Congressional request: Vulnerable Medicare beneficiaries' access to care

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October 7, 2021

MEDPAC

House Committee on Ways and Means' 2020 request

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

Examine emerging issues that affect access to care

New stratifications: Beneficiaries with chronic conditions, dual-eligible beneficiaries, and MUAs

Note: Medically underserved areas (MUAs).

Summary of June 2021 interim report on rural beneficiaries' access to care

- Survey and claims data from 2018 suggest that rural and urban beneficiaries had a similar ability to obtain care; results were similar to the Commission's 2012 report
- Variations in service use across states were often large, but differences between rural and urban beneficiaries (within states) tended to be much smaller
- Rural hospital closures
  - Increased since 2013
  - Associated with beneficiaries bypassing local hospitals before closure
  - Recently enacted rural emergency hospital designation could help maintain or improve access to ED and outpatient care in rural areas

Note: Emergency department (ED).

Beneficiaries with more chronic conditions used substantially more care in 2018

- Beneficiaries with more reported chronic conditions had a higher average number of E&M encounters, inpatient admissions, HOPD claims, SNF days, and home health episodes
  - Urban beneficiaries with 0-1 conditions: 0.02 admissions per capita
  - Urban beneficiaries with 6+ conditions: 0.85 admissions per capita
- Differences in service use between healthier and sicker beneficiaries were similar in rural and urban areas
- Systematic coding differences complicate comparing rural and urban beneficiary service use by number of chronic conditions

Note: Evaluation and management (E&M), hospital outpatient department (HOPD), skilled nursing facility (SNF).
Results are preliminary and subject to change.

Dual-eligible beneficiaries used substantially more care than other beneficiaries in 2018

- Dual-eligible beneficiaries' higher use persisted across all types of services we examined
- For example, among rural micropolitan beneficiaries:
  - Dual-eligible beneficiaries: 5.2 SNF days per capita
  - Non-dual-eligible beneficiaries: 0.9 SNF days per capita
- Access implications unclear
  - Positive: Many providers accepted and treated dual-eligible beneficiaries
  - Unknown: Whether level of service use was sufficient

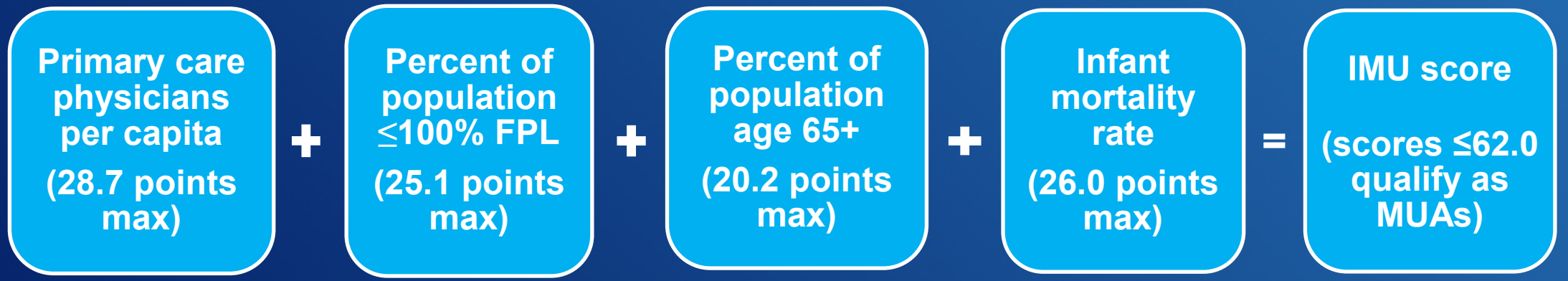
Note: Skilled nursing facility (SNF).
Results are preliminary and subject to change.

Dual-eligible beneficiaries' higher use driven by greater health needs

- Compared with other Medicare beneficiaries, dual-eligible beneficiaries more frequently:
  - Report being in poor health (20% vs. 6%)
  - Have limitations in activities of daily living (62% vs. 26%)
  - Live in an institution (27% vs. 5%)
- Commission's broader work on safety-net providers will examine dual-eligible beneficiaries' potential access issues in greater detail

Source: Medicare Payment Advisory Commission and Medicaid and CHIP Payment and Access Commission. 2018. Data book: beneficiaries dually eligible for Medicare and Medicaid.

Areas are designated as MUAs based on four criteria



Source: Health Resources & Services Administration.

- Different types of areas can be MUAs (e.g., counties, towns, census tracts)
- We define MUAs at the county level: Full, partial, or non-MUA counties

Note: Index of Medical Underservice (IMU), federal poverty level (FPL), medically underserved areas (MUAs).

Three quarters of Medicare beneficiaries lived in counties considered full or partial MUAs in 2018

Type of county	Share of Medicare FFS beneficiaries		
	Full MUA	Partial MUA	Non-MUA
Total (all counties)	18%	60%	21%
Urban	11	70	19
Rural micropolitan	35	32	33
Rural adjacent	62	23	16
Rural nonadjacent	60	21	18
Frontier	46	25	28

Note: Rows may not sum to 100% due to rounding. The frontier category is not mutually exclusive from the other rural and urban categories; we classify counties as urban, rural micropolitan, rural adjacent, or rural nonadjacent. In addition, we categorize all counties as frontier or not frontier.
Source: MedPAC analysis of Medicare enrollment data and Health Resources & Services Administration data.

Note: Fee-for-service (FFS), medically underserved area (MUA).
Results are preliminary and subject to change.

Residence in MUAs not associated with lower service use

- Service use was similar for beneficiaries in full, partial, and non-MUA counties in 2018
  - E.g., urban beneficiaries in full, partial, and non-MUAs averaged 13.4, 13.4, and 13.3 E&M encounters, respectively
- Why MUAs might not be associated with lower service use
  - Beneficiaries travel to access care
  - MUAs not regularly updated
  - MUAs defined broadly
  - Supply of primary care clinicians does not include APRNs and PAs

Note: Advanced practice registered nurse (APRN), evaluation and management (E&M), medically underserved areas (MUAs), physician assistant (PA).

Results are preliminary and subject to change.

Examining MUAs' measure of primary care supply

- We used claims data to classify APRNs/PAs as practicing in primary care or specialty care
- In 2018, we found that a minority of APRNs/PAs practiced in primary care
  - 27% of PAs practiced in primary care
  - 41% of NPs (most common type of APRN) practiced in primary care
- Despite predominantly practicing in specialty care, APRNs/PAs still represented a substantial share of all primary care clinicians

Note: Advanced practice registered nurse (APRN), medically underserved area (MUA), nurse practitioner (NP), physician assistant (PA).
Results are preliminary and subject to change.

APRNs and PAs accounted for a third of all primary care clinicians and up to half in rural areas

Location where clinician performed services	Clinicians who billed Medicare FFS in 2018 (in thousands)			Share of total primary care clinicians made up of APRNs and PAs
	Primary care physicians	APRNs/PAs who practiced in primary care	Total primary care clinicians (PCPs + APRNs/PAs)	
Total (all locations)	168	88	257	34%
Urban	148	71	219	32
Rural micropolitan	12	10	22	44
Rural adjacent	5	4	9	49
Rural nonadjacent	3	3	7	51
Frontier	1	1	3	52

Note: PCPs and APRNs/PAs may not sum to total primary care clinicians because of rounding and the fact that the frontier category is not mutually exclusive from the other rural and urban categories. We classify counties as urban, rural micropolitan, rural adjacent, or rural nonadjacent. In addition, we categorize all counties as frontier or not frontier.

Source: MedPAC analysis of Carrier and Outpatient files.

Note: Advanced practice registered nurse (APRN), fee-for-service (FFS), physician assistant (PA), primary care physician (PCP). Results are preliminary and subject to change.

MUAs might not be useful in Commission's ongoing work on safety-net providers

- Findings suggest the primary care supply measure used to identify MUAs likely misses 1/3 to 1/2 of all primary care clinicians
- Combined with other issues, suggests MUAs by themselves might not be useful in the Commission's work to identify vulnerable populations and support safety-net providers
- Commission anticipates exploring other measures in the future

Conclusions

- Beneficiaries with multiple chronic conditions had substantially higher service use than healthier beneficiaries
- Dual-eligible beneficiaries had higher service use than other beneficiaries, likely driven by their greater health needs
- Beneficiaries who lived in full, partial, and non-MUA counties had similar service use

Note: Medically underserved area (MUA).

Conclusions (continued)

- While we found no clear indications of widespread access issues, our results do not mean that no access challenges exist
- Our results do suggest that:
  - More granular analyses are needed
  - Some definitions of vulnerable beneficiaries, such as those living in MUAs, might be too imprecise to target additional Medicare financial support
- Consistent with the Committee's request, the Commission plans on undertaking a broader examination of vulnerable beneficiaries and safety-net providers

Note: Medically underserved area (MUA).

Next steps

- Commissioner feedback on descriptive statistics for beneficiaries with multiple chronic conditions, dual-eligible beneficiaries, and MUAs
- Final results will be published in June 2022 report
- Safety-net provider work continues at November meeting

Note: Medically underserved area (MUA).