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

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MEDPAC

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: Medically underserved areas (MUAs).

Roadmap for today's presentation

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Direct measures of rural beneficiaries' access to care

2

Trends in rural and urban beneficiaries' utilization

3

Effects of rural hospital closures on access to care

4

Recent policymaking and next steps

Survey data suggest similar satisfaction with access to care between rural and urban beneficiaries

- Rural and urban beneficiaries:
  - Report similar levels of satisfaction with care
  - Do not report significant differences in delaying or forgoing care
- Some differences exist in rural beneficiaries' ease of getting to care, which increase as rurality increases
  - More difficulty getting to specialty care
  - Less availability of care on nights and weekends

Source: MedPAC annual survey of beneficiary access to care (2020) and Medicare Current Beneficiary Survey (2019).

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Rural and urban providers' coding patterns may differ, affecting beneficiary risk scores

- The utilization data we present are not risk adjusted
- Using claims data to risk adjust rural and urban service use may create misleading results
  - A higher share of rural beneficiaries reported that their health was "fair" or "poor"
  - Research shows that rural beneficiaries have slightly lower life expectancy
  - However, rural beneficiaries have lower risk scores than urban beneficiaries

Source: MedPAC analysis of the 2019 Medicare Current Beneficiary survey and risk score data.

Overview of findings presented in November

Differences in utilization across states were generally far larger than differences between rural and urban beneficiaries within the same state

1) Similar hospital inpatient use and higher HOPD use per beneficiary in rural areas compared with urban areas in 2018
2) Rural beneficiaries had fewer E&M encounters than urban beneficiaries in 2018, driven mostly by fewer encounters with specialist physicians

Note: Evaluation and management (E&M). Hospital outpatient department (HOPD).
Source: MedPAC analysis of the Carrier file, Outpatient file, Medicare Provider and Analysis Review file, and Master Beneficiary Summary File.

Rural beneficiaries had fewer E&M encounters than urban beneficiaries, 2018

Beneficiary residence location	Number of E&M encounters per beneficiary
Urban	13.4
Rural micropolitan	11.5
Rural adjacent	11.4
Rural nonadjacent	10.6
Frontier	9.0

- Frontier beneficiaries' lower use is partially due to the facts that these beneficiaries disproportionately live in low-use states, are slightly healthier, and travel farther to access specialists

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 Influence Codes, and county level population per square mile.
Source: MedPAC analysis of Carrier file, Outpatient file, and enrollment data.

Rural beneficiaries traveled farther for E&M visits with specialist physicians than urban beneficiaries, 2018

Beneficiary residence location	Median distance (in miles) from beneficiary residence to the location where the service was performed	
	Specialist physicians	Primary care physicians
Urban	9	7
Rural micropolitan	26	9
Rural adjacent	35	16
Rural nonadjacent	43	13
Frontier	58	13

- The difference in travel distance between rural and urban beneficiaries for E&M visits with primary care physicians was modest

Note: Evaluation and management (E&M). Urban and rural areas are defined using county level designations established by the Office of Management and Budget, Urban Influence Codes, and county level population per square mile.

Source: MedPAC analysis of Carrier file and Outpatient file data.

Skilled nursing facility and home health use similar among rural and urban beneficiaries, 2018

- Rural beneficiaries' SNF and home health use per beneficiary was similar to (or slightly higher than) urban beneficiaries' rates
- From 2008 to 2018, SNF use declined among rural and urban beneficiaries, declining faster among urban beneficiaries
- Geographic variation was larger than differences between rural and urban beneficiaries in the same state

Note: Skilled nursing facility (SNF).
Source: MedPAC analysis of home health standard analytic file and Medicare Provider and Analysis Review file.
Results preliminary; subject to change.

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Dramatic declines in inpatient admissions preceded rural hospital closures, 2005 to 2014

In the years prior to closure, rural hospitals:

1. Had large declines in inpatient admissions
   - All-payer: 53% decline
   - Medicare FFS: 61% decline

   Mostly due to beneficiaries bypassing their local hospital for inpatient care

2. Continued to be an important source of emergency and outpatient care
   - ED volume increased
   - Overall HOPD volume declined slightly

Note: Emergency department (ED). Fee-for-service (FFS). Hospital outpatient department (HOPD).
Source: MedPAC analysis of Medicare cost report, Medicare Provider and Analysis Review file, and Outpatient file data.

Results preliminary; subject to change.

Rural hospital closures are associated with but may not have caused declines in hospital use

	Average annual change in years prior to closure (2005-2014)		Average annual change from pre-closure year (2014) to post-closure year (2018)	
	Closure markets	**Non-closure markets**	**Closure markets**	**Non-closure markets**
Inpatient admissions	**-4.3%****	-3.0%**	**-1.4%**	-0.8%
HOPD visits	**0.3%****	1.8%**	**-0.7%***	1.6%*

- Inpatient admissions per beneficiary declined faster for those living in closure markets well before the closures occurred
- Some HOPD volume "declines" may represent shifts to other settings

Note: *Indicates that closed hospital market differs from non-closed hospital market using a T-test at the P<.05 level of significance (*) or the P<.01 level of significance (**). Admissions of beneficiaries living in the market include admissions to hospitals within and outside the market.
Source: MedPAC analysis of the Medicare Provider and Analysis Review and Outpatient file claims.

Results preliminary; subject to change.

HOPD visits likely shifted to other settings after rural hospitals closed

From 2014 to 2018, E&M encounters per beneficiary increased faster in rural markets with a closure than rural markets without a closure

- FQHC E&M visits:
  - 11.6% increase per year in closure markets
  - 6.7% increase per year in non-closure markets
- Physician fee schedule E&M office visits:
  - 1.2% increase per year in closure markets
  - 0.6% increase per year in non-closure markets

Note: Hospital outpatient department (HOPD). Evaluation and management (E&M). Federally qualified health center (FQHC).
Source: MedPAC analysis of Carrier file, Outpatient file, and enrollment data.

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Select provisions from the Consolidated Appropriations Act, 2021

- The Act created a new category of hospitals beginning in 2023 – rural emergency hospitals (REHs)
  - REHs will not furnish inpatient services and must have 24/7 ED
  - Medicare will pay REHs a monthly fixed payment, OPPS +5%, and standard rates for other services
  - Creation of REHs is consistent with the Commission's 2018 recommendation on rural, freestanding EDs
- The Act also substantially increased payment rates for certain rural health clinics

Note: Emergency department (ED). Outpatient prospective payment system (OPPS).

Conclusions

1) Survey and claims data suggest that rural and urban beneficiaries have similar access to care
2) Variations in service use across states were often large, but differences between rural and urban beneficiaries tended to be much smaller
3) Rural hospital closures could disrupt access to care, but Congress recently enacted provisions to maintain or improve access to ED and outpatient care in rural areas

Note: Emergency department (ED).

Next steps

- Commission feedback on current work and suggestions for next cycle
- Interim report due June 2021
- Final report due June 2022, including analyses stratified by:
  - Dual-eligible status
  - Medically underserved areas
  - Beneficiaries with chronic conditions