

Review & Commentary on Health Policy Issues from a Rural Perspective - December 1st, 2001

Medicare Reform Inevitable, Its Shape Isn't

From "Reforming Medicare: Impacts on Federal Spending and Choice of Health Plans, Reductions in Medicare Spending are Likely to Occur Only if Beneficiaries' Premiums Go Up" by Kenneth Thorpe and Adam Atherly, *Health Affairs*, Nov-Dec. 2001:

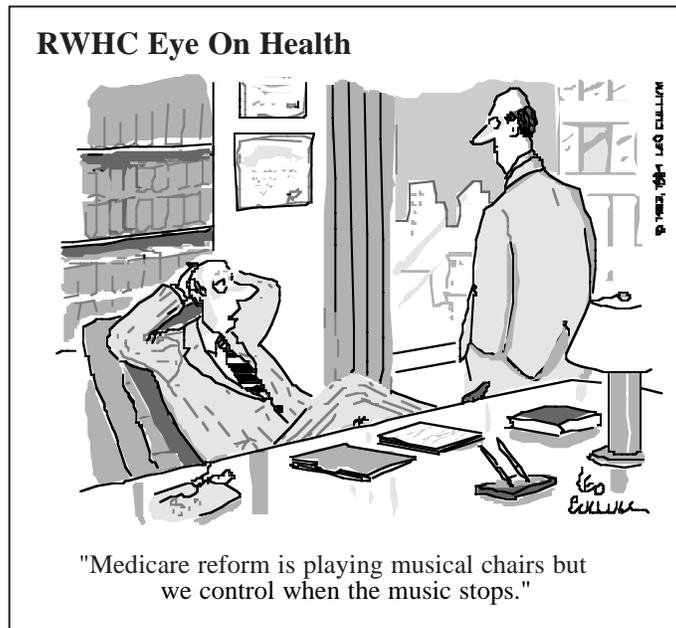
"Growing bipartisan interest in the need to 'reform' Medicare has been driven by three problems: the rising share of the federal budget and gross domestic product (GDP) consumed by Medicare; an outdated benefit package; and distortions and inefficiencies in the payment methodology for Medicare+Choice plans (M+C). It is hoped that solutions to the third problem can help to provide solutions to the first two. Several recent proposals for reforming payments to M+C plans have suggested abandoning the current administrative pricing system in favor of some form of competitive bidding among M+C plans. It has been suggested that competition among plans, combined with price incentives for beneficiaries to select lower-price plans, may serve to slow the overall growth in health care costs and Medicare payments."

"Under the current system, payments for M+C plans are unrelated to plans' underlying costs. Instead, payments are derived from costs in the fee-for-service (FFS) sector. Prior to the 1997 Balanced Budget Act (BBA), managed care payments were 95 percent of average costs in the FFS sector (the adjusted average per capita cost, or AAPCC). Since the BBA, M+C payments have been established

by a complicated formula that is the greater of a minimum payment (floor), a minimum update from the prior year's payment, or a blend of local and national rates, all of which are related to some degree to the 1997 AAPCC. The blend is subject to a budget-neutrality constraint, and no plan received the blended payment in 2001."

"This system has a number of problems. First, for plans above the floor (65.6 percent of projected M+C enrollment in 2002 is in counties where the payment rate is above the floor), payments are still linked to the 1997 AAPCC. Second, from the plan perspective, year-to-year adjustments in payments are volatile; as a result, some plans exit the Medicare market and others are deterred from entering new markets. Finally,

payments vary by county. Commercial plans and those in the Federal Employees Health Benefits Program (FEHBP) base payment on larger geographic units, such as metropolitan statistical areas (MSAs) or plan service areas. Plans operating in large MSAs, with a single provider network, face multiple reimbursement rates. For example, in 2002 the reimbursement rate in Bronx County, New York, will be \$812 per beneficiary; however, in nearby Queens plans will receive only \$735."



"Competitive bidding could alleviate these problems by assuring that plan payments reflect underlying costs and that, over time, payment increases reflect the costs of efficient health plans. Properly structured, the use of competition in Medicare should equate Medicare payments in the M+C sector with the (efficient) cost of delivering services by M+C plans."

“Despite these advantages, the extent to which M+C payment reform will generate federal budget savings is unknown. In concept, competition could reduce growth in Medicare spending in two ways. First, the competitive bidding process could result in additional efficiencies and lower payments to health plans than those established through regulation. Savings then could be realized if Medicare beneficiaries enroll in the lower-price health plans. Second, Medicare could collect additional premiums from beneficiaries choosing to remain in more expensive options. Most reform proposals provide financial incentives for beneficiaries to choose lower-price plans, although many will choose to remain in traditional FFS Medicare. Whether a competitive bidding process would reduce overall Medicare spending depends on the resolution of key design issues and how beneficiaries respond to them.”

“Given beneficiaries’ relative price-insensitivity, enticing them to enroll in M+C plans will require a substantial financial incentive. We now provide this incentive by passing on M+C savings in the form of additional benefits. However, our analysis reveals the difficulty of simultaneously eliminating these ad-

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ditional benefits, inducing additional plan switching, and generating savings to the Medicare program. This task is even more daunting since most reform proposals would include a prescription drug benefit with a uniform subsidy available to beneficiaries in either FFS Medicare or an M+C plan.”

“Under current law, Medicare beneficiaries receive approximately \$1,000, on average, in additional benefits when enrolling in an M+C plan. For these additional benefits, beneficiaries pay an average of \$276 per year in supplemental premiums. Most Medicare reform proposals would convert these additional benefits to cash, in the form of lower premiums. However, to entice additional Medi-

care beneficiaries to enroll in an M+C plan will require an even larger financial reward than under current law. These financial incentives may be structured as a financial ‘carrot’ or a financial ‘stick.’ One option provides financial incentives in the form of lower premiums. Beneficiaries now receive all of the savings generated by M+C plans in the form of lower benefits. Under this option, they would receive 75 percent of the savings in the form of lower monthly premiums, approximately the same ‘value’ provided by M+C plans today. Thus, this approach is unlikely to result in additional M+C enrollment and produces very limited savings to the Medicare program.”

“Other options are more substantial reforms, as they break the link between M+C payments and the FFS market and provide a financial ‘stick’ to move beneficiaries into M+C plans. Beneficiaries choosing to remain in traditional Medicare would face a substantial hike in monthly premiums-ranging from 19 percent to 77 percent-in our illustrative options. However, even under these approaches relatively few additional Medicare beneficiaries would be likely to enroll in M+C plans. This is in part traced to the small relative difference in premiums to purchase Medicare-covered services in the form of an M+C-delivered benefit or through traditional Medicare. These dollar differences are less than the value of additional benefits provided by M+C plans today. On the other hand, these approaches would generate program savings, as they increase premiums paid by beneficiaries when enrolling in Medicare Part B.”

The Rural Wisconsin Health Cooperative,

begun in 1979, intends to be a catalyst for regional collaboration, an aggressive and creative force on behalf of rural communities and rural health. RWHC promotes the preservation and furthers the development of a coordinated system of rural health care, which provides both quality and efficient care in settings that best meet the needs of rural residents in a manner consistent with their community values.

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“None of our results mean that Medicare reform and competitive bidding are bad ideas. These reforms would provide solutions to several important problems facing Medicare. Our results, however, highlight the fact that reforming the M+C payment system is unlikely to generate major federal budget savings absent substantial changes in the program. Each of the options examined produces virtually the same small savings in Medicare spending. The key difference across the proposals is the share of Medicare spending financed by Medicare beneficiaries. Reductions in net Medicare expenditures under reform are likely to occur only through substantial increases in premiums paid by beneficiaries.”

Rural Take Needed On Medicare Reform

From *Redesigning Medicare: Considerations for Rural Beneficiaries and Health Systems, Special Monograph* by the Rural Health Panel of the Rural Policy Research Institute. “They are not building an argument for any particular change in the Medicare program but they are specifying the rural interests to be considered in any proposed change.” The complete text is at <<http://www.rupri.org>>:

“There are two critical elements in which changes in Medicare policy should be considered:

- There is a *continuum of rural places*, which leads to variation in how new policies will affect the residents (including Medicare beneficiaries) of those places.
- There is a *continuum of approaches for changing the Medicare program*, which vary in their reliance on government regulation and/or activities in a competitive marketplace.”

“Each of these elements needs to be understood, and variation in the two continua should structure the specifics of any critiques. In brief, the effects of the Medicare program are wide-ranging, and the impact that changes in the program will have on the existing delivery system is complex.”

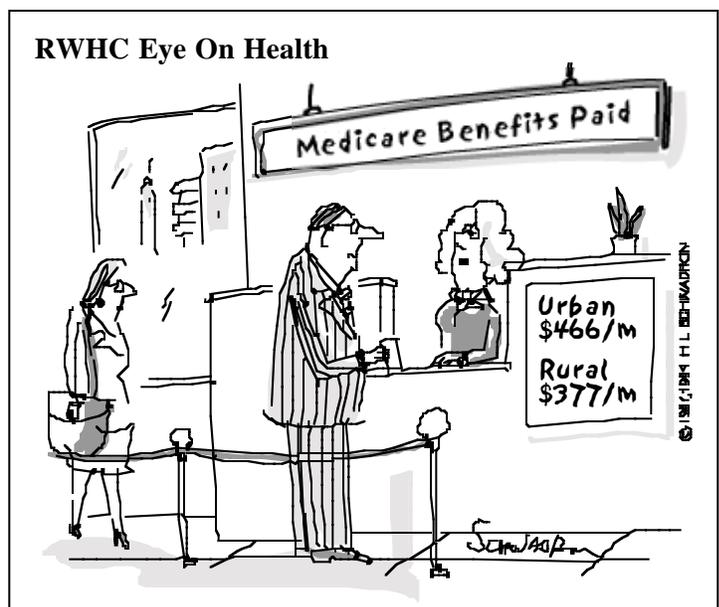
“There are a set of principles that should guide any redesign effort and it establishes the rural meaning of those principles:

1. The Medicare program should maintain *equity* vis à vis benefits and costs among its beneficiaries, who should be neither disadvantaged nor advantaged merely because of where they live.

2. The Medicare program should promote the highest attainable *quality* of care for all beneficiaries, defined in terms of health outcomes for beneficiaries.
3. The Medicare program should ensure that all beneficiaries have comparable *choices* available to them – among health care plans (e.g., benefits covered and out-of-pocket expenses potentially incurred) and among health care providers.
4. The Medicare program should ensure that beneficiaries have reasonable *access* to all medical services, including having essential services within a reasonable distance/time of their residence and being able to afford medically necessary services.
5. The Medicare program should include mechanisms to make the *costs* affordable, both to beneficiaries and to the taxpayers financing the program.”

“In addition, the Medicare program should be governed and administered using rules and structures that include opportunities for all important concerns to be considered, including those of rural beneficiaries and rural health care systems.”

“These principles may generate conflicting goals for public policy. A well-known triangle exists between access, cost, and quality—overemphasis on one principle as a policy goal can easily compromise one or both of the other two. For example, if we were to say access requires a highly skilled health professional no further than 20 minutes or 20 miles from every Medi-



care beneficiary, the delivery system would become quite costly, and some professionals who require continued experience to maintain skills would not get that experience. Issues involved in balancing across policy goals will be considered throughout this monograph. Of note at this point in our discussion, we believe that *no principle need be sacrificed entirely in order to optimize any other principle.*"

Rural Medicare Payment Fixes Decimal Dust

From MedPAC Staff Correspondence 10/31/01:

"At the request of Congressional staff, we have compared the impact of several policy options under consideration on the Medicare inpatient margins of low-volume hospitals and rural hospitals with negative margins. For comparison, we also show the impact of each policy option on all rural hospitals. The policies we considered are:

- A low-volume adjustment (in this case, a maximum 33 percent adjustment for hospitals with up to 600 total discharges per year.)
- Increasing the cap on disproportionate share (DSH) payments from 5.25 percent to 10 percent for rural hospitals (as well as urban hospitals with fewer than 100 beds.)
- Completing the phase-out of wage data for teaching physicians, residents, and certified registered nurse anesthetists from the hospital wage index.

- Reducing the proportion of payments adjusted by the wage index (in this case from 71 percent to 67 percent.)
- Increasing the base payment rate for other urban and rural areas to the level of the rate for large urban areas."

"Our analysis of the effects of scale found an inverse relationship between volume and costs per discharge for hospitals with up to 500 total discharges per year. In our June report we simulated a graduated adjustment to inpatient payments with a maximum 25 percent increase for hospitals with fewer than 500 discharges. At the request of Congressional staff, for this paper we modeled a more liberal adjustment (a maximum 33 percent adjustment for hospitals with fewer than 600 discharges). In our simulation the adjustment is linear, represented by the line between the maximum adjustment at zero discharges and no adjustment at the maximum number of discharges. If a low-volume adjustment were implemented, Congress or CMS would have to specify the exact adjustment formula."

"On the proportion of payments adjusted by the wage index, we recommended in June that CMS study how hospitals purchase inputs—including labor services—in national versus local markets to determine the appropriate labor share. For illustrative purposes here, we simulated a reduction in this labor share from 71 percent to 67 percent. We chose this level because it appears that at least some portion of labor-related cost elements accounting for about 8 percent of hospital costs may be purchased in national rather than local markets; the reduction to 67 percent splits the difference. The appropriate level of adjustment to the labor share should be determined after the input categories included in the labor share are reevaluated."

Impact Of Potential Medicare Payment Policy Changes On Rural Hospitals (2131 hospitals)

<u>Policy option</u>	<u>Change in payments to rural hospitals</u>	<u>Impact on baseline payments (millions)</u>
Low-volume adjustment	0.3%	\$31
Increase DSH cap from 5.25 percent to 10 percent	0.4	156
Complete phase-out of select salaries from the wage index	0.3	36
Reduce proportion of inpatient payments adjusted by the wage index from 71 percent to 67 percent	0.4	48
Equalize base payment rates	1.1	127

Note: Proposal options effect individual rural hospitals differently.

Data: MedPAC Staff Correspondence 10/31/01
Graph: RWHC 11/16/01

"The low-volume adjustment would have by far the biggest impact on payments for the low-volume group, providing a 6.2 percent increase in payments compared with 0.2 to 1.1 percent for the four other options. The amount of money needed to implement a low-volume adjustment (\$31 million) is relatively small because the hospitals involved have so few Medicare discharges. We recommended in June a requirement that low-volume hospitals be 15 miles from another hospital to qualify for the adjustment. Most low-volume hospitals are rela-

Blood Just Business To Red Cross?

tively isolated—with the 15 miles condition, about 80 percent of the 710 low-volume hospitals would qualify. The low-volume adjustment would have a modest impact for rural hospitals with negative margins and all rural hospitals (a 0.3 percent increase in payments for each group) because the impact is concentrated on a subset of hospitals.”

“The other four options have roughly equal impact on each of the three hospital groups. Three of the options (reducing the labor share, completing the phase-out of select salaries from the wage index, and increasing the base rate) would have widespread impact among rural hospitals, but differ in their aggregate impact. The impact of an increase in the DSH cap varies markedly at the hospital-specific level, but does not have a pattern of helping low-volume or negative margin hospitals more than other rural hospitals because the DSH adjustment is not targeted on factors that raise costs for Medicare patients, but rather on revenue loss from treating low-income patients.”

“As modeled here, the five options would have different effects on total spending. The two wage-index related policies are budget neutral but would shift payments from urban to rural hospitals. In order to control for differences in the absolute level of payments associated with each policy, we have looked at the share of new or shifted payments from each option going to rural hospitals with negative inpatient margins. The low-volume adjustment is highest at 32 percent, while the two wage index-related options and the base rate option provide between 27 and 29 percent. The lowest is the increased DSH cap at 23 percent; this reflects the fact that DSH payments are not targeted at a factor raising costs for Medicare patients.”

“Although the low-volume adjustment would help a subset of hospitals substantially, it alone might not provide sufficient assistance. Accordingly, MedPAC recommended in June that this option be used together with our other recommendations: an increase in the DSH cap, removing certain salaries from the wage index, and a possible change in the labor share. Each of these options would improve payments to rural hospitals, and their effect combined with the low-volume adjustment would be even greater. The low-volume adjustment we simulated here would alone raise the inpatient margin of low-volume hospitals to 4.8 percent, nearly comparable to that of all rural hospitals at 5.5 percent. That boost, when combined with the effects of the other options, might make staying in the prospective payment system an attractive option for many hospitals that are or could become critical access hospitals, which by definition have a zero inpatient Medicare margin.”

The following is from a letter which is part of a dialogue between Senator Dale Schultz, representing Wisconsin’s 17th Senate District, and the Red Cross Badger-Hawkeye Region Blood Services.

“Thank you for your reply to my earlier letter; unfortunately it raises more questions than it answers about your 70 to 100 percent price increases.”

“What continues to be very disturbing about American Red Cross blood services is that on one hand you expect your donor communities to be charitable but when you sell it back you suddenly adopt—‘this is just business.’ Why should communities in southwestern Wisconsin continue to subsidize your need for more blood than they use, while you make it very clear that you are not willing to subsidize back the higher costs of serving these donor communities? This is an incredible and unacceptable double standard not worthy of American Red Cross.”

“While there may be nine blood banks in Wisconsin and three neighboring states the critical supply of blood is very much a monopoly within our region. To say otherwise, is not to ‘correct a misconception’ but takes attention away from the primary issue—Wisconsin has been divided into separate non-competing regions. Perhaps a few hospitals have an option where the blood bank service areas abut one another, but most in my district don’t. The obvious consequence is that our communities are experiencing little to no choice, higher costs and less service.”

“While many non-profit organizations are the sole local provider, the public’s interest is protected through community boards. This is not true with Badger-Hawkeye Region Blood Services (serving four states) and given your earlier comments, the remote national office is in fact driving many decisions. There simply is no local accountability.”

“The barriers for competitors to come into southwestern Wisconsin are significant. At a minimum they include: establishing a network of local blood donation sites, establishing a courier system appropriate for the pickup and delivery of a blood as well as the significant capital and professional skills necessary to expand or establish a processing center. I have been told that whether or not it is made explicit, there is also clearly an implied threat or understanding by potential blood bank ‘competitors’—if you enter ‘my’ area I’ll enter ‘yours.’ ”

“Other important questions you have not adequately addressed include: It took ten years to accumulate the debt; why does American Red Cross think it is appropriate to recover it in one or two years? Why should hospitals in the counties I represent be asked to pay such an unfair share of the Red Cross debt? Why do you prohibit these hospitals from entering a group purchasing contract like they can do with most vendors?”

“I now understand better why the hospitals I represent have had such a tough time of getting a straight answer. You claim you are not a monopoly but then you turn around and imply that Red Cross’ superiority is such that you have no ‘competitors’ ”.

“This is a classic if it looks and walks like a duck, it’s a duck. What we have here looks much more like a public utility or at least a community service that should have public oversight comparable to a public utility. To avoid moving in that direction, what are you willing to do so that the charge for blood isn’t dependent upon where people live and receive care? In particular, what will it take for you to offer community hospitals a group purchasing contract, with prices equivalent to higher volume facilities? In addition, would you be willing to invite a representative of the national office to Wisconsin so that they can become sensitized to our local situation and be a part of the solution?”



"It's not complicated: when we do a blood drive we are a charity; when we sell it back we are a business."

“Along those lines, the ‘concierge’ physician practices described in an Oct. 22 special report by reporters Michael Romano and Laura B. Benko are likely to tarnish the image of the medical community. Under these arrangements, affluent people can pay a steep annual retainer for preferred services and special attention. Those wealthy patients like the ability to see doctors whenever they want and to avoid the unpleasantness that ordinary people endure. Participating physicians say the ‘boutique’ practices spare them

payment hassles and ensure that they don’t have to rush their patients.”

“This white-glove treatment would raise fewer eyebrows if this country could provide minimal healthcare coverage to all our citizens. Bioethicist Arthur Caplan of the University of Pennsylvania says it is morally objectionable to direct resources to the prosperous while nearly 40 million Americans can’t pay for basic insurance. ‘I think the healthcare system is teetering toward intolerable stratification,’ Caplan says.”

“Americans have always lived with economic stratification, with the wealthy getting a bigger piece of the pie. But when some people get no piece at all, trouble can ensue. Lawmakers, government agencies and medical associations are understandably beginning to take a long look at concierge practices.”

“Many people also will find it galling to contemplate the assertion that these practices allow doctors to spend more time with patients. The implication is that physicians will lavish their attention on people who shell out the most dollars. And consumers will reason, correctly, that if these doctors were willing to make less money, they could devote all the time they wanted to their patients.”

“Concierge physician practices are completely legal and, with proper regulation and restrictions, should be allowed in a free-market society. But that doesn’t mean these physicians are doing anything good for the profession.”

Lessons From For-Profit Networks

From an editorial in “Not looking good: ‘Boutique’ practices shameful with so many uninsured” Neil McLaughlin, acting editor in *Modern Healthcare*, 10/29/01:

“There are times when some things just don’t look good. Conspicuous consumption in hard times is one of them. Using money to muscle ahead of the common folk for services is another.”

Safer Health Care Starts With Common Sense

Five Steps To Safer Health Care, is a “low tech” approach to improving patient safety that all providers and consumer should memorize and promote according to Dr. Greg Meyer at the second annual conference of the Wisconsin Patient Safety Institute. Dr. Meyer is Director of the Center for Quality Improvement and Patient Safety at the Agency for Healthcare Research & Quality.

“This fact sheet was developed by Federal agencies in the Quality Interagency Coordination (QuIC) Task Force, in partnership with other health care purchasers and providers. The QuIC and its public- and private-sector partners are all working together to make the U.S. health care system safer for patients and the public.”

1. “Speak up if you have questions or concerns. Choose a doctor who you feel comfortable talking to about your health and treatment. Take a relative or friend with you if this will help you ask questions and understand the answers. It’s okay to ask questions and to expect answers you can understand.”

2. “Keep a list of all the medicines you take. Tell your doctor and pharmacist about the medicines that you take, including over-the-counter medicines such as aspirin, ibuprofen, and dietary supplements like vitamins and herbals. Tell them about any drug allergies you have. Ask the pharmacist about side effects and what foods or other things to avoid while taking the medicine. When you get your medicine, read the label, including warnings. Make sure it is what your doctor ordered, and you know how to use it. If the medicine looks different than you expected, ask the pharmacist about it.”

3. “Make sure you get the results of any test or procedure. Ask your doctor or nurse when and how you will get the results of tests or procedures. If you do not get them when expected—in person, on the phone, or in the mail—don’t assume the results are fine. Call your doctor and ask for them. Ask what the results mean for your care.”

4. “Talk with your doctor and health care team about your options if you need hospital care. If you have more than one hospital to choose from, ask your doctor which one has the best care and results for your condition. Hospitals do a good job of treating a wide range of problems. However, for some procedures (such as heart bypass surgery), research shows results often are better at hospitals doing a lot of these procedures.

Five Steps To Safer Health Care For Your Wallet

- Speak up if you have questions or concerns.
- Keep a list of all the medicines you take.
- Make sure you get the results of any test or procedure.
- Talk with your doctor and health care team about your options if you need hospital care.
- Make sure you understand what will happen if you need surgery.

Also, before you leave the hospital, be sure to ask about follow-up care, and be sure you understand the instructions.”

5. “Make sure you understand what will happen if you need surgery. Ask your doctor and surgeon:

- Who will take charge of my care while I’m in the hospital?
- Exactly what will you be doing?
- How long will it take?
- What will happen after the surgery?
- How can I expect to feel during recovery?”

“Tell the surgeon, anesthesiologist, and nurses if you have allergies or have ever had a bad reaction to anesthesia. Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.”

RWHC Quality Program Available Nationally

There are some small to mid-size hospitals throughout the country that are relying on expensive performance measurement systems which are ill suited for their needs. And the costs associated with these programs is sky rocketing, allegedly due to the adoption of JCAHO’s core measures.

This simply does not make sense to us at RWHC. We have been able to incorporate the new core measures into the RWHC Quality Indicators Program at little to no additional cost. And our program is one of only two rural-based performance measurement systems to be accepted for JCAHO accreditation through the ORYX initiative.

With over ten years of experience, our focus is on smaller facilities, so participants can benchmark their performance against their peers. We offer measure sets for hospitals, long-term care facilities,

home care agencies and behavioral health organizations. Critical access hospitals have found the program to be particularly suitable for their needs.

If you know of any hospitals or networks that might be struggling to maintain their performance measurement system, please refer them to the RWHC website (www.rwhc.com) so they can learn more about our affordable Quality Indicators Program. Thanks.

HIPAA Collaborative Of Wisconsin



RWHC with WHA and others have initiated HIPAA COW as a non-profit organization open to Wisconsin health care organizations that meet the definition of Covered Entity and/or Business Associate under the Health Insurance

Portability and Accountability Act (HIPAA). Administrative Simplification standards and rules promulgated will have a significant impact on health care organizations. As required by Congress in HIPAA, the standards cover health plans, health care clearinghouses, and those health care providers who

conduct certain financial and administrative transactions electronically. Compliance with HIPAA Standards for Electronic Transactions is required by October 16, 2002, and compliance with HIPAA Standards for Privacy of Individually Identifiable Health Information is required by April 14, 2003. The mission of HIPAA-COW is to:

- Create consistency among payers and providers regarding HIPAA implementation and develop a common HIPAA implementation vision.
- Facilitate and streamline HIPAA implementation through identification of “best practices” and benchmarking.
- Reduce duplicate efforts among payers and providers.
- Offer opportunities for partnering.
- Identify and elevate regulatory issues to state agencies and the legislature.

More information is at <http://www.hipaacow.org>.

Reminder--December 12, Summit on Bioterrorism by WHA in collaboration with SMS and RWHC at the Alliant Energy Center, Madison (8:00 to 3:30)

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