- Adequacy of rural payments (future presentation)

Characteristics of the current set of rural payment adjustments

- Adjustments can help preserve rural access
- Lack of common principles supporting the adjustments
- One set of adjustments for a diverse set of rural situations
  - Rural is defined broadly as areas outside of MSAs
  - Can apply to areas with a single provider that is essential to access
  - Can also apply to areas with multiple providers duplicating services in an area

Possible principles for evaluating rural payment adjustments

- Target providers that are the sole source of care
- Isolated providers a certain distance from others
- "Rural" is too diverse to be a target
- Low-volume is not a sufficient target, for there are two types of low-volume providers
    - Isolated providers with low volumes due to low population density – assist these to maintain access
    - Providers that have low volumes due to losing patients to nearby competitors
- Payments should be empirically justified
- Maintain incentives for cost control

Many rural adjustments – some reflect MedPAC recommendations to increase payments

- Hospital policies enacted 2001 to 2009
  - Increase rural base rate up to urban level (MedPAC rec.)
  - Increased rural DSH payments (MedPAC rec.)
  - Low-volume adjustment up to 200 total discharges (MedPAC rec.)
  - CAHs: Expand cost-based reimbursements and add-ons, fewer restrictions on size and services
  - Sole Community Hospitals / Medicare-Dependent Hospital enhanced inpatient add-ons
  - 7 percent outpatient add-on at SCHs
- Hospital policies enacted in PPACA (2010)
  - Low-volume adjustment (1,600 Medicare discharges)
  - Wage index floor of 1.0 in certain states
  - $400 million to hospitals in low-spending counties (rural and urban)
  - 340b drug pricing for most rural hospitals (CAH, SCH, RRC)

Adjusters for other sectors

- Physician
  - Work GPCI floor (enacted 2003)
  - PE GPCI 50% limit on adjustment (enacted 2010)
  - PE floor of 1.0 in frontier states (enacted 2010)
- IRF: 18.4% add-on (CMS can adjust annually)
- Psychiatric hospitals: 17% add-on
- Home health: 3% add-on (enacted 2010)

Focus on three adjusters

- Critical Access Hospital (CAH)
  - Example of not targeting payments
  - Example of how higher provider payments can end up effecting beneficiary cost sharing
- Low-volume adjusters: Illustrates how a policy may lack empirical justification for the magnitudes of the adjustment
- Telehealth: little effect on practice patterns

CAHs' importance for patient access varies widely

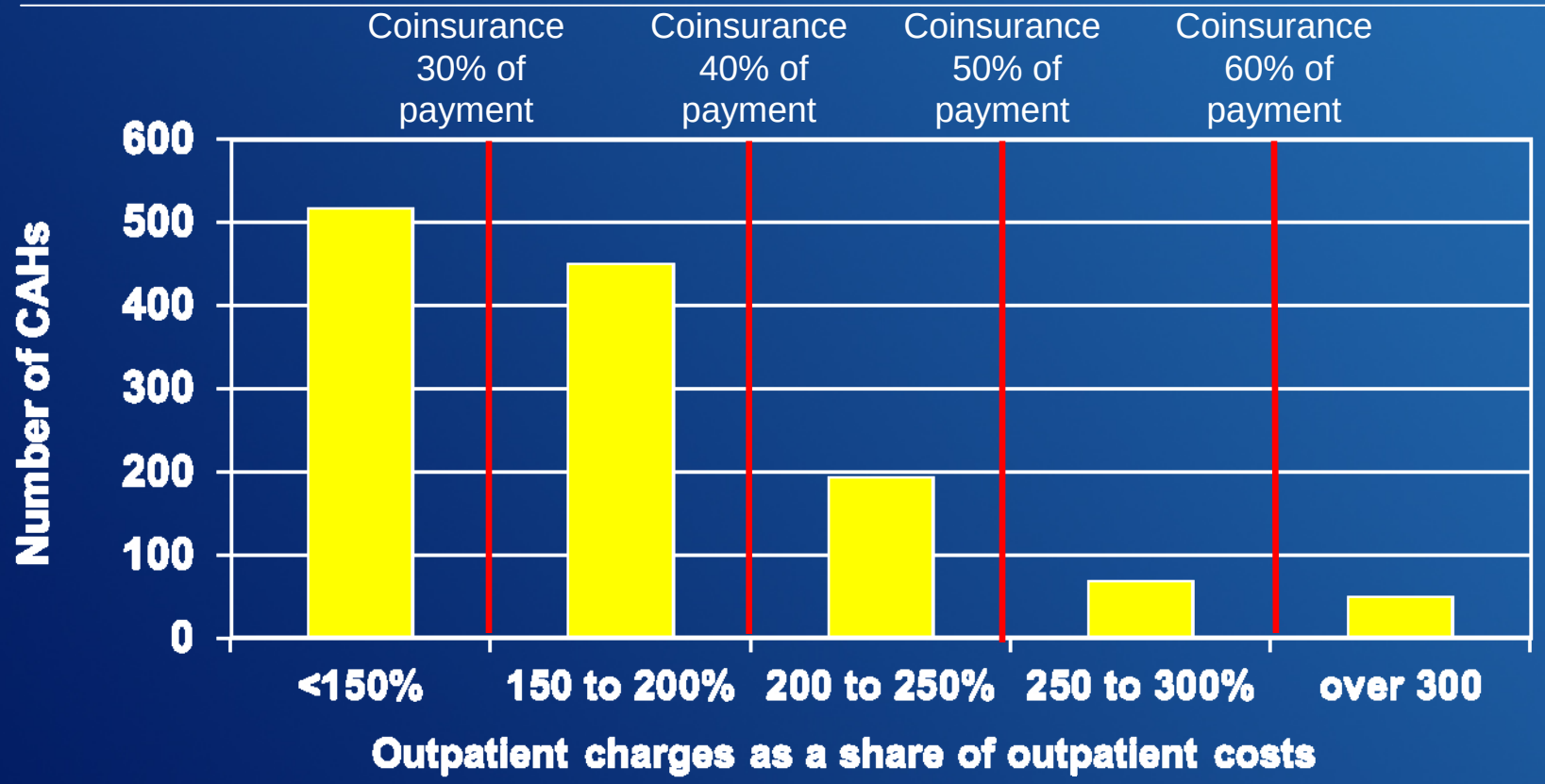
- Limit of 25 beds
- 1,300+ CAHs, not all are isolated
  - 17% are 35 or more miles from another hospital
  - 67% are 15 to 35 miles
  - 16% are less than 15 miles
  - Starting in 2006, all new CAHs must be isolated
- Effect of the program
  - Keeps isolated hospitals open – preserves access
  - Keeps neighboring hospitals open, even if there is excess capacity in the market

Financial effect of the CAH program on providers and Medicare patients

- CAHs receive roughly $8 billion of Medicare payments
- Roughly $2 billion increase above PPS rates
  - Almost $1 billion of the increase is due to higher payment rates for post-acute swing bed care
  - Almost $1 billion of the increase is due to higher beneficiary cost sharing on outpatient services at CAHs
    - Cost sharing is 20% of charges
    - Equal to over 40% of cost-based payments

Preliminary data – subject to change

As CAHs raise charges, outpatient coinsurance goes up



Source: RTI analysis of 2009 Medicare cost reports
Preliminary data subject to change

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CAH summary

- Keeps hospitals open, but not focused on isolated hospitals
- CAH outpatient coinsurance is high
  - Reducing coinsurance rates for beneficiaries would cost the Medicare program money
- How could Medicare offset the cost of reducing outpatient CAH coinsurance?
  - Use savings from focusing the program
  - Address CAH outpatient coinsurance as part of a broader benefit reform proposal

Hospital low-volume adjustment

- MedPAC Recommendation (2001)
  - Enact a low-volume adjustment based on total discharges
  - Limit to hospitals without nearby competitors
- Current temporary adjustment (2011-2012)
  - Can be any distance from a CAH, but must be 15 miles from a PPS hospital
  - Duplicative with the sole community hospital adjustments
  - Based on Medicare discharges only, and thus loses its empirical justification

Low-volume adjustment favors low Medicare share hospitals

Type of hospital	Medicare discharges	Total discharges	Low-volume adjustment
High Medicare share	1,550	2,200	1% increase
Low Medicare share	600	2,200	18% increase

Source: Medicare cost report data applied to 2011 low-volume adjustment criteria

Low-volume adjustment summary

- Estimate based on all admissions
- Use empirical estimates
- Do not duplicate low-volume adjustment on top of an historical-cost adjustment

Medicare telehealth coverage

- Long-standing goal to reduce isolated beneficiaries' travel times for specialty care

- Medicare covers certain services provided via live, interactive videoconferencing between a beneficiary at a certified rural site and a distant practitioner

Increase in payments, reduction in provider requirements in 2001

Topic	Initial policies (1999)	Policy changes (2001)
Payment	*One payment* Fee schedule rate split 75-25 between distant practitioner and originating practitioner	*Two payments* 100% of fee schedule rate to distant practitioner Separate payment to originating site, currently $24
Provider requirements	*Two practitioners present* Distant practitioner, plus originating site had to have practitioner present with beneficiary	*One practitioner present* Originating site practitioner requirement removed

Low telehealth service use

- In 2009,
  - 14,000 beneficiaries made one or more telehealth visits
  - 400 practitioners provided 10 or more telehealth services to beneficiaries
  - Most telehealth services (62%) were mental health services
- Why low levels of adoption?
  - Additional time required of specialists in some cases
  - Specialists have sufficient face-to-face patient loads

Promising new telehealth uses

- Tele-pharmacy:
  - Retail: additional pharmaceutical sales fully fund retail telepharmacy operations
  - Hospitals: telepharmacy may reduce medical errors for hospitals without on-site pharmacists
- Tele-emergency care:
  - May improve appropriateness of care through improving access to trauma center expertise
  - There is a lack of independent studies

Discussion topics

- Discuss principles for adjustments?
  - Is “rural” alone sufficient targeting?
  - Is “low-volume” alone sufficient targeting?
  - Periodically recalibrate the magnitude of the adjustments?
- Any further issues regarding:
  - Critical access hospital cost sharing?
  - Telehealth?