Issues in Rural Medicare Policy: Physician Payment, Medicare Advantage, ACA Implementation

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Equitable and reasonable compensation for primary care services

Payment policies that might attract physicians to underserved (including rural) areas

Equitable payment across geographic areas

Basis for geographic payment: 89 payment areas, many of which are entire states, not strictly urban-rural
Medicare Payment to Rural Physicians: Patient Protection and Affordable Care Act

Taken from: “Increases in Primary Care Physician Income Due to the Patient Protection and Affordable Care Act of 2010 – Continued Tweaking of Physician Payment” by A. Clinton MacKinney, MD, MS:

ACA extended floor on Work Geographic Practice Cost Index (GPCI) through 2011
Continued

- Changed calculation of Practice Expense GPCI and increased to floor payment in Frontier states

- Provided 10% for primary care services furnished by primary care practitioner (defined as practice with at least 60% of Medicare allowed charges being to specific primary care service codes
Increased physician personal income in prototypical primary care practice average of $3,537 (1.9%) in 2010, $12,013 (6.2%) in 2011

Need further evidence to determine effect of bonus for primary care because of using a 60% service threshold based on specific codes
But Wait … Effects of Overall Payment Change

- Continued problems with Sustained Growth Rate
- Medicaid payment constrained?
- Savings in the Medicare Program?
Findings

- Rural physicians more likely than urban physicians to accept all new Medicare patients (65% v 52%) in 2008
- Only 8% of rural physicians (11% urban) accepting no new Medicare patients [2004 numbers were 5% rural and 6.3% urban]
- Among rural physicians reason for not accepted most likely to be “have enough patients,” for urban physicians “inadequate reimbursement”
Rural Enrollment in Medicare Advantage Plans

- Total enrollment in March 2011 in rural was 1.5 million (15.7% of eligible beneficiaries)
- Shift in rural enrollment from private-fee-for-service plans to preferred provider organization plans: the former fell from 530,678 to 249,499; the latter grew from 396,006 to 702,315
Rural Enrollment in Medicare Advantage Plans

- Enrollment grew in last year led by growth in PPO plans (306,309 more) and health maintenance organizations (69,900 more)

- Variation in enrollment across the country; 10 states with more than 205% of rural enrollment, each of which has over 21% penetration; more than 41% in Hawaii and Minnesota
ACA Impact: Accountable Care Organizations (ACOs)

Still an unknown because only have the proposed final rule at this time for details of what they must be and do.

But principles are worthy of extended discussion and consideration because the ACO approach may be used in pilot and demonstration projects.
Sampling of rural considerations
- Assignment of patients to primary care physicians (physicians only)
- Participation of physician practices in only 1 ACO
- Shared savings threshold
- Access standards
- HIT
Impacts on payment to providers because of rating areas and access standards

Therefore impact on access to services for Medicare beneficiaries

Impacts on coverage of pre-Medicare population
ACA Impact: Value-Based Purchasing
For Further Information

The RUPRI Center for Rural Health Policy Analysis
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The RUPRI Health Panel
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