

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

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House Committee on Ways and Means' 2020 request

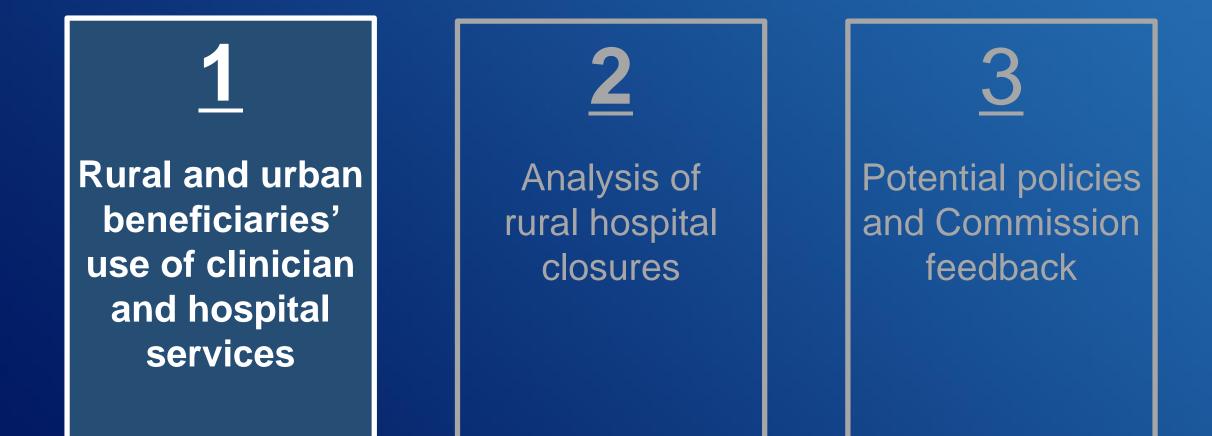
Update Commission's 2012 report on rural beneficiaries' access to care Add new stratifications: Dual-eligible status, MUAs, beneficiaries with chronic conditions

Examine emerging issues that affect access to care

Note: MUAs (medically underserved areas).



Roadmap for today's presentation





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

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- 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	Number of E&M encounters per beneficiary		
residence location	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

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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

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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).



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.



Roadmap for today's presentation





Analysis of rural hospital closures

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

Examined claims data from 40 hospitals that were:
 Open from 2005 to 2014
 Only hospital in town
 Closed between 2015 and 2019



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



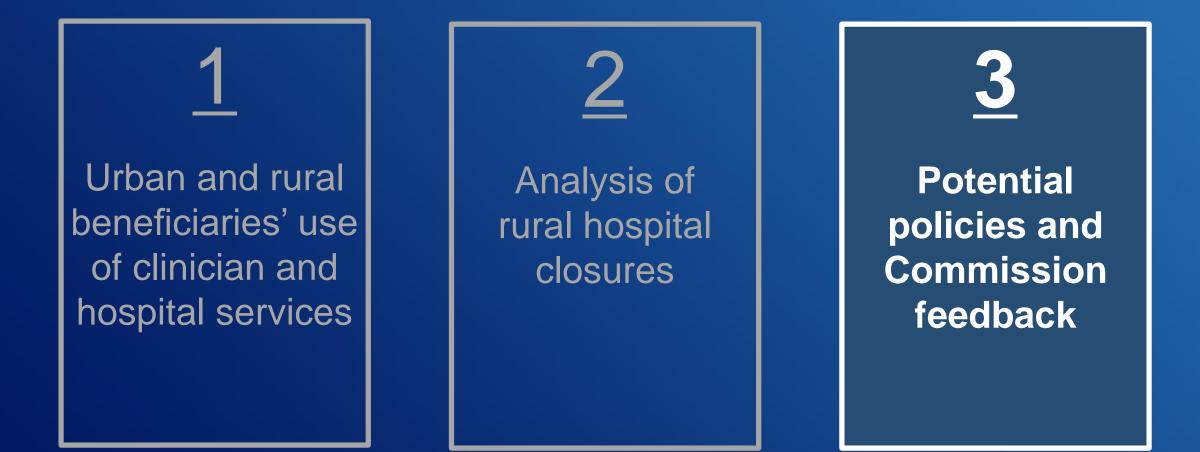
Communities prioritized access to emergency and urgent care after hospital closure

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

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



Roadmap for today's presentation





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.



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

ECICAC 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

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