Rural Medicare beneficiaries' access to care

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MEDPAC

Outline of today's presentation

1. Overview of MedPAC
2. Current work on rural beneficiaries' access to care and rural hospital closures
3. Policies to address rural hospital closures

MedPAC's mission and structure

- Provide independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program
- 17 commissioners selected by Comptroller General for expertise, not representation; include providers, payers, economists, researchers, beneficiary-focused individuals
- Commissioners supported by 25-30 analysts; most staff analysts are experts in their fields

MedPAC's principles of Medicare payment

- Ensure beneficiary access to high quality care in an appropriate setting
- Give providers an incentive to supply efficient, appropriate care and pay equitably
- Assure best use of taxpayer and beneficiary dollars

Current MedPAC work on access to care in rural areas

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

Examine emerging issue that affects access to care: rural hospital closures

Findings to be included in MedPAC's June 2021 report to Congress

MedPAC takes a multimodal approach to measure beneficiary access

MedPAC focuses on beneficiary satisfaction and volume of services to measure access

- Focus groups and site visits
- Survey data
- Medicare claims data

Capacity measures (e.g., hospital beds per capita) are of more limited utility to measure access

- Traveling for non-emergency care can be appropriate
- Capacity measures can be misleading

Survey data consistently 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).

Claims data indicate rural and urban beneficiaries received similar volume of services in 2018

Compared with urban beneficiaries, rural beneficiaries had:

- Similar hospital inpatient use but higher HOPD use
- Similar SNF and home health use
- Similar number of primary care clinician visits but fewer specialist visits

Regional variation was far larger than differences between rural and urban beneficiaries within the same state

Source: MedPAC analysis of the Carrier, Outpatient, home health, Medicare Provider and Analysis Review, and Master Beneficiary Summary files.

Hospital outpatient department (HOPD). Skilled nursing facility (SNF).
Results preliminary; subject to change.

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

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

Mostly due to beneficiaries bypassing their local hospital for inpatient care

Source: MedPAC analysis of Medicare cost report, Medicare Provider and Analysis Review file, and Outpatient file data.

Emergency department (ED). Fee-for-service (FFS). Hospital outpatient department (HOPD). Results preliminary; subject to change.

In markets where rural hospitals recently closed:

Inpatient care

- Care shifted to other hospitals
- Volume declines were similar compared with rural beneficiaries who lived in markets without a closure

Ambulatory care

- HOPD volume declined
- FQHC and PFS volume increased
- Suggests care shifted to non-hospital providers

Source: MedPAC analysis of Medicare cost report, Medicare Provider and Analysis Review file, Outpatient file, and Carrier file data.

Federally qualified health center (FQHC). Hospital outpatient department (HOPD). Physician fee schedule (PFS). Results preliminary; subject to change.

Summary of rural access to care findings

1) Survey and claims data suggest that rural and urban beneficiaries have similar access to care
2) Regional variation in service use was large, but within states, differences between rural and urban beneficiaries tended to be much smaller
3) Recent rural hospital closures could disrupt timely access (especially for ED care) and increase the need for other providers (e.g., FQHCs, RHCs, freestanding EDs)

Emergency department (ED). Federally qualified health center (FQHC). Rural health clinic (RHC).
Results preliminary; subject to change.

Medicare policy options to address rural hospital closures

Medicare already pays nearly all rural hospitals higher than standard rates

Policy proposals to address rural hospital closures include:

- Expand the number of hospitals eligible for cost-based payments or increase cost-based payments (e.g., 115% of costs)
- Allow outpatient-only hospitals to bill Medicare in rural areas
- Global budgets

MedPAC has substantial concerns regarding expanding cost-based payments

Cost-based payments:

- Do not always prevent closures
- Reduce incentives for cost control
- Benefit wealthier communities
- Distort competition

Given these concerns and because rural beneficiaries increasingly bypass their local hospitals for inpatient care, MedPAC favors expanding outpatient-only hospitals in rural areas

In 2018, MedPAC recommended allowing rural, outpatient-only hospitals to bill Medicare

Recommendation allows for rural, outpatient-only hospitals that are 35+ miles from other EDs to bill Medicare

In addition to standard payment rates, provides such outpatient-only hospitals with annual subsidies to assist with fixed costs

Emergency department (ED).

Congress recently created rural emergency hospitals

- Congress created a new category of hospitals beginning in 2023 – rural emergency hospitals (REHs)
  - REHs will not furnish inpatient services, must have 24/7 ED, and can furnish other services (e.g., outpatient clinic visits)
  - Medicare will pay REHs a monthly fixed payment, OPPS +5%, and standard rates for other services
  - Creation of REHs is consistent with MedPAC's outpatient-only hospital recommendation

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

Additional questions?

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