Advising the Congress on Medicare issues

Mandated rural study: rural payment adequacy and plan for the final report

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Mandated topics in the rural report – due June 2012

- Access to services (February, 2011)
- Quality of care (October, 2011)
- Adequacy of rural payments (December 2011 and today)
- Payment adjustments (September, 2011)

Findings on rural access to care

- There are fewer physicians per capita in rural areas; recruitment continues to be a challenge
- Volume of services per beneficiary is roughly equal in rural and urban areas
  - In some cases rural beneficiaries may travel farther
  - Travel times may not be longer for rural beneficiaries
  - Variation across regions of the country exceed urban/rural differences
- Rural and urban beneficiaries' satisfaction with their access is roughly equal

Guiding principles for rural access to care

- Rural Medicare beneficiaries should have equitable access to health care services
- Equity in access:
  - Can be measured by volume of visits or services, and beneficiaries' experience
  - Some rural beneficiaries may drive longer distances than some urban beneficiaries

Findings on rural quality of care

- Quality is similar across rural and urban areas for:
  - Skilled nursing facilities
  - Home health agencies
  - Outpatient dialysis facilities
- Hospital quality is mixed
  - Readmissions are roughly equal
  - Mortality and process measures tend to be worse (partially explained by volume)

Guiding principles for rural quality of care

- Quality of care in rural and urban areas should be equal for non-emergency services rural providers choose to deliver
- Quality of emergency care may differ between rural and urban areas due to limitations of small rural hospitals and the necessity to treat the patient at the rural facility
- All providers should be evaluated on all the services they provide, and the data should be publicly reported

Rural payment adequacy

- Use the same framework to evaluate payment adequacy (i.e. access, quality, Medicare payments and costs)
- Determine if rural payments are adequate relative to urban payments
- Compare different types of rural areas

Medicare payments are adequate for rural physicians

- Rural and urban access is equitable
  - Our survey shows a similar ability to obtain physician appointments
  - Medicare claims data show they have roughly equal numbers of physician visits
- Limited financial data on physician practices, urban and rural

Medicare payments are adequate for rural home health agencies

- Home health episodes per capita are similar in rural and urban areas
- Quality is similar
- Medicare margins are similar

		Rural		
	Urban	Micropolitan	Adjacent to urban	Not adjacent to urban
Number of agencies	4,791	525	224	200
Medicare margin	19.4%	18.7%	19.9%	20.9%

Source: Medicare cost reports 2010
Note: Data are preliminary and subject to revision.

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Medicare payments are adequate for rural skilled nursing facilities

- SNF episodes per capita are similar in rural and urban areas
- Quality is similar
- Medicare margins are similar

		Rural		
	Urban	Micropolitan	Adjacent to urban	Not adjacent to urban
Number of facilities	9,096	1,953	1,034	746
Medicare margin	18.5%	18.6%	18.4%	18.0%

Source: MedPAC analysis of 2010 cost reports

Medicare payments are adequate for rural hospices

- Hospice use is lower in rural areas, but growing
- Medicare margins are slightly lower, though positive

		Rural		
	Urban	Micropolitan	Adjacent to urban	Not adjacent to urban
Number of hospices	1,798	458	148	151
Medicare margin*	8.0%	3.1%	3.5%	6.5%

Note: Figures are preliminary and subject to change. Hospices that exceed the cap are excluded from this analysis. Analysis excludes non-reimbursable costs.
Source: *MedPAC analysis of 2009 Medicare hospice claims, cost reports, and provider of service file from CMS.

Medicare payments are adequate for rural inpatient rehabiliation facilities

- Not all counties have IRFs but similar services are often provided in other settings
- Medicare margins are mixed by type of rural facility

		Rural		
	Urban	Micropolitan	Adjacent to urban	Not adjacent to urban
Number of IRFs	922	169	13	17
Annual discharges	942	413	104	164
Medicare margin	9.0%	4.3%	-5.6%	16.1%

Source: MedPAC analysis of 2010 Medicare hospital cost reports from CMS

Need to monitor new Medicare dialysis payment system

- Access and quality of care appear adequate; capacity has grown in rural areas
- Rural dialysis facilities had lower volumes and lower margins in 2010
- New low-volume adjuster for dialysis:
  - Began in 2011
  - Increases base payment rate by 18.9% for all low-volume dialysis facilities
  - Does not target isolated facilities (does not consider distance to nearest facility)
- Will revisit rural financial performance next year

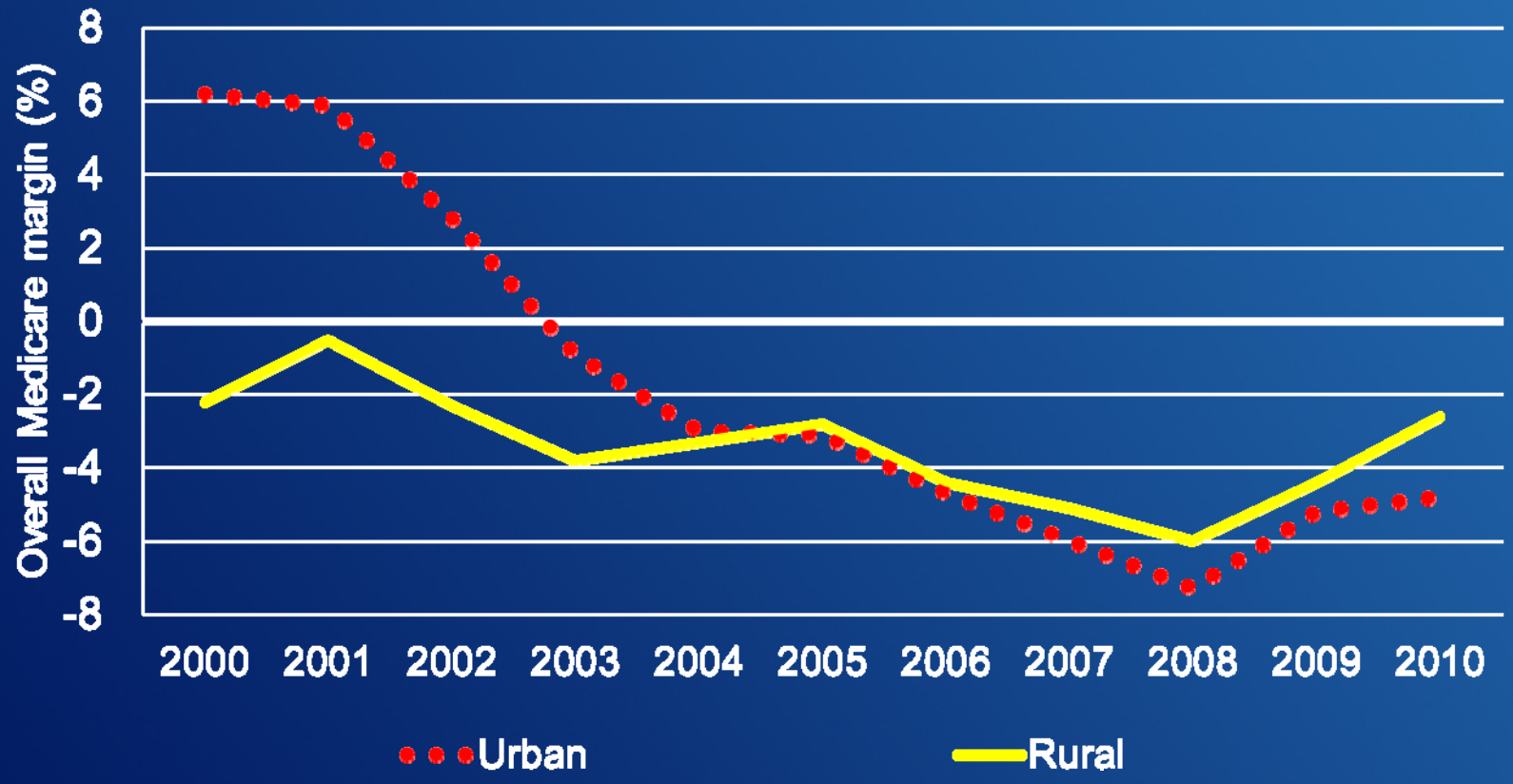
Medicare payments are adequate for rural hospitals

- Hospital use is similar in rural and urban areas
- Quality of care is mixed
- Medicare margins are higher in rural areas

		Rural		
	Urban	Micropolitan	Adjacent to urban	Not adjacent to urban
Number of hospitals	2,323	700	190	135
Overall Medicare margin	-4.8	-3.4	-0.9	0.8

Note: 2010 margins do not reflect the new low-volume adjustment that starts in 2011
Source: MedPAC analysis of 2010 Medicare hospital cost reports from CMS. Does not include CAHs which receive cost-based payments

Rural hospital Medicare margins are now higher than urban



Preliminary data subject to change

Selected hospital special payments

- Increase rural base rate up to urban level (MedPAC rec.)
- Increase rural DSH payments (MedPAC rec.)
- Low-volume adjustment up to 200 total discharges (MedPAC rec.)
- CAHs: Expanded cost-based reimbursements and add-ons, loosened restrictions on size and services
- Sole Community Hospitals (SCH) / Medicare-Dependent Hospital (MSH) enhanced inpatient add-ons
- Increased outpatient add-on at SCHs by 7 percent
- Increased low-volume adjustment (PPACA 2010)

Selected special payments for other sectors

- Physician
  - HPSA
  - 15 % add-on to physician payments billed by a CAH
  - Work GPCI floor of 1 (enacted 2003)
  - PE GPCI 50% limit on adjustment (enacted 2010)
  - PE floor of 1.0 in frontier states (enacted 2010)
- Home health: 3% add-on (enacted 2010)
- IRF: 18.4% rural add-on (CMS can adjust annually)
- Dialysis: 18.9% add-on (started low-volume new in 2011)

Hospital low-volume adjuster poorly targeted

- Concerns with program design
  - Not all isolated, can be close to CAH
  - Not empirically based and uses only Medicare discharges
  - Duplicates SCH and MDH program payments
- Low-volume rural hospitals already have higher Medicare margins than other hospitals
- Low-volume adjustment would raise inpatient margin to 14.0 percent for the smallest rural hospitals

Guiding principles for rural special payments

- Target providers that are the sole source of care
- Payments should be empirically justified
- Low-volume adjustments should be tied to total volume
- Don’t duplicate adjustments
- Maintain incentives for cost control

Discussion

- Comments on findings
- Comments on principles
- Other guidance for the report