IMPROVEMENTS FOR BENEFICIARIES IN RURAL AREAS

Encouraging Plans to Serve Rural Areas

The Medicare+Choice program struggled to bring plan options to rural areas. Despite the Balanced Budget Act's addition of "floor" payments that would have increased reimbursements for rural counties, large swaths of rural America were left with only original Medicare as a plan choice. Consequently, coverage for prescription drugs was less available in rural areas than in cities, where Medicare+Choice plans often added drug coverage to attract beneficiaries. The MMA sets up a new system of regional preferred provider organization (PPO) plans to help bring new plan choices to rural areas and give those beneficiaries the same options that their urban counterparts have enjoyed. A recent market study found that even the most rural of states like Montana, the Dakotas, and Wyoming have three or more risk-bearing PPOs operating in the commercial insurance market. The MMA and the proposed rule would give CMS several ways to attract those plans into Medicare.

Financial incentives. The MMA and the proposed rule would give CMS several tools to attract and retain regional PPOs, including start-up risk corridor payments, an entry and retention fund, and special payments to essential hospitals treating regional plan enrollees.

- Risk Corridors. Risk sharing for Part A and B health benefits will be in effect for 2006 and 2007. The government pays plans if costs are above the target and recoups its share of the savings when costs are below the target.

- Stabilization Fund. Starting in 2007 through 2013, a stabilization fund initially funded at $10 billion will be available to Medicare Advantage regional plans to encourage plan entry and retention. The fund can be used several ways:
    - *National Bonus.* If a health plan enters the program nationally (by bidding to provide a Medicare Advantage regional plan in all regions), then its benchmark payment in each region is increased by 3 percent. This payment is available for one year only, and it is not available if a national plan was available the prior year.
    - *Regional Plan Entry Bonus.* If no regional Medicare Advantage plans serve a given region in one year, then the Secretary may increase the payments for that region for the following year. The Secretary can choose how large the increase is and how long it lasts.
    - *Regional Plan Retention Bonus.* If plans signal that they are going to leave a region, the Secretary may, under certain conditions, increase the benchmark in that region in an effort to retain plans and/or attract new bidders.

- Essential Hospitals. The MMA specifies that $25 million a year be made available to "essential hospitals" that treat regional Medicare Advantage plan enrollees. Acute care hospitals that do not have a contract with a regional Medicare Advantage plan, but which treat an Medicare Advantage regional plan enrollee, can be paid an additional amount from the Medicare Part A trust fund if they show that their costs for providing care to an Medicare Advantage regional plan enrollee exceeded the amount that Medicare would normally pay for such a service.

Moratorium on Local PPOs. In order to encourage the establishment of regional PPOs, the MMA provides for a two-year moratorium on new local preferred provider organization plans from January 1, 2006, through December 31, 2007. PPOs that exist prior to January 1, 2006, (including demonstration PPOs) may continue to operate and expand enrollment in their existing service areas only.

Network Adequacy Standards. The proposed regulation includes an exception to the comprehensive network adequacy access requirements for regional PPOs in order to encourage their development. The rules propose to permit regional PPOs with lower out-of-network cost sharing to have less robust networks of contracted providers, while proposing to permit regional PPOs with more robust networks of contracted providers to impose higher cost sharing charges on individuals going out-of-network.

Encouraging Rural Providers to Participate

As described above, $25 million in "essential hospital" funds would be available per year to certain acute care hospitals in cases in which the Medicare Advantage regional plan has been unable to contract for services, but is paying no less than inpatient fee-for-service hospital prospective payments and the hospital's costs are shown to be greater than the fee-for-service payment rate. These payments help to ensure that a hospital is not financially disadvantaged by treating members of regional Medicare Advantage plans with which the hospital does not have a contract.

In addition, the MMA requires that Medicare Advantage organizations that contract with Federally Qualified Health Centers (FQHCs) include a level of payment that would be equal to what the Medicare Advantage organization would pay other providers for similar services. Supplemental CMS payment, up to the normal Medicare FQHC payment amount, is also made to MA-contracting FQHCs.

Improving Benefits for Rural Beneficiaries

Most rural beneficiaries do not have access to coordinated care Medicare Advantage plans today. Regional PPOs will give these beneficiaries new access to important benefits, including:

- Catastrophic limit. Regional PPOs will have caps on beneficiary costs for Medicare services they receive both in- and out-of-network. Such protection is not provided with traditional Medicare coverage.
- Additional benefits. Regional PPOs that bid below the benchmark will be able to offer beneficiaries benefits beyond those currently covered by Medicare (e.g., dental) and/or reductions in Part B or Part D premiums.

- Care coordination. Regional PPOs may provide higher quality care than traditional Medicare by coordinating services for enrollees.

Comments on the proposed regulations will be accepted until October 4, 2004. Comments should be submitted to the Centers for Medicare & Medicaid Services at www.cms.hhs.gov/regulations/ecommentsT