
# Congressional request: Medicare beneficiaries' access to care in rural areas

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# House Committee on Ways and Means' 2020 request

Update Commission's 2012 report on rural beneficiaries' access to care

Add new stratifications: Dual-eligible status, MUAs, beneficiaries with chronic conditions

Examine emerging issues that affect access to care

Note: MUAs (medically underserved areas).

# Roadmap for today's presentation

**1**

**Rural and urban beneficiaries' use of clinician and hospital services**

2

Analysis of rural hospital closures

3

Potential policies and Commission feedback

# Methodology used to analyze clinician services

- Refined our 2012 methodology to provide more granular results
- Focused on E&M encounters to measure clinician service use
  - Represent about half of physician fee schedule spending
  - Billed by many types of clinicians in a wide variety of settings
- Tracked utilization across multiple billing pathways
  - Physician fee schedule
  - Rural health clinics
  - Federally qualified health centers
  - Critical access hospitals (method II billing)

Note: E&M (evaluation and management).

# Rural beneficiaries had fewer E&M encounters than urban beneficiaries

| Beneficiary residence location | Number of E&M encounters per beneficiary | |
|---|---|---|
| | 2010 | 2018 |
| Urban | 12.7 | 13.4 |
| Rural micropolitan | 10.9 | 11.5 |
| Other rural | 10.3 | 11.0 |

Source: MedPAC analysis of Medicare claims and enrollment data.

Note: E&M (evaluation and management). Urban and rural areas are defined using county-level designations established by the Office of Management and Budget. Urban areas contain an urban cluster of 50,000 or more people; rural micropolitan areas contain a cluster of 10,000 to 50,000 people; and other rural areas do not contain a cluster of at least 10,000 people.

- Differences in utilization across geographic regions of the country were larger than differences between urban and rural beneficiaries within the same region

# Lower E&M utilization among rural beneficiaries was driven by fewer encounters with specialist physicians

| Beneficiary residence location | Average number of E&M encounters per beneficiary by clinician specialty, 2018 | | |
|---|---|---|---|
| | Specialists | PCPs | APRNs and PAs |
| Urban | 7.1 | 3.5 | 1.8 |
| Rural micropolitan | 5.1 | 3.3 | 2.3 |
| Other rural | 4.9 | 3.0 | 2.2 |

Source: MedPAC analysis of Medicare claims and enrollment data.
Notes: APRNs (advanced practice registered nurses). E&M (evaluation and management). PAs (physician assistants). PCPs (primary care physicians). Values do not sum to totals on previous slide because other clinicians, such as psychologists, are excluded from this table.

- Commission's annual beneficiary survey has consistently found that rural beneficiaries have no more difficulty obtaining specialist appointments than urban beneficiaries



Results preliminary; subject to change.

# Rural beneficiaries increasingly received clinician care in urban areas and at hospitals from 2010 to 2018

- Rural beneficiaries receive more of their clinician care in urban areas, suggesting increasing travel times
- Rural beneficiaries are more dependent on hospitals to access clinician care, and this dependence is growing
  - In 2018, urban beneficiaries had 29% of their E&M encounters in hospitals, compared with 34% to 40% for rural beneficiaries
  - Shift to hospitals occurred among all beneficiaries, but the shift was more than twice as rapid for rural beneficiaries over time

Source: MedPAC analysis of Medicare claims and enrollment data.
Note: E&M (evaluation and management).

Results preliminary; subject to change.

# Rural/urban differences in hospital use are smaller than regional differences

- Inpatient use
  - Similar in admissions per capita in rural and urban areas
  - Large regional variation across states
    - Within states, the rural and urban admission rates are often similar
- Outpatient use
  - Higher in rural areas (rural: 4.5 claims/year, urban: 3 claims/year)
    - May reflect where care is received, rather than how much care is received
  - Regional variation is larger than rural/urban differences

Source: MedPAC analysis of Medicare claims and enrollment data.

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# Analysis of rural hospital closures

- Rural hospital closures increased modestly after 2013
- To analyze rural hospital closures, we:

1. Examined claims data from 40 hospitals that were:
   - Open from 2005 to 2014
   - Only hospital in town
   - Closed between 2015 and 2019
2. Conducted interviews to understand how care was delivered in the community before and after closure

# Rural hospital closures preceded by declining inpatient admissions

- Large decline in admissions prior to closure (2005 to 2014)
  - All-payer: 53% decline (1,045 to 488 per year)
  - Medicare: 61% decline (627 to 243 per year)
- Most of the Medicare declines due to beneficiary bypass
  - Two-thirds of the decline reflected a loss of market share: Beneficiaries were increasingly bypassing the local hospital
  - One-third of the decline reflected a shrinking market for inpatient services

Source MedPAC analysis of Medicare cost report and claims data.

# Rural hospitals were important sources of emergency and outpatient care prior to closure

- ED volume was relatively constant prior to closure (2005 to 2014)
- Overall outpatient volume declined slightly prior to closure
- Therefore, it appears the hospitals were more important for emergency and other outpatient access than inpatient access prior to closure

Source: MedPAC analysis of Medicare claims data.
Note: ED (emergency department).

Results preliminary; subject to change.

# Changes in access to care due to hospital closures

We conducted virtual site visits to three rural communities with hospital closures

Inpatient care dropped to an average of one or two patients a day

Patients bypassed their local hospitals in favor of larger, regional hospitals for inpatient care

Ensuring timely access to emergency and other outpatient care was the first priority

# Communities prioritized access to emergency and urgent care after hospital closure

| Town A | Town B | Town C |
| --- | --- | --- |
| Off-campus ED, wraparound outpatient care, FQHC-led primary care | FQHC-led UCC staffed by emergency medicine physician | UCC staffed by primary care physician, FQHC mobile unit |

Note: ED (emergency department). FQHC (federally qualified health center). UCC (urgent care center).

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# Special payments to rural hospitals do not always prevent hospital closure

- Medicare's primary response to rural hospital closures has been to increase payment rates (e.g., inpatient add-on, cost-based payments)
- Over 95 percent of rural hospitals received higher than standard inpatient rates in 2018
- Increased payments have not always prevented hospital closures

Source: MedPAC analysis of 2021 Final Rule impact files.

Results preliminary; subject to change.

# Policy for alternative payment mechanism: Global budgets

- Global budgets are currently used in Maryland (all hospitals) and Pennsylvania (some rural hospitals)
- Global budgets:
  - Provide revenue stability
  - Remove fee-for-service volume incentives
  - Require claims/encounter data
  - Require enhanced administrative authority

# Policies for alternative delivery models: Stand-alone EDs and additional FQHCs

- In June 2018, the Commission made a recommendation on isolated, stand-alone EDs
  - Eliminates inpatient costs for providers
  - Maintains 24/7 emergency services for communities
  - Provides a fixed annual payment to help cover fixed costs
- Stand-alone EDs may not be appropriate for all communities
  - Some rural communities will maintain a full hospital
  - In other rural communities where volume is low, FQHCs could be encouraged to fill in the gap for urgent and outpatient care

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Note: ED (emergency department). FQHC (federally qualified health center).

# Next steps for interim report and Commission feedback

- Next steps
  - Expanding utilization analyses
  - Examine beneficiaries who are dual-eligible, have multiple chronic conditions, or live in a medically underserved area
- Feedback from Commission
  - Clarifications on utilization analyses
  - Interest in additional policies on rural beneficiary access
- Interim report due June 2021; final report due June 2022