

BIPA IMPLEMENTATION issues

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IMPLEMENTATION ISSUES FACING RURAL PROVIDERS: Impact of BIPA

Question: *Does BIPA create significant changes in the CAH program?*

Answer: By expanding the scope of covered CAH services eligible for cost-based reimbursement to include swing beds, ambulance services, and certain “on-call” emergency room costs, BIPA is likely to extend the CAH’s role as a significant safety-net provider in rural America. Moreover, in allowing for the inclusion of enhanced reimbursement for professional services in a CAH, BIPA will allow CAHs to become important hubs in the network of delivering services throughout rural America.

Question: *Does BIPA create new rules for determining provider-based status?*

Answer: Yes. First, the legislation relieves provider-based entities of certain regulatory requirements until October 1, 2002, if they were treated as provider-based as of October 1, 2000. Second, the legislation expands the geographic location requirement found in existing regulations so that more entities may be entitled to provider-based status. Third, the legislation creates new temporary criteria for entities seeking provider-based status after October 1, 2000 and before October 1, 2002.

Question: *How does the law impact payment to provider-based Rural Health Clinics (PBRHC)?*

Answer: While there is no change for Medicare, there is a significant change for Medicaid. The law requires state Medicaid programs to pay 100% of costs to PBRHCs and FQHCs based on the average costs of the clinic’s 1999 and 2000 actual cost per visit. With this figure determined, future payments will be increased at the Medical Economic Index (MEI) rate each year, which historically hovers around 2%. There is a provision to allow for significant changes in the scope of services. For new clinics, costs in the first year of operation will be used to establish the base for payment. New clinics should carefully assess how to assure they will be in a position to maximize their payment rate through careful feasibility analysis.

Question: *The new legislation allows for cost-based reimbursement for emergency room physicians who are “on-call.” Does this mean I will be reimbursed for the locum tenens I have under contract for my emergency room?*

Answer: The new law provides for cost based reimbursement for reasonable compensation and related costs of emergency room physicians who are “on-call but off the premises of a CAH” (CAHs who qualify are already reimbursed for the costs of “standby” physicians, those doctors who are on the premises of the facility). In addition, the on-call physician may not otherwise be furnishing services during the on-call time or be on-call for another facility. The legislation leaves the definition of “on-call” to the Secretary, therefore requiring HCFA regulations to clarify this issue.

Question: *With the addition of enhanced payment for professional services in a CAH, will I need to continue to maintain my provider-based Rural Health Clinic?*

Answer: The answer to this question requires comprehensive, facility-specific analysis. First, does your state Medicaid program follow Medicare guidelines for the reimbursement of CAHs? If not, what is the percentage of clients in the PBRHC who are Medicaid beneficiaries? If Medicaid does not follow Medicare in your state and your outpatient Medicaid payor mix is significant, it is likely that keeping the PBRHC and its cost based reimbursement for primary care physicians is the best strategic decision. If Medicaid does follow Medicare in your state and/or you have a minimal outpatient Medicaid load, is current reimbursement in the PBRHC more or less than 115% of the Medicare fee schedule? If it is more, on average, then keeping the PBRHC is likely the best strategic decision. However, the answer to this question may vary depending on the procedures or services provided under Part B and how payment for each of these procedures compares to your PBRHC per visit rate.

“BIPA ensures that cost-based payment for CAH lab services is uninterrupted.”

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Question: *Can I continue with the PBRHC for primary care and use the enhanced fee schedule payment for ER and specialty physician services?*

Answer: It would appear that the answer to this question is “yes,” the PBRHC can be used for the provision of primary care services and the enhanced fee schedule payment for ER and specialty physician services. Again, however, the implementation of this concept and the types of arrangements with physicians that will be permitted await further specificity in regulation.

Question: *What is the effective date for lab cost-based reimbursement in a CAH?*

Answer: The effective date is retroactive to the passage of the BBRA. The effect of this is to eliminate any period of time that CAHs were subject to lab fee schedules and ensure that cost-based payment for lab services is uninterrupted.

Question: *Did the legislation solve the problems of repayment of lab co-pays?*

Answer: No. The legislation simply clarifies that beneficiaries are not subject to cost sharing for clinical lab services in CAHs. It offers no guidance to CAHs on the process or method of repaying previously collected co-pays.

Question: *Now that ambulance services furnished by a CAH are reimbursed on a cost basis, should I merge our local ambulance service with my CAH?*

Answer: Ambulance services operated by a CAH are only eligible for cost-based reimbursement if they are the only provider of such services within a 35-mile radius of the CAH. A thorough analysis of the financial benefit of such a merger should be undertaken before making this decision. It is likely that there is no global answer to this question and the results will vary from facility to facility.

Question: *Currently, we do not have swing beds in our CAH; given the new law, should I consider adding swing beds in the facility?*

Answer: This question encompasses clinical, financial, and regulatory issues. Has the patient population been adversely affected by the lack of availability of swing beds? Do you have CON or other regulatory constraints in your state? Will developing swing beds require a separate state inspection? In general, if the clinical need is present and regulations allow for them, the addition of swing beds will probably enhance revenues. The use of swing beds can also serve as a key component of your policy for maintaining compliance with the CAH length of stay and bed/census restrictions. A thorough analysis of the financial impact of adding swing beds, however, is a prudent initial step.

Question: *Does the legislation allow CAHs to operate distinct-part psychiatric or rehabilitation units?*

Answer: No. The legislation mandates that GAO, as part of a study on the CAH average length of stay and bed-size limitations, provide recommendations regarding whether distinct-part units should be permitted in CAHs, the payment methodologies that should apply to such units, and whether such units should be included or excluded from CAH bed-size limits. A report on the study is due to Congress by the end of the year.

This section of *Hot Topics in Rural Health* addresses some of the questions that we have been asked about the new legislation. BIPA also addresses telehealth, Sole Community Hospital and Medicare Dependant Small Rural Hospital status, Disproportionate Share Hospital payment, ambulance payment, and other important issues. Careful analysis will be required to determine the impacts of these provisions on your facility or practice.

ISSUES and options

“BIPA makes a comprehensive analysis of the effects of CAH conversion even more important.”

ASSESSING THE FINANCIAL IMPACT OF BIPA 2000

In earlier newsletters we have discussed the fact that, in our experience, we have found that CAH conversion is not an economically viable option for all rural hospitals. Our findings indicate that conversion to CAH status is financially advantageous to approximately half of the hospitals that consider it. With the new legislation, the complexity of the decision to become a CAH is compounded and a number of new issues must be addressed. These issues include: the clinical, regulatory, and financial feasibility of participating in the swing bed program or expanding the current number of swing beds in the facility; the financial feasibility and other impacts, including regulatory and political, of the merger of the local ambulance service into the CAH; the CAH's relationship with its physicians and the employment, contractual, or other arrangements that may be needed to take advantage of the enhanced payment for professional services provided in the outpatient department of the CAH; coverage of the ER and the impact of payment for on-call services, etc.

The following table highlights the increased complexity of analysis for hospitals considering conversion, as well as the new cost-based elements that existing CAHs must examine. The ongoing monitoring of costs and utilization will require added diligence as well.

ASSESSING THE FINANCIAL IMPACT OF BIPA 2000

Assessment Components of a Comprehensive CAH Financial Impact Analysis	Rural Hospitals Considering CAH Conversion	Existing CAHs Need to Examine
Inpatient Impact	X	
Outpatient Impact	X	
Lab Impact	X	
Swing Bed Impact	X	X
Enhanced Professional Fee Impact	X	X
On-call ER Physician Impact	X	X
Ambulance Services Impact	X	X
Provider Based Rural Health Clinic	X	X