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RURAL IMPLICATIONS OF THE MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000
Final Bill: P.L. 106-554

P2001-3

**A Rural Analysis of the Health Policy Provisions:
A Consolidation of P2000-16 and PB2001-1**

RUPRI Center for Rural Health Policy Analysis

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**Principal Author:
Keith J. Mueller, Ph.D.**

RUPRI Rural Health Panel:

Andrew F. Coburn, Ph.D.
Charles W. Fluharty, M.Div.
J. Patrick Hart, Ph.D.
A. Clinton MacKinney, M.D., M.S.
Timothy D. McBride, Ph.D.
Keith J. Mueller, Ph.D., Panel Chair
Rebecca T. Slifkin, Ph.D.
Mary K. Wakefield, Ph.D., M.S.N.

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EXECUTIVE SUMMARY

To secure significant savings for the Medicare program and embark on a new policy direction, the Balanced Budget Act of 1997 (BBA) included sharp reductions in payments to rural health care providers and encouraged the spread of Medicare managed care (M+C) plans into rural areas.

With less pressure to reduce spending (because of a budget surplus) and in the face of withdrawals by managed care plans from rural service areas, the BBA has been modified, first in 1999 (Balanced Budget Refinement Act), and again in 2000. This paper[1] summarizes provisions of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) and assesses the impact of those provisions on rural health care delivery.[2] Congress passed BIPA on December 15, 2000, and President Clinton signed it on December 21.

The following summary points represent the major changes in this legislation and do not encompass all the points included in this paper.

Payment changes for Rural Hospital Services include:

- increasing inpatient payment by the full market basket for FY 2001 and spreading the reduction of 1.1 percentage points over two years;
- adding 1% to disproportionate share hospital (DSH) payments in 2001 and 2002;
- applying a full market basket increase to outpatient payments in CY 2001;
- lowering the threshold requirement for DSH payment to 15% for all hospitals (a change from the requirements that predate the BBA);
- clarifying the legislation providing cost-based reimbursement for clinical lab services provided by Critical Access Hospitals (CAHs);
- reimbursing CAHs for the cost of having emergency physicians on call;
- reimbursing CAH-operated ambulance services based on their costs;
- allowing the physician component of all-inclusive payment to CAHs to be based on 115% of the fee schedule; and
- freezing the Medicaid allotment for DSH payment at the FY 2001 amount for FY 2002.

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[1]This *Policy Paper* is a consolidation of *Paper 2000-16* and *Brief PB2001-1*. *Paper 2000-16* was based on legislation that passed the U.S. House of Representatives on October 26, 2000; *Brief PB2001-1* reported changes made during final deliberations, as reflected in the law passed by the entire Congress on December 15, and signed by President Clinton on December 21. Changes were made in several sections of the law, and a few new provisions were added that are of special interest to rural health care delivery. Thus, this *Policy Paper* is our complete analysis of the health policy provisions included in BIPA that affects services in rural areas.

[2]Earlier documents from the Rural Policy Research Institute (RUPRI) critique the BBA and the refinement legislation. Other RUPRI documents have examined the impact of these legislative acts. All previous documents can be downloaded from the web site: www.rupri.org.

Implications include:

- relief from major reductions in payment;
- unresolved issues in DSH payment (formulas calculating the amount of additional payment are capped for rural hospitals);
- postponement of the impacts of outpatient PPS through the full market basket update and continuing the hold harmless for rural hospitals with less than 100 beds – but the system takes effect for all hospitals in 2004; and
- immediate benefits to CAHs, but some issues are left unresolved (particularly treatment of distinct-part units).

<u>Payment changes for Other Services include:</u>

- establishing a PPS for federally-qualified health centers (FQHCs) and rural health clinics (RHCs), based on their costs during fiscal years 1999 and 2000;
- paying for telemedicine (professional consultation, including psychiatric) in all non-metropolitan counties;
- paying a facility fee for services delivered through telemedicine and not requiring a physician or practitioner at the originating site;
- eliminating a scheduled CY 2001 decrease in ambulance payment;
- allowing direct billing of Medicare for RHCs owned by physician assistants;
- providing for an additional one-year delay in the 15% reduction for home health payments;
- increasing payment for home health services furnished in a rural area by 10% through April 1, 2003;
- paying for home health services delivered using telehealth;
- using a full market basket increase to establish the FY 2001 payment to skilled nursing facilities (SNFs); and
- providing a 5% increase for hospice services as of April 1, 2001, and including that increase as part of the base used in calculating future updates.

Implications include:

- providing some immediate and limited fiscal relief to vulnerable rural providers;
- supporting limited innovation in the delivery of health care services to rural beneficiaries; and
- following the suggestion of rural centers and clinics to create a separate payment system.

<u>Changes in Medicare+Choice Policies include:</u>

- establishing a new floor payment of $475 (increased from $415) for rural counties;
- establishing a new minimum update of 103% (increased from 102%);
- providing a 10-year phase-in of risk adjustment;

- extending bonus payments for entering new service areas to include areas where plans ceased to be offered as of January 1, 2000; and
- changing regulations and practices concerning marketing plans, expanding service areas, and adding benefits.

Implications include:

- potential to sustain the existing enrollment in Medicare+Choice (M+C) plans in rural counties;
- potential for new entries of M+C plans into rural counties; and
- continued uncertainty about the future of M+C plans in rural counties, pending analysis of actual costs of operating successful rural plans.

<u>The RUPRI Rural Health Panel recommends:</u>

- continued analysis of the effects of the BBA, as amended, on small rural hospitals;
- assessment of the different strategies involved in paying for outpatient services provided by rural hospitals;
- reconsideration of the percentage of the inpatient payment to which the area wage index is applied;
- examination of the availability of, and appropriate payment for, ambulance and home health services in rural areas (beyond changes in CAH payment);
- assessment of the efficacy of telehealth services in rural areas by examining the experience of federally-funded demonstration projects;
- acceleration of the time line for analysis of the costs of providing ambulance services in rural areas, and in the interim holding rural providers harmless vis á vis the new fee schedule;
- full consideration of the required report from the General Accounting Office (GAO) before any reduction in home health payment occurs;
- thorough consideration of the need for additional payment to remote, low volume providers of home health services;
- ongoing assessment of payment to SNFs, to include an assessment of the impacts on rural SNFs, and assessing variation in impacts by size, ownership, and geographic isolation;
- no further changes in M+C payment until the relationships between payment level and the costs of operating rural plans are fully understood; and
- studies from third parties (not the industry and not the U.S. Department of Health and Human Services) that yield a more thorough understanding of the costs involved in sustaining an M+C plan.

INTRODUCTION

On December 15, 2000, the U.S. Congress passed the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) (attached as an amendment to the Appropriations Bill). It was signed into law (P.L.106-554) by President Clinton on December 21, effectively changing provisions previously enacted in the Balanced Budget Act of 1997 (BBA) and the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 (BBRA 99). Several of the provisions of BIPA were written for the express purpose of sustaining rural health care delivery systems, and other provisions would impact rural health care providers, residents (including Medicare beneficiaries), and/or health plans enrolling rural members. In this *Policy Paper*, the RUPRI Center for Rural Health Policy Analysis presents a summary of all provisions of BIPA affecting health care services in rural areas and discusses implications for current and future delivery of health care in rural areas.

RUPRI published *Policy Paper* P2000-16 on November 27, 2000. P2000-16 was based on legislation that passed the U.S. House of Representatives on October 26, 2000. After President Clinton signed BIPA into law (P.L.106-554), RUPRI updated the original analysis with *Policy Brief* PB2001-1. Because changes were made in several sections of the law, and a few new provisions were added that are of special interest to rural health care delivery, this *Policy Paper* was written, combining P2000-16 and PB2001-1, for an updated analysis of the health policy provisions included in BIPA.

As written in PB2001-1, the following changes were made by Congress:

- Disproportionate Share Hospitals (Section 211): The formula used to calculate the additional payment for eligible rural (and small urban) hospitals is changed to apply to disproportionate shares from 15% to less than 19.3% (instead of 17.3%), making the ceiling payment an additional 5.25% instead of 4%.
- Clarification of Temporary Payment Increases for 2001 (Section 547): This is a new provision added by Congress that expresses the intent that unless otherwise specified, payment increases are for a limited time and not to be considered when calculating updates for subsequent years.
- Assistance with Fee Schedule Payment for Professional Services Under All-Inclusive Rate (Section 202): The effective date is changed from April 1, 2001 to July 1, 2001.
- Payment for Telehealth Services (Section 223): The period of time during which an additional fee of $20 will be paid is changed. The new starting date for the payment is October 1, 2001, not July 1, 2001. Payments remain in place through calendar year 2002.
- Assistance for Providers of Ambulance Services in Rural Areas (Section 221): The starting date for increased payment based on miles per trip, previously reported as the implementation of the new fee schedule, is July 1, 2001.

- Payment for Ambulance Services (Section 423): The starting date for this provision is changed to July 1, 2001 (not January 1, 2001), and the increase for the second half of 2001 is set at 4.7% to create the effect of having a full CPI increase for the year.
- Temporary Extension of Periodic Interim Payments (Section 503): The earlier version of the legislation had this provision being effective December 1, 2000. The current version changes to "as soon as practicable."
- Temporary Increase for Home Health Services Furnished in a Rural Area (Section 508): This is a new provision increasing the payment for home health services furnished in a rural area by 10% on or after April 1, 2001 and before April 1, 2003. Budget neutrality is waived.
- Five Percent Increase in Payment Rate (Section 321): This new provision increases the base payment rate for hospice care by 5 percentage points in fiscal year 2001, applied as of April 1, 2001. Calculations for FY 2002 will use the rate as of April 1, 2001 as the base.
- Increase in Minimum Payment Amount (Section 601): This provision is effective March 1, 2001, not January 1.
- Minimum Update (Section 602): This provision is now effective March 1, 2001 (previously January 1). This is an increase in the minimum to 103% for one year only.
- Phase-In of Risk Adjustment (Section 603): Beginning with the first year that risk adjustment is based on new data, it will be phased in over 10 years, based on the following schedule:

    - 30% of the risk adjusted capitated rate in 2004;
    - 50% of the risk adjusted capitated rate in 2005;
    - 75% of the risk adjusted capitated rate in 2006; and
    - 100% of the risk adjusted capitated rate in 2007 and succeeding years.

In addition, the authors of this document made two changes to the analysis written in P2000-16:

- Determining Provider-Based Status for Certain Entities (Section 404): This provision has been added to the analysis. It restricts these entities to those that are within 35 miles of the base provider.
- Clarification of No Beneficiary Cost-Sharing for Clinical Diagnostic Lab Tests (Section 201): The effective date is as if the provision were included in the Balanced Budget Refinement Act of 1999, not October 1, 2000, as previously reported by P2000-16.

This *Policy Paper* follows previous publications of the RUPRI Rural Health Panel that analyzed provisions of the BBA (P97-10; P99-5) and BBRA 99 (P99-11). The four major sections of this paper, along with major subsections, are:

I. Payment for Acute Care
   - A. Hospital Payment (General)
   - B. Payment for CAHs
   - C. Payment for Safety Net Providers
   - D. Payment for Other Acute Care
   - E. Beneficiary Copayments and Additional Benefits

II. Payment for Post Acute Care
   - A. Home Health Services
   - B. Skilled Nursing Services and Hospice Care

III. M+C Policies
   - A. Monthly Per Member Payment
   - B. Additional Provisions

IV. Demonstrations and Studies
   - A. Studies Specific to Rural Health Delivery Systems
   - B. General Studies with Particular Meaning in Rural Areas
   - C. General Studies with Potential Special Meaning in Rural Areas

After a description of relevant legislative provisions, each subsection includes a discussion of implications. Within implications, the concerns expressed by the RUPRI Panel and advocacy groups are summarized, the response of this legislation to those concerns are specified, and next steps that could further address specific concerns are offered.

I. MEDICARE PAYMENT FOR ACUTE CARE

I. A. *Hospital Payment (General Category)*

Disproportionate Share Hospitals (DSH) (Section 211)

The formula used to calculate the additional payment for eligible rural (and small urban) hospitals is changed to apply to disproportionate shares from 15% to less than 19.3%, capping the additional payment at 5.25%. The effects of these changes are best seen in the revised Tables 1 and 2. *The net impact of the change from the October cap of 4% to 5.25% was to make an additional $900 million available to eligible hospitals during the five years beginning April 1, 2001.* Effective April 1, 2001.

Table 1. Changes in the DSH Calculation

Type of Hospital	1999 Threshold	Current Formula[3]	New Threshold	New Formula
Urban > 99 Beds Rural > 499 Beds	**15%**	**If 15% to 20.2% then 2.5% + .65 (DPP-15). If ≥ 20.2 then 5.88 + .825 (DPP-15).**	**15%**	**Same**
Sole Community	**30%**	**10%**	**15%**	**If < 19.3% then (P-15)(.65) + 2.5. If ≥ 19.3% and < 30% then 5.25%. If ≥ 30% then 10%.**
Rural Referral	**30%**	**4% + .6 (DPP-30%)**	**15%**	**If < 19.3% then (P-15)(.65) + 2.5. If ≥ 19.3% and < 30% then 5.25%. If ≥ 30% then (P-30)(.6) + 5.25.**
Urban < 100 Beds	**40%**	**5%**	**15%**	**If < 19.3% then (P-15)(.65) + 2.5. If ≥ 19.3% then 5.25%.**
Other Rural 1-99 Beds	**45%**	**4%**	**15%**	**If <19.3% then (P-15)(.65) + 2.5. If ≥ 19.3% then 5.25%.**
Other Rural 100-499 Beds	**30%**	**4%**	**15%**	**If < 19.3% then (P-15)(.65) + 2.5. If ≥ 19.3% then 5.25%.**

[3]Specifies an "add on" to the DRG-based payment, for example, currently 10% additional for qualifying sole community hospitals.

Table 2. Percentage of Additional Payment

DSH %	Large Urban, Large Rural	Sole Community	Rural Referral	Small Urban	Other Rural
15%	2.5%	2.5%	2.5%	2.5%	2.5%
16%	3.15%	3.15%	3.15%	3.15%	3.15%
17.3%	4.0%	4.0%	4.0%	4.0%	4.0%
18%	4.45%	4.45%	4.45%	4.45%	4.45%
19%	5.1%	5.1%	5.1%	5.1%	5.1%
19.3%	5.25%	5.25%	5.25%	5.25%	5.25%
20%	5.75%	5.25%	5.25%	5.25%	5.25%
31%	14.79%	10.0%	5.85%	5.25%	5.25%
40%	22.22%	10.0%	11.25%	5.25%	5.25%
45%	26.34%	10.0%	14.25%	5.25%	5.25%

Medicare Dependent Hospitals (MDHs) (Section 212)

Eligibility criteria is changed to allow hospitals to use at least two of the last three audited cost reporting periods beginning during FY 1996 to prove at least 60% of days or discharges were attributable to Medicare. Effective on or after April 1, 2001.

Payment for Inpatient Care (Section 301)

In FY 2001 the payment update is market basket (MB) minus 1.1 until April 1, and then MB + 1.1 until September 30. In FY 2002 and FY 2003 the update is MB -.55. In FY 2004 and beyond, the increase is the market basket.

DSH Add Back (Section 303)

An additional 1% is included in DSH payments in 2001 and 2002, making the cuts 3% and 2%, respectively. The FY 2001 payment is cut 3% in the first six months and 1% in the second six months.

Wage Index Change (Section 304)

Hospitals who are reclassified in a different wage area (most often rural to urban) will have that reclassification for three years. The Department of Health and Human Services (HHS) may permit statewide classifications of wage areas, but only for the purposes of reclassification. The Secretary of HHS will implement an occupational mix adjustment by October 1, 2004. The three-year reclassification is effective for FY 2001. The statewide provision is available for FY 2002.

Rebasing for Sole Community Hospitals (SCH) (Section 213)

Any SCH may elect payment based on hospital-specific updated FY 1996 costs if doing so means higher payment. This will be phased in, fully effective after FY 2003. Effective on enactment of this Act.

Payment of Hospital Bad Debt (Section 541)

Hospital bad debt relief is increased from 55% to 70%. Effective October 1, 2000.

Payment for Rehabilitation Hospitals (Section 305)

In FY 2001, total payments for rehabilitation hospitals will equal 98% of what would have been paid in the absence of PPS. In 2002 the payment will be 100% of that amount. *There are 20 rehabilitation hospitals in rural areas.* Effective August 5, 1997 (as if part of the BBA).

Payment for Psychiatric Hospitals Inpatient Services (Section 306)

Psychiatric hospitals are eligible for an incentive payment of 3% based on the relationship of costs to the national cap, for FY 2001. *There are 80 psychiatric hospitals in rural areas.* Effective on or after October 1, 2000.

Long-term Care Hospitals (Section 307)

Hospitals subject to the national cap limitation have the cap increased by 2% for cost reporting periods beginning October 1, 2000. Hospitals not subject to the national cap have targets increased by 25%. These payments are not factored into the development of the PPS for long-term care hospitals. *There are nine long-term care hospitals in rural areas.* Effective on enactment of this Act.

Outpatient PPS Update (Section 401)

There is a full market basket update for CY 2001.

Pass Through Payments (Section 402)

Using public rule-making procedures, the Secretary of HHS is required to establish criteria for defining special payment categories under the outpatient PPS for new medical devices by April 1, 2001. Effective on enactment of the Act.

Determining Provider-Based Status for Certain Entities (Section 404)

After October 1, 2000 the following rules apply to designating any entity to be provider-based:

- satisfy the requirements of section 413.65(d)(7) of title 42, Code of Federal Regulations (having to do with the process of being designated by HCFA); or
- be located not more than 35 miles from the main campus of the hospital or critical access hospital.

- or -

- be owned or operated by a unit of State or local government, be granted governmental powers, or be under contract with a State or local government that includes the operation of clinics to assure access in a well-defined service area to low-income individuals; and
- have a disproportionate share adjustment percentage greater than 11.75%.

A grandfathering provision allows facilities currently treated as provider-based to continue that status until October 1, 2002. Facilities requesting provider-based status between October 1, 2000 and October 1, 2002 shall have that status until a determination is made with respect to their request.

Additional Payment for Hospital Inpatient Care When New Technologies Are Used (Section 533)

New medical services and technologies are incorporated into the clinical coding system used to determine payment for inpatient services, using methods recommended by the Secretary of HHS. If new services or technologies are adopted during any payment year (after the determination of DRG-based payment) an additional payment could be made, as determined by the Secretary. There are no additional appropriations to cover this expense, so a redistribution of inpatient payment dollars will occur, from diagnosis-related groups (DRGs) not using new services or technology, to those that do. The report from the Secretary is due April 1, 2001, with payment to be effective as of October 1, 2001.

Clarification of Temporary Payment Increases for 2001 (Section 547)

This provision restricts the following payment increases to only those years specified in the law and states that they are not to be included in the base for future updates:

- acute care hospital payment update in FY 2001;
- indirect medical education percentage adjustment;
- disproportionate share “add back” in FY 2001;

- FY 2001 increase in skilled nursing facility payment;
- transitional allowance for full market basket increase in home health payment;
- temporary increase for rural home health services; and
- FY 2001 increase in payment for outpatient department services.

Implications

Concerns Being Addressed

These provisions address a major concern raised since the passage of the BBA: that rural hospitals, in particular, were being asked to make extensive financial sacrifices in order to achieve cost savings for the Medicare program. The RUPRI Panel, in February 1999, called attention to the cumulative impact on rural hospitals of up to 12 reductions in payment. Others, including the Medicare Payment Advisory Commission (MedPAC) (June 2000 report) have suggested that the operating (profit) margin for all Medicare payments combined should be the measure of the program's impact on hospital finance.

Analysis completed by the Lewin Group. Using Medicare Cost Report and American Hospital Association Annual Survey data (the latter to account for costs not allowed by Medicare and therefore not found on the cost reports), the Lewin Group analyzed the Medicare margins of rural hospitals for general categories of services (inpatient, outpatient, home health, and PPS-exempt units). After accounting for the provisions of the BBRA 99 and assuming costs growing at 1% below market basket increases, total Medicare margins for rural hospitals would be *-3.3%* in 2004. The most significant contributing services to those margins, as percent negative margins, would be outpatient services (-20.2%), PPS-exempt units (-10.2%), and home health (-8.2%). The largest reductions in dollars would occur in inpatient PPS (including operating, capital, and bad debt), $5.6 billion; outpatient services, $2.8 billion; and home health, $2.6 billion. The lowest total Medicare margins the Lewin Group found were for CAHs (-11.9%) and the smallest hospitals, with an average daily census less than 12 (-10.4%).[4]

MedPAC analysis shows that the percentage of all hospitals with negative total margins increased from 21.7% in 1996 to 34.2% in 1998. The hospital group with the lowest 1998 total margin of 0.4% was rural hospitals under 50 beds that were not Sole Community Hospitals. The highest percentages of hospitals with negative margins were:

- 36.8% of all rural hospitals;
- 36.2% of Sole Community Hospitals;

[4]The Lewin Group. *The Impact of the Balanced Budget Act of 1997 and The Balanced Budget Refinement Act of 1999 on Rural Hospitals*. Report to the Federal Office of Rural Health Policy. August 31, 2000.

- 52.0% of Medicare-dependent hospitals; and
- 44% of other rural hospitals with less than 50 beds.[5]

With that backdrop of empirical evidence of fiscal strain on small rural hospitals in particular, various concerns and recommendations have been expressed since early 1999. The RUPRI Panel stated (July 1999) that post-BBA "Medicare payments to small rural hospitals . . . are inadequate to sustain financial viability of those institutions."[6] The National Rural Health Association (NRHA) has advocated for the following: provide a full market basket update for rural hospitals under 100 beds; reform the hospital wage index; and change the Medicare-dependent hospital program to lower the 60% threshold to 50%, using federal fiscal years 1997 or 1998 to determine status, and reimburse using the same methodology used for Sole Community Hospitals.[7] MedPAC has recommended that inpatient prospective payments to hospitals increase by a rate equal to the market basket increase *plus* between 0.6 and 1.1 percentage points.[8] The American Hospital Association has advocated for full market basket update for all hospitals and a "stop loss" on outpatient payments.[9]

Response of the Legislation

- All hospitals would benefit from changing the PPS update to the market basket increase in FY 2001, and modifying the subsequent reduction to be MB -.55 in FY 2002 and FY 2003 (the BBA had been MB -1.1 in FY 2001 and FY 2002; full MB in FY 2003 and beyond). *The legislation does not differentiate small rural hospitals, nor does it provide those hospitals full market basket updates in FY 2002 and FY 2003. No hospital would receive an update greater than MB.*

- The change in the basis for receiving DSH payment (making the 15% threshold uniform for all hospitals) provides additional revenues to approximately 870 rural facilities presently not receiving such payment, two-thirds of which are in areas with small towns

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[5]Medicare Payment Advisory Commission (MedPAC). *Report to the Congress: Selected Medicare Issues*. Washington, DC: MedPAC. June 2000.

[6]RUPRI Rural Health Panel. *Implementation of the Provisions of the Balanced Budget Act of 1997: Critical Issues for Rural Health Care Delivery*. Columbia, MO: Rural Policy Research Institute. July 29, 1999.

[7]National Rural Health Association. *Roadmap to a Healthy Rural America*. January 2000.

[8]Op. cit. MedPAC. June 2000. p. 125.

[9]See AHA web site: www.aha.org/bba/BBAIssues.html

(2,500 - 20,000 population).[10] DSH payment for all hospitals increases from BBA levels. *The amount of the DSH payment per hospital remains less for small urban and rural hospitals than for large urban hospitals.* For MDHs, the use of two recent cost audits to determine eligibility may increase the number of qualifying hospitals. *The MDH threshold and payment calculations remain the same.*

- Changing the period of reclassification for the wage index from one year to three years will help the rural hospitals reclassified to urban areas (over 75% of the reclassifications in 1992 were rural); in FY 2000, 441 hospitals were reclassified to a labor market with a higher wage index.[11] Implementing an occupational mix adjustment is responsive to positions taken by the NRHA and others. *The legislation is silent on another issue in calculating the wage index – the percentage of the DRG payment to which the index should be applied*.[12]

- Two other provisions have broad implications for rural hospitals. Increasing bad debt relief from 55% to 70% will benefit rural hospitals by varying degrees as a function of bad debt incurred. The full market basket update in outpatient PPS payments will help the more than 475 rural hospitals with 100 or more inpatient beds (those under 100 beds are held harmless vis à vis inpatient PPS payments being less than cost-based payments).

- Other changes in payment for acute care services will provide fiscal relief to particular categories of rural hospitals: SCHs that were not included in the BBRA 99 provision allowing election of hospital-specific payment, rehabilitation hospitals, psychiatric hospitals, and long-term care hospitals.

- This definition of provider-based entities could affect access to care in any areas currently served by provider-based entities not affiliated with state or local government and more than 35 miles from their "parent" facility.

<u>Next Steps</u>

- The window of opportunity is closing to suggest changes in the outpatient PPS for rural hospitals with under 100 beds. The choice to use cost-based payment ends January 1, 2004. Given the time needed for full debate of alternatives, assessment of different strategies should begin during 2001.

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[10]Data provided by the North Carolina Rural Health Research & Policy Analysis Center.

[11]Anthony Wellever, *The Area Wage Index of the Medicare Inpatient Hospital Prospective Payment System: Perspectives, Policies, and Choices.* Rural Policy Research Institute: P2000-12; August 27, 2000.

[12]Ibid., p. 7.

- Consistent with the RUPRI Panel's recommendation from July 1999, continued analyses of the effects of Medicare payment change on small rural hospitals, other vulnerable institutions, and essential community providers is necessary. The June 2001 report of MedPAC should help inform policies regarding future updates in payment to those hospitals. Consideration should be given to different updates for FY 2002 and FY 2003.

- Further refinement of payment systems for current special categories of hospitals – SCHs, MDHs – should be considered, based on objective analysis of the need for adjustments and the effects of specific changes. Projected negative 2004 margins of 5.2% for SCHs and 2.8% for MDHs[13] need to be reassessed given the provisions of this legislation, and if they remain negative, the need for change in payment formulas may become more urgent. Similarly, the impact of creating parity in payment of DSH for all hospitals should be examined.

- This legislation requires use of an occupational mix adjustment in calculating the wage index. The effect of that step on all rural hospitals, if one assumes budget neutrality, needs to be monitored. Further, the percentage of the DRG payment to which the index is applied needs to be reconsidered.

- Providing additional inpatient payment to certain DRGs based on use of new services or technologies would result in a redistribution of PPS. The effect on rural hospitals should be investigated prior to implementation in October 1, 2001.

I. B. *Payment for CAHs*

Clarification of No Beneficiary Cost-Sharing for Clinical Diagnostic Lab Tests (Section 201)

Medicare beneficiaries are not liable for any coinsurance, deductible, copayment, or other cost sharing with respect to clinical lab services as an outpatient service. The CAH is to be reimbursed on a reasonable cost basis for outpatient clinical diagnostic laboratory services. Medicare beneficiary cost sharing provision is effective on or after the enactment of this Act. Cost-based payment for CAH would be effective as if included in the BBRA 99, which makes it November 29, 1999.

Assistance with Fee Schedule Payment for Professional Services Under All-Inclusive Rate (Section 202)

CAHs may elect to be paid an all-inclusive amount that incorporates a professional fee, based on 115% of the Medicare fee schedule. Effective on or after July 1, 2001.

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[13]Op. cit., The Lewin Group, p. 23.

Exemption of CAH Swing Beds from Skilled Nursing Facility (SNF) PPS (Section 203)

CAHs with swing beds are paid for covered SNF services based on reasonable cost. Effective for cost reporting periods beginning on or after enactment of this Act.

Payment in CAHs for Emergency Room On-Call Physicians (Section 204)

Physicians who are on call but not present on the premises of the CAH, not otherwise furnishing services, and not on-call at any other provider or facility are compensated for being on-call at the CAH. The Secretary of HHS will define the reasonable payment amounts and the meaning of the term "on-call." Effective with reporting periods beginning on or after October 1, 2001.

Treatment of Ambulance Services Furnished by Certain CAHs (Section 205)

Ambulance services provided by a CAH are paid on a reasonable cost basis if the CAH is the only provider or supplier of ambulance services within a 35-mile drive of the CAH. Effective for services furnished on or after the date of enactment of this Act.

Study on Certain Eligibility Requirements for CAHs (Section 206)

The GAO will study the requirements with respect to limitations on the average length of stay and number of beds, as follows:

- the feasibility of having a distinct part unit as part of a CAH; and
- the effect of seasonal variations on inpatient admission.

The report is due one year after enactment, and will include recommendations. Effective on enactment of this Act.

Implications

Concerns Being Addressed

In July 1999 the RUPRI Panel recommended adoption of all-inclusive payment for services rendered by physicians and other practitioners during outpatient visits. The BBRA 99 included a provision for all inclusive payment but used the physician fee schedule rather than a cost-based methodology. The National Rural Health Association subsequently advocated use of cost-based payment for both the facility and professional components of the all-inclusive payment. The RUPRI Panel also recommended that HCFA report on the need to continue cost-based payment for swing bed use in CAHs, beyond the three-year exemption provided in the BBA.

During the implementation of the State Rural Hospital Flexibility Program (SRHFP), other issues were voiced by the CAHs being designated (as of October 20, 2000 there were 277 certified CAHs and 168 applications in process):[14]

- allow CAHs to house PPS-exempt units;
- reimburse for CAH-based ambulance services using a cost-based methodology;
- reimburse based on the cost for home health services furnished by CAHs;
- consider variation from the bed limit during seasonal epidemics; and
- create a payment for on-call physicians supporting the CAH emergency room.

Response of the Legislation

- A technical fix is made to the BBRA 99, such that CAHs are reimbursed based on cost for clinical lab services provided on an outpatient basis.

- The all-inclusive provision of the BBRA 99 is modified to pay the professional fee based on 115% of the Medicare fee schedule, not cost-based.

- Provisions that have been sought concerning swing bed payment, emergency room on-call physicians, and ambulance services are included. The ambulance service provision applies only to those services wherein there are no other ambulance services within 35 miles. Without further research, it is unknown how many of the approximately 55 CAHs with ambulance services are affected.

- The GAO report will inform future debates about exceptions to the bed limit and length of stay requirements of the program, as applied specifically to distinct part units and seasonal variation.

Next Steps

- Much of the activity surrounding designation, certification, and paying CAHs assumes these providers anchor the health care delivery system in their communities. Hence, if they are not providing such services as ambulance response and home health, there is a high risk that those services would not be available. This assumption, while intuitively appealing, requires testing and presumably empirical support.

- The SRHFP, including funding for grants to states, creates opportunities to think more broadly about rural health care delivery systems that are responsive to local needs and

[14]See the web site of the Tracking Project for the SRHFP: www.rupri.org/rhfp-track/mrhfgrid/html (data collected and reported by the North Carolina Rural Health Research & Policy Analysis Center).

financially sustainable. When considering essential services–including ambulance services and home health agencies–appropriate changes in payment systems and technical assistance should be applied in all vulnerable areas. Assuming there will be approximately 500 CAHs by mid-2001, many rural communities served by financially vulnerable providers would not include CAHs.

I. C. *Payment for Safety Net Providers (Medicaid Payment)*

New PPS for FQHCs and RHCs (Section 702)

In fiscal year 2001, payment to FQHCs and RHCs is 100% of the average of costs of the center or clinic during FY 1999 and 2000. In FY 2002 and after, the annual payment is based on the percentage increase in the Medical Expenditure Index applicable to primary care services, adjusted to account for an increase or decrease in the scope of services furnished by the center or clinic during that year. The GAO will complete a study of the need for, and how to rebase or refine costs for, making payment under the Medicaid program. The report is due four years after the date of enactment of this Act. Effective on January 1, 2001 and applicable to services furnished on or after such date.

Medicaid DSH Allotments (Section 701)

The Medicaid allotment for DSH payment is frozen at the FY 2001 amount for FY 2002.

Implications

Concerns Being Addressed

The RUPRI Panel has recommended developing a prospective payment system specific to FQHCs and RHCs that incorporates all costs incurred by those providers. If payment is made on any other basis that deviates from cost-based reimbursement, the Panel recommended supplemental payments to compensate for services not incorporated into the specific calculation. The NRHA has favored either continuing cost-based reimbursement or developing a payment system that covers reasonable costs. The National Association of Community Health Centers (NACHC) has advocated adopting a PPS specific to these safety net providers.

Response of the Legislation

- The recommendation of the RUPRI Health Panel, and the more specific position advocated by the NACHC, is adopted in this legislation.

Next Steps

- The GAO should receive input from providers and other analysts as it prepares its report.

I. D. *Changes in Payment for Other Services*

Payment for Telehealth Services (Section 223)

The facility in which the patient is presented for a telehealth visit is paid a fee of $20, beginning on October 1, 2001, through CY 2002, which is adjusted by the Medical Expenditure Index in subsequent years. The provisions in this section establish the following conditions for payment for services delivered using telemedicine:

- payment for telehealth services, meaning professional consultations, office visits, and office psychiatry services;
- services are furnished via telecommunications systems located in a health professional shortage area, a county not included in a Metropolitan Statistical Area, or a Federal telemedicine demonstration project;
- sites for receiving telemedicine services include: the office of a physician or practitioner, a critical access hospital; a rural health clinic; a Federally qualified health center; or a hospital;
- payment to the consulting physician or practitioner shall equal what would have been paid without the use of a telecommunications system;
- the originating site will be paid a facility fee of $20 initially, increased by the percentage increase in the Medical Expenditure Index after 2002; and
- an eligible individual need not be presented by a physician or practitioner.

The Secretary of HHS is required to conduct a study to identify settings and sites, practitioners, and geographic areas that are appropriate for payment for telehealth services. The report is due within two years of enactment. Effective for services furnished on or after April 1, 2001.

Assistance for Providers of Ambulance Services in Rural Areas (Section 221)

Additional payments are made for trips in a rural area or rural census tract of a metropolitan area for trips greater than 17 miles and up to 50 miles. The rate is increased by a minimum of ½ of the additional per mile rate set for the first 17 miles; in 2001 that would be .50 x $2.50 = $1.25 per mile. This rate is in place from July 1, 2001 through January 1, 2004. The Comptroller General is required to conduct a study of the costs of efficiently providing ambulance services in rural areas, the means by which rural areas with low population densities can be identified, and an analysis of the additional costs of providing ambulance services in low population density areas. The report is due to Congress by June 30, 2002. The Secretary will take recommendations from that report into consideration when setting rates for 2004 and beyond. Effective July 1, 2001.

One-year Extension of the Moratorium on Therapy Caps (Section 421)

The BBA created per-beneficiary limits on payment for outpatient therapy services provided by non-hospital providers: a $1,500 per-beneficiary annual cap. The BBRA 99 suspended those limits in 2000 and 2001. A study of claims will be submitted to Congress not later than 18 months after the date of enactment. This provision extends the moratorium on the cap through CY 2002. Effective on enactment of this Act.

Payment for Ambulance Services (Section 423)

The 1.0 percentage point reduction from the CPI increase, scheduled for 2001, is eliminated. The increase for the second half of 2001 is set at 4.7% to create the effect of having a full CPI increase for the year. Effective July 1, 2001.

Full Update for Durable Medical Equipment (Section 425)

The BBRA 99 increased payment rates to 0.3% over FY 2000 rates for 2001 and to 0.6% over 2001 rates for 2002, rather than the BBA freeze at 1997 levels. This provision provides a full CPI-based increase for 2001, and a 1% increase for 2002. Effective as if enacted with the BBRA 99.

Payment for Certain Physician Assistant Services (Section 222)

A scheduled sunset is repealed, meaning that PA's who own RHCs are allowed to continue billing Medicare directly. Effective on enactment of this Act.

Access to Rural Health Clinics (Section 224)

Small urban hospitals (under 50 beds) qualify for exemption from the per-visit payment limitation in the RHC program. Effective on or after July 1, 2001.

Modification of Medicare Billing Requirements for Certain Indian Providers (Section 432)

Indian Health Service free-standing ambulatory care clinics are authorized to receive payments under Medicare Part B for providing covered services to Medicare beneficiaries. *There are 22 such clinics nationwide.* Effective January 1, 2001.

Implications

Concerns Being Addressed

The RUPRI Panel has not made previous recommendations concerning any of the provisions summarized in this subsection. The NRHA has advocated more extensive use of Medicare reimbursement for services delivered through telehealth, including: payment based on medical effectiveness and utilization rather than delivery platforms; eliminating requirements that the referring physician or other professional must always be present to present the patient; reimbursing for any service currently covered by Medicare; paying a professional fee to both providers when there are two providers involved in presenting the patient; paying a fee to the facilities; and expanding eligibility for payment beyond health professions shortage areas.

Ambulance provider associations and individual providers have argued for a delay in implementing the new fee schedule, on grounds that the fee schedule is unfairly based on charges that do not reflect actual costs (charges from subsidized providers and providers with large numbers of volunteers underestimate costs) and that low-volume providers would have particular difficulties sustaining services.[15]

Response of the Legislation

- In the provision of services though telemedicine, there is an originating site fee of $20, paid beginning April 1, 2001. A physician or other practitioner is only required to present the patient when medically necessary. Demonstration projects in Alaska and Hawaii may show the efficacy of other payment methodologies. The GAO study, due in three years, will identify additional services for reimbursement.

- The use of the CPI for ambulance payment increase in 2001 helps all providers but does not address any rural disadvantages in payment (particularly those that result from different volumes of services and/or different patterns of historical charges). The mileage payment provision is targeted more directly to rural provider needs, and the required GAO report will help specify the extent of any payment problem and provide recommendations for remedial action.

- Other actions affecting payment to certain providers may help keep services available in rural areas: a) enhancing payments for therapy services and durable medical equipment; b) ending the sunset of physician assistant billing for RHCs they own; and c) allowing small suburban hospitals to qualify for exemption. Payment under Medicare Part B may help Indian Health Service clinics make services available to Medicare beneficiaries.

[15]Detailed information is available at these web sites: www.ncemsc.org www.maa.gen.mn.us

Next Steps

- Information concerning the efficacy of telehealth services should be collected and synthesized, based on the experiences of sites that have been awarded demonstration grants. Analysis of that information could accelerate the time line for decisions concerning what services to reimburse, appropriate sites, and appropriate payments.

- The time line for studying the costs of providing ambulance services in rural areas could be accelerated such that the Secretary has recommendations upon which to act for payment periods 2003 and beyond (one year sooner). In the interim, policies could be adopted that hold harmless those rural providers adversely affected by the new fee schedule.

I. E. *Beneficiary Copayments and Additional Benefits*

Acceleration in Reduction of Beneficiary Copayment for Hospital Outpatient Services (Section 111)

The BBA froze beneficiary copayments at their current amounts, intending to reduce the percentage to 20%. However, the Medicare Payment Advisory Commission estimated that the full impact of the reduction would not be in place for some outpatient services for 40 years. The BBRA 99 limited beneficiary copayments for hospital outpatient services to the amount of the hospital inpatient deductible ($776 in 2000). This provision reduces the effective copayment rate for outpatient services to a maximum of 60% in 2001, to 55% in 2002 and 2003, and then by 5% each year until 2006, at which time it will hold at 40%. The GAO will complete a study of the extent to which premiums set by supplemental policies reflect the reductions in coinsurance. The report is due no later than April 1, 2004. Effective January 1, 2001.

Billing Limits on Prescription Drugs (Section 114)

Medicare payment for drugs (those that are included as a Medicare benefit) is 95% of the average wholesale price (AWP). Beneficiaries are liable for a 20% coinsurance and may be liable for balance billing charges (charges in excess of 95% of the AWP). This provision specifies that payment for drugs under Part B must be made on the basis of assignment (no balance billing). Effective on or after January 1, 2001.

Implications

Concerns Being Addressed

Evidence presented by the Maine Rural Health Research Center and the RUPRI Rural Health Panel has demonstrated a disproportionate impact of any Medicare cost-sharing on rural beneficiaries, because they:

- are more likely to report their health status as fair or poor;
- are in households with lower personal incomes;
- have lower access to employer-sponsored retirement health plans;
- are less likely to be enrolled in Medicare+Choice plans; and
- are less likely to purchase comprehensive Medigap plans.[16]

Response of the Legislation

- The intended reduction of beneficiary copayment for outpatient services, to 40%, will be a reality by 2006. Payment based on assignment will lower beneficiary financial liability for the prescription drugs currently covered by Medicare.

Next Steps

- Further attention to beneficiary liability should be an important consideration in any comprehensive reform of the Medicare program.

[16]Maine Rural Health Research Center and the RUPRI Rural Health Panel. *Designing a Prescription Drug Benefit for Rural Medicare Beneficiaries: Principles, Criteria, and Assessment.* Andrew F. Coburn and Erika C. Ziller, principal authors. P2000-14. Omaha Nebraska: RUPRI Center for Rural Health Policy Analysis. August 31, 2000.

II. MEDICARE PAYMENT FOR POST-ACUTE CARE

II. A. *Home Health Services*

One-Year Additional Delay in the 15% Reduction on Payment Limits (Section 501)

The aggregate amount of Medicare payments in the second year of the PPS (FY 2002) is equal to the aggregate amount from the first year, updated by the market basket increase minus 1.1 percentage points. The 15% reduction to aggregate PPS amounts is delayed until October 1, 2002. The GAO is required to submit a report by April 1, 2002, analyzing the need for the 15% or other reduction. The BBRA 99 requirement for the Secretary of HHS to do such a study is vitiated. Effective for episodes occurring on or after October 1, 2001.

Restoration of Full Home Health Market Basket Update for Fiscal Year 2001 (Section 502)

For cost reporting periods beginning in FY 2001, the updates to home health payments are equal to the full market basket index increase. This raises the base for that year and all subsequent years. The Secretary of HHS can adjust PPS amounts to eliminate the effect of coding or classification of service needs that reflect real changes in case mix. Effective: market basket on or after October 1, 2000; case mix adjustments for cases closed after October 1, 2001.

Temporary Extension of Periodic Interim Payments (PIP) (Section 503)

The BBA repealed PIP, effective with the implementation of PPS. This provision provides a single PIP for those home health agencies who were receiving them as of September 30, 2000, equal to 4 times the last PIP the agency received, amounting to a two-month payment. Effective as soon as practicable.

Use of Telehealth in Delivery of Home Health Services (Section 504)

Home health agencies can receive payment, under PPS, for services delivered via a telecommunications system, provided they do not substitute for services ordered by a physician as part of a plan of care and are not considered a home health visit for purposes of eligibility or payment. Effective on enactment of this Act.

Treatment of Branch Offices (Section 506)

Neither time nor distance between a home health agency parent office and a branch office is the sole determinant of branch office status. The Secretary can include forms of technology in determining "supervision" for purposes of determining branch office status. The GAO will conduct a study of the provision of adequate supervision to maintain the quality of home health services delivered in isolated rural areas. The report is due January 1, 2002. Effective on enactment of this Act.

Temporary Increase for Home Health Services Furnished in a Rural Area (Section 508)

Payment for home health services furnished in a rural area is increased by 10% on or after April 1, 2001 and before April 1, 2003. Budget neutrality is waived.

Implications

Concerns Being Addressed

The RUPRI Panel expressed concern that small rural agencies would be especially vulnerable to changes in the payment system. The Panel suggested that the new payment system assure that agencies serving remote rural populations receive adequate payment to compensate for higher travel and other costs. The Panel also suggested that the payment and technical assistance needs of home health agencies who are essential community providers in isolated rural areas be addressed.

The NRHA advocated for the following: "HCFA should include a low-volume adjustment in its proposed prospective payment system for home health services to address the inability of small and rural providers to spread their fixed costs, as well as costs associated with high-cost cases, among a large volume of cases."[17]

The Visiting Nurse Association of America (VNAA) has recommended repeal of the 15% cut in payment, originally scheduled to be effective with the implementation of PPS, and new expenditures to ensure successful transition to PPS. Five national home health associations jointly recommended the following:

- repeal the 15% cut;
- improve the PPS outlier system;
- create a fee schedule for non-routine medical supplies; and
- instruct HCFA to authorize emergency payments during the first six months of PPS.

[17]National Rural Health Association *2000 Legislative and Regulatory Agenda.* Available from the web site: www.nrharural.org

The VNAA also recommends the following:

- clarify a uniform, reasonable, and up-to-date definition of a Medicare home health agency branch office; and
- increase payments for home health services in rural areas by 10%.[18]

Response of the Legislation

- There is an additional one-year delay in application of the 15% reduction, and the GAO study may indicate there is no need for the reduction. Shifting responsibility for that study from the Secretary to the GAO may enhance its objectivity (the GAO has no "line" responsibility for the program).

- Temporary relief is provided through use of the full market basket and the one-time issuance of a two-month periodic interim payment.

- The definition of branch office has been changed.

- There is an additional payment of 10% for home health services delivered in rural areas, effective for 2 years.

Next Steps

- The adequacy of payment for rural home health agencies remains in question. Objective analysis of that issue is needed, including assessment of the need for additional payments (and amount, if need is demonstrated) to remote, isolated agencies. The MedPAC study of rural health payment issues, expected in June 2001, may include the necessary analysis (the BBRA 99 mandated a study of the feasibility of exempting agencies in rural areas from the PPS).

- The delay in the 15% reduction allows time for adjustments and further deliberations. Any reduction in home health payment should occur only *after full consideration* of the GAO report.

- The new definition of branch offices and the payment for services delivered using telehealth are implicitly encouraging the home health industry to develop and implement strategies to improve the cost-effectiveness of delivering services.

[18]Judith G. Sutherland, Chairman of the Board of Directors, Visiting Nurse Association of America. *Testimony Before the Subcommittee on Health of the House Committee on Ways and Means*. Hearing on Additional Refinements to the Balanced Budget Act of 1997. July 25, 2000.

II. B. *SNF Services and Hospice Care*

Full Market Basket Increase in FY 2001 (Section 311)

The per diem rate for FY 2001 is increased over the FY 2000 rate by the full market basket index increase, and for FY 2002 and 2003 by the market basket index (MBI) increase minus .5 percentage points. Effective on enactment of this Act.

Increase in Nursing Component of the Federal PPS (Section 312)

The nursing component of each resource utilization group is increased by 16.6% for care furnished after April 1, 2001 and before October 1, 2002. The Comptroller General will conduct an audit of nurse staffing ratios and report to Congress by August 1, 2002. The report will include an assessment of whether the 16.6% addition should continue. Effective on enactment of this Act.

Establishment of a Process for Geographic Reclassification (Section 315)

The Secretary may establish a process for geographic reclassification of SNFs based upon the method used for inpatient hospital patients. This can be done after completing the data collection necessary to calculate an area wage index based on the wages paid by SNFs. Effective date not specified.

Five Percent Increase in Payment Rate (Section 321)

The base payment rate for hospice care is increased by 5 percentage points in fiscal year 2001, applied as of April 1, 2001. Calculations for FY 2002 will use the rate as of April 1, 2001, as the base.

Implications

Concerns Being Addressed

The RUPRI Panel has recommended changing the wage index used to calculate the SNF payment rate, to make it specific to SNFs. Similarly, the NRHA has recommended that the hospital wage index be limited to inpatient hospital services.

The American Health Care Association has made the following recommendations:

- adjust the SNF PPS to account for a flawed update factor between 1995 and 1998; a one-time upward adjustment of 13.5%;
- delay implementation of RUG Refinement Rules until deficiencies are corrected;

- develop a process for revising the SNF market basket; and
- update the SNF benefit (protect beneficiaries from excessive copayments).[19]

Response of the Legislation

- The calculation of the area wage index will change if Section 315 is implemented. However the Section wording indicates the Secretary *may* establish a procedure for geographic reclassification, but only *after such time* as data have been collected to establish an area wage index based on wage data from SNFs.

- The payment provisions of this legislation provide temporary relief and in one instance (increasing the nursing component) potential for long-term action following a GAO report.

Next Steps

- Ongoing assessment of the impact of the new payment system on SNFs should include assessment of impacts on rural SNFs, and within rural SNFs, variation by size, ownership, and geographic isolation.

- Prior to establishing any geographic reclassification of SNFs, the Secretary should complete analysis regarding the following: consideration of the ingredients of the wage index; implications of using the hospital wage index vs. a separate index for SNFs; and effects on rural SNFs and the beneficiaries they serve.

[19]Michael R. Walker, on behalf of the American Health Care Association. *Testimony Before the Subcommittee on Health of the House Committee on Ways and Means*. July 25, 2000.

III. MEDICARE+CHOICE POLICIES

III. A. *Monthly Per Member Payment*

Increase the Floor Payment (Section 601)

For 2001 the minimum monthly payment in the M+C program is $525 in a Metropolitan Statistical Area with a population of more than 250,000, and $475 in all other areas. Effective March 1, 2001.

Minimum Update (Section 602)

The minimum update for M+C payment in 2001 is 103%. Effective March 1, 2001, for one year only.

Phase-In of Risk Adjustment (Section 603)

Until risk adjustment is based on data from inpatient hospital and ambulatory settings, 10% of payments are based on risk adjustment using the PIP-DCG method and 90% on the previous method. Beginning with the first year that risk adjustment is based on new data, it will be phased in over 10 years, based on the following schedule:

- 30% of the risk adjusted capitated rate in 2004;
- 50% of the risk adjusted capitated rate in 2005;
- 75% of the risk adjusted capitated rate in 2006; and
- 100% of the risk adjusted capitated rate in 2007 and succeeding years.

Transition to Revised M+C Rates (Section 604)

Revised rates will be determined and announced within two weeks after date of enactment. Plans which previously announced an intention to terminate contracts or reduce service areas in 2001 will have two weeks after that announcement to rescind their notice and submit an adjusted community rate (ACR). Any M+C organization that will receive a higher rate because of this legislation must submit a revised ACR within two weeks after date of enactment. Effective on enactment of this Act.

Implications

Concerns Being Addressed

The RUPRI Panel has suggested the following:

- not changing the payment formula until current changes are fully implemented;
- using area rates rather than county rates;
- easing the regulatory burden;
- providing full information about the impact of risk adjustment in rural areas;
- linking risk adjustment to desired outcomes; and
- reducing payment variation by consolidating county rate across service areas.

The American Association of Health Plans (AAHP) has argued for three "principles:"

- ensure that M+C payments are adequate and stable and that they are comparable to those in fee-for-service Medicare (specifically arguing for $15 billion over 5 years);
- re-examine the beneficiary information and education effort and re-focus it to meet beneficiary interests and needs; and
- promote and enforce a responsive regulatory environment.[20]

The changes in payment to M+C organizations come in the context of reductions in the rate of growth in enrollment into Medicare HMO plans, from an annual growth of:

- 25.8% between December 1996 and December 1997;
- 13% from December 1997 to January 1999;
- 3.4% from January 1999 to January 2000; and
- 17.6% from December 1997 to June 2000.[21]

In rural areas (defined as non-metropolitan), enrollment growth slowed:

- 55.8% between December 1996 and December 1997;
- 15.8% from December 1997 to January 1999; and
- a *negative* 6.8% from January 1999 to January 2000.

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[20]Karen Ignani, Executive Director, American Association of Health Plans. *Testimony before the Subcommittee on Health & Environment, House Committee on Commerce.* August 4, 1999; and George Renaudin, Senior Vice President of Ochsner Health Plan. *Testimony before the House Committee on Ways and Means*. July 25, 2000.

[21]Analysis done by the RUPRI Center for Rural Health Policy Analysis, using data in the RUPRI Medicare County Capitation File.

A great deal of concern has been expressed about Medicare beneficiaries losing access to M+C plans because of plans withdrawing from service areas. In the past three years (for plan offerings starting in January, announcements are made in July), the numbers of beneficiaries affected have been 407,000; 327,000; and 934,000. A disproportionate share of the beneficiaries affected live in rural areas; 47,600; 79,000; and 69,266. In rural areas the beneficiaries are less likely to have HMO alternatives once a plan withdraws.[22]

Response of the Legislation

- Payment is increased for *all* M+C plans. The increase in floor payments will affect 2,151 of the nation's 3,150 counties. The floor payment increases from $415.01 to $475. The legislation does not incorporate provisions contained in earlier drafts that would have implemented a fully blended rate (50% national, 50% local) in FY 2002, without the constraint of budget neutrality.

- Changes in payment will not be sufficient to induce M+C plans to seek beneficiary enrollment in markets they have not previously entered, or markets from which they have exited. Significant payment increases (e.g., the floor payment in certain rural counties) may convince some M+C plans to remain in place, and could induce a few that withdrew in the past 12 months to re-enter markets where they could quickly develop the administrative infrastructure needed to support beneficiary enrollment. In other areas, the calculus used by plans in deciding to enter or not enter will continue to include an assessment of other conditions, including: the number of beneficiaries in the market area; the existing experience with managed care; the availability of providers willing to contract with the M+C plan; and the other competitors in the region.

Next Steps

- Consistent with the RUPRI Panel's July 1999 recommendation, no further changes in M+C payment should be made until the relationships between payment level and the following are fully understood:

    - minimum payment needed to cover costs associated with M+C plans that offer benefits not currently included in the Medicare program;
    - payment needed to entice market entry (likely to exceed costs by some factor); and
    - likelihood for market entry regardless of price.

[22]Ibid.

- Policy makers need to be prepared for further increases in minimum payment levels, if the policy objectives include encouraging plans to offer comprehensive benefits, and charging beneficiaries premiums below current market prices for supplemental insurance plans.

III. B. *Additional Provisions*

Permitting Premium Reductions as an Additional Benefit (Section 606)

M+C organizations can rebate a portion of Part B premiums as an additional benefit to enrollees. 80% of the amount will be cash for enrollees, and 20% will be returned to the U.S. Treasury. The rebate cannot exceed 125% of the amount of the Part B premium. Effective beginning with CY 2003.

Encouraging Offering of M+C Plans in Areas Without Plans (Section 608)

The BBRA 99 created bonus payments of 5% the first year a plan enters a previously unserved area, and 3% the second year. The bonus applies to areas where there had been an M+C plan since 1997. This provision extends the bonus to areas in which a plan ceased to be offered as of January 1, 2001 and applies the payment to M+C plans which first were offered in an area during the two-year period beginning January 1, 2000. The bonus applies to multiple plans if they all initiate offerings at the same time in previously unserved areas. Effective as if included in the BBRA 99.

Payment of Additional Amounts for New Benefits Covered During a Contract Term (Section 611)

If legislative change results in significant increased costs to M+C plans, payment will be adjusted accordingly. Effective on enactment of this Act.

Restriction on Implementation of Significant New Regulatory Requirements in Mid-Year (Section 612)

The Secretary cannot implement new, significant regulatory requirements, other than at the beginning of a calendar year. Effective on enactment of this Act.

Timely Approval of Marketing Material (Section 613)

The Secretary is required to make decisions approving or modifying marketing material within 10 days (previously was 45 days), provided that the organization uses model language specified by the Secretary. Effective on or after January 1, 2001.

Service Area Expansion for Medicare Cost Contracts During the Transition Period (Section 634)

Reasonable cost reimbursement contracts will not be extended beyond December 31, 2004 (BBA provision). This provision allows Medicare cost contractors to enroll new members and to expand their service areas until such time as their contracts are not in place. Effective with applications submitted on or before September 1, 2003.

Restoring the Effective Date of Elections and Changes in Elections of M+C Plans (Section 619)

Elections or changes in elections are effective on the first day of the following month. Effective for elections and changes of coverage made on or after June 1, 2001.

Implications

Concerns Being Addressed

Same as in Subsection III. A.

Response of the Legislation

- These provisions remove some non-financial barriers that currently trouble at least some M+C organizations. Field research by faculty at the RUPRI Center for Rural Health Policy Analysis supports the argument that the specific issues addressed by Sections 611, 612, 613, 619, and 634 have created unnecessary burdens and costs for M+C organizations. The other two sections (606 and 608) may result in increased enrollment by beneficiaries, because plans would have an incentive to enter new markets (the 5% and 3% bonuses added to the new floors may have an effect not seen by the bonuses added to previous floors), and because plans may entice beneficiaries with rebates of Medicare premiums.

Next Steps

- Studies are needed from third parties (not the industry and not U.S. HHS) that yield a more thorough understanding of the costs involved in maintaining an M+C plan. Policy makers need information regarding the costs of using this vehicle as a means of providing a more comprehensive array of benefits to Medicare beneficiaries. This would become even more important should the debates about redesigning the Medicare program be renewed in the 107th Congress.

IV. DEMONSTRATIONS AND STUDIES

IV. A. *Studies Specific to Rural Health Care Delivery Systems*

MedPAC Report on Access to, and Use of, Hospice Benefit (Section 323)

MedPAC will study factors affecting the use of hospice benefits, including delay of entry into the program, and urban and rural differences in the use of hospice benefits. The report is due 18 months after enactment.

MedPAC Study on Medicare Reimbursement for Services Provided by Certain Providers (Section 434)

MedPAC will study the appropriateness of the current payment rates for services provided by a certified nurse-midwife, physician assistant, nurse practitioner, and clinical nurse specialist. The report is due 18 months after enactment.

MedPAC Study on Medicare Coverage of Services Provided by Certain Non-Physician Providers (Section 435)

The study will determine the appropriateness of providing coverage for services provided by the following: surgical technologist, marriage counselor, marriage and family therapist, pastoral care counselor, and licensed professional counselor of mental health. The study will include short- and long-term benefits, and cost to the program. The report is due no later than 18 months after enactment.

GAO Study on the Costs of Emergency and Medical Transportation Services (Section 436)

The study will focus on the costs of providing emergency and medical transportation services across the range of acuity levels of conditions for which such transportation are provided. The report, due within 18 months, will include recommendations for any changes in payment methodology necessary to fairly compensate providers and to ensure beneficiary access.

GAO Study of Inclusion of Distinct Part Rehab and Psych Units as Separate Units within CAHs (Section 206)

In action leading up to BIPA, the Senate and House Committees of Jurisdiction (Finance and Ways and Means) passed contradictory provisions, one not allowing CAH designation if there are distinct part units (Ways and Means) and the other allowing CAHs to operate distinct part units that do not count against the bed limit (15 acute care beds). A study will be completed regarding the effects of allowing CAHs to operate distinct part units.

MedPAC Report on Rural Health to Include Psychiatric Units (Section 214)

MedPAC is instructed to include the impact of volume on the per unit cost of rural hospitals with psychiatric units in its report on the impact of low volume on rural providers.

GAO Study of Costs of Providing Ambulance Services in Rural Areas (Section 221)

The GAO is required to study the costs of efficiently providing ambulance services for trips originating in rural areas. The report is due June 30, 2002.

MedPAC Study on Low-Volume, Isolated Rural Health Care Providers (Section 225)

MedPAC will study the effect of low patient and procedure volume on the financial status of isolated rural providers for the following Medicare providers:

- hospital outpatient departments:
- ambulance services;
- inpatient hospital services;
- skilled nursing facilities; and
- home health services.

A report is due within 18 months of date on enactment indicating:

- whether such providers experience decreased Medicare margins resulting from current payment methodologies;
- whether such providers should receive a special designation under the Medicare program, and criteria for such a designation; and
- any changes in payment methodology necessary to provide appropriate reimbursement.

IV. B. ***General Studies with Particular Meaning in Rural Areas***

MedPAC Study on Consumer Coalitions (Section 124)

MedPAC is required to examine the use of consumer coalitions in the marketing of M+C plans. A consumer coalition is a non-profit community-based organization that provides information to beneficiaries about their options under Medicare, and negotiates with M+C plans on benefits and premiums for members of the coalition. The report will include recommendations on whether and how a demonstration project might be conducted for the operation of consumer coalitions under Medicare.

Studies on Preventive Interventions in Primary Care for Older Americans (Section 127)

The Secretary will conduct a series of studies to identify preventive interventions that could be delivered in the primary care setting. Within one year of enactment and annually thereafter the Secretary will report to Congress with recommendations for legislation and administrative actions.

GAO Study on Medicare Payments (Section 437)

The GAO will study the post-payment audit process used in the Medicare program as it applies to physicians. The study will include assessing the proper level of resources that the Health Care Financing Administration (HCFA) should devote to educating physicians regarding: coding and billing, documentation requirement, and the calculation of overpayments. The GAO will also study the aggregate effects of regulatory, audit, oversight, and paperwork burdens on physicians and other health care providers participating in the Medicare program. The report is due within 18 months of enactment of this Act.

GAO Study of the Effects of the Emergency Medical Treatment and Active Labor Act (EMTALA) on Hospital Emergency Departments (Section 546)

The effects of EMTALA on hospitals, emergency physicians, and physicians covering emergency department call will be studied. The report will evaluate:

- the extent to which the various providers provide uncompensated services in relation to the requirements of EMTALA;
- the extent to which the requirements of EMTALA have expanded beyond the legislation's original intent;
- any possible estimates for the total dollar amount that EMTALA-related care costs the various providers;
- the extent to which different portions of the country may be experiencing different levels of EMTALA-related care;
- the extent to which EMTALA would be classified as an unfunded mandate;
- the extent to which states have programs to provide financial support for uncompensated care;
- the extent to which funds under Medicare hospital bad debt accounts are available to hospitals to underwrite the cost of uncompensated EMTALA-related care; and
- the financial strain that illegal immigrant populations and the uninsured place on hospital emergency departments.

The report is due May 1, 2001.

Report on Inclusion of Costs of the Department of Veteran Affairs and Military Facility Services in Calculating M+C Payment Rates (Section 609)

The Secretary of HHS will develop a method to phase-in the costs of military facility services to Medicare-eligible beneficiaries in the calculation of the area's M+C capitation payment. The report is due January 1, 2003.

IV. C. *General Studies with Potential Special Meaning in Rural Areas*

Demonstration Project for Disease Management for Severely Chronically Ill Beneficiaries (Section 121)

A project will be conducted to illustrate the impact of disease management on costs and health outcomes. It will include beneficiaries with diagnosed, advanced-stage congestive heart failure, diabetes, or coronary heart disease. Projects will be carried out through contracts with up to three disease management organizations, who will be paid a negotiated fee established such that there is a net reduction in Medicare expenditures. The Secretary will submit a report to Congress within two years after the date the project is first implemented.

Study Cancer Prevention and Treatment Issues for Ethnic and Racial Minorities (Section 122)

The Secretary of HHS will be required to conduct demonstration projects which would develop models and evaluate methods that:

- improve quality of services provided to target individuals in order to reduce disparities in early detection and treatment of cancer;
- improve clinical outcomes, satisfaction, quality of life, and appropriate use of services and referral patterns;
- eliminate disparities in the rate of preventive cancer screening measures; and
- promote collaboration with community-based organizations to ensure cultural competency of health care professionals.

Within two years of enactment there will be at least nine demonstration projects, including two for each of the four major racial and ethnic minority groups, and at least one project each in a rural area and an inner-city area.

Studies of the GI Site-of-Service Differential and the Resource-Based Practice Expense System (Section 411)

The GAO will study the appropriateness of furnishing specialist physician services in physician offices rather than in hospital outpatient departments as is usually the case. The report is due July 1, 2002. MedPAC will study refinements to the practice expense relative value units during the transition to a resource-based practice expense system for physician payments. The report is due July 1, 2001.

Demonstration of Physician Volume Increases to Group Practices (Section 412)

The purpose of the demonstration is to encourage coordination of care under parts A and B by institutional and other practitioners, and suppliers of health care items and services; encourage investment in administrative structures and processes to ensure efficient service delivery; and to reward physicians for improving health outcomes. Fee-for-service payments will be made to a single group entity.

Study on Coverage of Surgical First Assisting Services by Certified Registered Nurse First Assistants (Section 433)

The GAO will study the effect of including coverage of surgical first assistants in the Medicare program. The study will include potential impact on quality of care, appropriate education and training requirements for certified nurse first assistants, and appropriate rates of payment. The study is due one year after enactment.

Study of Access to Outpatient Pain Management Services (438)

MedPAC will complete a study of the barriers to coverage and payment for outpatient pain medicine procedures. The study will examine barriers on the provision of pain management procedures in hospital outpatient departments, ambulatory surgery centers, and physicians' offices; and the consistency of payment in different settings.

Development of Patient Assessment Instruments (Section 545)

The Secretary will report to Congress on the development of standard instruments for the assessment of the health and functional status of patients. The report will include recommendations on the use of standard assessment instruments for payment purposes. The report is due January 1, 2005.

RUPRI Rural Health Panel

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

Charles W. (Chuck) Fluharty, M.Div., is the Director of the Rural Policy Research Institute. He also currently serves as Interim Director of the Missouri Institute of Public Policy, and holds Adjunct Faculty Appointments in the University of Missouri Graduate School of Public Affairs and Department of Rural Sociology. He was the recipient of the 1999 Friend and Partner Award from the National Association of Counties Rural Action Caucus, 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. He received his M.Div. from Yale University Divinity School, and has focused his career upon service to rural people, primarily within the public policy arena.

J. Patrick Hart, Ph.D., is President of Hart and Associates in Larimore, North Dakota. Before assuming his current responsibilities, Dr. Hart held faculty positions in Public Health, Allied Health, and Medicine serving at the University of Minnesota-Duluth, Tulane University, the University of Oklahoma, the University of Texas Southwestern Medical Center at Dallas, and the University of North Dakota. He has directed community-based rural health, human resource, and health professions education programs and worked with rural organizations, communities, and networks in the United States, Pakistan, and Honduras providing consultation in community and organization development, information systems, program evaluation and training design. Dr. Hart is past President of the Board of Directors of the National Rural Health Association, past Chair of the Rural Health Committee of the American Public Health Association, and served on the National Advisory Committee of the Robert Wood Johnson Foundation Program on Improving the Health of Native Americans. He received his M.S. in Social Psychology and his Ph.D. in Human Ecology from the University of Oklahoma.

A. Clinton MacKinney, M.D., M.S., is a board-certified family physician. He is currently practicing with HealthPartners Central Minnesota Clinics in St. Cloud, Minnesota. He earned his medical degree at Medical College of Ohio and completed residency training at the Mayo-St. Francis Family Practice Residency. His MS degree is in Administrative Medicine, University of Wisconsin. He has lectured and published articles regarding rural health, and has served on committees for the American Medical Association, the American Academy of Family Physicians, the Robert Wood Johnson Foundation, and the National Rural Health Association.

Timothy D. McBride, Ph.D., is an Associate Professor of Economics, Public Policy and Gerontology at the University of Missouri-St. Louis. 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, and health care reform. He is the author of over twenty research articles and co-author of a monograph titled *The Needs of the Elderly in the 21st Century*. Dr. McBride joined the Department of Economics in 1991 at the University of Missouri- St. Louis after spending four years at the Urban Institute in Washington, D.C.

Keith J. Mueller, Ph.D., is a Professor and the Director of the Nebraska Center for Rural Health Research, University of Nebraska Medical Center. Dr. Mueller is also the Director of the RUPRI Center for Rural Health Policy Analysis. He was the 1996-97 President of the National Rural Health Association, and the recipient of the Association's Distinguished Rural Health Researcher Award in 1998. He is the author of a University of Nebraska Press book, *Health Care Policy in the United States*, and has published articles on health planning, access to care for vulnerable populations, rural health, and access to care among the uninsured. He is a member of the Secretary's National Advisory Committee on Rural Health. Dr. Mueller's expert testimony has been solicited by Committees of the U.S. Congress, the Medicare Payment Advisory Commission, and the Bipartisan Commission on the future of Medicare.

Rebecca T. Slifkin, Ph.D., is the Director of the North Carolina Rural Health Research and Policy Analysis Center, one of six centers funded by the federal Office of Rural Health Policy. She is also Director of the Program on Heath 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 Assistant Professor in the Department of Social Medicine in the Medical School. Her work has spanned a broad array of topics, including Medicare Graduate Medical Education payments, Medicaid managed care, CAHs, and access to care for rural minorities.

Mary K. Wakefield, Ph.D., M.S.N., is 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, 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.

The Rural Policy Research Institute provides objective analyses and facilitates dialogue concerning public policy impacts on rural people and places. The Rural Health Panel receives continuing support from RUPRI, the result of a Congressional Special Grant, administered through the Cooperative State Research, Education, and Extension Service, U.S. Department of Agriculture.

Recent Health Policy Documents

Rural Implications of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000: An Updated Rural Analysis of the Health Policy Provisions. January, 2001. **(PB2001-1)**

Rural Implications of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. November 27, 2000. **(P2000-16)**

Designing a Prescription Drug Benefit for Rural Medicare Beneficiaries: Principles, Criteria, and Assessment. A Joint Policy Paper of the Maine Rural Health Research Center and the RUPRI Rural Health Panel. August 31, 2000. **(P2000-14)**

Redesigning the Medicare Program: An Opportunity to Improve Rural Health Care Systems? August 31, 2000. **(P2000-13)**

The Area Wage Index of The Medicare Inpatient Hospital Prospective Payment System: Perspectives, Policies, And Choices. August 27, 2000. **(P2000-12)**

Health Insurance in Rural America. August, 2000. **(PB2000-11)**

Improving Prescription Drug Coverage for Rural Medicare Beneficiaries: Key Rural Considerations and Objectives For Legislative Proposals. June 30, 2000. **(P2000-8)**

A Rural Assessment of Leading Proposals to Redesign the Medicare Program. (P2000-4)

A Report on Enrollment: Rural Medicare Beneficiaries in Medicare+Choice Plans. (PB2000-1)

Rural Implications of the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999: A Rural Analysis of the Health Policy Provisions. (P99-11)

Implementation of the Provisions of the Balanced Budget Act of 1997: Critical Issues for Rural Health Care Delivery. July, 1999. **(P99-5)**

Taking Medicare into the 21st Century: Realities of a Post BBA World and Implications for Rural Health Care. February, 1999. **(P99-2)**

Considerations for Federal Legislation to Improve Rural Health Care Delivery: Recommendations for the 106th Congress. A RUPRI Rural Policy Brief. **(PB99-1)**

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.

RUPRI Vision Statement

"The Rural Policy Research Institute will be recognized as the premier source of unbiased, policy relevant analysis and information on the challenges, needs and opportunities facing rural people and places."

Additionally, RUPRI will be viewed as a national leader and model in demonstrating how an academic-based enterprise can--

- Build an effective and lasting bridge between science and policy.
- Meet diverse clientele needs in a flexible and timely fashion
- Foster and reward scientists who wish to contribute to the interplay between science and policy.
- Overcome institutional and geographic barriers.
- Make adjustments in the academic "product mix" to enhance relevancy and societal contributions.

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