Medicare Update

National Rural Health Association
New Orleans, LA
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Mary Wakefield, Ph.D., R.N., F.A.A.N.
Associate Dean for Rural Health and Director

“Impacts of the Medicare Modernization Act on Rural Health Systems and Beneficiaries.”

RUPRI (Rural Policy Research Institute)
Rural Health Panel, P2005-01 (February 2005).

The Medicare Payment Advisory Commission

- An independent federal body
- To advise the U.S. Congress on issues affecting the Medicare Program
- Commission consists of 17 members with diverse expertise appointed to three-year terms

Products

Two Reports
- Issued in March and June
- Comment on reports and proposed regulations issued by HHS
- Testimony/briefings for the hill
- Complete mandated studies and reports
Medicare – 4 Parts

Part A: Hospital Insurance
Part B: Supplementary Medical Insurance
Part C: Medicare Advantage
Part D: Outpatient Drug Benefit

Medicare Spending

2003 $ 281 Billion
$ 7000 per beneficiary

Medicare beneficiaries = 15% of the U.S. population and account for 37% of national personal health care spending

(MedPAC, 2005)
Medicare Spending

Medicare accounts for nearly 12% of total federal spending. This will increase with Part D outpatient drug benefit beginning 2006 and when baby boomers reach eligibility.

Distribution of Medicare Benefit Payments by Type of Service

- Hospital: 45%
- Physicians: 17%
- Managed Care: 13%
- Administrative Expenses: 2%
- Other: 14%
- SNF: 5%
- Home Health Care: 3%

(MedPAC, 2005)
Medicare and Quality

Strategies:
- Conditions of Participation
- Quality Improvement Organizations
- Public Reporting Initiatives
- Demonstrations tying payment to quality

However...
Payments are neutral and sometimes negative

Pay for Performance

Base a portion of provider payment on performance to incent the provision of high quality care

Reward ⟷ Improvement
Attaining/Exceeding Benchmarks

Implications for Rural Healthcare Infrastructure…
March 2005
Quality Recommendations

Recommendation: Congress should establish a quality incentive payment policy for hospitals in Medicare.

Recommendation: CMS should require hospitals to identify which secondary dx were present on their claims forms.

March 2005
Quality Recommendations (cont.)

Recommendation: Congress should establish a quality incentive payment policy for Home Health Agencies in Medicare.

Recommendation: Secretary should develop a valid set of measures of Home Health adverse events including adequate risk adjustment.
Medicare Payment Recommendations

Payment adequacy determined by considering:
- Beneficiary access to care
- Change in service volume
- Change in care quality
- Hospital access to capital
- Relationship of Medicare payments and costs (reflected as the Medicare margin)
- Efficient provision of services (MMA)

Trends in Overall Medicare Margins:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2005 projected</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>5.8</td>
<td>3.0</td>
<td>-1.3</td>
<td>-1.3</td>
</tr>
<tr>
<td>Rural</td>
<td>-1.3</td>
<td>-3.3</td>
<td>-6.2</td>
<td>-3.1</td>
</tr>
</tbody>
</table>

All PPS Hospitals, 2003

(MedPAC, 2005)
Home Health

<table>
<thead>
<tr>
<th>Freestanding Medicare Margin</th>
<th>2003</th>
<th>2005 (est.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caseload of Agency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>14.1</td>
<td>13.2</td>
</tr>
<tr>
<td>Mixed</td>
<td>13.2</td>
<td>11.6</td>
</tr>
<tr>
<td>Rural</td>
<td>10.6</td>
<td>6.1</td>
</tr>
</tbody>
</table>

Critical Access Hospitals

- Congress mandated that MedPAC “analyze the effect on total payments, growth in costs, capital spending, and such other payment effects” of a broad range of rural provisions in the MMA. (December, 2006)

- Interim step, Congress also mandated “The Commission shall submit to Congress an interim report on the matters…with respect to changes to the Critical Hospital provision under section 405” of the MMA. (June, 2005)
## Small Hospitals Benefit from CAH Conversion

<table>
<thead>
<tr>
<th></th>
<th>All-payer margin in 1998</th>
<th>All-payer margin in 2003</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAHs (n=498)</td>
<td>- 1.2%</td>
<td>2.2%</td>
<td>3.4%</td>
</tr>
<tr>
<td>Comparison Hospitals (n=551)</td>
<td>2.2%</td>
<td>- 0.2%</td>
<td>- 2.4%</td>
</tr>
</tbody>
</table>

(MedPAC, 2005)

## Who is Eligible for CAH Benefits? (mileage from CAHs to the nearest hospital)

<table>
<thead>
<tr>
<th>Mileage Range</th>
<th>Number of CAHs</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 to 5</td>
<td>8</td>
</tr>
<tr>
<td>5 to 15</td>
<td>143</td>
</tr>
<tr>
<td>15 to 25</td>
<td>401</td>
</tr>
<tr>
<td>25 to 35</td>
<td>215</td>
</tr>
<tr>
<td>35+</td>
<td>172</td>
</tr>
</tbody>
</table>

Number of CAHs as of July 2004

(MedPAC, 2005)
Projected Cost of the Program

<table>
<thead>
<tr>
<th>Projected number of CAHs in 2006</th>
<th>Projected difference between cost-based payments and PPS payments in 2006 per hospital</th>
<th>Marginal cost of the CAH program</th>
</tr>
</thead>
<tbody>
<tr>
<td>1,300</td>
<td>$ 1 million</td>
<td>$ 1.3 billion</td>
</tr>
</tbody>
</table>

(Medpac, 2005)

Swing Bed Payment

- Medicare payment rates for post-acute care in CAH swing beds are significantly higher than rates paid to competing SNFs

- Current swing-bed payment rules are complex and make it difficult for CAH administrators to compute the net financial benefit of serving one additional post-acute patient

(MedPAC, 2005)
For more information contact:
Center for Rural Health
School of Medicine and Health Sciences
University of North Dakota
Grand Forks, ND 58202-9037

701-777-3848
website: http://medicine.nodak.edu/crh