

## **9. POLICY IMPLICATIONS AND RECOMMENDATIONS**

In this section, we consider the implications of our research findings regarding the Medicare special payment provisions for rural providers and the goals they were intended to address. First, we explore findings regarding possible effects of the special payment policies on access to and costs of care for rural Medicare beneficiaries and implications for Medicare payment policy to further support these goals. Then we present recommendations for additional research to examine some of the specific issues involved with the numerous payment policies and their effects on access and costs of care.

### **IMPLICATIONS OF THE MEDICARE SPECIAL PAYMENT PROVISIONS**

#### **Special Payments for Rural Hospital Inpatient Services**

Despite continuing concerns regarding the viability of the hospital infrastructure in rural areas, the findings of these descriptive analyses offer some evidence of stability in the supply of Medicare-certified hospitals during the 1990s. For example, the number of rural hospitals declined slowly, and hospitals increased staffing levels (which suggests growth in outpatient activity) and diversified into new services. These service changes likely were made to strengthen financial viability and competitive positions. In particular, rural hospitals with Medicare special payment designations appeared to play important roles in the delivery of services to beneficiaries in non-metropolitan counties, as shown by their shares of both inpatient stays and Medicare payments. The question remains about the extent to which these hospitals rely on the special payments for their financial viability.

Another general issue highlighted by the utilization analysis is that of the relationships between geographic access to hospital inpatient care, beneficiary health status, and observed utilization of inpatient services. Clearly, beneficiaries residing in the most remote rural counties, including the frontier counties, have to travel longer distances to hospitals, and access to hospitals with specialty capability may be even more difficult. Despite apparent access challenges, we found that beneficiaries in remote locations and in shortage areas (MUAs and HPSAs) had higher rates of inpatient utilization than other rural beneficiaries. Could this utilization include some hospital stays or rehospitalizations that could have been avoided if they had better access to outpatient services? We also found lower average payments per beneficiary for these beneficiaries, suggesting that their hospital stays were for less intensive procedures or that they were less likely to travel to urban hospitals for care. This issue argues for the special payment provisions for sole community hospitals and rural referral centers to help ensure that such facilities remain available in rural areas.

#### **Effects of Rural Hospital Special Payments on Part A Costs**

In considering the effects of the Medicare special payments for rural hospitals on Medicare Part A spending, we first examined the effects of these payments on hospital payments per inpatient stay, then looked at effects on payments per beneficiary for hospital inpatient services, and finally extended the analysis to effects on total Medicare Part A spending. This stepped approach allowed us to develop an understanding of the factors contributing to the

ultimate effects of these payment provisions on Part A spending for non-metropolitan beneficiaries, including the costs per stay, rates of hospital inpatient utilizations, and the share of Part A spending that was for hospital inpatient services. Variations across counties in these factors also were examined in the analysis.

Overall, the special payments for rural hospitals represented an estimated 2.6 percent of the payments for inpatient services for Medicare beneficiaries residing in non-metropolitan areas. We found wide variation across counties in the effects of the special payment provisions, such that the special payment component represented less than 1 percent of the average payment per inpatient stay for almost half the non-metropolitan counties, whereas it was 5 percent of the average payment per stay for 17 percent of the counties. Special payments were the largest share of Medicare payments in the most remote counties and frontier counties, where access to care poses the greatest challenges. The 2.6 percent of Medicare payments for inpatient services translates to an estimated average 1.9 percent of Medicare payments for all Part A services.

Although the special payment provisions have had a relatively small overall effect on Medicare spending for inpatient services, these provisions have been important for the rural hospitals that qualified for the special payment designation. Without the special payment components, these hospitals would be paid 9.5 percent less per Medicare inpatient stay, on average, which could have a substantial effect on their financial viability. Given that Medicare patients tend to make up a large share of inpatient stays for non-metropolitan hospitals, and that many hospitals operate with small margins, these payments could be very important to them. This issue merits further analysis using Medicare hospital cost report data to estimate effects of special payments on hospital margins.

### **Rural Health Clinics and Federally Qualified Health Centers**

Although RHCs and FQHCs differ in the scope of services they provide and, in many cases, the populations they serve, they both have become important health care resources for rural populations across the country. The supply of RHCs and non-metropolitan FQHCs increased substantially between 1992 and 1998, and the mix of facility types changed. With greater numbers of FQHCs and RHCs delivering primary care services to Medicare beneficiaries across rural areas, Medicare utilization and spending for these services increased accordingly. Medicare spending for all FQHC and RHC services (for rural and urban beneficiaries) was an estimated \$54.5 million in 1991. Spending more than tripled to \$175.8 million in 1994 and doubled again to \$390.3 million in 1998. As of 1991, the highest utilization rates of FQHCs and RHCs were for beneficiaries in the most remote counties (with no town of at least 2,500), which are of special policy interest regarding access to care. The percentage of beneficiaries who used each type of facility also increased over time.

The distribution of Medicare spending shifted toward payments for provider-based RHC services during the 1990s. As of 1998, 28.8 percent of spending was for provider-based RHCs (up from 6.2 percent in 1991), 37.3 percent for independent RHCs (down from 47.1 percent in 1991), and 33.9 percent for FQHCs (down from 46.7 percent in 1991). Even with this shift in shares, the amounts of spending increased for all three types of facilities during this time. The average Medicare spending per beneficiary increased more than sixfold (from \$1.54 per beneficiary in 1991 to \$10.16 in 1998), indicating that only a small portion of the increased spending was due to growth in the size of the beneficiary population. Despite this rapid growth, the Medicare per capita costs remain small, with the 1998 amount of \$10.16 representing less than one dollar per capita on a monthly basis (which is the basis for the AAPCC rates).

## **Physician Bonus Payments**

The trends in physician bonus payments during the 1990s raise issues regarding the ongoing effectiveness of the bonus payment program. Some evidence was found that this program has been successful in supporting primary care providers and services and, possibly, enhanced services for beneficiaries residing in the more remote parts of our country, especially those in HPSAs. On the other hand, low levels of bonus payments in general, coupled with declines in those amounts since 1994, bode ill for its future potential to support physicians practicing in rural areas and, thus, to protect access for rural Medicare beneficiaries. For these goals to be achieved, physicians must use the bonus payments, yet they clearly are not taking advantage of the extra payment amounts available to them. If bonus payments continue to decline faster than basic Medicare payments for physician services, their effects will be further diluted.

Factors that could be contributing to these trends in bonus payments include the extent to which physicians are knowledgeable about bonus payments, the perceived value of the payments to physicians, and effects of administrative procedures on the ease of receiving the payments. Because the bonus payments are administered by the Medicare carriers, policies and procedures for informing physicians, administering payment requests, and auditing appropriateness of payments may vary widely across carriers, which could explain some of the observed regional variation. With the data used for our analyses, we are limited in our ability to explore the relative contributions of such factors to the declining trends in bonus payments.

When considering the policy option of extending bonus payments to NPP services, the small share of Medicare payments for NPP services makes it clear that such a policy would have limited short-term financial impact for Medicare, even if NPPs submitted claims for all eligible services. One might speculate, however, that NPP bonus payments would grow over time because these payments might be a stronger financial incentive for NPPs than for physicians to locate in rural areas.

## **FUTURE RESEARCH NEEDS AND UNANSWERED QUESTIONS**

The Balanced Budget Act of 1997 and the Balanced Budget Refinement Act of 1999 made some significant changes to the ways that Medicare providers are reimbursed for the care they provide. In rural areas, the BBA and the BBRA will have the greatest impact on sole community hospitals, Medicare-dependent hospitals, rural health clinics and federally qualified health clinics. The provisions of the BBA and the BBRA include the following:

- Allowed sole community hospitals to rebase special payments on the basis of the hospitals' costs per discharge for the fiscal year 1996 reporting period, if the hospitals were paid during 1999 on the basis of either their 1982 or 1987 costs per discharges.
- Reinstated and extended the Medicare-dependent hospital designation from October 1, 1997, through October 2001; the BBRA further extended it another five years through October 2006.
- Created the Rural Hospital Flexibility Program through which participating states can regionalize rural health services and designate critical access hospitals (CAHs).
- Refined the definition of what constitutes a qualifying rural shortage area for RHC eligibility.

- Established criteria for determining which clinics may continue as approved Medicare RHCs in areas that lose designation as shortage areas.
- Placed limitations on waivers of some non-physician staffing requirements in clinics.
- Extended the all-inclusive rate and related payment limits to provider-based RHCs except in hospitals with fewer than 50 beds.
- Established rules to prevent “commingling” of RHC and non-RHC resources; and established a quality assurance program (HCFA, 2000).

We can anticipate that these new rules will contribute to changes in the supply and utilization of health care services in rural areas, which will affect access to and costs of services provided in these settings. An analytic capability should be in place to track these changes and extend the trend analysis begun in this research endeavor.

### **Continuing Trend Analyses**

The analyses presented in this report document the historical trends for 1991 through 1998 in utilization of health care services by Medicare beneficiaries in non-metropolitan counties and the associated costs. Recent legislative action in the BBA and BBRA have shifted payment levels and potentially affected access to care in many rural areas.

***Recommendation 1:*** Continue the trend analyses to understand how these legislative changes influence future costs and access to care.

***Recommendation 2:*** Perform a focused analysis of the utilization and Medicare costs of care for CAHs and of the financial viability of these newly designated facilities.

In response to requirements in the Health Centers Consolidation Act of 1996 and to extensive comments received on proposed rules, HRSA is revising the criteria and procedures for designating HPSAs. The methodology is being changed substantially, and HRSA plans to publish a revised proposed rule in the near future. In an early analysis of the impact of changes to HPSA designations by HRSA, an estimated 50 percent of rural counties with a full-HPSA designation would lose that designation (Goldsmith and Ricketts, 1999). Changes to the HPSA definition have the potential to substantially influence access to health care services and affect many of the special payment programs including the bonus payment program and rural health clinics.

***Recommendation 3:*** Model the different criteria for designating HPSAs, and forecast trends in payments under Medicare special provisions for rural providers using these different models.

### **Observing the Impact of Special Payments on Hospital Financial Viability**

Our analyses show that special payment policies are an estimated 1.9 percent of all Medicare Part A payments for services to beneficiaries in non-metropolitan counties. The hospitals receiving the special payments would be paid 9.5 percent less per Medicare inpatient stay, on average, if they were discontinued, which could have a substantial effect on their financial viability. How do the special payment policies influence the fiscal health of individual

hospitals? What are the specific characteristics of those hospitals that remain viable over time? What happens to hospitals that lose their special hospital designations?

**Recommendation 4:** Use hospital cost reports to estimate the contribution of the special payments to hospitals' net margin.

### **Patient Perspective on Care**

The analyses we performed relied entirely on secondary data analyses that used Medicare claims and provider files for non-metropolitan counties. We cannot comment on the perceptions of Medicare beneficiaries in rural areas regarding issues such as quality of care, availability of services, or ease of physical access. We observed in our analyses that approximately 45 percent of Medicare payments for inpatient care received by non-metropolitan Medicare beneficiaries was in hospitals in metropolitan areas. Was their use of metropolitan hospitals consistent with their health care needs? Do rural Medicare beneficiaries have confidence in their local health care providers? Do they feel confident that they will be transferred to another hospital better equipped for their condition should they need it? Does trust in the system indicate the willingness to travel longer distances to get care? Who are the non-metropolitan beneficiaries who travel to metropolitan areas for their care; what conditions do they have and what services do they receive? Do they consistently receive their care in metropolitan areas? Do patients observe a difference when they go to their doctors depending on whether the doctors work in their own offices or whether they are employed by an RHC?

**Recommendation 5:** Conduct beneficiary surveys to gather data on how rural beneficiaries perceive their care, including access to physicians and inpatient care and their perceptions of quality of care.

**Recommendation 6:** Using claims data for Medicare beneficiaries residing in non-metropolitan areas, characterize the types of services received by those who received at least some services in metropolitan areas, with comparisons to those who did not.

**Recommendation 7:** Conduct beneficiary surveys to understand how rural beneficiaries perceive care provided in a physician's office compared to the care provided in an RHC or FQHC.

### **Bonus Payments**

Of all the Medicare special payment programs for rural providers, the bonus payment program appears to have been the least successful. Overall expenditures constituted less than 1 percent of total physician reimbursements in any year and they declined by 1998. Why do eligible physicians choose to claim or not claim a bonus payment? In part, physicians may not be aware that they are eligible to claim the bonus payment for services provided in a HPSA. They may also be reluctant to claim the bonus payment for fear of an audit from the Medicare carrier. Carriers may also play a role in encouraging or discouraging physicians from claiming a bonus payment. The regulatory burden of the bonus payment program is quite substantial compared to the size of the program. Do carriers fulfill their regulatory requirements for the program? Understanding the answers to these questions can be helpful in determining the future of the bonus payment program.

**Recommendation 8:** Survey physicians to gather data on their views about the bonus payments and how this option compares to converting their practice to an RHC, sampling from physicians who claim bonus payments and those who are eligible but do not make claims.

**Recommendation 9:** Interview Medicare carriers to gather data on how they administer the bonus program, issues they believe are important, and their perception regarding the burden it creates for physicians and carriers.

Currently, non-physician providers are not eligible to claim bonus payments for services provided in a HPSA to Medicare beneficiaries. Our analysis of the potential effect of NPPs on the bonus payment program was substantially limited because of data limitations. NPPs may function in their own independent practices or as employees or contractors to physician offices or clinics. Independent NPPs can bill Medicare separately, whereas the physicians or clinics bill Medicare for the services of NPPs that work with them. Until 1998, independently practicing NPPs could bill at 75 percent of the physician fee schedule rate. The BBA increased the rate to 85 percent of the physician's fee, and it also authorized PAs to bill Medicare directly without restriction in all health care settings. PAs are paid an amount equal to 80 percent of the lesser of the actual charge or 85 percent of the physician fee schedule. This fee structure creates a financial incentive for physicians and NPPs to forge relationships so the physicians can bill for NPP services under the higher payment rates for physician services. If NPPs were made eligible for bonus payment, would they be encouraged to bill independently rather than through the physician? Would making NPPs eligible for the bonus payment program increase access to care, particularly primary care?

**Recommendation 10:** Using claims data for a HPSA, including the actual provider of record (rather than the billing provider), analyze the role NPPs play in providing care in those populations and estimate the potential effects of allowing NPPs to claim a bonus payment.

## Data Issues

We were faced with several limitations to our analyses because of the quality of the data available for analysis. The ARF was used to capture county-level characteristics including HPSA and MUA designations. We did not have enough detail in this data to understand the full effects of the special payment policies in partial HPSAs and MUAs. As a result, some of our conclusions were based on the average effect of these policies over a larger geographic region.

Additionally, the HRSA file with MUA designations reflected cumulative designations as of 1998. Using these designations for identifying MUAs in earlier years overestimates their presence. We had more data points to identify HPSA designations over time (1991, 1993, 1995, 1996, and 1997).

**Recommendation 11:** Develop more detailed data on HPSA and MUA designations in each year, including more accurate profiling of partial HPSAs and MUAs.

We had difficulty confirming the counts of RHCs and FQHCs, for which the annual Medicare POS files were the data sources. Our counts tended to be larger than those obtained by others. Our counts probably were higher because we included all facilities that were certified at any time during a year rather than at a point in time during the year (which we did because we were analyzing claims that occurred throughout the year). Also, some facilities may have

discontinued Medicare in previous years but were not removed from the POS files. In addition, the POS counts of FQHCs should be larger than the number of corporate entities with Medicare certification because many of the FQHCs have clinics at multiple locations, with each clinic location having its own Medicare provider number. Each of these clinics is listed separately in the POS file which would yield larger counts than those for the corporate entities that own them. This fact also points out the lack of accessible data on “chain ownership” of Medicare providers.

***Recommendation 12:*** Perform an internal review of data on RHCs and FQHCs in the POS files to assess the extent to which counts of these facilities in the files are inaccurate, including checks for facilities that are no longer Medicare-certified and for multiple clinic locations owned by larger organizations.