

**Section I: Health System Savings**

***Ensuring Appropriate Payment – Adjusting Annual Market Basket Update***

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> <li>• Reduce or eliminate market basket updates in 2010 for provider payment               <ul style="list-style-type: none"> <li>○ Adjust from MedPAC recommended levels</li> <li>○ Accomplish over multiple years</li> </ul> </li> <li>• Establish differential payment updates for low and high-margin areas for fiscal year 2010 and in additional years</li> </ul>	<ul style="list-style-type: none"> <li>• Policies deriving savings from provider payment should account for differences in current and expected margins such that low margin but essential rural providers are not threatened.</li> </ul>

***Ensuring Appropriate Payment – Updating Payment Rates for Home Health Services***

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> <li>• Implement MedPAC recommendations regarding adjustments in 2010 and contemplate further adjustments given current levels of payment in the system</li> <li>• Direct Secretary to “re-base” home health payments to better reflect number and mix of services and level of intensity to take into account relative margins related to specific conditions and service areas</li> <li>• Establish a provider-specific annual cap on the number of allowable outlier episodes in a year</li> </ul>	<ul style="list-style-type: none"> <li>• Accounting for differences in conditions and service areas should be sensitive to special circumstances in serving sparsely populated rural areas, which often include substantial drive times for a home visit and therefore fewer visits per day.</li> </ul>

***Ensuring Appropriate Payment – Updating Payment Rates for Inpatient Services***

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> <li>• Adjust current GME and DSH payment levels to better reflect actual costs hospitals currently incur in treating low-income and uninsured patients and in training medical residents</li> <li>• Adjust DSH payment levels over time as need for resources decreases as more individuals become insured as result of health care reform</li> <li>• Consolidate Medicare and Medicaid payments to hospitals as way to streamline and better account for and coordinate federal funding within DSH and GME payment</li> </ul>	<ul style="list-style-type: none"> <li>• Any change in DSH policy, including downward adjust over time, creates an opportunity to make all hospitals, including Critical Access Hospitals (CAHs), eligible for DSH payments. CAHs are not currently eligible for DSH because they are not paid under PPS, but if the policy purpose of these funds is to cover the costs of treating the uninsured, CAHs should be eligible for payments.</li> </ul>

**A Rural Perspective/Commentary Regarding (Description of Policy Options)**  
**“Financing Comprehensive Health Care Reform: Proposed Health System Savings and Revenue Options**  
**Senate Finance Committee, May 20, 2009**

**Section I: Health System Savings**

***Ensuring Appropriate Payment – Adjusting Reimbursement for High-Growth, Over-Valued Physician Services***

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> <li>• Implement reforms that appropriate value services, such as MedPAC recommendation to increase utilization rate for calculating the payment for advanced diagnostic imaging services</li> <li>• Establish expert panel to assist CMS in evaluating and adjusting payment for potentially misvalued physician services</li> </ul>	<ul style="list-style-type: none"> <li>• If income of physicians in shortage and underserved areas is reduced as a consequence of capturing savings, it could result in increased difficulty recruiting and retaining physicians in these areas.</li> </ul>

***Ensuring Appropriate Payment – More Appropriate Payment for Durable Medical Equipment***

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> <li>• Explore options to improve payment accuracy for DME items and services</li> </ul>	<ul style="list-style-type: none"> <li>• Exploring accuracy in payment for services in rural areas should account for increased costs of providing DME due to distance to clients and low volume.</li> </ul>

***Capturing Productivity Gains***

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> <li>• Include requiring annual market basket adjustments for certain fee-for-service providers be adjusted by some or all of expected productivity gains as a way to improve accuracy of Medicare payments: options could include requiring adjustments beginning fiscal year 2011 and in subsequent years or requiring change one for a set time period</li> </ul>	<ul style="list-style-type: none"> <li>• A single productivity adjustment should be based on verification of productivity gains across all providers regardless of size and geographic location.</li> </ul>

***Reducing Geographic Variation in Spending***

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> <li>• Adjust Medicare Parts A and B spending per beneficiary to reflect differences in the price of inputs and health status of the local population in areas where spending is above a threshold compared with the national average</li> <li>• Require spending reductions for individual providers who are above a certain threshold in spending compared to their peers in their local area</li> <li>• Weigh these options against delivery system reform options under consideration which are also intended to reduce geographic variations in spending</li> </ul>	<ul style="list-style-type: none"> <li>• Current methods of assessing health status rely on claims history; typically an individual with more claims will appear to have poor health status. Adjustments based on claims history will result in lower payment in places where use is affected by lack of access to services. Therefore prior utilization is not an appropriate indicator of health status, especially in rural areas.</li> <li>• A modest percentage of savings captured by these options could be dedicated to leveling payment between high-spending urban and low-spending rural areas, thereby both addressing current inequities and increasing the financial rewards for providing services in rural areas.</li> </ul>

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 Senate Finance Committee, May 20, 2009**

**Section II: Options to Modify the Exclusion for Employer-Provided Health Coverage**

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> <li>• Limit value of employer-provided health coverage excluded from gross income based on the value of the plan or the income of the insured, or a combination of both</li> <li>• Limit exclusion from gross employer income based on percentage of value of the employer-provided health coverage, based on actuarial value of a benchmark plan</li> <li>• Apply limit only to taxpayers whose incomes exceed a threshold income level</li> <li>• Limit the exclusion based on both the value of employer-provided health insurance and the income of the taxpayer</li> <li>• Limit exclusion to a percentage of the total premium for health insurance coverage obtained through the employer for all taxpayers</li> <li>• Committee could discuss limits on exclusion that consider geographic variations in cost of living, including medical costs, in any option</li> <li>• Could reformulate exclusion as a tax credit, a tax deduction, or a combination of the two</li> <li>• Any change to exclusion could grandfather the exclusion for employer provided health insurance coverage a group plan maintained pursuant to one or more collective bargaining agreements in effect when the change is enacted</li> </ul>	<ul style="list-style-type: none"> <li>• The actuarial value of plans offered in rural and urban areas is currently not comparable; the overall actuarial value of plans offered in nonmetropolitan counties is 79.9%, compared with a value of 83.9% in metropolitan counties.<sup>1</sup> When considering geographic variation in setting policy the committee should consider market factors influencing premiums as well as benchmark actuarial value.</li> </ul>

<sup>1</sup> Gabel J, McDevitt R, Gandolfo L, et al. (2006). Generosity and adjusted premiums in job-based insurance: Hawaii is up, Wyoming is down. *Health Affairs*, 25 (3), 832-843.

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**Section III. Other Health Care Related Revenue Raisers**

***Modify the Requirements for Tax-Exempt Hospitals***

Proposed Option	Rural Commentary
<ul style="list-style-type: none"> <li>• Codify organizational and operational requirements for determining charitable organization status to include, among other things that hospitals:               <ul style="list-style-type: none"> <li>○ Regularly conduct a community needs analysis</li> <li>○ Provide a minimum annual level of charitable patient care</li> <li>○ Not refuse service based on a patient’s inability to pay</li> <li>○ Follow certain procedures before instituting collection actions against patients</li> </ul> </li> <li>• Certain hospitals critical to communities they serve or which have an independent basis for tax exemption (educational or scientific research organization) are excluded from minimum charity care requirement</li> <li>• Provide for excise taxes or “intermediate sanctions” to encourage compliance with operational requirements</li> </ul>	<ul style="list-style-type: none"> <li>• The requirement for minimal level of charitable patient care should apply to all hospitals providing patient care; this should be done in tandem with changes to Medicare DSH eligibility making hospitals eligible for DSH payments.</li> <li>• A requirement to conduct a community needs analysis, while appropriate, implies a cost to small charitable hospitals in rural areas; this may be met through collaboration with regional or state organizations that can provide appropriate tools and technical assistance for analysis, if appropriately funded.</li> </ul>