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***Providing decision makers with timely, objective, and expert analysis of the implications of policy for rural health.***

Policy Paper

# Impacts of the Medicare Modernization Act On Rural Health Systems and Beneficiaries

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The Rural Policy Research Institute (RUPRI) Rural Health Panel was established in 1993 to provide science-based, objective policy analysis to federal policy makers. While panel members are drawn from a variety of academic disciplines and bring varied experiences to the analytical enterprise, panel documents reflect the consensus judgment of all panelists.

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## PURPOSE

The purpose of this document is to offer legislators and legislative staff an analysis of rural-pertinent provisions of the Medicare Modernization Act of 2003 (MMA).

## INTRODUCTION

The MMA, passed by the U.S. Congress in November 2003, is complex, comprehensive legislation affecting all Medicare beneficiaries and those who provide care to Medicare beneficiaries. The Centers for Medicare and Medicaid Services (CMS) issued rules and implementation guidance for Titles I and II of the MMA, some of which responded to comments on the legislation from rural stakeholders. Some provisions of the legislation went into place immediately; others, most notably the new Prescription Drug Benefit Program, will be implemented in the next year.

This document presents an analysis by the Rural Policy Research Institute's (RUPRI) Rural Health Panel of the MMA and accompanying regulations. A highlights section summarizes legislative and regulatory provisions of special significance to rural beneficiaries and health care systems. The final section includes Panel analysis of all provisions identified by the Panel as important to rural interests. The Panel identifies provisions that (1) benefit rural areas and require no further legislative attention, (2) potentially need modification through legislation, and (3) warrant monitoring during the implementation process.

The Panel used the following principles to assess the relevance of legislative provisions to rural America:

- equity of benefits and costs among beneficiaries regardless of where they live;
- quality of care for all beneficiaries;
- comparability of choice among plans and providers;
- access to health services, including essential services within a reasonable time/distance; and
- affordable costs to beneficiaries and to taxpayers.

## HIGHLIGHTS

### TITLE I: Medicare Prescription Drug Benefit—Part D

***The timeliness of outreach to and education for beneficiaries is especially important given the provisions in the final regulations that specify a six-month enrollment period (11/05-5/06) and impose a penalty for late enrollment.***

The provisions for informing beneficiaries about plans and assisting them in plan selection are of particular concern to rural beneficiaries as they have little prior experience selecting from multiple plans. Their choices will be premised on their understanding of options, financial resources, and assessment of options against personal health needs. New infrastructures are being developed to disseminate information and provide assistance. The expense and complexity of reaching rural beneficiaries raises concerns that enrollment may be delayed.

***The success of Medicare Part D for rural beneficiaries depends on having reasonable choice of prescription drug plans (PDPs) and access to service providers. However, because of the broad definition of rural adopted by CMS, a PDP will be able to meet access standards without providing access to populations considered rural using more common definitions.***

In the final rule, CMS responded to public comment by combining states that have large rural populations with states that have large urban populations to create the PDP regions. Although creating multi-state regions increases the likelihood that rural beneficiaries will have a choice between multiple plans, it raises the issue of the appropriate application of access standards to ensure rural beneficiary participation. Although the final rule requires application of access standards at the state level, the definition of rural as any ZIP code with fewer than 1,000 persons per square mile (as defined in the TRICARE plan—a health care plan for U.S. military personnel and their families) is exceptionally broad and covers most of the geographic United States.

***The application of access standards also has implications for the formation of networks and the inclusion of small rural pharmacies. Several provisions raise questions regarding the ability of independent pharmacies to effectively negotiate contracts with PDPs.***

PDPs must permit any pharmacy willing to meet the plan's terms and conditions to participate. Whether local pharmacies benefit from this provision will depend on the specific terms of their contracts with the PDPs. Compared to pharmacies in urban areas, a greater proportion of rural pharmacies are independent and rely more heavily on prescription drug revenues. This may limit their ability to enter into contracts requiring substantial discounts.

Dispensing fees paid to pharmacists as a reimbursement for their expenses and services, negotiated between PDPs and contracting pharmacies, are another area of concern. Independent pharmacies depend more heavily than chain pharmacies on revenue from prescription drugs. Given the TRICARE definition of rural, many rural pharmacies will not need to be included in networks to satisfy access requirements. This raises concerns that rural pharmacies will have limited bargaining power in negotiations with PDPs over dispensing fees.

## TITLE II: Medicare Advantage

***The stabilization fund, available to the Secretary to supplement payment to Medicare Advantage (MA) plans in otherwise underserved market areas, could be effective in expanding rural choices of MA plans, but funds may need to be targeted to make them more effective.***

The purpose of the stabilization fund is to make choices available in all places (all local areas within a region). To achieve this purpose, there are bonus payments for entering and staying in a region, or for having a nationwide plan. The bonus is applied to the premium for every enrollee in that plan, in that region. This methodology may not create sufficient incentive to motivate a PDP to market a plan in all local areas in a region, in which case legislative intervention may be needed to target the bonus payment in unserved local areas.

***The adequacy of the network of participating MA plan providers needs to be consistent with historical community patterns of utilization.***

Plans that submit their proposals to CMS for certification to participate in the MA program have to provide criteria by which they are going to meet the general access standard. The MA application

will be reviewed and approved by CMS to assure consistency with historical community patterns of utilization. This process has been followed since 1997 in the Medicare+Choice program. However, this process is untested in large multi-state regions. Therefore the process should be monitored and potentially refined to work toward data driven standards to assure appropriate access to services in rural areas.

***The process of determining payment rates to plans may favor local urban plans and regional plans over local rural plans, limiting choice of plans for rural beneficiaries.***

Rural and urban local area plans are paid based on historical expenditures within that area. Historical expenditures have been higher in urban than in rural areas. The methodology for determining payment rates to regional MA plans begins with the historical Medicare expenditures in each county in the region. The actual payment to a regional plan is adjusted to account for enrollees' residence within the region. Therefore, local urban plans will tend to be paid the highest rates, regional plans the second highest, and local rural plans the lowest. Local urban and regional plans will have a competitive advantage over local rural plans and may be able to offer more extensive benefits at a lower cost.

## HIGHLIGHTS FROM OTHER TITLES IN THE LEGISLATION

***Payment policies regarding disproportionate share (DSH) and the wage index adjustment were both improved but further modifications are needed.***

The MMA increases DSH payments to rural hospitals, but caps them at 12%. This provision was responsive to rural concerns, but it is not clear why DSH payments remain capped. The labor-related share to which the wage index is applied was lowered to 62%, a change justified by empirical analysis. However, providers with a wage index above 1.0 were held harmless, and their labor-related share remains unchanged; an opportunity for budget savings was lost by including the hold harmless provision.

***The MMA sunsets the authority of state governors to designate as necessary providers small rural hospitals that do not meet the 35-mile federal requirement, for the purpose of conversion to Critical Access Hospital status. A new national standard for identifying necessary providers should be developed.***

The sunset is effective on January 1, 2006. The broad use of governor-designation to date suggests that the original mileage standard is inadequate for identifying all hospitals critical to maintaining beneficiary access.

***The 5% increase in home health payments in the MMA expires in March 2005, but the impact on rural beneficiary access is unknown.***

Before this provision expires, analysis of impacts on access is needed, using more sophisticated analytic methods than have been used to date.

## SUMMARY OF PROVISIONS

| Legislative Section | Statement of Rural Relevance | Relevant Principle | RUPRI Rural Health Panel Comment |
|---|---|---|---|
| **TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT** | | | |
| **Subpart 1—Part D Eligible Individuals and Prescription Drug Benefits** | | | |
| **I.1.1860D–1.** Eligibility, Enrollment, and Information. | Rural residents have little prior experience selecting from multiple plans. Their choices will be premised on their understanding of options, financial resources, and their evaluation of options against personal health needs. Beneficiaries will need both access to information and assistance in understanding plan options. Meeting both of these needs may be more expensive and complex in rural areas than realized in the legislation. | Access | A new infrastructure for beneficiary education and assistance is being developed that relies on new partners such as Area Agencies on Aging and state insurance agencies. The expense and complexity of reaching rural beneficiaries raises concerns that enrollment may be delayed, potentially invoking penalties for late enrollment. The effectiveness of this component of the program should be monitored. |
| **I.1.1860D–3.** Access to a Choice of Qualified Prescription Drug Coverage. | Rural areas are the most likely targets of provisions to assure choices of PDPs, or in the absence of choice, a fallback plan. This section, combined with new Section 1860D-11, seeks to assure that all rural beneficiaries will have access to plans offering the new prescription drug benefit. | Equity, Choice | Beneficiaries in regions that are predominately rural are more likely to only have a fallback plan than are beneficiaries in predominantly urban regions. Although the legislation requires actuarial equivalence with competitively offered plans, fallback plans may not include other benefits offered through competitively bid plans. In addition, beneficiaries will not have access to supplemental coverage under fallback plans. |

| Legislative Section | Statement of Rural Relevance | Relevant Principle | RUPRI Rural Health Panel Comment |
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| **I.1.1860D–4(b)(A).** Participation of Any Willing Pharmacy. | The private PDP sponsor must permit any pharmacy willing to meet the plan's terms and conditions to participate, though the plan may also set up a more restrictive pharmacy network and use reduced cost-sharing to steer enrollees to in-network pharmacies. This section is potentially important for protecting beneficiary access to local pharmacy services and the financial viability of local pharmacy providers. | Access | Whether local pharmacies benefit from this provision will depend on the specific terms of their contracts with the PDPs. A greater proportion of rural pharmacies are independent and rely more heavily on prescription drug revenues than do urban pharmacies. These characteristics may limit their ability to enter into contracts requiring substantial discounts. Implementation of this provision requires careful monitoring to assess impact. |
| **I.1.1860D–4(b)(1)(C).** Convenient Access for Network Pharmacies. | The MMA adopted the access standards used by the TRICARE plan. Although the access standards by themselves seem reasonable, the degree to which they offer protections to rural beneficiaries depends on the definition of rural (which is not defined in the legislation). CMS has chosen to adopt TRICARE's definition of rural, which is any ZIP code with fewer than 1,000 persons per square mile. This definition is exceptionally broad and covers most of the geographic United States. The proposed rule would have applied this standard to each region. The final rule, after comment, will apply it to each state. | Access | The result of such a broad definition of rural is that a PDP will be able to meet the access standards without providing access to many of the populations considered rural using more common definitions.<br><br>Although the requirement that the access standards be met in every state is positive, there may be states in which large portions of their rural populations will be excluded. |
| **I.1.1860D–4(b)(1)(D).** Level Playing Field. | Beneficiaries will be provided with convenient access to local pharmacies and local pharmacies will be allowed to compete with mail order and other suppliers. Beneficiaries will be required to pay the differences in cost between local retail and mail order. This provision is particularly relevant to rural beneficiaries that live in places where access to pharmacy services is more limited and pharmacies are more financially vulnerable. | Access | Because beneficiaries have to pay the difference in cost, it remains to be seen whether the goal of increasing convenience and access for beneficiaries by allowing comparable services from local pharmacies will be achieved. |

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| **I.1.1860D–4(c)(6).** Establishment of Safe Harbor. | This section includes a safe harbor provision for certain rural providers. Arrangements will be allowed between hospitals with medical staffs, group practices and their members, or PDP sponsors and pharmacies. The safe harbor will allow the provision of hardware, software, information technology, and technical assistance. | Access, Quality | This safe harbor provision may be especially important for small rural providers who would not have the ability to purchase the necessary hardware or software on their own. This may serve as a model for encouraging the provision of other shared information communication technology applications. |
| **Subpart 2—Prescription Drug Plans; PDP Sponsors; Financing** | | | |
| **I.2.1860D–11.** PDP Regions; Submission of Bids; Plan Approval. | Combining states that have large rural populations with states that have large urban populations will increase the likelihood of choice for rural beneficiaries. | Access | In response to comments, CMS proposed rules creating multi-state regions. However, this proposal raised concerns about the application of access standards. Final rules were responsive to those concerns by requiring application of access standards at the state level. |
| **I.2.1860D–13.** Premiums; Late Enrollment Penalty. | The final regulations specify a six-month enrollment period (November 2005 to May 2006). This provision cannot be changed through regulation. A late enrollment fee will be imposed on those who wait to enroll until after the original six-month enrollment period, and the penalty for late enrollment will increase each month after the open period. | Access, Cost | While avoiding adverse selection (people waiting to enroll until they know they will be using the benefit) is an important policy objective, the complexity of the information and choices facing beneficiaries is likely to result in delayed enrollment, especially in the first year. A penalty for late enrollment may disadvantage rural beneficiaries if they delay enrolling because of more limited access to information and assistance in making plan choices. |

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| **TITLE II—MEDICARE ADVANTAGE** | | | |
| **Subtitle B—Immediate Improvements** | | | |
| **II.B.**<br>Immediate Improvements. | Rates paid to all MA plans were increased by 7.8% effective January 1, 2005. The payment has been structured to be the greatest of four different formulas, making it at least as much as the level of the fee-for-service expenditure in the MA plan's service area. In the short run, this payment structure will increase the likelihood that MA plans will remain in places where they already exist and that there will be service area expansions and some new plan entries. Most of this activity will occur in urban areas, but at least some rural areas will see increased MA plan enrollment. | Equity, Choice, Cost, Access | The Panel does not believe that these provisions by themselves will result in significant increases in MA enrollment in rural areas. They will, however, increase costs to the Medicare program. These payments apply to approximately 13% of Medicare beneficiaries. Because the payment to urban-based plans will now increase to at least the local fee-for-service level, Medicare expenditures will increase by $4 billion. |
| **Subtitle C—Offering of Medicare Advantage Regional Plans; Medicare Advantage Competition** | | | |
| **II.C.221(c).**<br>Rules for MA Regional Plans. | Following a market survey, the Secretary will establish 10 to 50 MA regions, designed to maximize plan participation. A regional PPO plan must serve the entire region. Plans may offer a PPO in more than one region or in all 36 regions. | Equity | These provisions were responsive to requests from advocates and analysts. |

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| **II.C.221(e).** Stabilization Fund. | A stabilization fund will be established to provide plans with incentives to enter and remain in MA regions. The fund will have an initial capitalization of $10 billion beginning January 1, 2007. The money will be available until December 31, 2013. The stabilization fund will also receive one-half of the government's 25% share of any rebates that result when regional MA plans bid below the regional MA benchmarks.<br><br>Subject to budget constraints, the stabilization fund can be used in several ways:<br>• NATIONAL BONUS—For organizations that offer a national plan by bidding on all regions, CMS increases the benchmark payment by 3% for each of the organization's regional plans.<br><br>• REGIONAL PLAN ENTRY BONUS—If a region had no MA regional plans offered in the prior year, the Secretary may increase the benchmark amount for the region. The amount and duration of the increase are at the Secretary's discretion, and the increase will be available to all plans that enter.<br><br>• REGIONAL PLAN RETENTION BONUS—If plans notify the Secretary that they intend to exit, and the Secretary determines that fewer than two MA regional plans would be available, and the enrollment in regional MA plans in that region is below the national average, then the Secretary may increase the benchmark payment for plans in that region. The maximum increase is the greater of either 3% of the regular benchmark or an amount that would bring the region's benchmark up to the average benchmark relative to average adjusted per capita costs in traditional Medicare. This plan retention funding cannot be used more than two consecutive years in a region. It also cannot be used in a region that received a plan entry bonus payment in the prior year. | Access, Equity, Choice | Exactly how much change will occur is difficult to predict, based on prior experience with Medicare+Choice (M+C). The MMA creates incentives to establish preferred provider organizations (PPOs) whereas M+C had very few PPOs participating.<br><br>The effect of this provision on rural areas will depend in part on the effectiveness of network adequacy/access requirements. The latter will be determined by CMS' review of MA applications.<br><br>Bonuses are not targeted to the sub-region wherein there have not been participating MA plans actively enrolling beneficiaries. area of interest. For example, a multi-state regional plan may receive the bonus for enrolling those in Minneapolis, while not necessarily enrolling residents in Montana. This policy should be evaluated by assessing beneficiary choices to enroll in different plans in rural areas not previously served by multiple MA plans. If plans are not enrolling rural beneficiaries, an appropriate policy response may be to target a bonus payment to beneficiary enrollment within local areas of the region where previously there was little or no enrollment. |

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| **II.C.221(h).** Assuring Network Adequacy. | MA plans will submit applications that define the network adequacy standard such that all covered services are available and accessible. The application materials will state the criteria they will use, and CMS will review the submitted plan to determine network adequacy. Generally, CMS expects that regional plans will have a comprehensive preferred network with access standards consistent with community patterns of care. | Access | The standard is appropriate. The review process should include a thorough assessment of meeting community patterns of care, as the critical question is how the standard will be operationalized. |
| **II.C.222.** Competition Program Beginning in 2006. | Benchmark rates will be set for local areas (aggregations of counties smaller than regions) and for regions. In either case, the benchmark will be a function, at least in part, of historical expenditures by the Medicare fee-for-service program. For regional plans, the historical payment for the region (weighted average of all the counties, the weight being based on the number of beneficiaries) will be combined with a weighted average of the bids by all plans in that region. Hence, plans serving a local area within a region will have their payment pegged to an average of the payment rates in that area only, while regional plans will have their rates pegged to a region-wide weighted average, regardless of where the beneficiary resides in the region. Finally, those payments will be adjusted to account for the geographical source of enrollment into a plan. By this methodology, a regional plan will begin with a higher benchmark than a local rural plan because of historical differences in payment to urban and rural counties (the former influences the regional benchmark). Local area urban plans, where historical Medicare expenditures are generally higher than in rural areas, would receive payments based on the highest possible benchmark. Payment per enrollee, regardless of where the enrollee resides, will be based on the area or regional benchmark. | Choice, Equity | Regional plans will receive higher payments per enrollee than will local plans located in the rural areas of the region. However, regional plans will get lower payments than local plans located in urban areas. This provision may make it difficult for local rural plans to survive while not affecting the survival of local urban plans.<br><br>It is important to assess the impact on local rural beneficiaries if local plans were driven out of the market and regional plans did not provide the same service activities that local plans once provided. |
| **Subtitle D—Additional Reforms** | | | |
| **II.D.231.** Specialized MA Plans for Special Needs Individuals. | Rural beneficiaries are disproportionately disabled, but it remains unclear if MA will offer plans for special needs individuals in rural areas. | Equity, Quality | Some plans have either been approved or are applying, including statewide plans that include rural beneficiaries in Kentucky and Colorado. |
| **II.D.234.** Extension of Reasonable Cost Contracts. | Cost contracts will not be allowed to continue if two MA regional plans, or two MA local area plans, are present and if, in rural areas not adjacent to metropolitan areas, at least 1,500 beneficiaries are enrolled. | Access, Cost | Most cost contracts are in rural areas. Two plans entering the market with at least 1,500 enrollees represents viable competition and it is appropriate to discontinue cost contracts when that occurs. |

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| **II.D.237.** Reimbursement for Federally Qualified Health Centers Providing Services Under MA Plans. | Federally Qualified Health Centers in rural areas will continue to receive the payment they would have received from non-MA patients, an important protection in an environment of contract pressures to limit payment by plans to providers. | Access | The same principle of holding essential (safety net) providers harmless could apply to Critical Access Hospitals (CAHs) and Rural Health Clinics. |
| **II.D.238.** Institute of Medicine Evaluation and Report on Health Care Performance Measures. | The goal of this provision is to encourage broad-based quality improvement and to identify potential for performance improvement, especially in systems and processes of care. | Quality, Cost | The Institute of Medicine's evaluation of pay-for-performance should address rural participation and unique rural issues. (Premier/CMS demonstration project appears to be successfully achieving the goals.) Pay-for-performance should include performance measures that benchmark against what would occur if access is sacrificed because resources are constrained (e.g, service does not include the most expensive diagnostic capacity, but does render treatment in a "golden hour" that contributes to patient survival). |
| **TITLE IV—RURAL PROVISIONS** | | | |
| **Subtitle A—Provisions Relating to Part A Only** | | | |
| **IV.A.401.** Equalizing Urban and Rural Standardized Payment Amounts Under the Medicare Inpatient Hospital Prospective Payment System. | Standardized payment between rural, small urban, and large urban hospitals reimbursed under the prospective payment system (PPS) will be equalized. | Equity, Access, Quality | The legislation was responsive to rural concerns. |

| Legislative Section | Statement of Rural Relevance | Relevant Principle | RUPRI Rural Health Panel Comment |
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| **IV.A.402.**<br>Enhanced DSH Treatment for Rural Hospitals and Urban Hospitals with Fewer Than 100 Beds. | DSH payments to rural hospitals will be increased from 5.25%, but capped at 12%. | Equity | This provision was responsive to rural concerns. However, it is not clear why DSH payments remain capped. In addition, the extension of DSH payments to CAHs should be considered. |
| **IV.A.403.**<br>Adjustment to the Medicare Inpatient Hospital Prospective Payment System Wage Index to Revise the Labor-Related Share of Such Index. | The labor-related share to which the wage index is applied will be lowered to 62%. However, providers with a wage index above 1.0 will be held harmless, and their labor-related share will be unchanged. | Equity<br>Cost | The legislation was responsive to rural concerns. The change was justified by empirical analysis. However, an opportunity for budget savings was lost with the inclusion of the hold harmless provision. |
| **IV.A.405(a).**<br>Increase in Payment Amounts. | These provisions will affect the CAH/Flex program and include ending the authority of state governors to designate as CAH-eligible small rural hospitals that do not meet the 35-mile federal requirement as necessary providers. The sunset will be effective January 1, 2006. | Access | The broad use of governor-designation to date suggests that the original mileage standard is inadequate for identifying all hospitals critical to maintaining beneficiary access. A new national standard should be developed. |
| **Subtitle B—Provisions Relating to Part B Only** | | | |
| **IV.B.411.**<br>Two-year Extension of Hold Harmless Provisions for Small Rural Hospitals and Sole Community Hospitals Under the Prospective Payment System for Hospital Outpatient Department Services. | Rural hospitals with no more than 100 beds will be paid no less under outpatient PPS than they would have received under prior reimbursement systems, until January 1, 2006. The Secretary will be required to submit a report to Congress specifying a new methodology to pay those hospitals using a PPS for outpatient services. | Access | Until the final report is complete and has been reviewed, the hold harmless extension should be continued. |
| **IV.B.412.**<br>Establishment of Floor on Work Geographic Adjustment. | Income will be improved for physicians practicing in Medicare localities with work geographic practice cost indices less than 1.0 (often rural). | Access,<br>Equity,<br>Cost | This provision is responsive to rural concerns. |

| Legislative Section | Statement of Rural Relevance | Relevant Principle | RUPRI Rural Health Panel Comment |
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| **IV.B.413.** Medicare Incentive Payment Program Improvements for Physician Scarcity. | A 5% bonus will be added to physician payment in "scarcity areas" in addition to a 10% health professional shortage area (HPSA) payment (payment becomes automatic). The Government Accountability Office will study physician geographic payment differences. | Access, Equity, Cost | Assessment of the impact of this provision is needed before conclusions can be drawn. |
| **IV.B.414.** Payment for Rural and Urban Ambulance Services. | An alternate fee schedule will be developed that blends national and regional rates, increases payment for trips over 50 miles, and increases the base payment rate for trips originating in the lowest quartile rural county population. | Access, Equity, Cost | This provision is responsive to rural concerns. An evaluation is needed to determine whether these changes achieve payment adequacy. |
| **IV.B.415.** Providing Appropriate Coverage of Rural Air Ambulance Services. | Air ambulance appropriateness language will be clarified, allowing for reimbursement of their services. | Access, Cost | This policy change is responsive to rural concerns. |
| **IV.B.416.** Treatment of Certain Clinical Diagnostic Laboratory Tests Furnished to Hospital Outpatients in Certain Rural Areas. | Cost-based reimbursement will be extended for outpatient Part B lab testing to rural hospitals with less than 50 beds for two years (as is currently done with CAHs). | Access, Cost | This continued reimbursement is responsive to rural concerns. |
| **IV.B.417.** Extension of Telemedicine Demonstration Project. | A four-year program will be extended for four more years with an additional $30 million. | Access, Quality | This extension is responsive to rural concerns. |
| **IV.B.418.** Report on Demonstration Project Permitting Skilled Nursing Facilities to be Originating Telehealth Sites; Authority to Implement. | Skilled nursing facilities in rural areas could be originating sites for telehealth services. | Access, Quality | This is a helpful provision as it does not limit the telehealth location to a doctor's office or hospital. |

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| **Subtitle C—Provisions Relating to Parts and B** | | | |
| **IV.C.421.** One-Year Increase for Home Health Services Furnished in a Rural Area. | Home health services delivered in rural areas will receive a one-year increase (5%) in payment (through March 2005). | Equity, Cost, Access | Before this provision expires, analysis of the impact on access is needed, using more sophisticated analytic methods than have been previously used. |
| **IV.C.422.** Redistribution of Unused Resident Positions. | Rural hospitals with fewer than 250 acute care beds will be exempt from reductions in payment scheduled to start July 1, 2005. The Secretary will be authorized to increase resident limits for hospitals for portions of cost-reporting periods by an aggregate number that does not exceed the overall reduction in such limits. The priorities for redistribution will be first to hospitals located in rural areas, second to hospitals located in urban areas that are not large, and third to hospitals in a state if the program involved is in a specialty for which there are not other programs in the state. | Access, Equity | This provision is responsive to rural concerns. |
| **Subtitle D—Other Provisions** | | | |
| **IV.D.431.** Providing Safe Harbor for Certain Collaborative Efforts that Benefit Medically Underserved Populations. | The concept behind this provision, which applies specifically to Federally Qualified Health Centers, could be extended to other rural providers. Any remuneration between a health center entity and an individual or entity providing goods, items, services, donations, loans, or a combination to the center pursuant to a contract, lease, grant, loan, or other agreement that contributes to serving a medically underserved population will be considered a safe harbor exception to the Stark Law. | Choice, Cost, Access | This provision is responsive to rural concerns. |
| **IV.D.433.** MedPAC Study on Rural Hospital Payment Adjustments. | MedPAC will conduct a study of the impacts of Sections 401 through 406, 411, 416, and 505. It will analyze the effect on total payments, growth in costs, capital spending, and other such payment effects. | Equity, Cost, Access | MedPAC should consider input from rural researchers. |
| **IV.D.434.** Frontier Extended Stay Clinic Demonstration Project. | A new demonstration project will be authorized, which could develop into a template for very low volume CAHS. | Equity, Access | This new program is responsive to rural concerns. |
| **TITLE V—PROVISIONS RELATING TO PART A** | | | |
| **Subtitle A—Inpatient Hospital Services** | | | |
| **V.A.505.** Wage Index Adjustment Reclassification Reform. | Reclassification will be allowed based on commuting patterns of hospital employees into the area with the higher wage index. | Equity | This is a reasonable adjustment to how reclassification decisions are made. |

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| **TITLE VI—PROVISIONS RELATING TO PART B** | | | |
| **Subtitle A—Provisions Relating to Physicians' Services** | | | |
| **VI.A.604.** GAO Study on Access to Physicians' Services. | A study of access to physician services will be required, which will include examination and assessment of the effect of payment on access. | Access | Study results should be reviewed when the report is released. |
| **VI.A.605.** Collaborative Demonstration-Based Review of Physician Practice Expense Geographic Adjustment Data. | A demonstration project will use a new practice expense geographic adjustment, which will change payment in rural areas. | Access, Cost | The results of the GAO study mandated in section 604 will inform the design of the demonstration. The demonstration project results should be reviewed when completed. |
| **Subtitle B—Preventive Services** | | | |
| **VI.B.** Preventive Services | Access to physicals, cardiovascular exams, diabetes screening tests, and mammograms will be expanded under these provisions. | Access, Quality | Expanding preventive health benefits is a necessary but insufficient condition for improving Medicare population health. |
| **Subtitle C—Other Provisions** | | | |
| **VI.C.629.** Indexing Part B Deductible to Inflation. | The Part B deductible will be updated by the growth rate in Medicare program expenditures. Rural residents are less able than urban residents to afford increases. | Cost, Equity | This provision is important because rapid growth in Medicare costs will rapidly increase deductible costs. Beneficiaries with Medigap insurance may be at least temporarily insulated from these changes. |
| **Subtitle D—Additional Demonstrations, Studies, and Other Provisions** | | | |
| **VI.D.** Additional Demonstrations, Studies, and Other Provisions. | Several of the demonstration project groups require rural participation. Quality improvement demonstrations should be structured to use models appropriate for rural areas. | | Quality improvement demonstration projects should include rural participants. Structure quality improvement demonstrations with models that will be appropriate for rural areas. |

| Legislative Section | Statement of Rural Relevance | Relevant Principle | RUPRI Rural Health Panel Comment |
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| **TITLE VII—PROVISIONS RELATING TO PARTS A AND B** | | | |
| **Subtitle A—Home Health Services** | | | |
| **VII.A.**<br>Home Health Services. | Several provisions will increase base payments for home health. There will be two demonstration projects related to defining homebound and adult day programs, including suspension of OASIS requirements. A mandated MedPAC study of Medicare margins has been completed. The issue of defining "homebound" is critical for rural areas because of a disproportionate number of potentially homebound elderly. Establishing a financially reasonable update is the most issue in this section. The Secretary should consider administration burden of OASIS. | Access, Quality, Cost, Choice | It will be important to track how CMS, MedPAC, and others are considering home health issues. |
| **Subtitle B—Graduate Medical Education** | | | |
| **VII.B.713.**<br>Treatment of Volunteer Supervision. | Hospitals will be allowed to count family practice resident FTEs even if residents are training in non-hospital sites. | Quality, Access | This provision is important because it encourages training in multiple rural sites. |
| **Subtitle C—Chronic Care Improvement** | | | |
| **VII.C.722.**<br>Medicare Advantage Quality Improvement Programs. | The heading of Section 422.152 (rules) will be changed from "quality assessment and performance improvement program" to "quality improvement program." Each MA plan, except private fee-for-service and medical savings account plans, will be required to have an ongoing quality improvement program. | Quality | The specifics of quality improvement programs remain to be determined. MA plans could select their own means of implementing a quality improvement program, possibly creating flexibility for implementing appropriate programs in rural areas. However, if MA regional plans are creating the programs, it could impose programs developed in one part of the region on the entire region.<br><br>The implementation of this provision should be monitored. Special attention should be given to determine the roles of quality improvement organizations and providers. |

| Legislative Section | Statement of Rural Relevance | Relevant Principle | RUPRI Rural Health Panel Comment |
|---|---|---|---|
| **VII.C.723.**<br>Chronically Ill Medicare Beneficiary Research, Data, Demonstration Strategy. | A large national demonstration project is underway to improve chronic care under Medicare fee-for-service for a program including at least 10,000 people. Nine sites have been selected for the pilot phase and they include entire states, so there will be rural participants. | Quality | At least four of the sites include rural beneficiaries. Chronic care models (and payment systems) appropriate for rural areas should be evaluated. |
| **TITLE IX—ADMINISTRATIVE IMPROVEMENTS, REGULATORY REDUCTION, AND CONTRACTOR REFORM** | | | |
| **IX.**<br>Administrative Improvements, Regulatory Reduction, and Contractor Reform. | There will be no retroactive application of substantive changes in the regulations, and no penalty, interest, or repayment if the provider reasonably relied on program guidance.<br><br>Competitive contracting for administrative contracts and criteria will include provider and beneficiary satisfaction. Plan reports for implementation were due October 2004, with competitive bidding beginning in October 2005.<br><br>The Secretary will required to provide assistance to small providers and suppliers upon request.<br><br>The Secretary will be required to enter into extended repayment of at least six months where repayment within 30 days would be a hardship.<br><br>Certain five-year exclusions from Medicare could be waived if the exclusion of a sole community physician or source of specialized services in a community would impose a hardship.<br><br>Final regulations must be posted within three years of the proposed or interim final regulation, and a regulation that is not a logical outgrowth of the original proposed rule must be a new proposed rule.<br><br>The Secretary will report to Congress on areas of conflict or inconsistency in regulations. This could help address problems that concern rural hospitals.<br><br>The Secretary will be required to study developing a simpler system for documenting claims for evaluation and management services. The pilot has to include a rural area; study due to Congress by October 2005.<br><br>A three-year demonstration program will be implemented wherein specialists provide assistance to beneficiaries in at least six local Social Security offices, of which two must be rural. | Choice<br><br>Choice, Cost<br><br>Choice, Cost<br><br>Cost, Access<br><br>Access<br><br>Choice<br><br>Choice<br><br>Cost, Access | This reform that was part of a request from rural providers.<br>This and the following provisions are helpful and are no longer being monitored. |

| **Legislative Section** | **Statement of Rural Relevance** | **Relevant Principle** | **RUPRI Rural Health Panel Comment** |
|---|---|---|---|
| **TITLE X—MEDICAID AND MISCELLANEOUS PROVISIONS** | | | |
| **Subtitle B—Miscellaneous Provisions** | | | |
| **X.B.1011.** Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens. | $250 million will be appropriated for services provided to undocumented aliens. The proportion of undocumented aliens is higher in rural areas. | Access, Cost | This should be monitored to understand the impact on rural areas. |
| **TITLE XII—TAX INCENTIVES FOR HEALTH AND RETIREMENT SECURITY** | | | |
| **XII.1201.** Health Savings Accounts. | Health Savings Accounts will be created under this provision. Subsidies to employers for retiree health plans are not counted as income. | Access, Costs, Equity, Choice | At this time, there is insufficient data to provide an informed analysis. |

## RUPRI Rural Health Panel

**Andrew F. Coburn, Ph.D.,** is a Professor of Health Policy and Management and directs the Institute for Health Policy in the Muskie School of Public Service at the University of Southern Maine. Dr. Coburn is a senior investigator in the Maine Rural Health Research Center and has published extensively on rural health issues related to health insurance coverage and long-term care. He is a contributing author of the book *Rural Health in the United States* published in 1999 by the Oxford University Press.

**Charles W. (Chuck) Fluharty, M.Div.,** is Founding Director of the Rural Policy Research Institute (RUPRI), the only national policy institute in our country solely dedicated to assessing the rural impacts of public policies. A Research Professor and Associate Director for Rural Policy Programs in the Harry S. Truman School of Public Affairs at the University of Missouri-Columbia, he also holds an Adjunct Faculty appointment in the UMC Department of Rural Sociology. He is the 2002 recipient of the Distinguished Service to Rural Life Award from the Rural Sociological Society, the 2002 USDA Secretary's Honor Award for Superior Service (jointly to RUPRI), the 2002 President's Award from the National Association of Development Organizations, the 1999 National Rural Development Partnership Recognition Award, the 1998 Distinguished Service Award from the National Association of Counties, and the 1998 Recognition Award from the National Organization of State Offices of Rural Health. Chuck was born and raised on a fifth generation family farm in the Appalachian foothills of eastern Ohio, and is a graduate of Yale Divinity School. His career has centered upon service to rural people, primarily within the public policy arena.

**A. Clinton MacKinney, M.D., M.S.,** is a board-certified family physician delivering emergency medicine services in rural Minnesota. Dr. MacKinney also works as a senior consultant for Stroudwater Associates, a rural hospital consulting firm. Lastly, Dr. MacKinney is a contract researcher for the RUPRI Center for Rural Health Policy Analysis at the University of Nebraska Medical Center. Prior to these positions, Dr. MacKinney served as the medical director for a large primary care practice and practiced full-time family medicine for 14 years in rural Iowa. Dr. MacKinney graduated from the Medical College of Ohio in 1982 and completed a family practice residency through the Mayo health care system in 1985. He maintains Family Practice board certification and a Geriatric Certificate of Added Qualifications. In 1998, Dr. MacKinney completed his Master's Degree in Administrative Medicine from the University of Wisconsin. Dr MacKinney's professional interests include healthcare quality improvement, organizational performance improvement, physician-administration relationships, rural health policy, and population-based medicine.

**Timothy D. McBride, Ph.D.**, is a Professor of Health Management and Policy in the School of Public Health at St. Louis University. Dr. McBride's research focuses on public economics, with special emphasis on the economics of aging and health. In the health policy area, Dr. McBride's research has focused on Medicare policy reform, the uninsured, long-term care, rural health, and health care reform. He is the author of over 25 research articles, book chapters, and monographs. Dr. McBride joined St. Louis University in 2003 after spending 13 years at University of Missouri-St. Louis and four years at the Urban Institute in Washington, DC.

**Keith J. Mueller, Ph.D.,** is a Professor and the Director of the Nebraska Center for Rural Health Research, University of Nebraska Medical Center. He is also the Director of the RUPRI Center for Rural Health Policy Analysis. He was the 1996-7 President of the National Rural Health Association and the recipient of the Association's Distinguished Rural Health Researcher Award in 1998. He served a four-year term on the National Advisory Committee on Rural Health and Human Services, and is beginning service on the Advisory Panel on Medicare Education for the Centers for Medicare and Medicaid Services. He has published more than 40 articles on health planning, access to care for vulnerable populations, rural health, and access to care among the uninsured. His RUPRI publications include a

summary of the rural-relevant provisions of the Medicare Modernization Act of 2003. Dr. Mueller has directed major health services studies funded by the U.S. Agency for Healthcare Research and Quality, the Federal Office of Rural Health Policy, and the Robert Wood Johnson Foundation. He has testified on numerous occasions before committees of Congress and in other forums, including the Institute of Medicine and the Medicare Payment Advisory Commission.

**Rebecca T. Slifkin, Ph.D.,** is the Director of the North Carolina Rural Health Research and Policy Analysis Center, one of eight centers funded by the federal Office of Rural Health Policy. She is also Director of the Program on Health Care Economics and Finance at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, and a Research Associate Professor in the Department of Social Medicine in the Medical School. Her work has spanned a broad array of topics, including Medicare payments, Medicaid managed care, Critical Access Hospitals, and access to care for rural minorities.

**Mary K. Wakefield, Ph.D., R.N.,** is Professor and Director of the Center for Rural Health at the University of North Dakota. Before assuming her current responsibilities, Dr. Wakefield was Professor and Director of the Center for Health Policy at George Mason University, Fairfax, Virginia. From January 1993 to January 1996, Dr. Wakefield was the Chief of Staff for United States Senator Kent Conrad (D-ND). Prior to that she served as Legislative Assistant and Chief of Staff to Senator Quentin Burdick (D-ND). Throughout her tenure on Capitol Hill, Dr. Wakefield advised on a range of public health policy issues, drafted legislative proposals, and worked with interest groups and other Senate offices. From 1987 to 1992, she co-chaired the Senate Rural Health Caucus Staff Organization. Dr. Wakefield served on President Clinton's Advisory Commission on Consumer Protection and Quality in the Health Care Industry. She was appointed to the Institute of Medicine's Committee on Quality of Health Care in America and is a member of the Medicare Payment Advisory Commission.

## Selected Recent Publications from the Rural Policy Research Institute

Available at www.rupri.org

***Perspectives: On Poverty, Policy and Place.*** Summer, 2004. Volume 2, Number 2. October 2004

***Definition of Rural in the Context of MMA Access Standards for Prescription Drug Plans*** (P2004-7). A Joint Publication of the RUPRI Center for Rural Health Policy Analysis and the North Carolina Rural Health Research and Policy Analysis Center (Working Paper No. 79). September 2004

***Place Matters: Addressing Rural Poverty.*** A summary of the RUPRI Rural Poverty Research Center Conference: The Importance of Place in Poverty Research and Policy, April 2004. Published September 2004.

***Rural Physicians' Acceptance of New Medicare Patients*** (P2004-5). RUPRI Center for Rural Health Policy Analysis. August 2004

***A Rural Perspective Regarding Regulations Implementing Titles I and II of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003*** (P2004-6). RUPRI Center for Rural Health Policy Analysis. August 2004

***Urban and Rural Differences in Utilization of State Earned Income Tax Credit Programs - Minnesota's Experience*** (Rural Poverty Research Center Working Paper No. 04-08). Donald P. Hirasuna and Thomas F. Stinson. August 2004

***The Cumulative Effect of Rural and Regional Residence Upon the Health of Older Adults*** (Rural Poverty Research Center Working Paper No. 04-07). Jessica S. Ziembroski and Erica L. Hauck. August 2004

***Policy Intervention and Poverty in Rural America*** (Rural Poverty Research Center Working Paper No. 04-06). Hema Swaminathan and Jill L. Findeis. August 2004

***Poverty over Time and Location: An Examination of Metro-Nonmetro Differences*** (Rural Poverty Research Center Working Paper No. 04-05). John M. Ulimwengu and David S. Kraybill. August 2004

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The Rural Policy Research Institute (RUPRI), located within the Truman School of Public Affairs at the University of Missouri-Columbia, is a multi-state, interdisciplinary research consortium jointly sponsored by Iowa State University, the University of Missouri, and the University of Nebraska. RUPRI conducts research and facilitates dialogue designed to assist policy makers in understanding the rural impacts of public policies. Continual service is currently provided to Congressional Members and staff, Executive Branch agencies, state legislators and executive agencies, county and municipal officials, community and farm groups, and rural researchers. Collaborative research relationships also exist with numerous institutions, organizations and individual scientists worldwide. To date, over 200 scholars representing 16 different disciplines in 80 universities, all U.S. states and twenty other nations have participated in RUPRI projects.

**RUPRI Mission**

*The Rural Policy Research Institute provides objective analysis and facilitates public dialogue concerning the impacts of public policy on rural people and places.*

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