NOSORH National Organization of State Offices of Rural Health

Rural Health Policy Discussion

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National Issues

2014 Appropriations

Sequestration

Appropriations

The current Continuing Resolution Expires on January 15, 2014. Congress must renew the CR or enact individual appropriations by that date or we will be facing another government shutdown.

This is Temporary!

Budget

House and Senate Budget Conferees have been appointed and have been directed by their respective chambers to work out a unified budget by December 15, 2013.

This is Important!

Appropriations/Sequestration

The current CR is spending money at the 2013 approved levels. The Budget Control Act, which mandated sequestration, set a FY 2014 TOTAL spending level approximately $20 billion below the 2013 level.

Under the Sequester process authorized by the Budget Control Act of 2011, a total cap on spending was set for Fiscal Year 2014 of approximately $967 Billion. This was a reduction below the FY 2013 spending cap of $986 Billion.

The resolution of the shut-down effectively extended the FY 2013 spending levels, this means that the government is spending at a rate consistent with total spending of $986 Billion and will, if it were to continue through the remainder of the 2014 Fiscal Year, exceed the $967 Billion mandated by the BCA.

If federal discretionary spending approved by Congress exceeds the $967 Billion cap, across the board cuts in discretionary spending sufficient to lower total spending to the authorized level must commence.

This means that prior to January 15th, Congress and the President will have to agree on new spending levels consistent with the $967 Billion cap OR there will have to be a sequestration of approx. $20 Billion between non-defense discretionary spending and defense discretionary spending.

Sequestration

If Congress fails to adopt an alternative, and come January 15 adopts a 2nd Continuing Resolution, across the board cuts would be mandated concurrent with adoption of the new CR – unless spending levels are reduced.

It is not clear, however, how sequestration related cuts would be applied given that most non-defense spending is at the BCA approved levels. The higher spending is largely attributed to defense spending.

Be careful what you ask for. Other Possibilities…

Congress could replace appropriations cuts with additional cuts in Medicare…

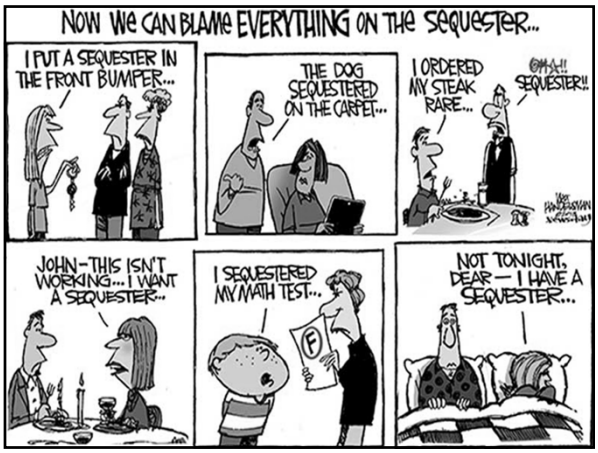
- Reduce CAH payments to 100% of costs instead of 101?
- Reduce amount of bad debt RHCs and CAHs can claim?
- Other provider cuts?

Sequester/Budget Update

- We do not expect any NEW sequester related cuts for Medicare HOWEVER, the existing reduction remains in place.
- Absent Congressional action, Medicare will continue the 1.6% reduction in provider payment for the foreseeable future.

Sequester/Budget - Medicare

- Earlier this year, Sequester mandated a 2% cut in Medicare payments to all providers.
- Because of how CMS calculated this 2% cut, it actually became a 1.6% cut.
- Beginning April 1, Medicare reduced provider payments under the fee schedule from 80% of the approved amount to 78.4% of the approved amount.



What will this mean for 2014?

On January 1, 2014, provider payments MAY go up by inflation.

Example: Allowable is $100.00.

Medicare payment is 78.4% of this amount or $78.40 cents.

On 1/1/14 the allowable goes up by 1% due to medical inflation.

Sequestration

As of 1/1/2014, the allowable goes up by 1% and is now $101.00.

Medicare payments is 78.4% of this new amount or $79.18.

2013 - $78.40
2014 - $79.18

Sequester/Budget Update

- Congress and the President are expected to engage in additional budget deliberations over the next few months.
- The President has asked Congress to repeal his sequester idea and it appears that most Members of Congress are unhappy with how sequester has been implemented.
- The current disagreement is over what to do in lieu of sequester given the stated goal of each side to ultimately reduce the long term federal deficit.

NOSORH

- Reauthorization of the State Offices of Rural Health Grant program.

SORH Reauthorization

1. Reauthorize the program.
2. Eliminate the Aggregate spending cap adopted in the late ’90s.
3. Expand the scope of services/activities SORHs can engage in.
4. Develop NEW initiatives for SORHs new dollars to support those activities.

SORH Reauthorization

5. Matching requirement: 0:1, 1:1; 3:1?
6. If there is a match, should it be static or adjust by year?

WARNING

We have uncovered a problem with how Medicaid expansion is being implemented in some states that could adversely affect the ability of RHCs, FQHCs and certain providers in those states to qualify for the Medicaid EHR Incentive Payment.

Medicaid Expansion

The ACA authorized Medicaid expansion for all individuals with incomes up to 138% of poverty.

Some states rather than expanding the existing Medicaid program are opting to pay the premiums (or partially pay the premiums) for these individuals to enroll in private health plans being sold through the Exchange.

Here's the Problem

These individuals are Medicaid covered individuals and therefore when an RHC, FQHC or physician sees one of these patients he/she can be counted towards achieving the 30% "needy" threshold necessary to qualify for an EHR incentive payment.

If these individuals are enrolled in private health plans – paid for by Medicaid – how will the RHC, FQHC or physician know they are a Medicaid patient so they can count them towards their EHR threshold?

OIG CAH Report

Should we be concerned?

Other OIG Reports?

- Critical Access Hospitals—Payments for Swing-Bed Services
- Rural Health Clinics—Compliance With Location Requirements
- Hospitals—Compliance With Medicare's Transfer Policy
- Hospitals—Payments for Discharges to Swing Beds in Other Hospitals
- Hospitals—Acquisitions of Ambulatory Surgical Centers: Impact on Medicare Spending

Proposals

Eliminate the RHC regulatory requirement for physician on-site availability and instead, defer to applicable state law/state regulatory mechanism.

Proposed by CMS – COULD be in place by end of year

And…

Allow some PAs and NPs to be independent Contractors in the RHC setting rather than "employees"

Proposed by CMS – COULD be in place by end of year

ACA Implementation

How Will ACA Affect Rural?

Do You <u>think</u> it will be:

A. Good for rural patients and providers
B. Good for patients but unclear for providers
C. Good for providers but unclear for patients
C. Too soon to tell

"Health Care Law Fails to Lower Prices for Rural Areas"

- NY Times, October 24, 2013

How will ACA affect Rural?

Medicaid expansion should be beneficial for many rural patients and providers. Individuals previously uninsured can be covered by Medicaid and providers delivering care to these patients will get paid for that care – even if the amount is lower than they would like.

How Will ACA Affect Rural?

It appears that many of the ACA plans being sold in the Exchanges in rural markets are network (HMO/PPO) plans with high deductibles and limited networks.

Establishing the Health Insurance Marketplace

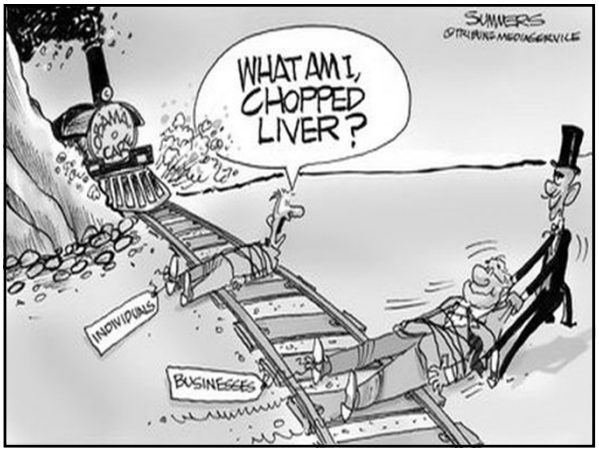
Beginning in 2014, individuals and small businesses (< 50 employees) can buy affordable and qualified health benefit plans in this insurance marketplace.

Beginning October 1, 2013

Individuals and Small Businesses have able to begin enrolling in Health Plans for benefits/coverage to begin on January 1, 2014.

ACA

- **Mandatory coverage for individuals begins January 1, 2014.**
- **The employer mandate has been delayed until January 1, 2015**



Open Enrollment

For FY 2013/14 **ONLY**:

Begins October 1, 2013
Ends March 31, 2014

For October 2014/15 and beyond

Begins October 1
Ends JANUARY 1

Questions?

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