Connecting Dots: The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (DIMA) And Achieving Stability in Rural Health Care Systems And Rural Communities

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CONTEXT

- Major investment in the Medicare program -- $400 billion minimum over 10 years
- Major change to Medicare entitlement – include a prescription drug benefit
- Major shift in thinking about the Medicare program
  - Includes income-scaled contributions from beneficiaries
  - Squeezes out others who have been selling prescription drug coverage
  - Pushes two new ways of thinking about Medicare payment
    - To private sector companies who will use different approaches to payment
    - Toward payment for performance

SO WHERE DO STATES FIT INTO THE PICTURE?

First Principles:

- States and their localities – quality of life linked to health care
- State budgets – costs of health care

  Broader Picture
- Helping health care providers
- Service to citizens
  - Medicare beneficiaries
  - Low income residents

DIRECT IMPACTS ON STATES

Medicare will assume the prescription drug benefit for dually eligible persons in 2006

HOWEVER: States will contribute to the fund that pays for those benefits, initially at 90% of what would otherwise have been spent, then to 75%

Medicaid revenues

Disproportionate Share (DSH) allotments increased by 16% in FY 2004 and then at that amount after

Increase in the floor DSH payment by 16%

HOWEVER: These are based on Medicaid spending, which means the state expenditures must increase to generate the federal match.

The federal government will pay $250 million each year 2005 – 2008 for emergency service to undocumented aliens.

HOWEVER: The payment is directly to providers.

IMPACTS ON RURAL HOSPITALS

- Increased payment for all: standardized payment
- Increased payment for all: DSH floor increased from 5.25% to 12%
- Wage Index changes
  - Labor share redefined to 62% (from 71%)
  - One time reclassification
  - Commuting Patterns formula
- Low Volume Adjustment
- Rural Community Hospital Demonstration Program
  - Fewer than 51 beds
  - Different payment methods
- Hold harmless for outpatient PPS

THE RURAL HOSPITAL FLEXIBILITY (FLEX) PROGRAM

- Reauthorized for 4 years (beginning with 2005) at $35 million per year
- Includes the small hospital improvement program
- Increased payment for CAHs
- Benefits of stable revenue flow to CAHs
  - Allows Periodic Interim Payments
  - Coverage for all on-call emergency personnel
- Key provision on ending the state waiver authority for distance requirement, effective January 1, 2006

PHYSICIAN PAYMENT

- All will be increased in 2004 and 2005 by 1.5% instead of decreased over 4%
- Floor established for the geographic adjustment for the work component
- New program to pay an additional 5% for physicians practicing in areas with fewest beneficiaries
- The 10% bonus payment is automatic in counties designated as shortage areas

AMBULANCE PAYMENT

- Calculating a blended rate of national and regional schedules to use if higher than national
- Payment increased for trips longer than 50 miles
- Increase base payment in rural areas with lowest population densities
- Increase payment for ground ambulance services in rural areas by 2%
- Covering rural air ambulance services

OTHER PAYMENT POLICIES

- Frontier Extended Stay facilities will be paid
- Moratorium on capping payment for therapy extended through calendar year 2005
- Payment for home health updates will be full market basket through the first quarter of 2004, then reduced by 0.8 percentage points
- Payment for home health services in rural areas increased by 5% from April 1, 2004, through March 31, 2005
- Wrap around payment for the reasonable costs of care to Medicare managed care patients

REGULATORY CHANGES

- Prescription plans to permit any willing pharmacy to participate
- A nurse practitioner can be designated as the attending physician in a hospice
- Each Medicare Advantage organization is required to have an ongoing quality improvement program

BACK TO THE BIG PICTURE: BENEFITS TO RURAL BENEFICIAIRES

- 75% of rural prescription drug plan enrollees have to have a pharmacy within 15 miles of their residences
- All plans must permit enrollees to receive benefits through a community pharmacy
- Information comparing plans must be provided through special outreach efforts
- Coverage is authorized for: initial preventive examination, cardiovascular screening blood tests, diabetes screening tests, and mammography services

ADVANCING THE PRIVATE SECTOR MODEL

- Secretary ensures at least 2 qualifying private plans offer the new benefits in all areas of the country, and only when that cannot be done negotiates with a “fallback plan”
- Secretary establishes a fund to attract Medicare Advantage plans to stay in certain areas
- Demonstration of competitive bidding in 2010
- Durable medical equipment will be purchased through competitive contracting, with exception for rural areas
- Medicare specialists will be assigned to Social Security Offices to assist beneficiaries

PAYMENT LINKED TO QUALITY

- Advantage in one time reclassification to hospitals reporting on the quality indicators
- Advantage in PPS updates to hospitals reporting on quality indicators
- Demonstration program to examine factors which encourage delivery of improved patient care quality
- 3 projects to evaluate methods to improve quality of care provided to beneficiaries with chronic conditions (one must be rural)

PAY FOR PERFORMANCE

- IOM to study drug safety and quality, including evaluating approaches to reduce medication errors and strategies to achieve drug safety goals
- IOM to evaluate leading performance measures and options to implement policies that align payment with performance

CONSIDERING THE FUTURE

- A “Citizen’s Health Care Working Group” to be established and funded in fiscal years 2005 and 2006 to produce reports regarding expanding coverage options, the cost of health care, innovative state and community strategies to expand coverage or reduce costs, and the role of evidence-based medicine and technology in improving quality and lowering costs.

CONCLUSION

- Mixed bag of good news and bad news for states
- Mixed bag of good news and bad news for providers
- It's what we make of it from here.

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