

Medicare Reform: A Rural Perspective

A Report to the Secretary
U.S. Dept. of Health and Human Services

The National Advisory
Committee on Rural Health

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About the Committee

NACRH is a 16-member citizens' panel of nationally recognized rural health experts that provides recommendations on rural health issues to the Secretary of the Department of Health and Human Services. The Committee was chartered in 1987 to advise the Secretary of Health and Human Services on ways to address health care problems in rural America. Chaired by former U.S. Senator Nancy Kassebaum Baker of Kansas, the Committee's private and public-sector members reflect wide-ranging, first-hand experience with rural issues—in medicine, nursing, administration, finance, law, research, business and public health.

The Committee meets three times annually, once in Washington, D.C. and twice in the field. At each meeting, the Committee hears testimony from experts on any number of issues affecting rural health. The Committee then debates the issue and drafts recommendations, which are forwarded to the Secretary for review and consideration. Committee members, who serve staggered, four-year terms, represent the various dimensions of rural health, including provision and financing of services, research and development, workforce education and training and health services administration.

Department Secretaries, senators, members of Congress, governors, state legislators, and many national, state and local health care leaders have worked with the National Advisory Committee in recent years to help shape its recommendations. Since its inception, the committee has developed a substantial body of formal recommendations to the Secretary for improving rural health.

Forward

*By Wayne Myers
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You can't really discuss Medicare reform and its implications for rural beneficiaries without first getting a basic understanding of what rural means and what it may not mean. Depictions of rural America often fall victim to a nostalgic vision of peaceful farm country that look and feel like a homogenous subset of the rest of the more urbanized country. The assumptions inherent in that notion tend to create unanticipated problems across the board but particularly so in health care.

Consequently, any discussion of rural is best served by providing some important context about the issues at hand. How large is the rural population? Is it cheaper to provide care in rural areas? Are rural health care providers inefficient? Do rural residents really have trouble accessing health care services? Is farming the dominant rural occupation?

When the Committee asked me to provide a rural "context" for the report, I thought the best approach would be to examine the myths and realities that often get lost in any discussion about health care, rural America and the Medicare program.

Myth No. 1: Rural populations are disappearing.

"Rural" can be defined in many ways. The Office of Management and Budget (OMB) defines certain counties as "metropolitan." Policy analysts regard counties not included by OMB in metropolitan areas as "rural." This county-based system permits recognition of medical/social/economic functions of providers and the logistic challenges faced

by consumers. It also considers the proportion of county residents commuting to jobs in cities as well as the presence or absence of "cities" in a county in deciding whether the county is functionally metropolitan or non-metropolitan.

Changes in the non-metropolitan population are complex because the criteria for designating areas as "non-metropolitan" have changed over the years. Counties designated as non-metropolitan in 1960 had 66 million people, 37 percent of the nations' population. By 1996 those counties were home to 101 million people, but many of these counties had become parts of metropolitan areas.

In 1980 the population of counties designated as non-metropolitan had declined to 48 million, or 27 percent of the United States population. By 1996 the non-metropolitan population had climbed to 53 million, but constituted only 20 percent of the population.¹

In fact, rural areas are showing modest growth, though slower than that of metro areas. Areas undergoing marked growth are likely to be redefined as "metropolitan." Improvements in transportation make it easier to commute to more distant jobs, and qualify more counties for designation as metropolitan, even without changes in population distribution. Although the proportion of the United States population living in non-metropolitan counties is declining,

¹ US Census Bureau. Statistical Abstracts of the United States, 119th Edition. 1999, p. 916-917.

the absolute number of non-metropolitan people is rather constant at around 50 million. The Committee believes this significant population subgroup of Americans merits serious attention to their problems accessing and paying for health care.

Myth No. 2: Rural health care should be cheap.

Generally speaking, Medicare payment formulas are widely regarded as approximating the cost of providing health care efficiently. These formulae reflect an accumulation of Congressional choices related to which factors are to be included in estimating the costs of providing “efficient” health care. The reality is that of the various elements contributing to the cost of a unit of health care, some are more costly in large cities than in small towns, and some are less costly. Physicians and other health care professionals, especially advanced practice nurses and therapists, cost just as much in rural areas as in urban areas. Others, such as custodial workers, cost less. There is a perception that urban workers are more highly paid than their rural counterparts. This is not necessarily true. In many cases, rural providers compete with their urban neighbors for patient care and for many skilled workers. In the extreme, some providers often have to pay higher wages to attract skilled employees.

Myth No. 3: Rural health care is inordinately expensive.

As noted previously, Medicare payment formulae recognize costs that are particularly high in urban areas and disregard costs that are particularly high in rural areas. Hence, rural providers, particularly small rural hospitals, seem always on the edge of fiscal collapse. A variety of special payments have been instituted to help them survive, such as

payments to sole community hospitals (SCHs), critical access hospitals (CAHs) and Medicare Dependent Hospitals (MDHs). Despite these special provisions, payments per unit of care in rural hospitals remain well below payments to urban hospitals. Nevertheless, the need for special payments attracts more attention than the actual payment levels, leading to the perception that rural hospitals, with what otherwise would be seen as very economical operations, are relatively costly and inefficient. Rural advocates would argue that the need for special payments reflects problems with Medicare payment formulae rather than rural operations.

Myth No. 4A: Rural Medicare beneficiaries don't care about local access to care.

It is true that many rural people, particularly young people, choose to travel to urban areas for their health care feeling that they will receive higher quality and more confidential care. However, it should be noted that Medicare beneficiaries behave quite differently in securing health care than younger rural residents. Although they have financial access to care wherever they choose to be seen, rural senior citizens overwhelmingly select local care in preference to remote care.

Myth No. 4B: Rural health care needs can be met by urban centers.

Few would argue that highly complex care should be available in every small town. And, as is now widely acknowledged, rates of accidental injury and death are far higher in rural than urban areas.²

² Ricketts, T (ed.). Rural Health in the United States. Oxford Press. 1999, p. 26.

Appropriate care that is received within the “golden hour” after injury or event is crucial. The Medicare population is also particularly vulnerable to heart attack and stroke. “Clot-buster” therapy, administered early and appropriately, can prevent devastating damage from evolving heart attacks and strokes. The decision whether to administer this treatment requires immediate access to moderately sophisticated diagnostic equipment and consultation. The consultation and imaging interpretation can be provided through telemedicine technology, but the first-level clinical judgment and diagnostic instrumentation cannot. Finally, it should be noted that the likelihood that a person will get appropriate chronic or acute care is related to ease of access. For older patients such as Medicare beneficiaries, transportation to health care is a major access barrier. More rural beneficiaries live in poverty (25% compared to 20% of urban beneficiaries),³ lack access to public transportation (only 12% of communities with < 2500 people have access to public transportation)⁴ and have conditions interfering with activities of daily living⁵ than their urban counterparts. Convenient local access to appropriate comprehensive care is important to the health and quality of life of rural Medicare beneficiaries.

Myth No. 5: Rural America is an idyllic, homogenous, healthy agrarian society.

The typical nostalgic depiction of rural America may be as misleading as any of

³ National Economic Council/Domestic Policy Council. “Prescription Drug Coverage and Rural Medicare Beneficiaries: A Critical Unmet Need.” June 13, 2000, p. 1.

⁴ Ricketts, T (ed.). *Rural Health in the United States*. Oxford Press. 1999, p. 26.

⁵ National Economic Council/Domestic Policy Council. “Prescription Drug Coverage and Rural Medicare Beneficiaries: A Critical Unmet Need.” June 13, 2000, p. 1.

the myths that have been discussed but may be the hardest to dispel. The reality is that rural Americans are more likely to be poor (14% vs. 11% in urban areas),⁶ old,⁷ and experiencing poor health and disabilities than their urban counterparts. They are less likely than their urban counterparts to have access to an automobile or public transportation or to have a telephone. Thus, access to primary medical services is problematic in many rural communities.

The rural/urban disparity in mental health and social services is even greater. The rural elderly are less likely than the urban elderly to have private supplemental insurance and more likely to be on Medicaid. The rural elderly who stay in one place as they age are in poorer health than either their urban colleagues or those who relocate upon retirement. Depression and other mental disabilities are equally or more common among rural than urban people, though intervention services are relatively sparse. The rural elderly are also more likely to live alone, far from other family members.

Few rural families have any involvement in farming. In 1990 only ten million people (4% of the population) were members of families earning any farm-related income. Only three million people, or 1.3%, were members earning most of their income from farming. These percentages have probably declined further in the past decade. Manufacturing, on the other hand, provides similar proportions of jobs in rural and urban areas.

⁶ US Census Bureau. “Poverty in the US, 1999.” *Current Population Reports*. September, 2000.

⁷ US Census Bureau. “Metropolitan Population Estimates for July 1, 1999” and “March 1999 Current Population Survey.”

While rural America has fewer members of minority groups than urban areas, it is becoming more diverse. Many agricultural and food processing areas are witnessing rapid growth of their Hispanic populations, particularly in the Midwest and the South. Other communities are hosting new communities of immigrants from Southeast Asia.

Summary

Simply put, rural America in 2001 may not fit the perceptions that have long been a staple of the public consciousness. These views, both directly and indirectly, have helped shape health policy decisions and not always for the better. As the debate on Medicare reform continues, the Committee believes it is important that policymakers give considerable thought to the 8.1 million rural beneficiaries across the country as they decide how to restructure and improve the Medicare program.

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Executive Summary

A recent study indicates that it will cost twice as much money to provide today's Medicare benefits in the year 2030 as it did in 1998 if no changes are made to how the program is structured or financed.¹ Those figures clearly point to the need for some kind of Medicare redesign.

And yet the timing presents another distinct challenge to lawmakers and policymakers. The health care system is going through one of its more turbulent periods in recent memory. The dramatic cuts and payment policy changes mandated by the Balanced Budget Act of 1997 have not yet been fully implemented and their combined impact on the health care system remains unknown.

It is important to note that during its first 25 years, Medicare underwent very few major changes until the creation of the inpatient prospective payment system (PPS) in 1983, followed shortly thereafter by the introduction of the physician fee schedule.²

Since 1998, Medicare has added or will add new prospective payment systems for skilled nursing, home health, outpatient departments, rehabilitation facilities, long-term care hospitals, psychiatric facilities, ambulatory surgical centers and ambulance services. These changes figure to have a dramatic effect on the health

care environment.³ The prospect of following those changes with an even more far-reaching restructuring of the Medicare program may make the task ahead even more difficult.

This report will not focus on the relative merits or problems with any specific legislative proposals put forth either by members of Congress or past administrations nor will it focus on the reform proposals put forth during the 2000 Presidential campaign. Rather, this report will broadly examine the current status of the Medicare program as it relates to rural beneficiaries while also focusing on key issues that policymakers need to address to ensure that rural beneficiaries are treated equitably under a newly designed Medicare program.

The report begins with a forward by Dr. Wayne Myers, a former Executive Secretary for the Committee, that provides a brief discussion of rural considerations designed to dispel some myths and reinforce certain realities. The report then focuses on four broad categories: access, finance, workforce and quality. From there, it moves into a discussion of reform that cuts across the initial four categories and identifies key rural issues that should be addressed in any redesign of the Medicare program. Each of the chapters begins with a background section and a discussion of key policy issues followed by a summary of the Committee discussion on that topic and recommendations to the Secretary.

¹ The National Academy of Social Insurance. "Financing Medicare's Future." September 2000.

² Medicare also added fee schedules for laboratory services, radiology and ambulatory surgical centers between 1983 and 1998 but none of these was as dramatic as the introduction of inpatient PPS or the physician fee schedule.

³ Guterman, S. "Putting Medicare in Context: How Does the Balanced Budget Act Affect Hospitals." The Urban Institute. July 2000.

Introduction

Since 1987, the National Advisory Committee on Rural Health has served as a voice for rural concerns to the Secretaries of the U.S. Department of Health and Human Services. In that role, the Committee has made a wide range of recommendations on specific health issues, the great majority of which have focused on Medicare payment policy.

During the past 10 years, the issue of Medicare reform has arisen at various junctures, most noticeably in 1994 with the discussion of health care reform and again in 1998 with the Bipartisan Commission on the Future of Medicare. More recently, Medicare reform was a key issue in the 2000 Presidential Campaign.

Few policy issues are as daunting as Medicare reform. The sheer size of the program and its enormous influence on the rest of the health care environment make any discussion of redesign or modernization a contentious undertaking. Each year, Medicare accounts for more than \$200 billion in Federal spending to cover the health care needs of close to 40 million beneficiaries, 8.7 million of whom live in rural areas.⁴

Regardless of the political difficulties, the challenges facing the Medicare program need to be addressed. There are 39 million Medicare beneficiaries now and another 77 million new beneficiaries will be eligible for Medicare by 2010.⁵ Without changes to the program, the Medicare

Hospital Insurance trust fund assets will run out by the year 2025.⁶

At the same time, a discussion of Medicare reform also presents an opportunity to redesign and modernize Medicare. The Committee and many rural supporters have long believed that the current Medicare program does not serve rural beneficiaries equitably compared to urban beneficiaries. Consequently, the prospect of Medicare reform affords policymakers a chance to create a new Medicare program that serves all beneficiaries equitably and effectively.

This report is intended to bring attention to some of the key rural issues that should be addressed in any redesign of the Medicare program. The Committee also hopes that the report will ensure that a rural voice is heard should the Congress and the Administration take on Medicare reform.

⁴ Health Care Financing Administration. Health Care Financing Review: Medicare and Medicaid Statistical Supplement. 1999, Table 6, p. 94.

⁵ Testimony by U.S. Senator Bill Frist before the U.S. Senate Committee on Finance. February 24, 2000.

⁶ "The Medicare Trustees Report." March 2000.

Finance

Background

Medicare financing plays a critical role in supporting the rural health care delivery system and continues to be the dominant source of health care reimbursement in rural areas. Medicare patient expenses in 1998 accounted for 47 percent of total patient care expenses for rural hospitals, compared to 36 percent of urban hospitals.⁷ That makes rural hospitals particularly vulnerable to Medicare payment policy changes.

The Medicare fee-for-service program remains the primary source of coverage for rural beneficiaries. Less than four percent of rural Medicare beneficiaries are enrolled in Medicare+Choice plans.⁸

Medicare + Choice

	Medicare +Choice Enrollment July '00	Medicare +Choice Enrollment Rate ¹ July '00	Growth in Enrollment Dec. '97–Jun. '00
Total	6,207,777	15.3	17.6
Urban	6,005,149	19.4	17.8
Rural	202,628	2.1	10.6

Source: Data compilation by Tim McBride, University of MI, Department of Economics, taken from the RUPRI Medicare County Capitation file.

The rural health care delivery system is dominated by small (50 beds or less) acute care hospitals with a low average daily

⁷ Medicare Payment Advisory Commission. Report to Congress: Medicare Payment Policy. MedPAC. June 2000, Table C-16, p. 189.

⁸ Rural Policy Research Institute. "A Report on Enrollment: Rural Medicare Beneficiaries in Medicare + Choice Plans." Rural Policy Brief. RUPRI Center for Health Policy Analysis. March 2000.

Hospitals By Bed Size Categories In 2000

Beds	Urban Hospitals		Rural Hospitals	
	Number	Percent	Number	Percent
0 - 99	672	25%	1,785	82%
0 - 49			1,170	54%
50 - 99			615	28%
100 - 199	924	35%	304	14%
100-149				
150-199			81	4%
200 + beds	1,069	40%	71	3%
All Hospitals	2,665		2,160	

Nonfederal, acute care, general hospitals.

Source: *Federal Register*, April, 2000. Adapted from Medicare program: Prospective payment system for hospital outpatient services. Health Care Financing Administration, U.S. Department of Health and Human Services.

census of used beds and a more limited patchwork of other services including general outpatient services, physician services, home health and skilled nursing care.

The Medicare program employs several mechanisms to encourage providers to practice in rural areas and increase access to care for Medicare beneficiaries. For example, physicians practicing in rural health professional shortage areas (HPSAs) qualify for a 10-percent payment bonus. In addition, providers who practice in either Rural Health Clinics or Federally Qualified Health Centers can receive reasonable cost reimbursement for providing service to Medicare beneficiaries.

The service mix in rural areas is considerably different than in urban areas. Health care in rural areas tends to be

Key Special Medicare Payment Categories

Rural Health Clinics: These providers were authorized in 1977 and designed to improve access to care for Medicare beneficiaries. The clinics, which receive reasonable cost reimbursement under Medicare, can be either provider-based or free-standing and must be located in a rural area that is either a health professional shortage area (HPSA) or a medically underserved areas (MUA). There are currently 3,448 RHCs.

Federally Qualified Health Centers: These providers were authorized as a new provider type under the Medicare program in 1990 and are designed to promote access to primary care services for beneficiaries in medically underserved areas (MUAs). The FQHC designation was created explicitly for government-subsidized community health centers (CHCs) and migrant health centers (MHCs) as well as several smaller variations. These facilities receive reasonable cost reimbursement under the Medicare program. There are currently 2,637 FQHCs in rural areas.

focused on short-term acute and primary care with limited access to tertiary care centers and the specialty services they provide.

Rural hospitals are often the focal point of the rural health care delivery system and the locus of inpatient and emergency care. These hospitals also are involved in providing home health, skilled nursing, long-term care and ambulance services for their communities.

For example, all rural hospitals operate outpatient centers and 59 percent of these facilities also provide home health services while 34 percent offer skilled nursing services. Seventy-two percent of these hospitals have either a home health agency or a skilled nursing facility (SNF) while 21 percent of the facilities provide outpatient, SNF and home health services.⁹

⁹ 1996 Medicare Cost Reports, PPS 13.

Current Status

The rural health care delivery system, like the health care system at large, is going through some turbulence. The Balanced Budget Act of 1997 attempted to slow Medicare growth by reducing reimbursement to all types of providers for all services. It also moved many of the Medicare payment systems that were still paid on a cost basis (most notably outpatient, skilled nursing, home health, and rehabilitation) to prospective payment systems while also creating a fee schedule for ambulance services. The Balanced Budget Refinement Act of 1999 continued that trend by moving long-term care and psychiatric hospitals into prospective payment.

Although originally intended to produce \$112 billion in Medicare savings over five years (1998-2002),¹⁰ the changes wrought by the BBA have had a far larger impact than expected. In FY 2000, Medicare spending will be \$29 billion less than expected and the rural portion of that is seven billion.¹¹

Typically, rural providers operate on thinner Medicare margins than their urban counterparts and the BBA cuts have greatly diminished that thin bottom line. Rural hospitals saw their Medicare margins fall from 9.5 percent in 1997 to 5.2 percent in 1998. Urban hospitals had an average margin of 15.8 percent in 1998, a drop of 2.3 percent from 1997.¹² In fact, 39.4 percent of rural hospitals had a

¹⁰ Guterman, S. "Putting Medicare in Context: How Does the Balanced Budget Act Affect Hospitals." The Urban Institute. July 2000.

¹¹ Testimony from Thomas Scully before the Senate Appropriations Subcommittee on Agriculture, Rural Development and Related Agencies. July 11, 2000.

¹² Medicare Payment Advisory Commission. Report to the Congress: Selected Medicare Issues. MedPac. June 2000, Table C-3, p. 178.

Percent of Hospitals with Negative Medicare Inpatient Margins, 1999 (excluding graduate medical education by hospital group)

Urban	26.3%
Rural	43.9%
Rural Referral	33.0%
Sole Community	42.2%
Medicare Dependent	36.1%
Other Rural < 50 Beds	54.5%
Other Rural > 50 Beds	45.1%

Source: Table B5, "Report to the Congress: Medicare Payment Policy." Medicare Payment Advisory Commission. March, 2001.

negative Medicare operating margin in 1998, compared to 20.6 percent of urban hospitals.¹³

Rural hospitals, which are heavily dependent on Medicare and Medicaid, face difficulty trying to balance losses by shifting costs to third-party payers. This is exacerbated by the continuing growth nationally in the number of uninsured patients, which makes it tough to shift costs to either Medicare or Medicaid or to private insurers to cover the losses faced in treating the uninsured.

The Balanced Budget Refinement Act (BBRA) of 1999 attempted to lessen the impact of the BBA by putting another \$1 billion back into the system for FY 2000 and \$15.8 billion over five years. Congress and the Administration agreed on further givebacks that provided another \$36 billion in adjustments at the close of the 106th Congress in the BIPA of 2000 legislation.¹⁴ That total, it should be noted, included payment adjustments for all

¹³ Medicare Payment Advisory Commission. Report to the Congress: Selected Medicare Issues. Medpac. June 2000.

¹⁴ Health Care Financing Administration. "CBO: BIPA gives providers \$36.8 Billion over five years, \$94.3 over 10." January 4, 2001, p. 4.

providers, including urban hospitals and HMOs.

A few of the payment changes in the BBA and the subsequent adjustments in the BBRA have not been fully implemented so it is difficult to know the full impact. Early indications are that rural providers may be at risk for the next few years due to their dependence on a variety of changing payment streams (outpatient, home health and skilled nursing care).

The Payment Differential: Key Policy Issues

Historically, Medicare has spent less per beneficiary in rural areas than in urban areas. Medicare spends \$5,696 per beneficiary in urban areas compared to \$4,652 in rural areas.¹⁵ In part, this lower level of spending stems from the belief that it costs less to provide care in rural areas. In constructing the original inpatient PPS, analysts based their methodology on historical costs in the aggregate. There was also a perception that rural areas had a lower cost of doing business whereas urban areas faced higher costs particularly when it came to wages.

Those perceptions became part of payment policy as the initial inpatient PPS included separate standardized rates for rural and urban hospitals, which led to considerable payment inequity.

Some rural advocates continue to question the initial assumptions upon which the payment system was created. They wonder whether the underlying assumptions of the payment system underestimated costs in the rural settings for reasons related to under-utilization or practice styles, or decisions by local

¹⁵ Health Care Financing Administration. Health Care Financing Review: Medicare and Medicaid Statistical Supplement. 1999, Table 15, p. 111.

governing boards to minimize charges thereby absorbing costs with non-patient revenue. There was also concern that, to their own detriment, rural providers may have charged less than their total costs for some services, either because of inadequate accounting systems or as a matter of policy.

The separate rural and urban standardized rates were eliminated in 1995. While this change helped rural hospitals, a payment gap remains. Some attribute the

Key Rural Medicare Hospital Classifications

Critical Access Hospitals (CAH): These small facilities serve as the sole source of inpatient care in a community either because they are geographically isolated or because severe weather conditions or local topography prevents travel to another hospital. These hospitals receive cost-based reimbursement from Medicare and also are given greater regulatory flexibility related to staffing and coverage.

Sole Community Hospitals (SCH): These facilities serve as the sole source of inpatient care in a community and must meet certain mileage and distance requirements in order to qualify for enhanced Medicare payments that are based on their historical costs.

Medicare Dependent Hospitals (MDH): These facilities have fewer than 100 beds, do not serve as a SCH and must have a Medicare patient load (by either count or revenue) greater than 60 percent in order to qualify for cost-based Medicare payments that are based on their previous costs.

Rural Referral Centers (RRC): These facilities are high volume, treat a range of complicated cases and serve as a regional or national referral center. They have more flexibility for reclassification to a higher urban wage index and may receive higher DSH payments than small urban or most other rural hospitals. They must have at least 275 beds, meet a minimum discharge standard or meet a specialty composition standard of medical staff, referral volume or source of inpatients in order to qualify for special consideration under Medicare's prospective payment system.

differential to the wage index while others point to the disproportionate share adjustment. Others say it correctly reflects the difference of providing care in rural versus urban areas. Still others attribute the discrepancy to GME payments – two standardized rates (large core urban hospitals and all other hospitals) are used.

Over the years, policymakers and lawmakers have acknowledged rural hospitals may be vulnerable under prospective payment systems that reimburse based on a national average and make no allowance for differences in volume and fixed costs.

Certain rural hospitals can qualify for special payment under Medicare payment by being classified as a critical access hospital (CAH), sole community hospital (SCH), Medicare-dependent hospital (MDH) or a rural referral center (RRC). Each of these classifications brings enhanced payment to qualifying hospitals.

The creation of this alphabet-soup of protections has served to provide some limited stability to the rural health care infrastructure but fails to address the core problem of why these hospitals struggle to survive.

Some point to the issue of volume as a problem. Many smaller hospitals have fewer cases upon which to spread their fixed costs. The logic behind the use of a prospective payment system is to encourage efficiency among providers by paying a set price that encourages providers to provide their services in a cost-effective manner. Rural providers typically handle a lower volume of cases and cannot achieve the same economies of scale as larger providers.¹⁶ That can

¹⁶ Atkinson, JG. "Needed: A 'Low-volume Adjustment' for Medicare Prospective Payment to

make survival under a prospective payment system somewhat difficult since payment is based on a national average cost in which the average is heavily weighted by the costs of large urban hospitals. Little research has been done on this issue to date. However, the Medicare Payment Advisory Commission (MedPAC) is expected to examine this issue in its June 2001 report.

Others argue that current payment policy adjustments are the key causes of the urban-rural payment differential. They are: wage index, disproportionate share payment, GME (which will be discussed in the Workforce chapter) and managed care payment.

The Wage Index

The wage index is part of a complex calculation of Medicare hospital payments that attempts to account for differences in the cost of labor between hospitals. HCFA uses the wage index to adjust the estimated labor-related portion, which is estimated to be about 71 percent, of the standard payment per discharge. As a result, the index has a dramatic impact on

**The Wage Index:
A Rural-Urban Comparison**

A hospital in Sylvester, Georgia will receive 11.8 percent less per Medicare discharge than a hospital located in Albany, Georgia, which is 22 miles away. This means Baptist Hospital Worth County in Sylvester would receive \$4,069.29 for a patient admitted for simple pneumonia, whereas Phoebe Putney Memorial Medical Center will receive \$4,550.69. Baptist Hospital Worth County would receive \$585,864 less per year if 50 percent of its admissions were Medicare and it were operating at 50 percent occupancy, or 25 patients per day, due to the difference in the area wage index.

Small Rural Providers.” For the George Mason University Center for Health Policy, Research & Ethics. World Wide Web publication. June 20, 2000.

Wage Index Reclassification

Medicare attempts to address some of the problems associated with the wage index by allowing some hospitals to reclassify from one wage index area to another.

As a result, rural hospitals located near an urban area with which they compete for labor can apply to get the same wage index as the nearby urban hospital. To qualify, the rural hospital must show that it is 15 miles from the area it wishes to be reclassified to. It must also show that its average hourly wage rate is less than 106 percent of the average hourly wage in its current labor market and at least 82 percent of the average hourly wage for the area it is trying to reclassify to.

At the same time, Medicare provides protection for the statewide rural wage rate area by calculating their wage index as if the reclassification had never taken place. This ensures that the hospitals remaining in the rural wage area do not suffer an aggregate reduction due to the loss of a reclassified hospital. This is important since the reclassified hospitals typically represent the higher end of the labor market that make up the statewide labor market calculation.

Medicare inpatient PPS payments because of this multiplier effect.

Some rural advocates point to several conceptual concerns with the current use of the wage index:

- The state-wide rural wage markets do not represent true labor markets because geographically disparate hospitals are lumped together whether they use a similar labor pool or not.
- The current calculation of the wage index fails to include an occupational mix adjustment that takes into account the differences in the types of workers used by rural and urban hospitals.
- The current inpatient hospital wage index will be used to adjust for wages in other areas of the Medicare program, including outpatient

services, skilled nursing care and home health.

Criticizing the wage index, however, has proven far easier than fixing it. While the issues cited above may be clear, the potential fixes are problematic. For example, changing or subdividing the state-wide rural wage areas could have the effect of lowering payment for smaller more isolated rural hospitals located far from urban settings. That would result in a decrease in the wage rate because it would no longer have the benefit of the higher labor costs of the rural hospitals located at the urban fringe.¹⁷

Similarly, the introduction of an occupational mix could have variable results. The Prospective Payment Assessment Commission (PROPAC) examined this issue in 1990 and found that while rural hospitals would be helped in the aggregate, some rural hospitals would face losses in specific regions of the country.¹⁸

Both MedPAC and the General Accounting Office (GAO) are expected to re-examine wage index issues in reports mandated by the Balanced Budget Refinement Act of 1999.¹⁹ This work may shed light on the question of a rural-urban differential.

There are also larger contextual policy issues to consider. The wage index is a zero-sum calculation. In order to give

more to rural hospitals, one would have to take more from urban hospitals. Any changes create winners and losers. It is also worth noting that it has taken HCFA years to refine the wage and hospital data it currently collects. Additional or substitute data would similarly take years to refine.

The Disproportionate Share Adjustment

Since 1986, Medicare has made special payments to hospitals that provide care to a disproportionate share of poor patients. MedPAC and others have long noted that the current DSH payment policy favors hospitals located in urban areas.

Almost half of all urban hospitals receive DSH payments while only one-fifth of rural hospitals receive DSH payments. The differential was due mainly to different eligibility thresholds for urban and rural hospitals. However, Congress took a significant step toward addressing this issue in FY 2000 by creating a uniform eligibility standard for all hospitals. The legislation allows for eligible rural hospitals to get a payment adjustment up to 5.25 percent for their inpatient services.²⁰

The equalization of the eligibility thresholds should result in significant payment gains for rural hospitals. However, the amount of DSH adjustments still differs for rural and urban hospitals. The adjustment still includes a formula that tends to reward urban hospitals with more than 100 beds by using steeply graduated payment adjustments.²¹

¹⁷ Dalton, K and Slifkin, B. Unpublished Research. University of North Carolina. Rural Health Research Center. Fall 2000.

¹⁸ Williams, D; Pettengill, J; Lisk, C. "Adjusting A Wage Index For Geographic Differences in Occupational Mix." Technical Report, 1-90-02. Prospective Payment Assessment Commission. June 1990.

¹⁹ Section 410 and 411 of the Balanced Budget Refinement Act of 1999.

²⁰ Section 211 of the Beneficiary Improvements and Protection Act of 2000.

²¹ Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. MedPac. March 1999.

Some rural advocates say the current formula makes a value judgment that rural hospitals do not have the same burden of providing care to low-income patients as urban hospitals. The original logic of that premise was based on the finding that overall urban hospitals provide greater levels of charity and uncompensated care than rural hospitals. However, those findings are not uniform and the levels of charity care differ from state to state. For example, a five-state study showed that financially vulnerable rural hospitals tend to have higher levels of uncompensated care.²² The reality is that many rural hospitals are the provider of last resort in their communities and must take all patients regardless of ability to pay.

Medicare Managed Care

Medicare enrollees have had the option of being cared for by a managed care plan since 1982. This option gained increased policy endorsement in the Balanced Budget Act of 1997 and the creation of the Medicare + Choice program. The idea was that plans would compete against each other and this would help derive savings for the Medicare program by paying less than would normally be spent in FFS.

The program, however, has been the source of some contention. The managed care plans have complained loudly that they have not been paid enough and have received payment adjustments in both the BBRA and BIPA.

²² Sutton, J; Blachfield, B; Milet, M. "Is the rural safety net at risk? Analysis of charity and uncompensated care provided by rural hospitals in Washington, West Virginia, Texas, Iowa and Vermont." Draft Report issued to ORHP May 2000.

The Urban Edge: Competition or Financial Advantage?

Medicare + Choice is more prevalent in urban than rural areas. Is it because the urban plans are more competitive and efficient or do they have an inherent financial advantage?

Rural advocates believe managed care plans are being overpaid in some urban areas. They believe this allows the plan to make profit and provides enough extra revenue to attract beneficiaries by offering expanded benefits such as prescription drugs and eye care. In rural areas, they argue, there is no excess above costs in the capitated payment. That makes it hard for rural plans to generate a profit and provides little financial flexibility to offer increased benefits.

Others disagree and say the plans are not overpaid and rather rely on the power of the market to compete for beneficiaries. They argue that they keep costs low and operate efficiently enough to cover the costs of the expanded benefits.

Others, including consumer advocates and watchdog groups, have claimed the plans have been overpaid, which has been confirmed in some cases by the Office of the Inspector General at the U.S. Department of Health and Human Services.²³

Some of the loudest complaints have come from rural advocates. Prior to 1997, some counties in rural areas received as little as \$221 per patient per month while some urban areas had monthly payment rates as high as \$767. Not surprisingly, rural enrollment has not kept pace with urban areas.

Despite significant changes in the Medicare + Choice program (including the establishment and then boost of a

²³ Office of Inspector General. "Review of Medicare Overpayments to Managed Care Organizations Due to Overstated Capitation Rates." U.S. Department of Health and Human Services. December 1999.

payment floor) and special initiatives designed to encourage participation, rural enrollment has lagged behind urban areas. Rural enrollees currently make up less than 4 percent of Medicare beneficiaries in managed care plans.²⁴

In FY 2000, 101 rural counties were affected by plans pulling out of their service area. In 27 of those counties, beneficiaries were left with one other Medicare + Choice plan to join. However, there were 27,000 beneficiaries in the 65 other rural counties that were left without a viable option other than returning to traditional FFS.²⁵

Rural advocates believe one of the primary problems with the Medicare + Choice program is that it is based on the existence of a competitive market. That model does not fit most rural areas where few plans are lining up to compete. In fact, interested plans are often scared off by the low payments.

Managed care plans are often further discouraged from moving into rural areas where the population is often spread out over a large geographic area. That makes it hard to set up the kind of provider network needed to effectively manage the care and the costs. Still other plans are concerned that they may face unexpected initial costs due to the historic under-utilization of services that may result in an early spike in utilization that is not

²⁴ Shay, B and McBride, T. "A Report on Enrollment: Rural Medicare Beneficiaries in Medicare + Choice Plans." Rural Policy Brief. RUPRI Center for Health Policy Analysis. March 2000.

²⁵ McBride, TD and Andrews, C. "An Update on Medicare+Choice: Rural Medicare Beneficiaries Enrolled in Medicare+Choice Plans through October 2000." Rural Policy Brief. RUPRI Center for Health Policy Analysis. March 2001, Vol. 6, No. 7 (PB2001-7).

Total Medicare Spending

Medicare Spending	Total Expenditures (in millions)	Amount per Enrollee	Amount per Person Served
Urban	\$134,200	\$5,696	\$6,228
Rural	\$40,140	\$4,652	\$5,046

Medicare enrollees in managed care plans are not included in the denominator.

Source: HCFA: Health Care Financing Review: Medicare and Medicaid Statistical Supplement, 1999. Table 15, page 111.

accounted for in the payment rate. The BBRA attempted to address this concern by creating additional payment for plans to accommodate those early utilization increases. The BIPA legislation extended that so that a plan could receive bonus payments in the first two years in a previously unserved county.²⁶ These provisions may help encourage more plans to reach out to unserved counties but the true impact may not be known for some time.

Issues Discussed

Many rural advocates believe the current Medicare payment system is not adequate to ensure access to care for rural beneficiaries. One area that continues to generate a great deal of attention is the inpatient hospital wage index. Hospital administrators, in particular, point to this measure as the key culprit behind underpayment in rural areas. They believe rural providers should be paid the same wage rate as the average urban hospital. Researchers and policymakers, however, are less convinced that the wage index is the primary reason for rural-urban payment differentials. Instead, they point to a variety of factors from DSH payments, practice patterns and the

²⁶ Section 512 of the Balanced Budget Refinement Act and Section 608 of the Beneficiary Improvement and Protection Act of 2000.

impact of volume within the DRG system as key issues to consider along with the wage index.

The question over how to structure a more equitable Medicare payment system poses an equally difficult challenge. The Committee discussed several philosophical approaches ranging from dramatic restructuring of Medicare to incremental adjustments to the current system.

On one extreme, Medicare could move away from its current reliance on fee-for-service delivery and develop a system that would emphasize local control. The idea behind this approach is to give control over how dollars are spent at the local community level so it can manage its own care more effectively, assuming there is adequate funding. This approach would help address the great variability across rural areas and avoid the problems of trying to fashion national payment policies that may or may not be relevant at the local level. This approach would also entail additional financial support to those communities that currently struggle to provide the necessary infrastructure to provide a basic level of care.

Another option would be to use the Medicare program to make a stronger investment in the sustainability of the local health care system. Under this approach, Medicare would not only pay for services but also make a minimum separate investment in some rural communities in order to ensure the viability of the local health care delivery system. Such an approach would then allow Medicare to pay solely for the costs of care in its current payment systems without the need for the myriad of payment adjustments now in existence.

On the other end of the spectrum, one could build on the current system in an incremental fashion. This approach could take two forms. The first would attempt to address current payment inequity by adjusting the current payment systems to reflect the reality of providing care in rural areas through the use of a volume-adjustment to the current prospective payment systems. The second form would take that concept a step further and construct completely new and separate rural prospective payment systems that would better reflect the realities of providing care in rural areas to isolated populations.

Committee Consensus

The Committee believes that in any redesign of the Medicare program special protections need to be put in place to ensure the viability of the fee-for-service delivery system. The Committee is concerned that reliance on managed care to address inequities in services for rural beneficiaries is problematic because of the lack of competing health plans in sparsely populated areas.

The Committee believes Medicare has responsibility for both guaranteeing reasonable access to care and for ensuring that the local health care delivery system is not put at a disadvantage solely because of geographic location.

At a minimum, the Committee believes Medicare policy should not create new problems for beneficiaries in terms of access to quality health care services. More appropriately, the Committee believes that Medicare payment policy should be adequate enough to ensure a basic benefit package that is available regardless of where the beneficiary is located. That benefit package, they noted, would include all of the current benefits as well

as access to preventive care, dental benefits and prescription drugs.

Recommendations

The Secretary should:

- Evaluate the need for a low-volume adjustment within all of the Medicare prospective payment systems (See National Advisory Committee recommendations, 1999).
- Conduct research to determine the true cost of providing care to Medicare beneficiaries in rural areas that takes into account factors related to access, geographic isolation and volume. The results of this research should be used in redesigning the Medicare program to ensure equity of benefits for rural beneficiaries.
- Continue collecting data on occupational mix and implement an adjustment to the wage index as soon as possible.
- Collect wage data for both the skilled nursing and home health service areas and evaluate the impact of constructing an occupational mix adjustment within the wage index for both of these payment systems.
- Continue to refine the methodology for the disproportionate share adjustment for hospitals to treat all hospitals equally.

Access

Background

The Medicare program was created in 1965 to provide health insurance coverage for elderly Americans and, by and large, it has done that. The health services research literature is rich with studies that attempt to find a uniform and policy-relevant way to assess whether patients can get the care they need. This endeavor typically involves some degree of value judgements not only in terms of the infrastructure needed to ensure proximity to care but also in terms of socioeconomic status, cultural concerns, geographic barriers and physical factors. And it may mean different things for one population, such as the elderly, than it does for another, such as children or the uninsured. For the purposes of this discussion, however, the focus is solely on Medicare and rural beneficiaries.

Rural populations are viewed as vulnerable to reduced access to health care services for a variety of reasons. Rural areas tend to have a limited number of health care providers, poorly developed health care systems, high prevalence rates of chronic illness and disability, socioeconomic hardships, and geographic and transportation barriers.²⁷ Rural residents are likely to blame the lack of local resources for care as a key reason that some residents do not have a consistent source of care.²⁸

²⁷ Schur, C and Franco, S. "Access to Care." Project Hope Walsh Center for Rural Health Analysis. 1998.

²⁸ Hayward, RA; Beynard AM; Freeman, H.E.; Corey, C.R. "Regular Sources of Ambulatory Care and Access to Health Services." American Journal of Public Health. 1991, Vol. 8, p. 434-438.

The 8.9 million rural Medicare beneficiaries²⁹ seek their care in a system that is markedly different from their urban counterparts. Rural Medicare beneficiaries are typically treated in a fee-for-service format and their provider base is heavily weighted toward primary care as 57 percent of the physicians in these areas are generalists. In urban areas, only 27% of all physicians practice primary care. There are more specialists than generalists in urban areas.³⁰ Not surprisingly, there are more than twice as many health professional shortage areas in rural areas (1,847) than in urban (893).³¹

Rural Medicare beneficiaries also

Health Professional Shortage Areas (HPSAs), 2000

	Urban	Rural
Medical designations	893	1,847
Percent of all designations	33	67
Percent of HPSA population	54	46

Source: Bureau of Primary Health Care, Division of Shortage Designation

²⁹ Health Care Financing Administration. Health Care Financing Review: Medicare and Medicaid Statistical Supplement. 1999, Table 6, p. 94.

³⁰ Rosenthal, TC and Fox, C. "Access to Health Care for the Rural Elderly." Journal of the American Medical Association. October 25, 2000.

³¹ The Bureau of Primary Health Care, Division of Shortage Designation. September 30, 2000. This is based on a physician to population ratio of 3000:1. A variety of factors (geographic, service area, and number of providers) determine HPSA designation. The provider to resident ratio is 3,500:1 or 3,000:1 if there is unusually high demand for primary care or there is insufficient capacity in contiguous areas.

experience somewhat higher rates of hospitalization,³² although, not surprisingly, this decreases by 15 percent for those living more than 30 minutes from the hospital.³³ Rural hospitals are staffed largely by generalists and have a vastly different case mix than urban hospitals. The rural facilities tend to focus on primary care, chronic care management and long-term care.

These rural facilities continue to be the focal point in their communities. Over the past decade, hospitals in sparsely populated areas have had trouble remaining financially viable in the face of increasing pressure to cut Medicare payments. Policy experiments with Medicare payments to Medical Assistance Facilities in Montana and Rural Primary Care Hospitals in seven other states led to Medicare recognition nationally of Critical Access Hospitals (CAHs). Over the past three years approximately 320 small rural hospitals have accepted some constraints on their size and the length of time they can keep patients hospitalized in return for CAH designation which allows them to receive cost-based reimbursement from Medicare for both inpatient and outpatient services.

Proponents argue that most of these hospitals are needed to assure immediate local access to urgently needed care, and that many of these hospitals would not have survived without the Critical Access Hospital provisions. The BBRA of 1999 and the BIPA of 2000 relaxed some of the constraints required for designation. This

³² Culler SD; Parchman JL; Przybylski, M. "Factors Related To Potentially Preventable Hospitalizations Among The Elderly." Medical Care. 1998.

³³ "The Distance to Community Medical Care and the Likelihood of Hospitalization: Is Closer Always Better?" American Journal of Public Health. 1997.

will increase the number of small hospitals surviving through this strategy, but may reduce the special character and contribution to access of the CAH.

Telemedicine

Telemedicine is often seen as a tool for increasing access to care, particularly for isolated rural areas. While telemedicine technology has been available as a technology for the past 40 years, it has gained increased acceptance in the last 10 years. Some rural communities have turned to this technology to improve access to specialty care. Typically, this technology allows specialists from urban areas to treat rural patients by using telecommunication technologies to transmit medical images and videos over distances. Telemedicine offers promise for rural communities located far from medical specialists and may also help better serve rural areas given the high degree of frail elderly who suffer from chronic conditions and have difficulty traveling.

The use of telemedicine appears to be growing, although few national studies have looked at utilization, clinical effectiveness or patient satisfaction. A 1999 industry survey found that there were 170 telemedicine programs in 1998, up from 157 the previous year. Those telemedicine networks provided 52,223 teleconsultations, an increase of 10,000 from the previous year. States with the most programs are California, New York, Texas, North Carolina and Pennsylvania.³⁴

The use of this technology by Medicare beneficiaries is less clear. Medicare began

³⁴ "1999 Report on U.S. Telemedicine Activity: Desktop Reference for a Rapidly Evolving Industry." The American Telehealth Service Providers and Telemedicine Today. 1999.

reimbursing for some telemedicine services in 1997 but that coverage was limited to rural health professional shortage areas. Between January 1, 1999 and September 30, 2000, HCFA paid 301 claims for a total of \$20,000.³⁵ This total does not include teleradiology, which is paid for the same as any radiology service and is not considered a teleconsultation under Medicare.

This limited number of teleconsultations may be due to several factors. Some rural advocates have complained that the payment methodology is too restrictive in terms of who can present the patient at the rural end and also in the range of services that are covered. Others believe there are still issues related to licensure and infrastructure that must be addressed to encourage more use of this technology.³⁶

Many of the concerns about the payment methodology were addressed in the legislation that passed late in the 106th Congress.³⁷ The other issues, however, have yet to be addressed and are beyond the scope of Medicare.

To date, it has been difficult to gauge the effectiveness of telemedicine technology and its impact on Medicare beneficiaries, given the limited history of Medicare reimbursement in this area. No definitive national studies have been done on these

³⁵ Department of Health and Human Services, Health Resources and Services Administration. "2001 Telemedicine Report to Congress." January 10, 2001.

³⁶ U.S. Department of Commerce, in consultation with the U.S. Department of Health and Human Services. "1997 Telemedicine Report to Congress." January 1997.

³⁷ Section 223 of the Medicare, Medicaid and SCHIP Beneficiary Improvement and Protection Act of 2000.

Telemedicine: A Panacea?

Many advocates have pointed to telemedicine as a tool for addressing access problems facing rural communities, but there are some questions about the extent to which this technology can address long-standing concerns.

Telemedicine advocates see this technology as a way to bring more specialty care to rural areas by linking them with specialists at distant tertiary care centers. They also note that telemedicine links can help strengthen and stabilize rural hospitals. Over the past 10 years, there have been substantial technological advancements and reductions in cost, putting this technology within closer reach for struggling rural providers.

Others, however, are more cautious. They are concerned that policymakers may overestimate the power of this technology to solve some of the more intractable problems faced by rural delivery systems. They are concerned that political leaders and policy makers may see investment in this technology as a substitute for funding other more traditional initiatives focused on stabilizing the rural health infrastructure.

issues, but further research may shed light on this topic.

Post-Acute Care

When rural beneficiaries are discharged from the hospital, they often face different choices than urban beneficiaries do in terms of access to specialized post-acute care services. There are 208 Medicare-certified rehabilitation hospitals across the country but only 21 in rural areas. Similarly, of the 245 Medicare long-term care hospitals, only 12 are in rural areas. Of the 520 Medicare psychiatric hospitals, 81 are located in rural areas.³⁸

This is not to say that rural Medicare beneficiaries do not have access to basic psychiatric, long-term care or rehabilitation services. Home health and skilled nursing facilities can often provide access to these services but they may not

³⁸ OSCAR File (January, 2000).

be as specialized or immediate for beneficiaries in rural communities. There are 2,637 home health agencies in rural areas and 4,678 SNFs in rural areas and these entities serve as major access points for beneficiaries.³⁹ In addition, rural hospitals also have the option to use swing beds through which they can provide skilled nursing care services in the acute-care setting for a limited time once the patient is discharged from acute care.

Of these services, home health and swing beds have been the dominant access points to post-acute care services for rural beneficiaries. Rural areas, like the rest of the country, saw an explosive growth in the number of home health agencies during the 1990s. Medicare home health spending increased 29 percent from 1990 to 1996, moving from \$3.9 billion to \$18.3 billion.

Access to Key Medicare Providers

	Rural	Urban	Total
Short-Term Acute	2,187	2,859	5,046
Long-Term Care	12	233	245
Psychiatric	81	520	601
Rehabilitation	21	187	208
Home Health Agencies	2,637	5,237	7,784
Skilled Nursing Care	4,678	10,224	14,902

Source: OSCAR File, 2000

That growth prompted many of the changes in home health payment in the BBA that began with the imposition of the Interim Payment System (IPS) and, eventually, the creation of a home health prospective payment system. The IPS and its payment and beneficiary limits wreaked havoc with the home health care system, resulting not only in some agency closures but also in agencies turning away some high acuity patients. The impact on rural

³⁹OSCAR file (January 2000) and PPS 14.

agencies has not been fully determined but there has been no apparent aggregate reduction of access to care according to the General Accounting Office and others. Others dispute those findings and argue that those studies failed to account for situations in which agencies are approved to cover services for an entire county but pulled back under the IPS payment reductions to cover only the highly populated service areas.

The home health studies to date have, however, shown some rural-urban differentials. The analysis indicates that rural beneficiaries used less physical and occupational therapy services and were more reliant on home health aide services than urban beneficiaries.⁴⁰ The difference may be more dramatic regionally and questions remain about the long-term implications of beneficiaries' access to care under the new PPS.

Some rural advocates are concerned that the more strict eligibility requirements under the new payment system may result in fewer visits to isolated and frail home health patients. This creates concerns over re-hospitalizations and greater costs to the Medicare program down the line. It also speaks to a possible issue of quality for Medicare beneficiaries in these communities. Little, however, is known about the full impact of either the new home health PPS or the SNF PPS because these systems have not been in place long enough to provide a thorough analysis of their time impact.

Policy Considerations

During the past 15 years, Medicare policy has been driven by two overriding

⁴⁰ Sutton, J. "Characteristics of Rural Home Health Users and Implications for Payment Reform." The Project Hope Walsh Center for Rural Health Analysis. March 2000.

concerns: controlling costs and ensuring access. There has been considerable dynamic tension between these two goals, particularly since the mid-1980s as Medicare began changing the way it pays for services in an effort to control rapidly escalating costs.

The creation of the inpatient PPS system in 1983 helped Medicare rein in its costs by moving to a payment methodology based on set payments for individual services. That move, however, is often pointed to as a primary cause of a rash of rural hospital closings; by 1991, 193 general, acute care rural hospitals closed their doors.⁴¹

The loss of those facilities had an impact on access to care for Medicare beneficiaries in those communities. It also led to the creation of special payment policies (Sole Community Hospitals, Medicare Dependent Hospitals, etc.) to help ensure access to care for beneficiaries by ensuring some degree of financial viability.⁴²

New concerns about rural beneficiaries have emerged in the wake of the Balanced Budget Act of 1997. This stems from the continuing reliance of rural providers on Medicare reimbursement and the numerous changes and reductions in Medicare payment that were part of the BBA.⁴³ Assessing the rural implications is often hampered by the difficulty of gathering and evaluating data in a timely

manner. This is due in part to the lag between providers submitting cost reports and the time the settled data are available from the fiscal intermediaries and carriers for analysis.

Most of the assessment to date has only looked at the issue in the aggregate. For example, in FY 2000, in contrast to the Project Hope study, the Office of the Inspector General at the U.S. Department of Health and Human Services released reports on access to care for Medicare beneficiaries seeking placement in either home health or skilled nursing facilities. The reports, which were limited in scope, indicated that the payment cuts and changes from the BBA had not created a problem overall. One report did mention some isolated problems in placing some beneficiaries in skilled nursing facilities (SNFs), but provided little additional detail.⁴⁴ ⁴⁵The reports failed to break the findings down either regionally or by urban and rural status, either one of which might have shed some light on the issue.

Issues Discussed

Access to care is not an isolated issue. It is tied to how the program is financed and to continuing problems with workforce, two issues that are discussed in detail elsewhere in this report. Consequently, the Committee discussed at length how efforts to strengthen the Medicare program overall will also serve to improve access to care. The extent of Medicare's responsibility, however, prompted considerable discussion.

⁴¹ Office of the Inspector General. "Trends in Rural Hospital Closure: 1987-1991." U.S. Department of Health and Human Services. July 1993.

⁴² Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. MedPac. March 2000, p. 23.

⁴³ Medicare Payment Advisory Commission. Report to the Congress: Medicare Payment Policy. MedPac. June 2000, Table C-16, p. 189.

⁴⁴ Office of the Inspector General. "Medicare Beneficiary Access to Home Health Agencies: 2000." U.S. Department of Health and Human Services. (OEI-02-00-00320; 9/00).

⁴⁵ Office of the Inspector General. "Medicare Beneficiary Access to Skilled Nursing Facilities: 2000." U.S. Department of Health and Human Services.

There was general agreement that current Medicare policy creates uneven access for beneficiaries and much of that is geographic. Some of it, however, is economic and deals with issues related to the ability of beneficiaries to cover co-pays and deductibles for all needed services. Others pointed to problems associated with Medicare's one-size-fits-all approach to providing health care and how that works against local innovation that might address access problems. While some argue that Medicare's main role is to pay a fair price for services for beneficiaries and nothing else, others felt the program had a deeper responsibility. They believe, for example, that Medicare has a responsibility to make sure that facilities that serve Medicare patients are adequately staffed and that this is particularly true in nursing homes, assisted living centers and with adult day-care services and that the program has failed to do that in many rural areas.

Committee Consensus

The Committee believes that all Medicare beneficiaries should have access to an equal benefit package regardless of where they live. That benefit package would include appropriate access to the full continuum of care. That range of care, however, need not all be local. Some have called for ensuring proximate access to care. Under this scenario, primary care, emergency care and basic chronic care management should all be available locally and through the existing local provider base. More specialized services could be available either through circuit-riding specialists or through telemedicine.

The Committee believes that ensuring access for rural beneficiaries should be a driving force behind Medicare policy development. New legislation and

regulation should be examined for its impact on the ability of all beneficiaries to receive care, but particularly for those in rural areas who already face daunting challenges in obtaining needed health care services.

Recommendations

The Secretary should:

- Develop a standard benefit package that includes access to a reasonable prescription drug benefit under Medicare fee for service.
- Provide demonstration waivers to rural communities for innovative models that improve access to care and that focus on chronic care, case management, and preventive care.
- Examine the impact of the new prospective payment systems for home health, skilled nursing, and outpatient services to determine what impact these changes have had on access to care for rural Medicare beneficiaries.
- Monitor closures of skilled nursing facilities and the impact of moving swing beds under skilled nursing facilities prospective payment to determine the impact on access to care for rural Medicare beneficiaries.

Quality

Background

Health care quality has emerged as a key health policy issue in the past few years. This is driven, in part, by the expansion of managed care but also by a market place that emphasizes delivering cost-effective care that doesn't compromise the quality of those services.⁴⁶

The Health Care Financing Administration, which administers the Medicare program, plays a lead role in assuring quality for Medicare services. All Medicare providers must meet certain quality standards in order to qualify for Medicare reimbursement. HCFA also strives to assure quality standards are maintained through its survey and certification activities, which are done in partnership with the states, and through enforcement activities that identify potential fraud and abuse situations.

Medicare is currently in the process of finalizing new rules for the Conditions of Participation (CoP) for hospitals that were originally proposed in 1997. These new regulations will address issues related to quality and medical errors. The latter item has garnered a great deal of attention across the health care industry in the wake of a report by the Institute of Medicine (IOM) that highlighted patient injuries associated with medical mistakes.⁴⁷

Medicare, however, is not alone in setting quality standards. Hospitals and other health care providers can seek

Key Variables of Health Care Quality

Location
Resources
Workforce
Structure
Education
Technology
Data
Sample Size
Accreditation
Leadership

accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The National Commission on Quality Assurance does the same service for health plans.

The issue of quality, however, continues to have a subjective component, particularly when it comes to rural communities. While all rural facilities must comply with the Medicare quality standards, the JCAHO process is voluntary. Of the approximately 2,200 rural hospitals, 58 percent are currently accredited by the JCAHO.⁴⁸ The reasons for this moderately low participation rate are varied. The JCAHO process is expensive and time consuming. Rural facilities with minimal financial and staffing resources often opt not to seek JCAHO accreditation. Still other rural hospital administrators say the process is geared toward urban providers and therefore has little relevance for rural

⁴⁶ Moscovice, I and Rosenblatt, R. "Quality of Care Challenges for Rural Health." January 1999

⁴⁷ Institute of Medicine, "To Err is Human: Building a Safer Healthcare System." 1999.

⁴⁸ Medicare Payment Advisory Commission. Report to Congress: Selected Medicare Issues. MedPAC. June 2000, Table 2-2, p. 44.

providers.

In 1997, JCAHO began an initiative named ORYX to build performance-based outcome measures into its accreditation process. While numerous vendors stepped forward to supply JCAHO-approved performance measurement systems, only a few catered to smaller rural facilities. JCAHO, however, has indicated an interest in working with rural providers to address their concerns and some progress has been made. In addition, JCAHO recently began a special initiative to work with Critical Access Hospitals (CAHs) on accreditation issues.

Defining Quality

The quality of health care in the United States needs improvement as reflected in the recent IOM report as well as the findings of the President's Commission on Consumer Protection and Quality in the Health Care Industry.

In the purest sense, quality health care is the same regardless of whether one is in a rural or an urban area. It consists of doing the right thing in the right way at the right time in the right place for the right reason for the right cost in a way that helps achieve health improvement goals. Unfortunately, there is a perception by some policymakers that rural care is often synonymous with a lower degree of quality.

Their argument is based, in part, on the link between volume and performance. This premise assumes rural facilities, which are typically low volume, will fail to do enough of a wide range of procedures to achieve the proficiency needed to assure a certain level of quality. That perception, however, assumes that rural and urban facilities are doing the same

Defining Quality

To define quality, one must evaluate both the technical aspects of the healthcare service being provided and the aspect of customer service. Quality can be viewed as effectiveness in achieving the intended health outcomes of the service provided.

While this definition of quality is blind to resource consumption and efficiency, these components are inseparable because, without appropriate resources and their efficient application, quality cannot exist. The perception of the recipient of services, the customer, is the other aspect of quality. Service to the customer must be of such a character that the recipient will perceive it as being at least adequate and hopefully a positive experience.

Less than this is unacceptable service and unacceptable quality. Quality cannot be meaningfully examined in isolation. Issues regarding the delivery system, technology, finance and resources, access, costs, and workforce all link, inescapably and vitally, to quality.

types of procedures, which they are not. Rural hospitals focus more on short-term inpatient care, primary care and chronic care management. For these procedures, the concern about volume and performance is not the same issue. The questions arise in how far you extend that measure of quality. Is it based on the typical services rural hospitals provide, or is it based on an urban model measuring more specialized services that rural hospitals typically do not provide. While some research has been done in the volume-performance relationship, very little analysis has examined a rural-specific context.

Rural advocates point out that the standard volume-performance analysis fails to take into account concerns about proximate access. Is it better for a rural facility not to offer some services at all because they don't meet a certain volume threshold? That assumption could have a dramatically negative impact on access to

care for rural beneficiaries who may not be able to travel to a distant urban center for certain services.

Some rural advocates add another wrinkle to the traditional quality debate. They posit that quality of care may decline when that care is offered in urban centers remote from the rural population, requiring significant travel time. They argue that such arrangements may be clinically and culturally inappropriate unless the volume/quality/cost equation requires that the service be offered only in urban centers. This is particularly true for the elderly patient due to the loss of close support and encouragement of local family and friends.

This issue cuts different ways based on the situation. For example, cardiac surgery is a procedure in which referral may be most appropriate. Short-term acute (or unspecialized) care and long-term care, however, are good examples of services that lose some quality characteristics as the distance of care from the home increases.

The reality is that defining quality of care is variable. There is no single universal measurement system available that will gather, assess and provide proper context on all of the key questions regarding health care quality in rural settings. A quality model based on urban health care systems and demographic characteristics will be of little use and potentially destructive in a rural setting.

Consequently, some rural policy advocates are pushing for increased flexibility in measuring and meeting quality standards.

Key Rural Variables

Any discussion of health care quality in rural areas requires an understanding of some of the key issues facing rural health

Ingredients of the Rural Quality Mix

- Population-based Measures
- Technology
- Community Engagement
- Local System Capacity
- Quality Improvement Management Philosophy
- Education of Health Professionals in Rural Settings
- Quality Assurance

care providers and the patients they serve. In rural areas, the lack of access to care plays a critical role in determining quality of care.

Other issues are equally important in the rural environment, which is typically characterized by low volume of essential and appropriate services. This is coupled with a resulting high cost per unit of service due to distribution of fixed overhead costs across a limited number of cases. Other important issues include population density, distance and transportation variables. Another oft-cited concern has to do with denominator issues that affect performance measurement in small populations. Rural areas typically have low population density and this creates concerns about small sample sizes that may affect analysis. The use of standard urban-based measures in rural areas may not accurately measure the level of care in a given community. For example, infant mortality rates may not be a useful measure of the quality of care in a rural community with a small number of deliveries.

Another quality challenge facing rural communities is the recruitment of qualified health professionals. Rural areas struggle to recruit health care providers, which may create a quality issue. Ultimately, chronic underservice has an impact on quality of care.

In previous health quality discussions

there has been an assumption by some rural providers and advocates that there is an inevitable collision between the ability to provide care and the ability to measure healthcare quality in rural communities. That approach, however, misses a key point. The question is not whether rural services should exist, but how to maximize quality in the rural environment.

While certain services may score better on quality indicators in urban rather than rural settings, that does not necessarily mean that those rural services should be eliminated if they are in rural areas. The challenge, and the requirement, is to define more effective approaches to rural quality improvement.

As the debate on quality continues, the issue over how to account for the great variability within the health care system looms large. MedPAC recently noted that Medicare will have to account for two key issues in the future. The first deals with the emergence of continuous quality improvement (CQI), rather than simply quality assurance, as an approach for addressing quality of care. The second is the development of quality measures that are facility specific.⁴⁹ Both of these developments could provide a more flexible framework for rural providers.

While quality assurance tends to be retrospective, quality improvement is more process-oriented and focuses on developing systems that promote quality on a continual basis.

Similarly, a facility-specific approach to addressing quality could help rural facilities. This would allow these facilities to measure their performance in a more

The Out-Migration Factor: A Quality Issue?

Local perceptions of the quality of care have a significant impact on rural healthcare systems and upon the quality of care, which they are able to provide. Rural communities often face a phenomenon in which some residents perceive that the providers generally gravitate toward high tech urban health centers and bypass rural communities, except as a last choice.

As a result of these perceptions, many consumers, particularly those covered by private health plans, choose to leave their local community and seek care in urban areas. This often creates a situation that becomes a self-fulfilling prophecy of perceived low quality.

rural-appropriate context that takes into account concerns about volume, distance, access to care, service mix and provider mix.

There is considerable sentiment that strengthening rural models of continuous quality improvement may serve as a springboard for rural communities to develop and implement quality improvement in rural America that focuses on improving the health status of the population. By expanding the focus to the entire community, there is no longer a concern about measuring population health status in a small population.

Coronary artery bypass grafting is a perfect example. A quality health care system would measure its effectiveness in preventing coronary heart disease. Part of the evaluation of the associated surgical procedure would be a determination of whether the system failed in preventing disease progression to a point requiring surgical intervention.

Whereas current quality measures tend to address management of complicated problems in the high-volume environment, rural quality is often determined in the primary care

⁴⁹ Medicare Payment Advisory Commission. Report to the Congress: Selected Medicare Issues. June 2000.

ambulatory environment where problems that are common in the population are addressed.

Issues Discussed

The discussion about quality often centers initially on what measures of quality are used and how. The Committee, however, focused much of its initial discussion on more general issues that affect quality of care in rural areas.

One of the issues that was examined is the lack of a clear continuum of care in rural communities. Some rural advocates have argued that improvements needed to be made in preventive care, case management, and disease management. Toward that end, the Committee identified a core set of essential services (see text box) that are essential in assuring access to quality care for all Medicare beneficiaries regardless of geographic location.

The quality discussion, however, also looked at some of the more systematic concerns that affect health care delivery in rural areas. For example, some of the debate focused on the link between a properly trained workforce and the delivery of quality care. A quality health care environment requires a sufficient number of health care professionals to provide that care.

Others pointed to how important it is to address community perceptions about quality. Losing patients to a distant health care provider for services that are available locally decreases local volume and revenue. This has a negative impact on the local community and the local economy. It can also serve to diminish esteem and perceived quality of local health care. That puts a premium on getting the local community engaged in

any discussion of health quality. The goal of this community engagement is the development of a small population-based organized delivery system with an ongoing and continuous emphasis on quality of care.

There was considerable attention to the issue of technology, which can play a key role helping rural communities improve their quality of care. State-of-the-art imaging and other diagnostic technology, information technology and communications capabilities are essential if disparities in health care for rural beneficiaries are to be eliminated (see text box). Still, policymakers need to also understand that there are very isolated areas in which some levels of technology may not be available and these areas shouldn't be penalized as a result.

Committee Consensus

The Committee believes there should be no differential in quality between rural and urban areas. However, the process of measuring that quality requires different approaches given the very different healthcare environments between rural and urban areas. Consequently, the Committee calls for a more flexible approach toward measuring quality in rural areas. Such an approach would

Essential Core Services

- Emergency Services and Transportation
- Inpatient Care
- Primary Care
- Prevention and Public Health
- Oral Health
- Home Health
- Mental Health
- Prescriptions
- Long Term Care
- Some Specialty Care
- Rehabilitation
- Case Management

recognize that rural health care is more focused on primary and ambulatory care in an environment that is typified by low volume. This flexibility should be part of a new quality assessment framework that emphasizes continuous quality improvement and outcome assessment that is appropriate for the many different contexts of care.

Recommendations

The Secretary should:

- Ensure that the core services (primary, preventive and chronic care management) and the full continuum of care are appropriately available for all Medicare beneficiaries.
- Seek to amend the Medicare Conditions of Participation and provide resources through entities such as the Peer Review Organizations to develop quality improvement tools to fit the rural environment with appropriate flexibility and an emphasis on outcome standards.
- Encourage the development of appropriate measures that take into account a rural environment that features low volume of primary care and ambulatory services.
- Recognize the link between quality health care and the workforce by encouraging more training of health professionals for rural communities to ensure access to high-quality care for Medicare beneficiaries.
- Support research that looks into issues related to volume and outcome in the rural context based on primary and ambulatory care.

Workforce

Background

Medicare, by its sheer size and scope, has a major influence on the health care workforce, both directly through its support of health care provider education and indirectly through policy decisions regarding reimbursement. While Medicare makes payments that support the training of a range of health care providers, the bulk of these payments, which run around \$6 billion year, are for physician training. Medicare also supports the training of nurses and allied health professionals. In 1998, these payments totaled \$222 million.

The Committee realizes that rural workforce issues are not limited to physician training or Medicare's graduate medical education (GME) funding. However, the physician training supported through Medicare GME payments dwarfs the other sources of training support. Consequently, this chapter will focus primarily on that aspect of Medicare policy.

Medicare's GME payments to teaching hospitals have been an important responsibility of the Medicare Trust Fund since its establishment in 1965. Medicare makes payments to hospitals, separate from the inpatient PPS, for costs incurred in connection with approved graduate medical education (GME) programs.⁵⁰

⁵⁰ Graduate Medical Education (GME) payments are broken into two different payments. There are direct GME payments that are made directly to the hospital to cover the direct costs of training residents such as salary. There are also indirect GME payments that cover the indirect costs associated with training, such as extra time spent with patients, the ordering of more tests and other

Major Sources of GME Support

Program	Graduate Health Professions Training Support 1998
Medicare	\$6.5 billion
Medicaid	\$2.3 billion
Veterans Administration*	\$428 million
Title VII of PHS Act*	\$80 million
National Health Service Corps (Title III of PHS Act)	\$75 million

Note: Title VII of the Public Health Service Act is designed to expand the supply of primary health care providers, improve the geographic distribution of health professionals, and increase access to primary health care services in both urban and rural underserved areas. The NHSC provides scholarships and loans to health care providers in exchange for service commitments in underserved areas.

*These figures include undergraduate training.

Source: Council on Graduate Medical Education: 15th Report – Financing Graduate Medical Education in a Changing Health Care Environment." December 2000.

Medicare's GME role has evolved into a multi-faceted policy tied to several key concerns. First, GME payments help cover the costs that teaching hospitals incur in training residents. Second, the payments also ensure that teaching programs have enough physicians and residents to provide care for Medicare beneficiaries. Finally, policymakers also wanted to ensure access to care for the populations served by the typical teaching hospital. There was a belief that teaching institutions that receive GME funding also provide care to the poor and other non-elderly populations.

intangibles. Indirect IME payments are an adjustment to the DRG rate.

Medicare's Role: Workforce

There are a variety of viewpoints about Medicare's original justification for making GME payments. At the most basic level, there was report language that accompanied the legislation that created the Medicare program in 1965. This language says that when Congress established Medicare in 1965 it recognized that:

Educational activities enhanced the quality of care in an institution, and it is intended, until the community undertakes to bear such education costs in some other way, that a part of the net cost of such activities (including stipends of trainees, as well as compensation of teachers and other costs) should be borne to an appropriate extent by the hospital insurance program.⁵¹

Over the years, other motivations have been attributed to Medicare's support of physician training. Some have noted that one of the early goals behind Medicare GME payments was to increase the physician supply at a time of perceived workforce shortage. Policymakers recognized the potential for expanding and strengthening graduate medical education by augmenting Medicare payments to teaching hospitals. There was also the acknowledgement that, with the creation of Medicare and Medicaid, the demand for physician services would continue to grow and that the supply at that time would not necessarily meet the need.

⁵¹ American Association of Medical Colleges. House Report Language 213, 89th Congress, First Session.

Medicare has been successful in increasing the supply of physicians. Currently there are more than 700,000 physicians in the United States. In 1950, there were 142 physicians per 100,000 population while in 1998 there were 275 per 100,000. While this trend appears to indicate that Americans have greater access to physician services, the reality is that a disparity in distribution and specialty mix exists. This comes at a time when record numbers of medical graduates are entering the work force from U.S. and foreign medical schools. Yet medical resources are scarce in 2,682 of the over 3,300 counties in the United States.⁵²

There is a definitive urban-rural disparity in physician distribution. Currently, 20% of the population lives in rural areas but only 9% of physicians practice there.⁵³ The mix of disciplines is equally skewed. Nationally, shortages exist in the supply of primary care practitioners. Thirty percent of physicians practice primary care compared to the widely recommended 50%.

Some attribute the distribution and specialty mix vagaries to incentives with Medicare GME payment that encouraged expansion of residency programs with little control over whether it resulted in an equitable distribution of generalists versus specialists. In examining the distribution of residents according to the type of training ultimately completed, the GAO reported that 72% of direct medical education (DME) payments were

⁵² Linking Rural Health Services Research with Health Policy Conference Report. Center for Health Policy Research and Ethics, George Mason University and RUPRI. November 2000.

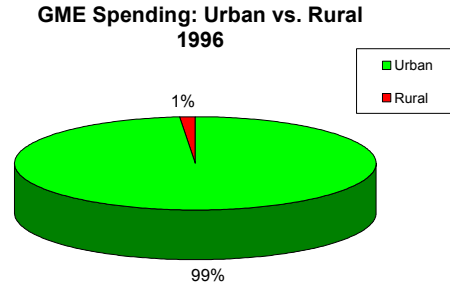
⁵³ The NACRH recognized that other health professionals (nurse practitioners, physician assistants, dentists, etc.) have an impact on rural health. However, the focus of this paper is on the physician workforce.

associated with non-primary care training while 28% of DME payments were associated with primary care.⁵⁴

Although the intent of GME payments was to create access for the elderly in all parts of the U.S., the system that has developed is one in which the vast majority of medical residency training programs are concentrated at academic medical centers located in urban areas. Critics point out that GME supplemental payments were open-ended, so any expansion of residents in any specialty was supported by Medicare payments.

Rural advocates have never felt that Medicare GME policy did much to address rural workforce needs. Because Medicare GME payments are tied to hospitals, teaching programs have tended to be centered in larger urban facilities affiliated with medical schools. Medicare GME payments for urban hospitals totaled \$6.5 billion in 1996 compared to \$93.1 million for rural hospitals.⁵⁵ More than one half of the residents in rural hospitals are accounted for by three institutions with very large programs.⁵⁶

Studies show that physicians trained in rural areas are more likely to practice in those areas.⁵⁷ Unfortunately, few rural



training opportunities exist. There are currently only 21 rural training tracks in which the residents spend the majority of their time training in rural areas under the 1+2 model of one year in a teaching hospital with two years in a rural practice site.⁵⁸ Of these, it is not known how many qualify for any Medicare GME funding.

It is worth noting that the small number of rural training tracks is due to a variety of factors, only some of which are directly related to GME funding. There are issues regarding accreditation and resources that also figure heavily.

The Changing Policy Landscape

While Medicare has always played a strong workforce role, it has never been a very effective tool for addressing issues related to specialty mix or distribution. And there is wide-ranging debate about whether Medicare should, in fact, play a stronger role in this area.

Some believe the market may be part of the solution to addressing concerns over the appropriate mix of providers. They point to the effect of managed care and its emphasis on primary care as a way to influence the specialty mix. While managed care has helped medical schools rediscover the benefit of producing primary care physicians it has done little

⁵⁴ "Medicare: Graduate Medical Education Payment Policy Needs to Be Reexamined" (Letter Report, 05/04/94, GAO/HEHS-94-33).

⁵⁵ From the PPS 13 Data Tape. The data for PPS 14 had an error in it but PPS 13 figures related to GME spending were consistent with previous years.

⁵⁶ Slifkin, R; Popkin, B; Dalton, K. "Medicare Graduate Medical Education and Rural Hospitals." *Journal of Health Care for the Poor and Underserved*. 2000, Vol. 11, No. 2.

⁵⁷ Bowman, RC & Penrod, J. "Family practice residency programs and the graduation of rural family physicians." *Family Medicine*. April 1998, Vol. 30, No. 4, p. 288-92.

⁵⁸ Malaty, W. "Factors that Affect the Match Rate of Rural Training Tracks in Family Practice." Draft unpublished report. 2001.

**Key Rural GME Provisions
From the BBA and the BBRA:**

The Balanced Budget Act of 1997

Sec. 4623: In calculating the FTE cap on residents, this provision gave the Secretary the authority to give special consideration to facilities that meet the needs of underserved rural areas.

Sec. 4625: Allowed direct GME payments to qualified non-hospital providers (Federally qualified health centers, rural health clinics, Medicare + Choice organizations and such other providers (other than hospitals) as the Secretary determines to be appropriate.

The Balanced Budget Refinement Act of 1999

Sec. 407: Hospitals located in rural areas are permitted to increase their resident limits by 30% for direct and indirect medical education payments. In addition, non-rural facilities that operate separately accredited rural training programs in rural areas, or that operate accredited training programs with integrated rural tracks, may receive direct graduate medical education and indirect medical education payments for cost reporting periods beginning on April 1, 2000 and for discharges occurring on or after April 1, 2000 respectively.

to ensure that the physician workforce is evenly distributed. In fact, some believe managed care may exacerbate the situation given the limited penetration of managed care into rural areas and anecdotal evidence that urban managed care plans may be drawing providers away from rural areas.

In its July 1999 report to Congress, the Medicare Payment Advisory Committee (MedPAC) asserts that Medicare GME policy should be strictly focused on how it relates to care for beneficiaries with no direct responsibility for larger workforce goals. The Commission believes workforce issues should be dealt with

through other more direct means separate and apart from Medicare.⁵⁹

While some applauded the Commission's recommendation, many disagreed with the recommendation. To date, the Congress has not made any legislative changes based on the MedPAC recommendations.

Legislative Changes

Medicare's GME policy remained fairly static over the years until 1997 when Congress imposed several changes in the BBA. The most dramatic alteration was the imposition of a cap on the total number of residency positions. This was done to restrain the rapid expansion of residency slots, and the resulting increase in GME costs to the Medicare program, that had taken place over the previous 20 years.

The legislation also attempted to address some rural concerns by directing the Secretary to take into account the needs of underserved rural areas in establishing rules for implementing the residency cap.⁶⁰ The intent of this provision was to create some flexibility to allow new programs in rural areas some relief under the residency cap.

The BBA took one other step, although not rural in focus, to address workforce concerns by creating a program to encourage hospitals to reduce their reliance on residents.⁶¹ This was modeled after a demonstration project in New York in which hospitals received incentive

⁵⁹ Medicare Payment Advisory Commission. Report to the Congress: Rethinking Medicare's Payment Policies for Graduate Medical Education and Teaching Hospitals. MedPac. August 1999.

⁶⁰ H.R. 2015, the Balanced Budget Act of 1997, Section 4623.

⁶¹ H.R. 2015, the Balanced Budget Act of 1997. Section 4626 .

payments for voluntarily reducing their number of residents.

The BBA also made other changes that may affect Medicare's influence on workforce policy. Recognizing the importance of training in ambulatory care sites (especially for primary care residents), lawmakers allowed hospitals to include residents who rotate outside the hospital in their FTE count for direct GME payments. The legislation also allowed hospitals to receive IME funding (depending upon which institution sponsors the resident) when residents rotate through a non-hospital site. Prior to the BBA, IME payments only covered residents rotating through the inpatient portion of the hospital, which created a disincentive for allowing non-hospital resident training.

Another BBA provision took a first step toward explicitly promoting community-based training. The legislation allows non-hospital providers such as federally qualified health centers (FQHCs), rural health clinics (RHCs), and Medicare + Choice organizations to receive funding for direct costs of training residents.

The Balanced Budget Refinement Act of 1999 (BBRA) included several provisions designed to encourage more rural training. The legislation allowed rural hospitals a 30% expansion of their resident FTE cap. The BBRA also added a provision that allowed non-rural hospitals operating a medical residency in a rural area or a program with an integrated rural track to receive an adjustment to the FTE cap.

As outlined by HCFA regulations, urban hospitals that wish to count FTE residents in rural tracks, up to a rural track FTE limitation, must comply with several conditions related to how much time the resident actually spends in the rural

An All-Payer Fund: A Workforce Solution?

Over the years, there has been an ongoing discussion about whether an all-payer graduate medical education fund should be created to help address workforce issues and reduce pressure on the Medicare trust fund.

Typically, an all-payer pool would ensure that both public and private beneficiaries contribute to subsidization of clinical education for physicians, advanced-practice nurses, and physician assistants. The proposed pool would be financed by a per-capita assessment on health plan enrollees and contributions from Medicare and other federal programs that subsidize GME. All entities that provide clinical education would be eligible for the all-payer payments.

While numerous legislative proposals on this concept have been introduced, there has been little serious action on this issue.

training site during the course of the residency.⁶²

The BBA and the BBRA legislative provisions represent a policy shift for Medicare GME funding. However, the true impact remains to be seen. Some rural advocates believe the benefits of these policies will be minimal at best. They cite the 30% expansion of residency slots for rural hospitals as an example.

These hospitals tend to have small programs so the expansions in the aggregate pale in comparison to the size of a typical urban academic medical center. Moreover, with less than one percent of GME funding currently supporting rural training, these critics point out that even the thirty percent increment will not have a perceptible impact on an aggregate level.

⁶² Federal Register. "Rules and Regulations." Tuesday, August 01, 2000, Vol. 65, No. 148: 47033-47035.

Issues Discussed

Rural advocates have never felt that Medicare has done much to support rural training or address its ongoing trouble in attracting providers. Rural areas have historically looked toward Federal programs apart from Medicare such as the National Health Service Corps and the various J1-Visa waiver programs sponsored by several Federal agencies and some states. While these programs have helped, they have failed to dramatically change the number of underserved communities in rural America during the past 30 years. As a result, some rural advocates have renewed the focus on Medicare GME policy and raised questions about why so few GME dollars support rural primary care training.

This has gone on at the same time that a larger debate about Medicare GME policy has taken center stage following the release of a 1999 report from the Medicare Payment Advisory Commission (MedPac). The Report built upon a recommendation put forth by the Bipartisan Commission on the Future of Medicare that recommended doing away with DME payments from the Medicare trust fund and instead making them subject to annual appropriations.

The Commission took that concept even further. It recommended that the DME and IME payments be combined into one payment stream that would be distributed to those teaching facilities that could provide evidence of "enhanced patient care" to Medicare beneficiaries and related increased costs to teaching hospitals.

The Commission argued that Medicare was never intended to play such a strong workforce role. Medicare support for resident training and subsequent policy decisions eventually led to large

expansions of hospital-based training that changed the system in ways that were, arguably, never intended. MedPAC's recommendations were part of an effort to more properly define Medicare's role in training physicians.

Understandably, the Commission's report garnered a great deal of attention and some strong opposition, particularly from the American Association of Medical Schools. Others were concerned that the Commission's recommendations would, in effect, divest Medicare of its traditional workforce role. In fact, the Commission recognized this fact and said that the Federal government would continue to have a workforce role but that this role was beyond the scope of the Medicare program or its report. It recommended using existing resources such as Title VII or Title VIII grants to achieve workforce goals.

That idea was not universally shared. Opponents charged that the reality is that Medicare cannot simply turn its back on its larger workforce role. Rural advocates were particularly concerned because MedPAC's argument that Medicare plays no workforce role would prevent discussion of the more substantive concern about ensuring a provider base that can serve Medicare beneficiaries regardless of where they live.

Those who opposed the MedPAC recommendations countered that GME reform must create a system that will support national workforce goals such as providing community relevant clinical training and supporting an appropriate physician specialty and geographic distribution. In a recent report on GME

financing,⁶³ the Council on Graduate Medical Education (COGME) identified key issues in trying to align GME funding with workforce goals:

1. Who should receive payments.
2. How to allocate funds.
3. How to establish accountability for funds.

The Committee believes these are important questions that should be addressed in any redesign of the Medicare program.

While the questions raised by MedPAC about Medicare GME payments focus on more global policy issues, the debate has ramifications for rural workforce. There are some advocates who believe that more equitable GME funding that emphasizes rural training of primary care physicians could help address long-standing rural

A Model That Works

Rural training can make a difference, as the Committee learned in a July of 2000 site visit to Hazard, Kentucky. This eastern-Kentucky community, working with the University of Kentucky, offers at least a partial solution to the workforce dilemma common in rural communities.

The UK Center for Rural Health operates a free-standing family practice residency, fully accredited master' level nursing and physical therapy and other programs in a rural Appalachian community. However, the residency has not yet qualified for GME payments to help cover the cost for training its physicians and is now reliant on state and local funding to cover the costs.

Still, the project's success shows that rural training can pay dividends. Studies show 70 percent of health professionals stay in rural communities if they train there. Moreover, the University estimates that a physician generates about \$35 million in revenue over the span of his or her career and costs \$6 million to train.

⁶³ COGME. "Financing Graduate Medical Education in a Changing Health Care Environment." June 22, 2000 draft of 15th report.

shortage issues. This, in turn, will help ensure an adequate provider base to ensure access to care for rural beneficiaries.

Committee Consensus

The Committee believes Medicare does, indeed, have a role to play in workforce. In fact, the Committee believes it should do more to encourage a more appropriate mix and distribution of physicians. This could be accomplished in several ways. Medicare could alter GME policy to provide more direct and indirect GME support to rural training sites. Medicare could also create incentives for the development of new primary care residencies in rural hospitals. Medicare could also explore the development of innovative demonstration projects that target specific workforce needs that could serve as models for future development.

The recent changes to GME policy in the BBA and BBRA offer a first step toward achieving that goal. The Committee supports the use of using incentives to reward programs with positive track records for placing health professionals in places of genuine need. In addition, the Committee believes more could be done to retain physicians to serve the Medicare beneficiaries by offering tax credits or perhaps increasing the HPSA bonus payment.⁶⁴

Recommendations

The Secretary should:

- Support changes to Medicare policy to provide exceptions to the residency cap for rural training programs and provide direct and indirect GME funding for these programs.

⁶⁴ The HPSA Bonus Payment pays a 10% bonus to physicians who practice in a health professional shortage area.

- Support changes to Medicare policy that promote more community-based training of residents.
- Support changes to Medicare policy so that residency programs receiving GME funding would be required to provide training in rural settings.
- Support Rural GME demonstration projects that address workforce shortages in rural areas.
- Expand the scope and focus of the Title VII and Title VIII training grants to promote more rural training.
- Increase funding for the National Health Service Corps to promote more placements of Corps clinicians in underserved rural areas to serve Medicare and Medicaid beneficiaries.

Reform

Background

The Medicare program is vitally important to rural America and to the 8.9 million beneficiaries who live there. Medicare revenues provide a key source of revenue for the rural hospitals and rural providers that provide services to rural Medicare beneficiaries. Medicare, however, is not working as effectively as it should in rural areas and changes need to be made. The problems run the spectrum. There are concerns about a financing system that pays significantly less for services in rural areas compared to urban areas. There are problems over access to care for needed services for rural beneficiaries. Concerns are also growing about how Medicare assesses and measures quality of care in rural communities. Finally, many advocates are troubled by Medicare's impact on the country's healthcare workforce and the way it contributes to a maldistribution of providers and an over-emphasis on specialty care that has troubling implications for rural beneficiaries.

The Administration and the Congress now have the opportunity to make changes to the Medicare program and restructure it in a way that ensures continued access to high quality care for all beneficiaries regardless of where they live. This is a unique opportunity but the key will be not repeating the mistakes of the past and ensuring that rural concerns are a key part of the debate over how to reform the program.

While proposals abound about how to restructure the Medicare program, little is known about how these proposals will affect the delivery of health care services in rural areas. Historically, these kinds of

differential impacts have not been thought about prospectively but rather examined after the fact and often in response to a crisis.

For example, after the introduction of prospective payment system (PPS) for Medicare inpatient services in 1983, there was a rash of small, rural hospital closings. Between 1987 and 1991, in particular, 193 general, acute care rural hospitals closed.⁶⁵ While all of these closings were not attributable solely to the change in Medicare payment, the impact of this payment change was nonetheless a deciding factor in all of the closings.

In the past few years, HCFA has taken steps to try to avoid such problems. The agency now includes an impact statement in all of its proposed regulations that examines the impact of its rules on small rural hospitals. Since the passage of the Balanced Budget Act of 1997, the regulation teams charged with the creation of new prospective payment systems across the acute and post-acute care settings have worked to examine the potential impact on rural providers.

Part of that charge has been to see if the data support the creation of any kind of special rural adjustments. Of the three main PPS programs (home health, skilled nursing and outpatient departments) that have been implemented from the BBA, none has a specific rural adjustment to compensate for the low-volume environment of rural health care. There

⁶⁵ Office of the Inspector General. "Trends in Rural Hospital Closure: 1987-1991." U.S. Department of Health and Human Services. July 1993.

was, however, a rural adjustment in the proposed PPS for rehabilitation hospitals. In addition, Congress created a temporary hold-harmless provision for rural hospitals with less than 100 beds in the new outpatient prospective payment system.⁶⁶ The early returns on the effectiveness of this provision indicate that some providers have experienced cash flow problems but the data on these claims is not yet available to determine how widespread the problem is. HCFA officials have met with the industry to assess any problems and to identify some potential solutions. This issue will bear watching over the next year.

Despite these efforts, the lesson learned from the hospital closures of the 1980s continues to serve as a reminder of the unintended consequences of the legislative and regulatory processes. That remains especially true in consideration of any reform of the Medicare program.

As the Administration and Congress examine the myriad of proposals for changing the financing system of the Medicare program it is important to take into account how each will affect the rural health care delivery system as it currently exists.

Successful redesign of the Medicare program requires that key stakeholders reach some degree of consensus. The failure to reach out to those affected can threaten the viability of any proposal, which was one of the more valuable lessons learned from the 1994 health care reform debates.

The key for policy makers will be redesigning the program in a way that includes enough flexibility to address the great degree of variability within rural communities. They must also create a new policy framework that assures that rural beneficiaries are treated equitably. The Committee urges policymakers to fully examine the impacts of different policy options on rural communities. This will ensure that urban and rural beneficiaries have equitable access to appropriate health care under any proposed redesign.

Medicare Reform Options

Given the parameters of the debate over the past year, it appears the new Administration and Congress have two options in redesigning the Medicare program. The first would be to try to refine current policy. This implies an incremental approach to reform and would continue Medicare as a government-administered benefit with two primary options: fee for service and Medicare + Choice. The second option is more dramatic and would make wholesale changes and dramatically redesign the Medicare program and moving toward a more market-driven model.

The primary focus of the incremental reform approach is to address the larger problems within current service delivery. On the fee for service side this might include greater flexibility in how the services are delivered and could include options such as primary care case management, disease and or chronic care management. Within the Medicare + Choice program, the incremental approach would favor using the policies previously used in competitive pricing demonstrations or expanded use of the private fee-for-service options or greater use of private sector strategies such as

⁶⁶ Section 202 of the Medicare, Medicaid, and State Children's Health Insurance Program Balanced Budget Refinement Act of 1999 (Public Law 106-113).

preferred provider organizations or provider service organizations.

The primary focus of the more market-driven approaches builds on the current Medicare + Choice program and attempts to use competition as a way to generate additional savings for the Medicare program while also providing for additional services such as prescription drugs and preventive services. The National Bipartisan Commission on the Future of Medicare and subsequent legislative proposals were based on a model of premium support. Under this model, beneficiaries would have a choice between a low-option plan with benefits similar to those included in the current fee for service (FFS) and a high-option plan that would require additional cost sharing on their behalf but provide additional benefits.

Committee Consensus

Redesigning and modernizing Medicare stands as a daunting challenge for policymakers but particularly so in today's complex and ever-changing health care system. Still, the Committee believes this challenge is also an opportunity to create a Medicare system that serves all its beneficiaries more effectively.

The Committee has concerns about both potential reform options. Under an incremental approach, there is the danger that past inequities will continue. Under a more market-driven approach, there is concern that the lack of competition in rural areas will put rural beneficiaries at a disadvantage in terms of equity of benefits.

Under either reform approach, the Committee believes any changes to the payment system should be based on new measures of cost. These measures should

not be tied solely to past expenditures but rather reflect the cost of providing care in today's health care system. Past expenditures do not reflect costs incurred because of changing labor markets, new treatment modalities and capital investments. Further, the Committee believes new models of service delivery need to be explored to assess their viability for rural providers.

The Committee urges policymakers to take into account several issues in considering Medicare reform proposals.

First, fee-for-service Medicare will continue to be a foundation of the rural health care delivery system and therefore needs to be strengthened and adequately financed in order to ensure access to needed care for Medicare beneficiaries.

Second, the conception of Medicare managed care in rural areas needs to be re-examined. Managed care in the current form of Medicare + Choice will likely never be a viable option for much of rural America. That is because the current form of managed care relies mostly upon competition as a tool for achieving budgetary savings and cost controls. This is predicated on an urban- and/or volume-based model of care.

Clearly, rural and urban health care systems operate in vastly different markets. That is why one of the common complaints about reform models such as premium support is their reliance on competition as a means of financing enhanced benefits. Current experience with the Medicare + Choice program in rural areas indicates that rural areas are often at a disadvantage when competition between plans is used as the strategy for providing additional affordable benefits

such as eye care or prescription drug coverage.⁶⁷

While there are ways rural areas can compete and models that work, it is important to remember that the rural market is different from the urban market. For example, rural markets typically have fewer beneficiaries spread out over larger geographic areas. They also typically have a single hospital and a limited supply of health care providers heavily weighted toward primary care. The hospitals and other providers in these communities tend to operate on thinner Medicare margins than do urban providers. Consequently, plans cannot come in and rely on traditional competitive pressures to demand deep discounts. In addition, it is important that any changes in policy do not damage the current patchwork safety net of providers that now receive special treatment under Medicare.

If the Medicare program moves toward more of a competitive market model, beneficiaries would be well served by making the proposals reflective of the difference between urban and rural markets. The Committee believes rural providers need to be adequately reimbursed for care. This alone would help ensure equity and access for all beneficiaries.

Rural advocates have long focused on the lack of Medicare + Choice plans in rural areas. Policy changes in the BBA, BBRA and BIPA have attempted to create incentives for more plans to enter rural areas. The results thus far have not indicated much change. The debate about

Medicare + Choice in rural areas, however, sometimes misses a critical point. The real policy issue is not about getting more managed care plans into rural counties but rather about equity of benefits for rural beneficiaries. The managed care plans, which often offer benefits such as prescription drugs and eye care, are merely the means to the larger end.

The Committee urges policymakers to be mindful of the concern over equity of benefits. The ultimate goal would be to ensure that under both fee-for-service and managed care, rural beneficiaries would be treated the same as their urban counterparts.

As the Administration and Congress debate how to reform the Medicare program, the Committee urges policymaker to consider the broad impact of any system changes. That assessment would look at issues related to quality of care, financing, access and quality. All of these elements are tied together. The current Medicare program is doing, at best, the minimum in addressing concerns across these categories for rural beneficiaries.

Ideally, a newly designed Medicare program would offer rural communities equal options to participate in the model that was most appropriate for each community. There might be some larger rural communities where the premium support model might work. There will be other communities, however, where it will be just as important to have a strengthened fee-for-service option that includes needed benefits such as preventive care and prescription drug coverage. The key is providing the kind of flexibility that takes into account the great variability in rural America and provides beneficiaries with comparable access to

⁶⁷ Coburn, A; Fluharty, C; Hart JP; MacKinney, AC; McBride, T; Mueller, K; Slifkin, R; Wakefield, M. "A Rural Assessment of the Leading Proposals to Redesign the Medicare Program." RUPRI Rural Health Panel. May 31, 2000 (P2000-4).

high-quality care regardless of geographic location.

Recommendations

The Secretary should:

- Protect and strengthen the Medicare Fee-For-Service service delivery option under any redesign or reform of the Medicare program. This should include an acknowledgment that Medicare + Choice in its present form is not a viable option for bringing managed care and equity of benefits to rural beneficiaries. Consequently, the Secretary should recognize that fee-for-service delivery will continue to be the dominant service delivery mechanism for rural Medicare beneficiaries.
- Ensure protections for key rural service providers (critical access hospitals, sole community hospitals, Medicare-dependent hospitals, rural referral centers, rural health clinics and federally qualified health centers) in any redesign of the Medicare program to ensure access to care for rural beneficiaries.
- Explore the development of new service delivery models for rural beneficiaries that recognize the special circumstances of providing care in sparsely populated rural areas. Options such as coordinated care, primary care case-management and other forms of partial risk or capitation that emphasize local control and flexibility should be explored.

Recommendations

Finance

The Secretary should:

- Evaluate the need for a low-volume adjustment within all of the Medicare prospective payment systems (See National Advisory Committee recommendations, 1999).
- Conduct research to determine the true cost of providing care to Medicare beneficiaries in rural areas that takes into account factors related to access, geographic isolation and volume. The results of this research should be used in redesigning the Medicare program to ensure equity of benefits for rural beneficiaries.
- Continue collecting data on occupational mix and implement an adjustment to the wage index as soon as possible.
- Collect wage data for both the skilled nursing and home health service areas and evaluate the impact of constructing an occupational mix adjustment within the wage index for both of these payment systems.
- Continue to refine the methodology for the disproportionate share adjustment for hospitals to treat all hospitals equally.

Access

The Secretary should:

- Develop a standard benefit package that includes access to a reasonable prescription drug benefit under Medicare fee for service.
- Provide demonstration waivers to rural communities for innovative models that improve access to care and that focus on chronic care, case management, and preventive care.

- Examine the impact of the new prospective payment systems for home health, skilled nursing, and outpatient services to determine what impact these changes have had on access to care for rural Medicare beneficiaries.
- Monitor closures of skilled nursing facilities and the impact of moving swing beds under skilled nursing facilities prospective payment to determine the impact on access to care for rural Medicare beneficiaries.

Quality

- Ensure that the core services (primary, preventive and chronic care management) and the full continuum of care are appropriately available for all Medicare beneficiaries.
- Amend the Medicare Conditions of Participation and provide resources through entities such as the Peer Review Organizations to develop quality improvement tools to fit the rural environment with appropriate flexibility and an emphasis on outcome standards.
- Encourage the development of appropriate measures that take into account a rural environment that features low volume of primary care and ambulatory services.
- Recognize the link between quality health care and the workforce by encouraging more training of health professionals for rural communities to ensure access to high-quality care for Medicare beneficiaries.
- Support research that looks into issues related to volume and outcome in the rural context based on primary and ambulatory care.

Workforce

The Secretary should:

- Support changes to Medicare policy to provide exceptions to the residency cap for rural training programs and provide direct and indirect GME funding for these programs.
- Support changes to Medicare policy that promote more community-based training of residents.
- Support changes to Medicare policy so that residency programs receiving GME funding would be required to provide training in rural settings.
- Support Rural GME demonstration projects that address workforce shortages in rural areas.
- Expand the scope and focus of the Title VII and Title VIII training grants to promote more rural training.
- Increase funding for the National Health Service Corps to promote more placements of Corps clinicians in underserved rural areas to serve Medicare and Medicaid beneficiaries.

Reform

The Secretary should:

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- Explore the development of new service delivery models for rural beneficiaries that recognize the special circumstances of providing care in sparsely populated rural areas. Options such as coordinated care, primary care case-management and other forms of partial risk or capitation that emphasize local control and flexibility should be explored..

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