

Mandated report: Serving rural Medicare beneficiaries

In the Patient Protection and Affordable Care Act (PPACA) of 2010, the Congress mandated that the Commission report on rural Medicare beneficiaries' access to care, rural providers' quality of care, special rural Medicare payments, and the adequacy of Medicare payments to rural providers. This report is included in the Commission's June 2012 report to the Congress.

METHODS

The Commission evaluates rural beneficiaries' experience in the Medicare program through multiple sources, including:

- beneficiary focus groups and site visits to providers in rural areas;
- beneficiary survey data, including the Commission's national telephone survey;
- examination and analysis of claims data to evaluate beneficiaries' service use and certain outcomes (e.g., mortality and readmissions); and
- examination and analysis of cost report data to evaluate providers' costs and the profitability of serving Medicare beneficiaries.

In conducting its analysis, the Commission acknowledged that rural areas may differ significantly from one another. Therefore, where possible the report subdivides rural areas into four (or five) categories based on proximity to urban areas and population:

- Metropolitan (urban)
- Rural micropolitan: counties with a city of 10,000 to 50,000 people
- Rural adjacent: counties without a town of 10,000 or more people that are adjacent to urban areas
- Rural nonadjacent: counties that are not adjacent to an urban area and do not have a town of 10,000 or more people
- Frontier: counties with a population density of six or fewer people per square mile. (The Commission distinguishes these counties where possible.)

FINDINGS

Access

- Beneficiaries in rural and urban areas receive similar amounts of health care services. The Commission noted large differences in health care service use across regions. However, we find little difference between rural and urban beneficiaries' service use within the same region (i.e. rural service use is high in regions where urban use is high, and low where urban use is low).
- Beneficiaries report similar levels of satisfaction with their access to care in rural and urban areas.
- In most rural areas, there are fewer physicians per capita and recruitment can be challenging.
- Service utilization for rural patients is maintained in part by patients traveling to urban areas for some care (due to lack of local providers or to patient preference).

Quality

The Commission did not find major differences in quality between rural and urban providers in most sectors.

- Patient satisfaction is comparable across urban and rural regions.
- Quality measures for skilled nursing facilities (SNFs), home health agencies, and outpatient dialysis facilities are similar across urban and rural areas.
- Hospital readmission measures are similar across urban and rural regions.
- Rural hospitals do not perform as well as urban on most hospital process measures and on condition-specific 30-day mortality rates. Rural hospitals tend to have below average outcomes on mortality and some process measures. These findings are consistent with literature from the past two decades.

Payment

In its March 2012 report, the Commission found that, in general, Medicare payments to rural providers are adequate.

- Some special rural payments are warranted, but some go beyond the Commission's previous recommendations and are not well targeted.
- Rural hospital payments are adequate, in part due to Congress's implementation of certain increases in rural hospital payments, some of which followed from recommendations in the Commission's 2001 report on rural health care. The number of rural hospital closures has declined dramatically in recent years because of higher prospective payment rates and enactment of the critical access hospital (CAH) program.
- Payments to rural physicians appear adequate compared with urban payments, as indicated by similar service use rates, similar ability to obtain appointments with existing and new physicians, and similar satisfaction with access. This is also suggested by MedPAC staff site visits and a review of literature. The Commission has raised concerns about the adequacy of primary care physician payments relative to subspecialist payments—concerns that apply to physicians in rural and urban areas.
- Medicare payments to rural SNFs, home health agencies, and other sectors appear adequate. PPACA instituted a new rural payment add-on for outpatient dialysis facilities beginning in 2012, which the Commission will monitor to ensure adequate payments and access for rural beneficiaries.

GUIDING PRINCIPLES

In the course of this report, the Commission developed principles to guide expectations regarding rural patients' access to care, rural providers' quality of care, and the Medicare program's payments to rural providers. These principles can be used to guide Medicare policy.

- **Access:** All beneficiaries, whether rural or urban, should have equitable access to health care services. Whether access is equitable can be evaluated by examining the volume of services received, as well as beneficiaries' reported satisfaction with access to services. Equitable access does not necessarily mean equal travel times for all services.
- **Quality:** Expectations for quality of care in rural and urban areas should be equal for nonemergency services rural providers choose to deliver. That is, if a provider has made a discretionary decision to provide a service, that provider should be held to a common standard of quality for that service, irrespective of whether the service is provided in an urban or rural location. Emergency services may be subject to different quality standards to account for different levels of staff, patient volume, and technology between urban and rural areas. Quality metrics should be reported by all hospitals (regardless of size). Certain quality metrics may be especially important for small, rural hospitals, such as timely communication with the emergency department after transfer of a patient and share of medications that are reviewed by a pharmacist before the first dose (or within 24 hours of drug administration).
- **Payment adequacy and special payments:** To maintain access, Medicare may need to make higher payments to low-volume providers that cannot achieve the economies of scale available to larger providers. However, low volume alone is not a sufficient measure to assess whether higher payments are warranted. Medicare should structure special payments as follows:
 - Payments should be targeted to low-volume isolated providers—that is, providers that have low patient volume and are at a distance from other providers. Distance is required because supporting two neighboring providers who both struggle with low volume can discourage mergers that could lead to lower cost, higher quality care.
 - The magnitude of special rural payment adjustments should be empirically justified—that is, the payments should increase to the extent that factors beyond the providers' control increase their costs.
 - Finally, rural payment adjustments should be designed in ways that encourage cost control on the part of providers. While all providers have some incentive for cost control (they must keep average costs below average revenue), fixed add-on payments generally have a greater incentive for cost control than cost-based payments.