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The Future of Rural Health: The MMA As a Change Agent

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Acknowledgements

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The Future is Descending Upon Us

- Private Sector: Leapfrog, Business Coalitions, Insurance Company Consolidation
- Public Sector: Medicaid, Medicare, Veterans Administration, TRICARE
- Intersection: National Quality Forum, Joint Commission for Accreditation of Healthcare Organizations, National Council on Quality Assurance
- Uninsured: Community burden

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Key Rural Driver is Medicare

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- People
- Impact as a pace setter

Categories of MMA Impact

- Delivery System
- Beneficiaries
- Intermediaries
- Communities

Follow the Money

- Don't need an FBI informant to figure this one out
- Direct and indirect effects
- Incentives and disincentives
- Stakeholders with leverage
- Purpose of any investment

Aligning with Objectives

- MMA has very general objectives
- A bit more specific from national agencies such as CMS
- But really determined ***locally***
  - Intentional planning
  - Ad hoc default

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MMA and Effects on the Rural Health Care Delivery System $$$$ To Stabilize

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Hospital Payment for PPS Hospitals

- Change in standardized payment
- Increase in the DSH cap from 5.25% to 12%
- Wage index applies to 62% instead of 72% of DRG payment
- Low volume adjustment

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Ambulance Payment

- Blended rate of national and regional schedules; use national if higher
- Payment increased for trips exceeding 50 miles
- Increased 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

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Physician Payment

- Update factor set to 1.5% for 2004 and 2005
- Geographic practice index for work has minimum value of 1.0 until 1-1-07
- Bonus of 10% in shortage areas becomes automatic
- Additional 5% in scarcity areas

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Critical Access Hospital provisions

- 101% cost reimbursement
- Reimburse on call Physician Assistants, Nurse Practitioners, Certified Nurse Specialists
- Periodic interim payments
- Changes in all inclusive billing

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Issues in payment policy that remain

- Payment for outpatient PPS – no replacement policy for the hold harmless provision
- Payment equity for physicians – reports from GAO may provide answers
- Specific issues for CAHs, such as payment for lab services outside the CAH
- Payment for telehealth services
- Appropriate payment for home health services in sparsely populated areas

MMA and Effects on the Rural Health Care Delivery System

Efforts to Shift Attention to Patient Safety and Quality

Chronic Care Improvement Program

- Nine program models in areas that include rural counties in Georgia, Mississippi, Oklahoma, and Tennessee
- Performance-based contracting
- Care management on behalf of FFS Medicare beneficiaries
- Awards to large Disease Management companies
- Bring this to community level in rural?

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Efforts to Shift Attention to Patient Safety and Quality

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Medicare Health Care Quality Demonstration

- "Identify, develop, test, and disseminate major and multi-faceted improvements to the entire health care system" (from a CMS request for information)
- Two rounds, 8-12 organizations
- Currently reviewing responses to request for information and writing request for proposals

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Efforts to Shift Attention to Patient Safety and Quality

Consumer-Directed Chronic Outpatient Services

- Improve quality of care to beneficiaries with chronic conditions by permitting them to direct their own health care
- Requires evaluation of best practices used by group health plans, Medicaid programs, or other methods first
- To be initiated within 2 years of the legislation

MMA and Effects on the Rural Health Care Delivery System

Efforts to Shift Attention to Patient Safety and Quality

Care management performance demonstration

- Encourages physician adoption of health information technology and use for
  - Promoting continuity of care
  - Stabilizing medical conditions
  - Preventing or minimizing acute exacerbations of chronic conditions
- There will be four sites, including 1 rural and 1 in Arkansas

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A Predecessor to MMA: Physician Group Practice Demonstration

- From the Benefits Improvement and Protection Act of 2000 (BIPA)
- Reward physicians for improving health outcomes
- Including groups in Billings, MT, Danville, PA, and Marshfield, WI
- Has withstood challenge of distribution of savings

Summary for Systems

- Fiscal stability requires continuous vigilance, but is improved by MMA
- Questions of investment of resources
- Clear signals to invest in safety and quality

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MMA and Impacts on Beneficiaries
$$$$ Coverage for Prescription Drugs

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Basic benefit

- Monthly premium of approximately $35-37
- Deductible of $250
- Copayment up to $3,600 out-of-pocket ceiling

Table 1. Overview of Low-Income Part D Benefits, 2006

Low-Income Subsidy Levels	Monthly Premium	Annual Deductible	Copayments
Full-benefit dual eligible; Income up to 100% FPL ($9,570/individual in 2005)	$0	$0	$1/generic $3/brand-name; no copays after total drug costs reach $5,100
Full-benefit dual eligible; income greater than 100% FPL	$0	$0	$2/generic $5/brand-name; no copays after total drug costs reach $5,100
Income less than 135% FPL ($12,920/individual in 2005) and assets <$6,000/individual; $9000/couple	$0	$0	$2/generic $5/brand-name; no copays after total drug costs reach $5,100
Income 135%-150% FPL ($12,920-$14,355/individual in 2005 and assets <$10,000/indiv; $20,000/couple	sliding scale up to ~ $37	$50	15% of total costs up to $5,100 catastrophic limit; $2/generic $5/brand-name thereafter
All others (non-subsidy eligible)	~ $37	$250	25% up to initial coverage limit; 100% up to $3,600 out-of-pocket spending

Source: Kaiser Family Foundation summary of Part D low-income subsidies in 2006.

Table 2. Drug Benefit Savings for a Beneficiary with $2,400 in Drug Spending

Beneficiary Group	Annual Spending	Out-of-Pocket Spending Under Part D	Percentage Savings After Premium	Dollar Savings After Premium
Beneficiary with standard coverage with incomes at or above 150% of FPL	$2,400	$697.50	53%	$1,262.50
Beneficiary with income under 150% FPL and low assets	$2,400	$348.50	77%	$1,831.50
Beneficiary with income below 135% FPL and low assets or beneficiary dually eligible for Medicaid above 100% FPL regardless of assets	$2,400	$109.85	95%	$2,290.00
Beneficiary dually eligible for Medicaid with income at or below 100% FPL	$2,400	$62.77	97%	$2,337.23
Beneficiary who is dually eligible for Medicaid and a nursing home resident	$2,400	$0	100%	$2,400.00

Source: Final Rules Implementing the New Medicare Law: A New Prescription Drug Benefit for All Medicare Beneficiaries, Improvements to Medicare Health Plans and Establishing Options for Retirees. Medicare Fact Sheet. January 21, 2005. Accessed July 21, 2005 at <http://www.cms.hhs.gov/media/press/release.asp?Counter=1324>.

Explanatory Notes: $2,400 is close to the projected median spending for all beneficiaries in 2006. Beneficiary out-of-pocket and percentage savings assume 15% cost management savings by Part D plans, through price discounts and utilization management. Premium for the 150% FPL group is assumed to be in the middle of the sliding scale between $0 and $440. The out-of-pocket calculation for the 135% FPL and 100% groups assumes an average prescription price of $65 and an average co-pay of $3.50 and $2, respectively. The "percentage savings after premium" column differs from other numbers presented in the text because it reflects an individual case and includes premium, whereas the text represents average coverage across the various income groups and does not include premium.

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MMA and Impacts on Beneficiaries $$$$ Coverage for Prescription Drugs

Particular rural relevance

- 9,008,480 rural beneficiaries
- 12% of elderly beneficiaries in households with below poverty incomes
- 14% have incomes between 100% and 150% of poverty
- Rural beneficiaries more likely than urban to users of prescription drugs
- Rural beneficiaries less likely to have current coverage, and spend more out-of-pocket

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MMA and Impacts on Beneficiaries Needing to Make Choices

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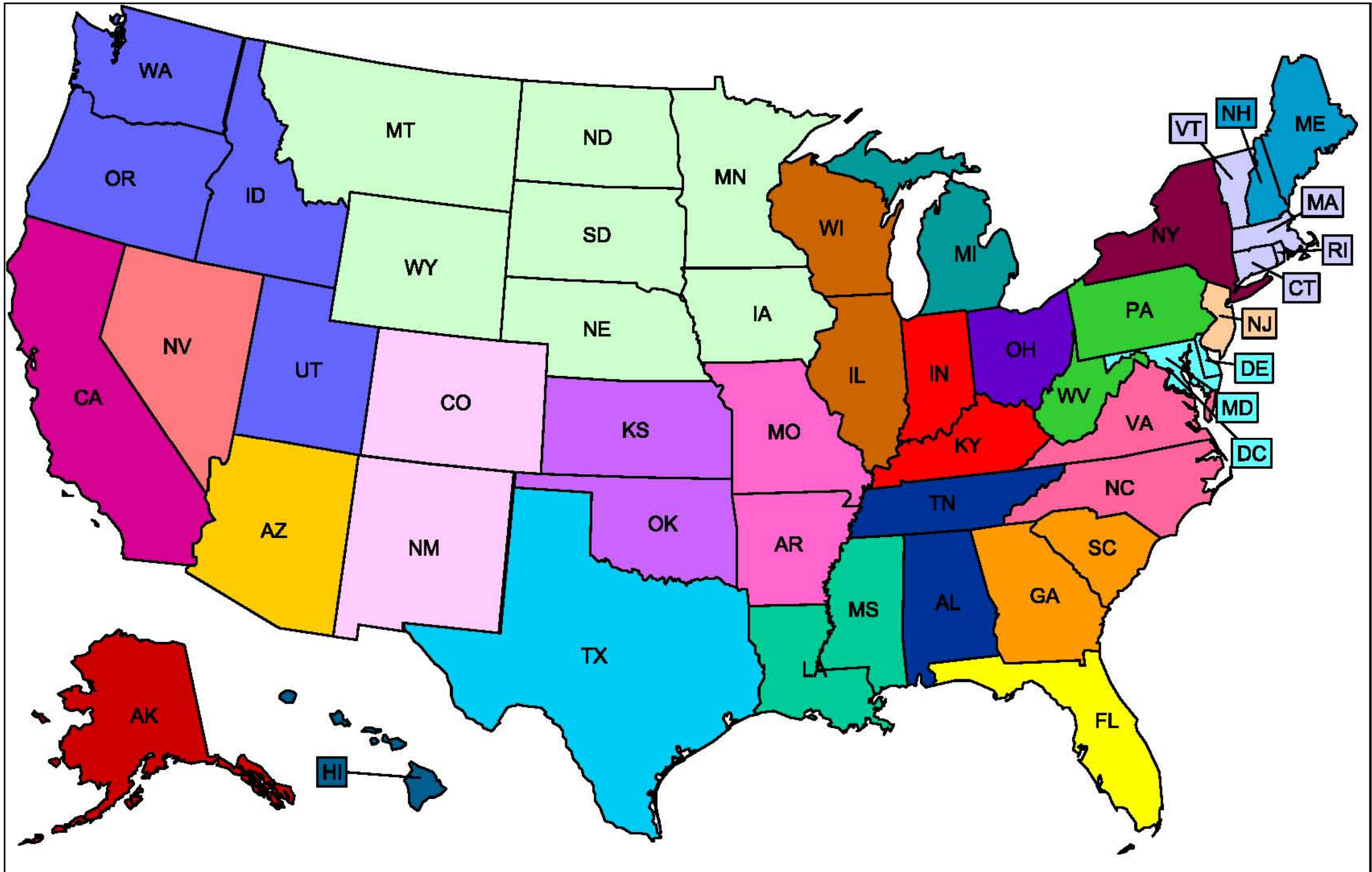
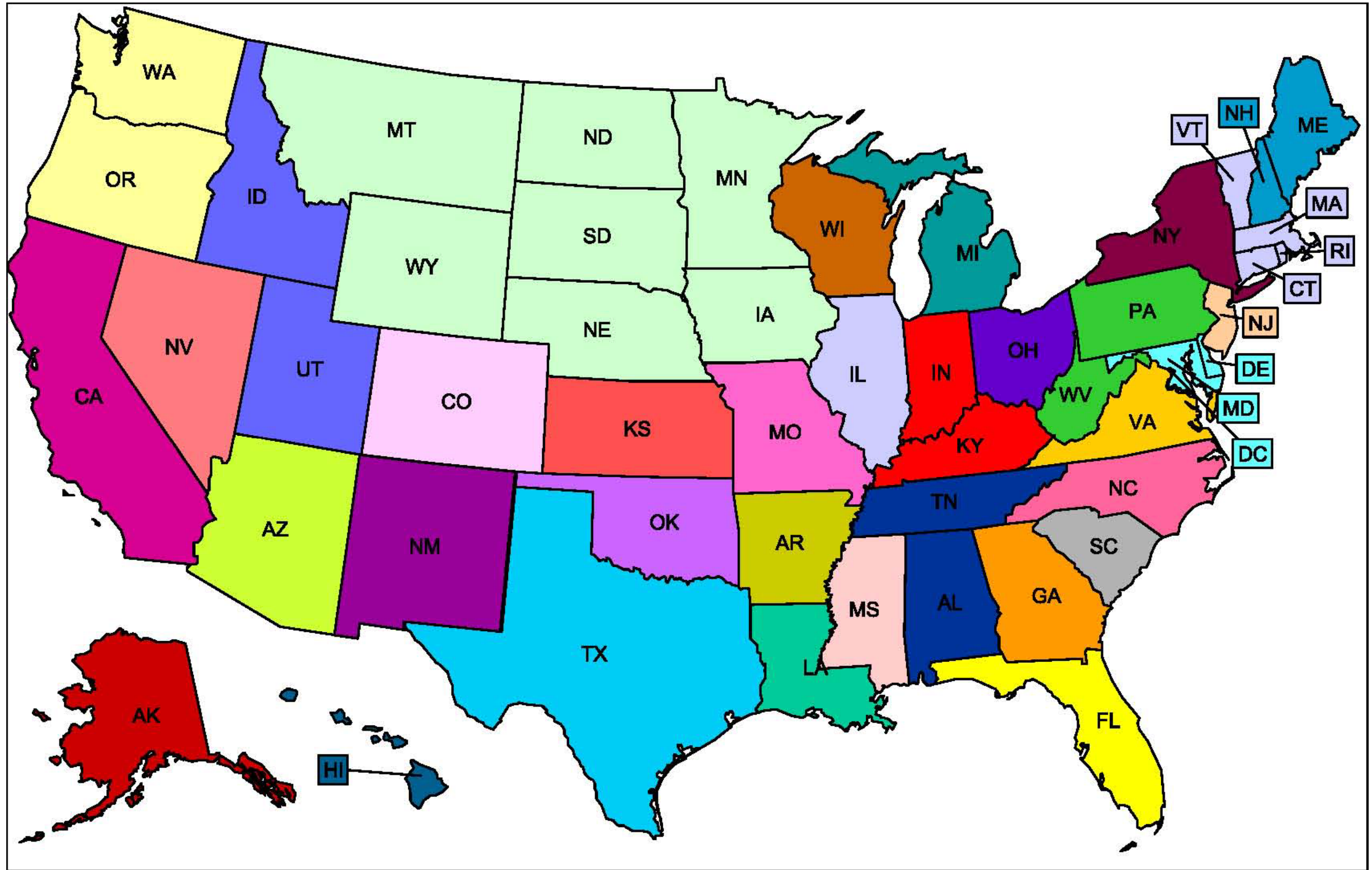
Medicare Advantage (MA) or PDP (Prescription Drug Plan)?

- In April, 2005 CMS estimated there would be regional MA plans in 21 of the 26 MA regions, including the multi-state region in the upper Midwest
- In 2005 CMS approved more than141 new MA plans, extending the availability of MA plans to 39 states
- Several PDPs have announced intention to market as national plans, so no “fallback” plans will be needed
- If at least equivalent, can stay in current plan
- Can opt not to join any plan

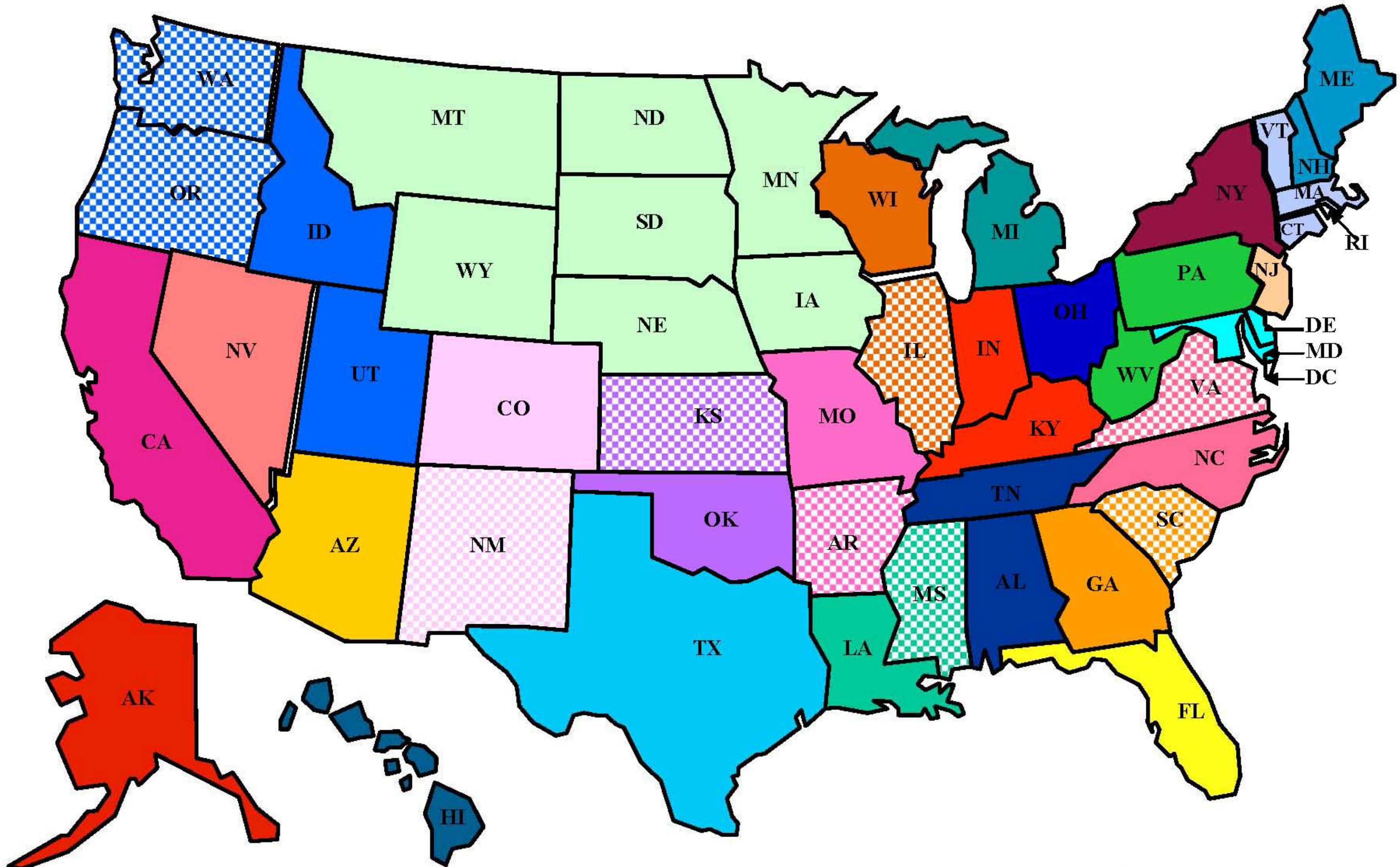
MA Regions



PDP Regions



MA and PDP Regions



Note: An MA region is one color. A difference in shading indicates that there are multiple PDP regions nested within the MA region No change indicates that the MA and PDP regions are the same. For example, Wisconsin and Illinois are in one MA region; they are each a separate PDP region. Each territory is its own PDP region.

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Why MA plan and which one?

- Comprehensive benefit package from one source
- Could be lower monthly premium (combined Part B and Part D premiums)
- But what is the coverage?
- And who are the providers?
- And what is the sustainability of the plan in my county?
- PPO? HMO? FFS?

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Why PDP and which one?

- Satisfied with current coverage for services other than prescription drugs
- Insure against unknown liability associated with prescription drugs
- Might be a dual eligible facing auto-enrollment
- Myriad of national and regional plans offered to me
- Choice based on cost, coverage, access

MMA and Impacts on Beneficiaries Needing to Make Choices

How to make the choice?

- Help from CMS web site
- Help from state health insurance assistance programs
- Help from other CMS partners
- Help from people in this room

MMA and Beneficiaries: Summary

- Major change in the program
- With implications for out-of-pocket expenses
- And lots of decisions to be made

MMA and Private Sector Intermediaries $$$$$ Payment to Plans

Attracting MA plans to rural areas

- Plans initiated in 2005 and 2006 must be regional
- Stabilization fund for bonus payments for entering and staying in a region or having a nationwide plan – applied to the premium for every enrollee in that region
- Regional plan payment rates likely to be more than local plan payment

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MMA and Private Sector Intermediaries
$$$$$ Payment to Plans

Payment for the Prescription Drug Benefit

- Think of this as subsidy for beneficiary
- 100% subsidy for the dually eligible
- High subsidy for low income
- Who are the high users?
- Balancing enhanced coverage and extending the donut hole
- Process of competitive bidding
- Plans have to balance cost, benefit, and bid

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MMA and Private Sector Intermediaries Meeting Access Requirements

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Medicare Advantage Plans

- Prevailing community pattern of utilization
- Applies to essential services
- Possible to declare negotiation impasse with essential hospitals
- Important to track negotiations with rural providers

MMA and Private Sector Intermediaries Meeting Access Requirements

PDPs

- Provision for any willing pharmacy (accept terms of the PDP)
- Use of TRICARE standards for convenient access – speculation that this may result in plans declaring they cannot meet the standard for a state because of absence of local pharmacy
- Allow local pharmacies to compete with mail order by selling 90 day supplies

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MMA and Private Intermediaries: Summary

- Evidence indicates the payment is attractive
- Access standards appear to be adequate, but concerns remain
- Payment is from the private plans to providers, not from Medicare through fiscal intermediaries to providers
- The future of rural systems and security for rural beneficiaries is at risk

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Conclusion: the Future of Health Care in Rural Places

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- Opportunity to build something better (we have the technology)
- Implications beyond single providers or health systems – community impacts from revenue, elderly staying in the community, professionals that serve them
- Implications for rural beneficiaries as they face difficult financial and health insurance decisions

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Conclusion: What is the Something Better?

- Care across the continuum for beneficiaries, from personal behavior and preventive care to palliative care

Stage 1	***Stage 2***	***Stage 3***	***Stage 4***	***Stage 5***	***Stage 6***	***Stage 7***
Personal Behavior	***Emergency Primary Care***	***Routine Specialty Care***	***Inpatient Care***	***Rehabilitative Services***	***Long-term Care***	***Palliative Care***

Conclusion: What is the Something Better? (continued)

- Focused on quality of care that benefits quality of life for individuals
- And quality of life in the community
- REQUIRES LOCAL ACTION

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Resources

- **"Preparing for Medicare Part D: A Job for State Offices of Rural Health and State Rural Health Associations."** RUPRI Center for Rural Health Policy Analysis *Policy Brief (*PB2005-2). Keith J. Mueller and Lisa Bottsford. July, 2005.

- **"Impacts of the Medicare Modernization Act on Rural Health Systems and Beneficiaries."** Columbia, MO: Rural Policy Research Institute. *Policy Paper (*P2005-01). Keith J Mueller, Andrew F Coburn, Charles W. Fluharty, A. Clinton MacKinney, Timothy D McBride, Rebecca T. Slifkin, and Mary Wakefield. February, 2005.

- **"Definition of Rural in the Context of MMA Access Standards for Prescription Drug Plans."** A Joint Publication of the RUPRI Center for Rural Health Policy Analysis *Policy Paper* (P2004-7) and the North Carolina Rural Health Research and Policy Analysis Center (Working Paper No. 79). Keith J. Mueller, Rebecca T. Slifkin, Michael D. Shambaugh-Miller, and Randy K. Randolph. September 27, 2004.

- **"A Rural Perspective Regarding Regulations Implementing Titles I and II of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA)."** A Joint Publication of the Walsh Center for Rural Health Analysis (W Series No. 6) and the RUPRI Center for Rural Health Policy Analysis *Policy Paper* (P2004-6). Curt Mueller, Keith Mueller and Janet Sutton. August 9, 2004.

- **"The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173): A Summary of Provisions Important to Rural Health Care Delivery."** *Policy Paper* (P2004-1). RUPRI Center for Rural Health Policy Analysis. Keith J. Mueller. January, 2004.

- **"Care Across the Continuum: Access to Health Care Services in Rural America."** *Working Policy Paper* (P2003-10). RUPRI Center for Rural Health Policy Analysis. Keith J. Mueller and A. Clinton MacKinney. December, 2003.

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Thank you!