



MedPAC Rural Report Woefully Incomplete

The National Rural Health Association (NRHA) strongly contests the June 15 MedPAC Report to Congress that infers access to health care by rural patients and inadequacy of reimbursement rates for rural providers is no longer a concern. **Access to health care by rural patients and inadequacy of reimbursements for rural providers continue to plague rural America.**

Experts Agree Access to Health Care by Rural Medicare Patients Continues to Plague Rural Areas:

- “Rural Americans are more likely to suffer from chronic health conditions such as diabetes, heart problems and cancer, and face greater difficulty getting quality healthcare than their urban counterparts.” UnitedHealth Center for Health & Reform Modernization
- “77 percent of rural U.S. counties are defined as health professional shortage areas (HPSAs). Furthermore, 164 rural counties throughout the country lack any primary care physician.” Rural Health Research Center
- “(R)ural areas have higher rates of poverty, chronic disease, and uninsurance, and millions of rural Americans have limited access to a primary health care provider.”¹HHS 2011 Report
- “Health care access and health status are a particular concern in rural areas, where the population is older, has lower education and income levels, and is more likely to be living in medically underserved areas than is the case in urban areas...Rural (nonmetro) residents have higher rates of age-adjusted mortality, disability, and chronic disease than their urban (metro) counterparts”. USDA

MedPAC Reports Conclusions on Access Contradict Experts:

- MedPAC Assertion: “Equitable access does not necessarily mean equal travel times for all services. Small rural communities are expected to have fewer physicians per capita.”

¹ See also: Radley and Schoen, “Geographic Variation in Access to Care — The Relationship with Quality”, The New England Journal of Medicine, June 13, 2012.

- Rural Response: While rural communities may be expected to have fewer physicians overall, there is no reason that rural areas should be subjected to fewer providers per capita simply because they are isolated.
- MedPAC Assertion: Rural beneficiaries do not have an access to care problem because utilization of care rates are comparable to urban areas.
 - Rural Response: Rural beneficiaries have similar utilization rates because of an access to care crisis and they must travel to urban settings for care. MedPAC admits this: “Service volumes for rural patients, who have few local physicians per capita, is maintained in part by patients traveling to urban areas for some of their care.” (MedPAC report p. 117.) That’s like saying a vegetarian can survive at McDonald’s as long as they eat somewhere else.
- MedPAC Assertion: Fewer providers in rural areas does not equate to an access to care concern for rural patients (because the volume of visits by beneficiaries between urban and rural patients is comparable), MedPAC assumes there is no access concerns.
 - Rural Response: If beneficiary visits are equivalent but there are fewer providers, logic dictates that there would be more strain on the system.
 - Recent census data shows that approximately 25% of the population lives in rural America while only 10% of physicians practice there.

Rural Hospitals provide quality, cost-effective care:

- Medicare utilization data shows that rural hospitals treat significantly more Medicare beneficiaries than do urban facilities. Approximately 46% of all patients in rural hospitals are Medicare beneficiaries, compared to 31% in urban facilities.
- Given rural hospital’s Medicare patient share and uninsurance rates, it is no surprise that rural hospital’s total margins are much worse than urban facilities. One study by Sano Capital Group showed that 35 percent of all rural hospitals currently operate at a financial loss. These facilities must depend on charitable contributions, system subsidization, or local taxes to make up the difference.
- Notwithstanding MedPAC’s conclusion that rural payment policies do not contain sufficient cost controls, Medicare payments for all rural residents are 3.7 percent less per beneficiary than their urban counterparts, according to a recent iVantage Health Analytics study.
- Medicare makes up a significant amount of the payment rural structure but not its entirety. Costs must be contained because private and self-payers may pay on different schedules and as a good overall business model.
- Rural hospitals provide approximately 18% of all patient care yet receive only 13.5% of all Medicare payments according to a study by the Sano Capitol Group.

- Medicare Dependent Hospitals' (MDHs)—one type of rural hospital designation—financial margins would degrade considerably without the designation's accompanying payment methodology.
 - Without hospital-specific payments, MDH margins in 2009 would have been a negative 12.6 percent.
 - Without transitional outpatient payments, margins for hospitals receiving those payments in 2009 would have been a negative 16.2 percent.
- Cuts to rural hospitals also hurt rural economies. A closed rural hospital can mean as much as a 20 percent loss of revenue in the local economy, 4 percent per capita drop in income, and a 2 percent increase in the local unemployment rate. Even if a hospital doesn't close, reduced services compromise local access to care and job loss in the community.

These congressionally established rural payment programs for hospitals are not 'bonus' or 'special' payments, but rather alternative, cost-effective and targeted payment formulas that maintain access to care for millions of rural patients and financial stability for thousands of rural providers across the country.