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
Iowa Map of MA Enrollment

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

Source of Data: Centers for Medicare and Medicaid Services (CMS), as of March 2015. Produced by RUPRI Center for Rural Health Policy Analysis, 2015
Figure 1: Rural Areas as Defined by the TRICARE Retail Pharmacy Program

Classification by Person per Square Mile (ppsm)

- Rural: less than 1,000 ppsm
- Suburban: 1,000 to 2,999 ppsm
- Urban: more than 3,000 ppsm


Note: Alaska and Hawaii not to scale.
Figure 3: Medicare Beneficiaries Categorized as Residing in a Rural Area, Using the TRICARE Definition of Rural

- Urban/suburban beneficiaries (number in ZIP codes with >1,000 people/square mile)
- Rural beneficiaries (number in ZIP codes with <1,000 people/square mile)
- 30 percent of rural beneficiaries

25,980,972
7,794,292
11,105,917

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

![Pie chart showing Medicare beneficiaries categorized by rural status.]

- **Urban/suburban beneficiaries**: 2,327,068
- **Rural beneficiaries**: 7,756,894
- **30 percent of rural beneficiaries**: 29,329,715


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

Map constructed as follows:
1. Top three chains identified by number of outlets in each state (none in North Dakota).
2. All outlets plotted.
3. All outlets buffered at 15 miles.
4. All ZIPs pulled for which any part was within the 15 mile buffer (liberal allowance since criteria is "on average").
5. Resulting areas contained 70% of rural elderly population, thus criteria was achieved without needing any additional ZIP codes.

Source: #MDA906-03-R-0002, DoD, 2003
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