

2015 DISTINGUISHED FACULTY LECTURE



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**HEALTH SERVICES RESEARCH MEETS POLICY
AND PRACTICE TO BENEFIT RURAL PEOPLE**



THE UNIVERSITY
OF IOWA

College of Public Health











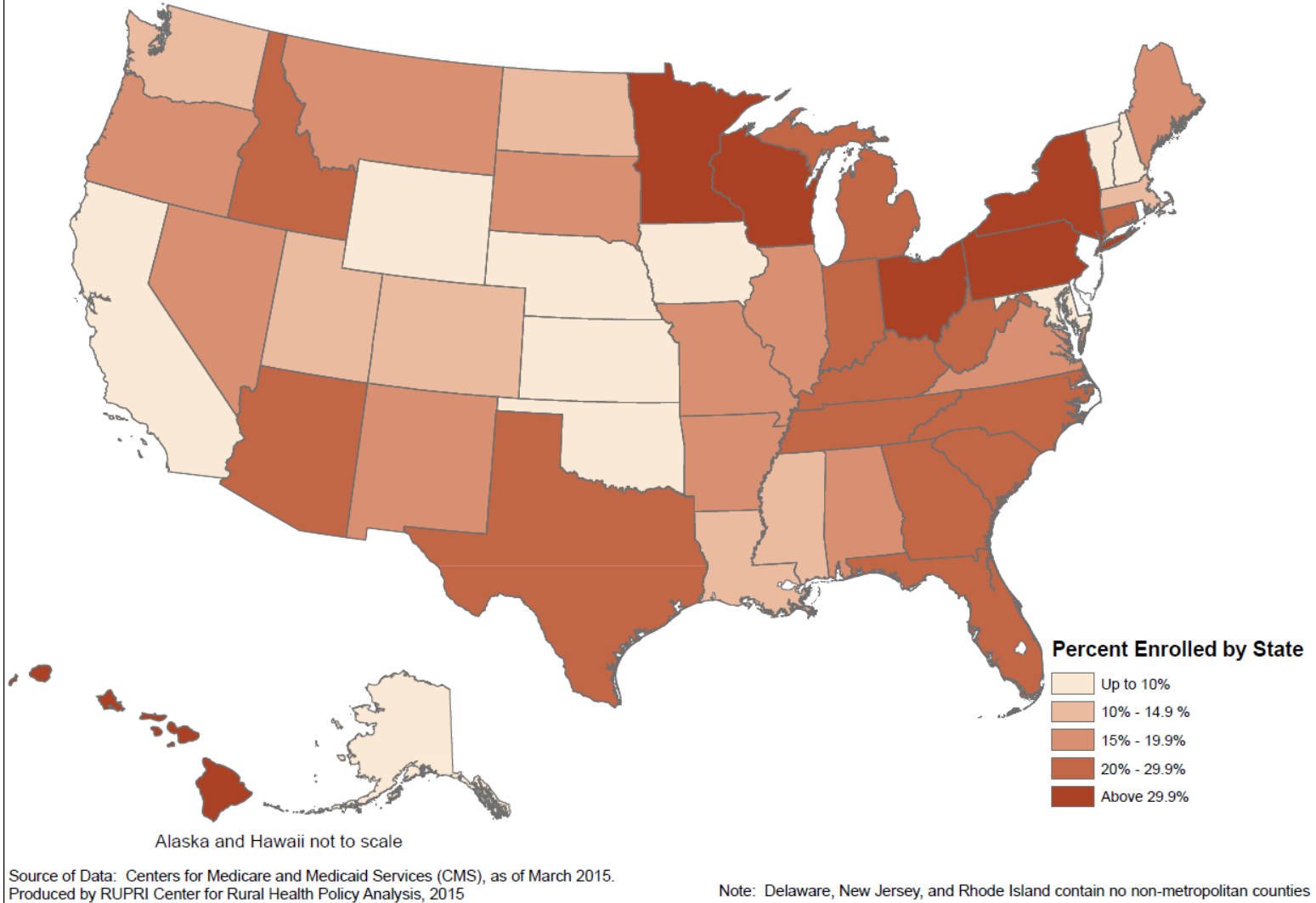






National Map of MA Enrollment

Percent of Eligible Non-Metropolitan Beneficiaries Enrolled in Medicare Advantage by State, March 2015



Iowa Map of MA Enrollment

Percent of Eligible Medicare Non-Metropolitan Beneficiaries Enrolled in Medicare Advantage in Iowa, March 2015

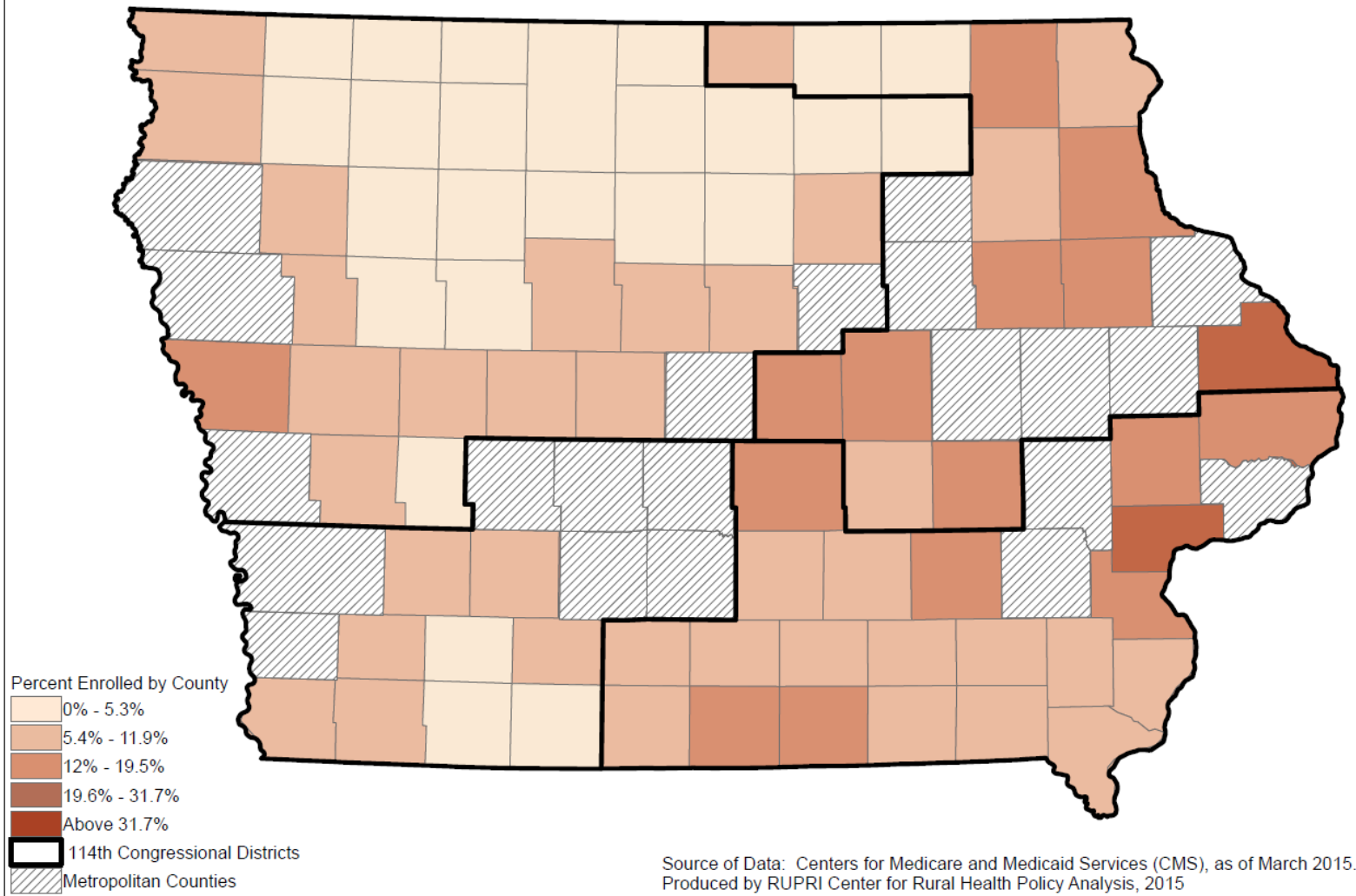
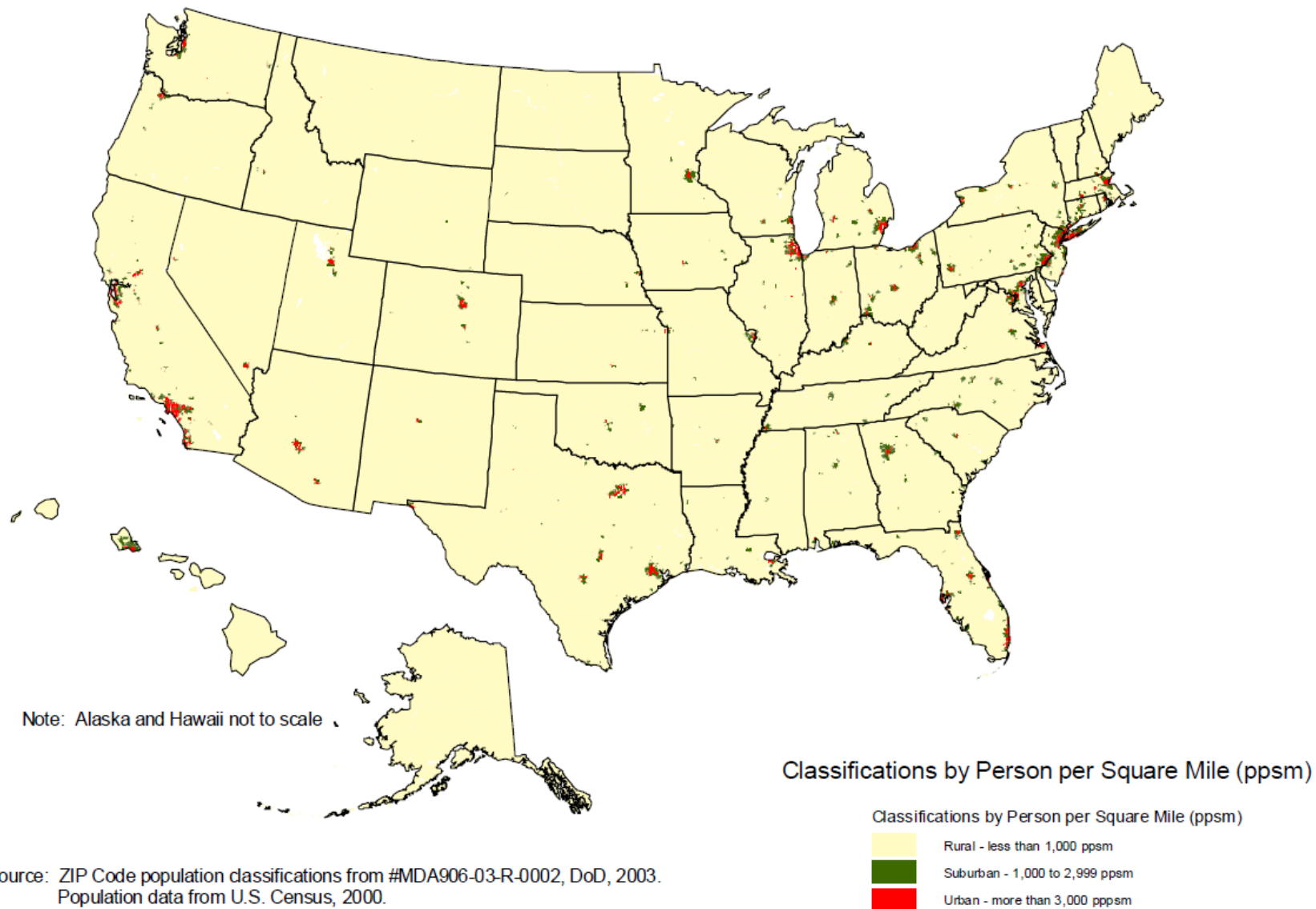


Figure 1: Rural Areas as Defined by the TRICARE Retail Pharmacy Program



Source: ZIP Code population classifications from #MDA906-03-R-0002, DoD, 2003.
Population data from U.S. Census, 2000.
ZIP code spatial files based on U.S. Census ZIP Code Tabulation Areas, 2000.
Cartography: RUPRI Center for Rural Health Policy Analysis, 2004.

Figure 2: Rural Areas as Defined Using the Office of Management and Budget (OMB) Category of Nonmetropolitan, 2003

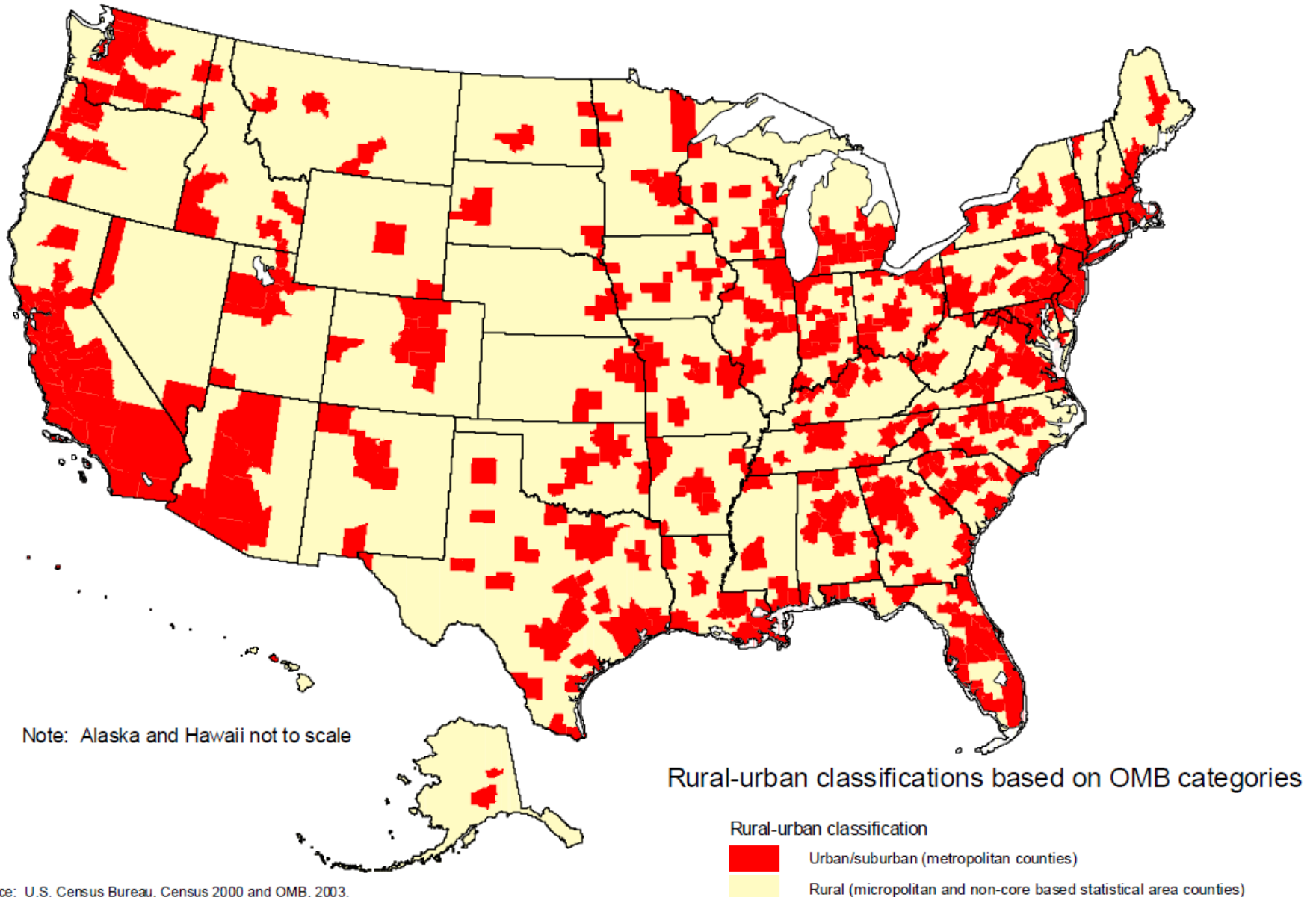
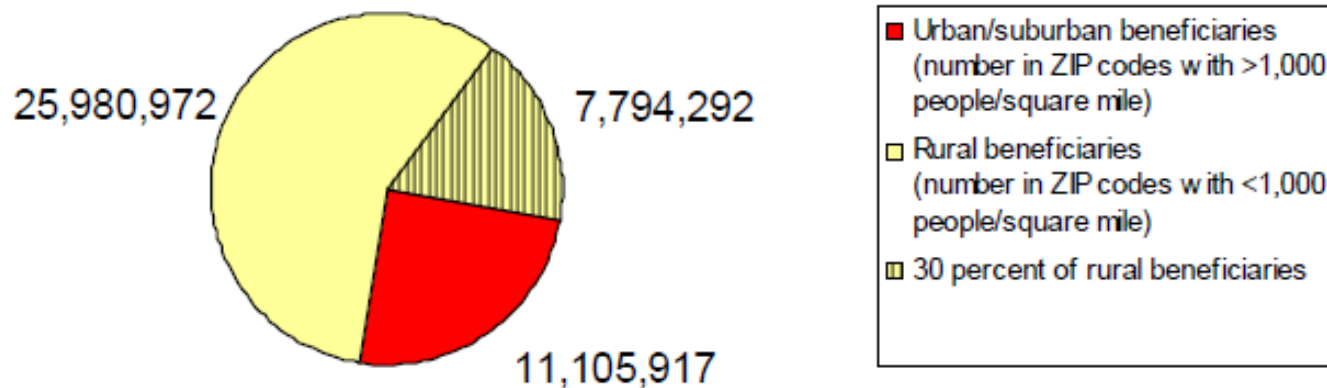


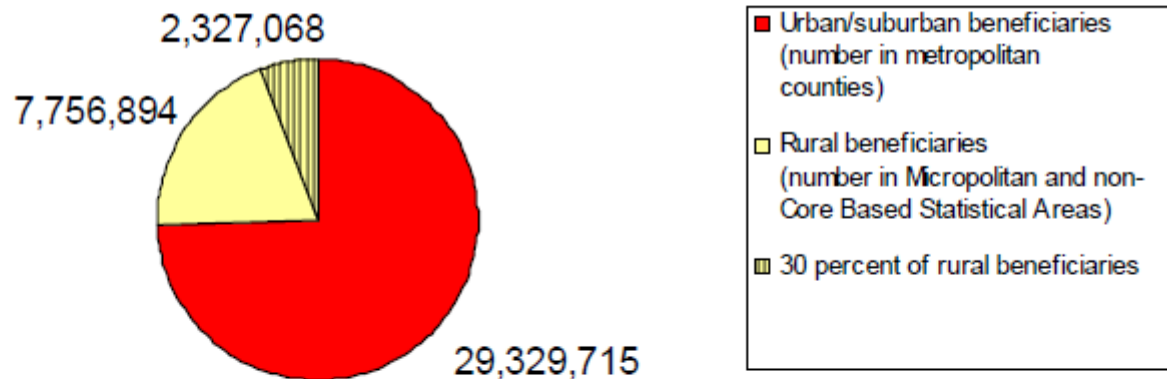
Figure 3: Medicare Beneficiaries Categorized as Residing in a Rural Area, Using the TRICARE Definition of Rural



Source: Claritas PopFacts, 2003.

Note: The figure presents the number of people aged 65 years and older as a proxy for Medicare beneficiaries. The actual number of beneficiaries will vary slightly from these estimates, as the estimates include the few individuals in this age category that do not qualify for Medicare, and do not include beneficiaries younger than 65.

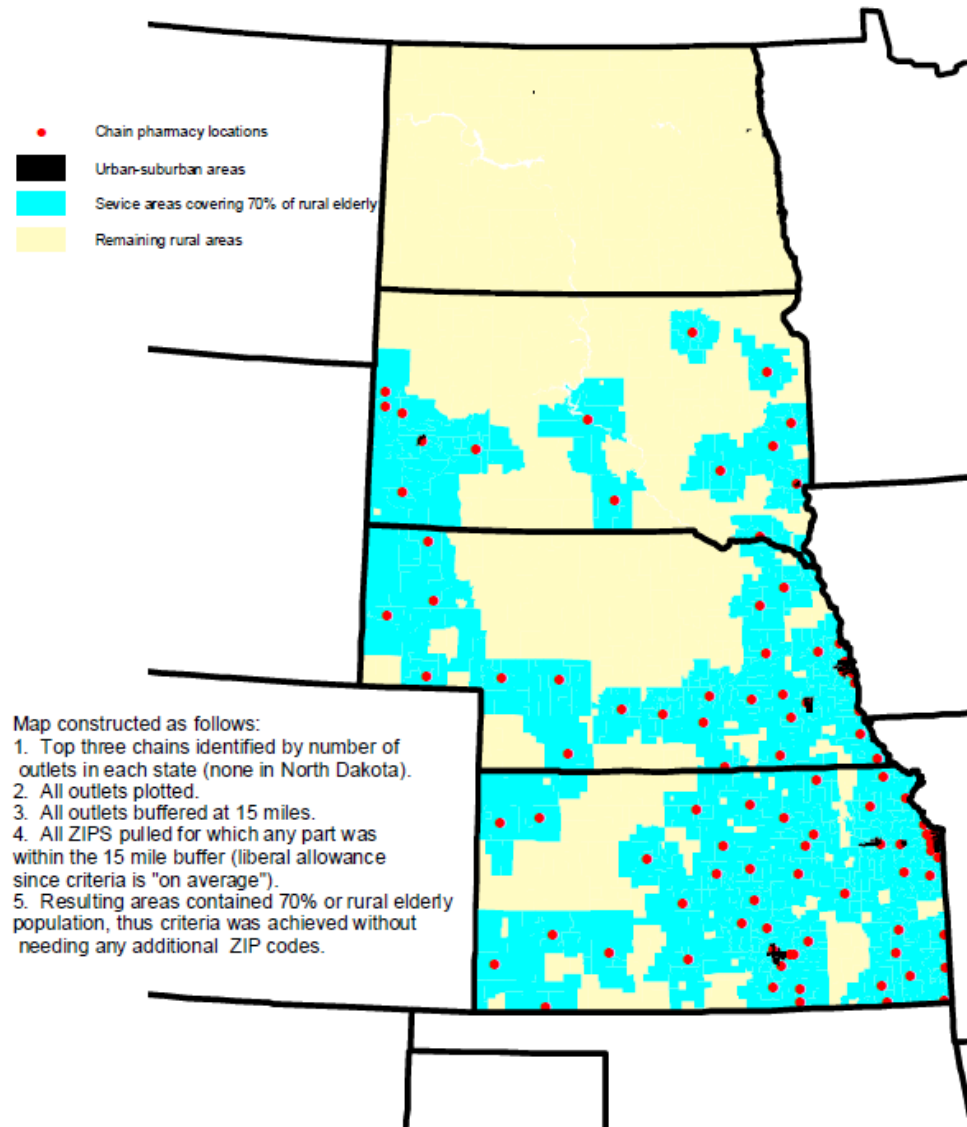
Figure 4: Medicare Beneficiaries Categorized as Residing in a Rural Area, Using the Office of Management and Budget Definition of a County as Nonmetropolitan



Source: Claritas PopFacts, 2003.

Note: The figure presents the number of people aged 65 years and older as a proxy for Medicare beneficiaries. The actual number of beneficiaries will vary slightly from these estimates, as the estimates include the few individuals in this age category that do not qualify for Medicare, and do not include beneficiaries younger than 65.

**Figure 5: Hypothetical Areas That Must be Served,
Using TRICARE Definition of Rural, Assuming Drug Plans
Contract With Largest Chain Pharmacies in a Multi-State Region**



The High Performance System

- **Affordable:** to patients, payers, community
- **Accessible:** local access to essential services, connected to all services across the continuum
- **High quality:** do what we do at top of ability to perform, and measure

The High Performance System

- **Community based:** focus on needs of the community, which vary based on community characteristics
- **Patient-centered:** meeting needs, and engaging consumers in their care

Approaches to Achieving the High Performance System

- Community-appropriate health system development and workforce design
- Integrated programs and governance
- Flexibility in facility or program designation to care for patients in new ways
- Financing models promote investment in delivery system reform

Policy Considerations:

System development and workforce

- Medicare Shared Savings Program improvements to engage rural providers, including CAHs, RHCs, FQHCs
- Continue developments in payment to support redesigned rural primary care systems, such as payment for care management

Policy Considerations:

System development and workforce

- Federal support for training a new health care workforce
- Federal research and planning related to workforce incorporate all participants in the workforce
- Grants programs support system development: Federal Office of Rural Health Policy Network and Outreach Grants, State Innovation Models (CMMI), Community Transformation Grants (CDC)

Policy Considerations: Governance and Integration

- Capital available through federal programs targeted to rural providers and places engaged in service integration and redesign
- Grant funding directed to collaboration among local provider and service organizations
- Federal task force review governing requirements for all types of health care and human service entities to identify inconsistencies in required composition

Policy Considerations: Governance and Integration

- White House Rural Council discuss new approaches to designing programs across agencies such that funding streams are easily merged
- Additional means of aggregating capital for local investment be explored



Policy Considerations: Flexibility in Facility or Program Designation

- Learn from demonstrations of Frontier Extended Stay Clinic and Frontier-Community Health Integration Project to establish new designations and associated payment policies
- Reconfigure some rural hospitals to medical hubs to provide essential local services that do not include inpatient hospitalization, requires changes in regulatory and payment policies
- Implement Sections 2703 and 3502 of the ACA to encourage rural innovation in medical homes

Policy Considerations:

Financing models promoting investment in delivery system reform

- In value based purchasing approaches use achievement and improvement in tandem to assess value
- New payment models should be designed, demonstrated, and implemented to facilitate transition to high performance systems
- Incentives for investment in information systems, personnel and physical infrastructure associated with meeting needs of populations outside of the “four walls” of hospitals and fixed-place clinics







Humboldt County, CA





