COMMENTS ON THE JUNE 2001 REPORT OF THE MEDICARE PAYMENT ADVISORY COMMISSION: "*MEDICARE IN RURAL AMERICA*"

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RUPRI Rural Health Panel

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RUPRI Rural Health Panel:

Andrew F. Coburn, Ph.D.
Charles W. Fluharty, M.Div.
J. Patrick Hart, Ph.D.
A. Clinton MacKinney, M.D., M.S.
Timothy D. McBride, Ph.D.
Keith J. Mueller, Ph.D., Panel Chair
Rebecca T. Slifkin, Ph.D.

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Executive Summary

The Rural Health Panel (Panel) of the Rural Policy Research Institute (RUPRI) is publishing this *Policy Paper* to provide a foundation for a discussion of the recommendations and findings presented in the June 2001 report (Report) of the Medicare Payment Advisory Commission (MedPAC), *Medicare in Rural America*. In this paper, the Panel comments on MedPAC's recommendations and offers a critique of several findings that did not prompt specific recommendations. **The purpose of this paper is to advance a policy discussion that yields changes in the Medicare program that are responsive to the special needs of rural America.**

The Report was an ambitious undertaking by MedPAC commissioners and staff, completed in a relatively short time on their calendar of reports (March and June of every year). The Report helps set a framework for analysis and provides some specifics, but it should not be treated as a definitive treatise on Medicare's role in rural health.

Comments on Recommendations

Most of the recommendations made by MedPAC call for incremental changes in Medicare policy that would have positive impacts on health care for rural beneficiaries (directly or indirectly):

- increasing rural beneficiaries' participation in government programs that pay current beneficiary out-of-pocket expenses in the Medicare program, including premiums, co-insurance, and deductibles;

- including rural populations and providers in the scope of work requirements for peer review organizations;

- increasing to at least once every three years the frequency of survey requirements for facilities to meet conditions of participation in Medicare;

- developing an adjustment to the inpatient prospective payment system to account for low volume (this recommendation is especially modest given that the data presented in the Report indicate that over one half of low volume hospitals would continue to experience negative inpatient Medicare margins);

- excluding teaching physicians, residents, and certified registered nurse anesthetists from the calculation of the hospital wage index;

- providing data to improve the hospital wage index, including reevaluating assumptions about the proportion of costs reflecting resources purchased locally;

- increasing the cap for disproportionate share payment from 5% to 10%;

- revisiting the outpatient prospective payment system when better information is available; and

- studying the financing of rural home health services.

Other recommendations related to changes in payment systems would not, given evidence currently available, have an adverse impact on rural health care delivery:

- requiring that a rural referral center's hospital wages must exceed the average wage in its area to qualify for geographic reclassification; and

- not exempting rural home health services from the prospective payment system (at least for the present time).

The discussion of access to services in the first two chapters of the Report suffers from disparities and weaknesses:

- MedPAC found important differences in out-of-pocket spending between rural and urban beneficiaries, which is identified in the literature as a reason for differences in access to care.

- Analysis of health care utilization, aggregated across all service types, is not the best method for assessing appropriate access to care.

- Although MedPAC concludes that rural and urban Medicare recipients use similar amounts of services, this conclusion depends heavily on the methods of analysis used to compute these figures. But concerns about these methods imply that "differences in use rates should be interpreted cautiously" (p. 17).

Recommendations for implementing systems of quality improvement in rural settings could be strengthened by:

- having the Secretary direct peer review organizations to work with local providers to identify quality concerns, encourage the use of national clinical topics whenever feasible, and establish state-level peer review organization rural performance goals; and

- providing financial incentives for rural providers to conduct quality improvement activities.

As supported by the data in Chapter 7 of the Report, basic market characteristics of most rural areas frustrate efforts to expand the use of Medicare+Choice plans in rural America. Given the lack of access to Medicare+Choice plans for the vast majority of rural Americans, MedPAC appropriately concludes that "rural beneficiaries are unlikely to see more generous benefits without an explicit or implicit subsidy" (p. 122).

Introduction

The Rural Health Panel (Panel) of the Rural Policy Research Institute (RUPRI) is publishing this *Policy Paper* to provide a foundation for a discussion of the recommendations and findings presented in the June 2001 report (Report) of the Medicare Payment Advisory Commission (MedPAC), *Medicare in Rural America*. The Panel comments on MedPAC's recommendations and offers a critique of several findings that did not prompt specific recommendations. **The purpose of this Policy Paper is to advance a policy discussion that yields changes in the Medicare program responsive to the special needs of rural America.**

This *Policy Paper* is organized parallel to the chapters of the Report, with discussions of the salient points from each of the first seven chapters.[1]

The Report fulfills requirements in the Balanced Budget Refinement Act of 1999 to "study and report on the adequacy and appropriateness of Medicare's payment policies for services furnished by various types of providers located in rural areas" (p. xv). MedPAC chose to respond to a series of specific requirements in a single, comprehensive report. Doing so provided an opportunity to consider the general responsiveness of Medicare to beneficiary needs in rural areas in addition to considering specific payment issues. This was an ambitious undertaking by MedPAC commissioners and staff, completed in a relatively short time on their calendar of reports (March and June of every year).

MedPAC's responsibilities are to advise Congress on payment issues and to analyze access to care, quality of care, and other issues affecting Medicare. The Report addresses all of these roles of MedPAC, focusing on Medicare's programmatic responsibilities to address the general issues affecting availability and delivery of services in rural areas. The focus on the implications of Medicare payment and not on the potential role of Medicare in addressing structural problems of access led to a MedPAC statement that, in cases where barriers to care exist in rural areas, "Medicare may not be the sole, or even the principal, problem" (p. xv). However, even after saying that "rural Medicare beneficiaries do not seem to be measurably disadvantaged...," MedPAC makes the following statement, which is a foundation for future considerations in Medicare policy:

> The fragility of the rural health care system calls for continued vigilance and special care to ensure that Medicare policies do not weaken rural medicine inadvertently and that, where appropriate, they reflect the special circumstances confronting rural beneficiaries and providers (p. xv).

[1] References to page numbers throughout this *Policy Paper* refer to pages in the June 2001 MedPAC report, *Medicare in Rural America.*

Chapter 1: "Medicare and rural health care: overview and challenges for policymakers"
Chapter 2: "Rural beneficiaries' access to care"
RUPRI Panel Comments

This section discusses Chapters 1 and 2 of the Report, since both of these chapters discuss the issue of rural beneficiaries' access to care. These chapters contain a comparison of urban and rural beneficiaries' health service utilization, based on a measure of use aggregated across all service types and locations. Two main points are made about these chapters:

1. **Analysis of health care utilization, aggregated across all service types, is not the best method for assessing appropriate access to quality care as aggregate analysis masks important differences in service type, location, and quality of care; and**

2. **Although MedPAC concludes that rural and urban Medicare recipients use similar amounts of services, this conclusion depends heavily on the methods of analysis used to compute these figures. But concerns about these methods imply that "differences in use rates should be interpreted cautiously" (p. 17).**

MedPAC concludes that "ensuring that beneficiaries have access to medically necessary care of high quality is one of the primary objectives of the Medicare program" (p. 41). MedPAC's use of utilization to assess whether or not "beneficiaries living in rural areas always receive all of the care they need" (p. 20) does not sufficiently measure whether appropriate access is achieved. As MedPAC notes, "Unusually high or low [health care utilization] rates do not necessarily mean that beneficiaries are receiving too much, too little, or an inappropriate mix of care" (p. 17). Furthermore, "Use rate differences may or may not be associated with differences in the quality of health outcomes; outcomes depend on the appropriateness and technical quality – rather than the amount – of care received" (p. 18).

Despite the limitations of analysis of utilization to detect significant differences in care sought and received, statements in the Report create an impression that MedPAC concluded that there are no significant differences in access. The second paragraph of the Executive summary states: "Despite these barriers, rural Medicare beneficiaries do not seem to be measurably disadvantaged compared with urban beneficiaries" (p xv). A later passage in the Executive summary reads: "Although similar use rates do not guarantee that rural and urban beneficiaries receive equally appropriate and effective care, this finding suggests that major new Medicare policy interventions may not be needed to preserve rural beneficiaries *access* [emphasis added] to high-quality care" (xv-xvi). Thus, although MedPAC is careful to say that there is no direct link between evidence about utilization and conclusions concerning access, the general theme of

the Report has been interpreted to say that there is no fundamental access problem for rural beneficiaries.[2]

Analysis of aggregate utilization does not sufficiently measure whether appropriate access is achieved. MedPAC and others find that rural beneficiaries have greater health care needs, use fewer preventive services, and are more ill at hospitalization. Also, rural beneficiaries have fewer financing options, travel farther for health care, and spend more out of pocket. These rural/urban disparities indicate health care access is problematic for many rural beneficiaries.

1. Rural Beneficiaries Are Less Healthy. MedPAC concludes that, "overall, rural beneficiaries report lower health status than urban beneficiaries. Thirty-three percent of beneficiaries living in the most remote areas reported fair or poor health status" (p. 27). Furthermore, most of the prior research indicates that rural Medicare beneficiaries have poorer health status than their urban counterparts (Coburn and Bolda, 1999, pp. 182-183). Therefore, if rural Medicare beneficiaries have a greater need for health care services, then equivalent health care use rates might actually indicate that rural beneficiaries are underutilizing health services and, therefore, may lack appropriate access to care.

2. Rural Beneficiaries Use Fewer Preventive Services and Are More Ill at Hospitalization. MedPAC draws its conclusions about access from aggregated health care utilization data (measured in dollars), which can mask important access problems. MedPAC concludes that rural Medicare beneficiaries receive a smaller amount of physician care but a greater amount of hospital inpatient stays (p. 19). These differences tend to cancel each other out and overall dollars of utilization are roughly equivalent between rural and urban Medicare beneficiaries. But if rural persons lack appropriate access to physician care, then some of their health problems may accelerate to the point of hospitalization. The cumulative effect of this pattern of care is that a rural person may receive a larger dollar amount of health care than does an urban person (as shown in the Report), which results not from greater access to services, but from a lack of access to physician services. Adding to this problem, rural persons may have less access to preventive services and emergency care (pp. 30-31). Analysis of the Medical Expenditure Survey data shows that rural seniors significantly underutilize preventive services such as routine physical exams and mammograms (Ziller & Coburn, 2001, unpublished data). Similarly, MedPAC found that "remote rural

[2]The first paragraph of MedPAC Chairman Hackbarth's testimony to the House Ways and Means Subcommittee on Health, June 12, 2001 was: "Our starting point in evaluating rural health care for Medicare beneficiaries was to look at the most important objective, which is to assure access to quality care....Overall, we have found that the services used in volume and quality are very similar to those used by urban beneficiaries. There are some important exceptions to that that I would be glad to go into later on, but, overall, the numbers are quite comparable." In that same Hearing, Representative Stark's opening remarks included this interpretation of the MedPAC Report: "A brief review of the report confirms what I have always thought to be the case, and MedPAC has reported this in the past, that there is no systemic access problem in rural areas. In fact, the report released today shows that there is no real difference in access to Medicare services between urban and rural populations." The hearing transcript is available at the Subcommittee web site: http://waysandmeans.house.gov/health/107cong/6-12-01/107-33final.htm.

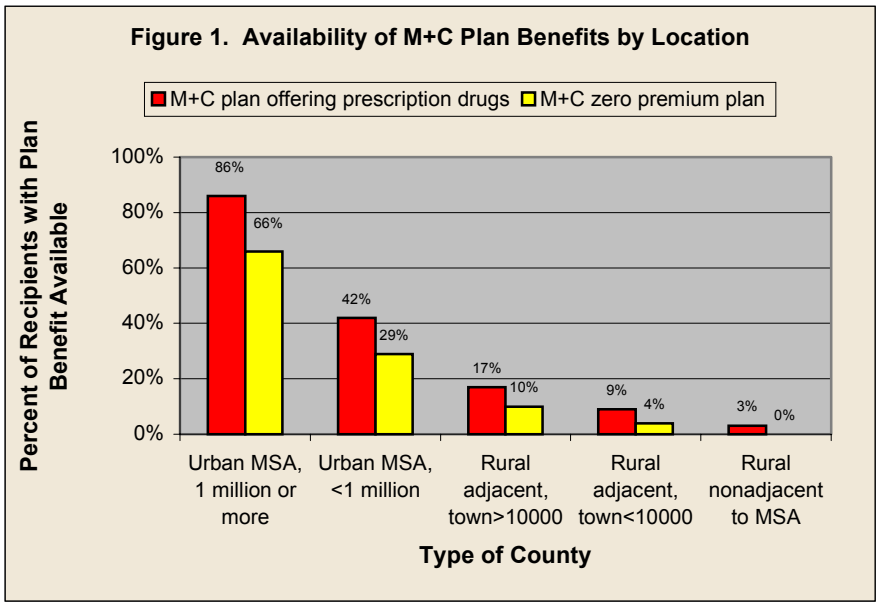
beneficiaries were somewhat less likely to receive three types of care: electrocardiograms (except during an emergency room visit), timely follow-up after hospital discharge, and mammograms" (p. 31). This rural health care utilization pattern – less preventive health care, less physician contact, and greater hospital utilization – implies that rural beneficiaries may be less healthy and/or are facing greater problems of access to appropriate health care, than are their urban counterparts.

3. Rural Beneficiaries Have Fewer Financing Options. Rural Medicare beneficiaries are less likely than urban Medicare beneficiaries to be covered by a supplemental Medigap policy (Coburn & Bolda, 1999, pp. 182-183) and, if they are covered, rural Medicare beneficiaries are likely to have more limited coverage for health services and prescription drugs than are their urban counterparts (Coburn & Ziller, 2000). Moreover, the lack of access to Medicare+Choice (M+C) plans in rural America has a significant negative impact on overall *access* to health care for rural Americans. While 86% of people living in large metropolitan statistical areas (MSAs) have access to an M+C prescription drug plan, only 3% of people living in rural areas not adjacent to an MSA have access to an M+C prescription drug plan (Figure 1). Sixty-six percent of people living in a large MSA have access to an M+C zero-premium plan, while less than one percent of beneficiaries in rural areas not adjacent to an MSA have access to an M+C zero-premium plan (Figure 1). Similar disparities are found in access to plans with zero premiums and to plans with other extra benefits offered by M+C plans (e.g., eye care, preventive care, low copayments). This lack of access to significant benefits under M+C plans means that rural Americans face a significant access problem not adequately acknowledged by the Report.

4. Distance to Health Care Providers Is a Factor for Rural Beneficiaries Accessing Services. Aggregate travel time data fail to reveal significant rural/urban differences (p. 30). However, response time in emergency situations is longer in rural areas, which is related to increased mortality when the times exceed 30 minutes (p. 30). Therefore, despite aggregate travel time data that demonstrates no rural/urban disparity, increased distance to health care may result in prolonged emergency response time leading to increased severity of illness and mortality caused by delayed intervention. Access to basic services, including hospitalization for conditions not requiring the resources of tertiary care hospitals, is a local concern. The Report implicitly recognizes this very real need when saying that the Critical Access Hospital program "appears to play an important role in preserving access to care and should definitely be maintained" (p. 62).

5. Rural Beneficiaries Spend More Out of Pocket. "The greatest barrier to care for rural beneficiaries appears to be the cost of care. Beneficiaries in most types of rural areas were found to be significantly more likely (10%-11%) than their urban counterparts (7%) to say that they delayed getting care in the past year because of costs" (p. 32). In fact, a forthcoming AARP Public Policy Institute analysis of 1995 Medicare Current Beneficiary Survey cost and use data projected to 2000

will demonstrate that rural beneficiaries spend $2,700 out of pocket (23% of their income) while urban beneficiaries spend $2,540 (18% of their income) out of pocket (p. 32).



Source: MedPAC, based on Tables 7-1 and 7-2, equal to percent with M+C plan available times percent with benefit type available.

MedPAC's recommendation (2, p. 24) "to increase rural beneficiaries' participation in government programs that cover Medicare premiums and/or deductibles and coinsurance" helps to alleviate the financial barriers to care that are common among low-income rural beneficiaries.

Since there are financial barriers to care other than deductibles and coinsurance, including the cost of uncovered benefits, it is imperative that MedPAC "continue to study out-of-pocket spending differences between urban and rural beneficiaries and model effects of introducing variable cost-sharing" (p. 32).

MedPAC draws its conclusion that there are few significant differences in health utilization between urban and rural areas from Medicare health spending data for the Medicare fee-for-service population aggregated across service types and adjusted for differences in risk as measured by health status and differences in input prices. The methods used to compute these estimates raise a number of concerns:

1. Risk Adjustment. Without adjustment for health status, urban beneficiaries' health care utilization rates are higher than rural beneficiaries' utilization rates (see Table 1). After adjusting expenditures for differential health status risk across beneficiaries, MedPAC concludes that rural and urban beneficiaries use

health care services equally (see Table 1). However, this conclusion is only accurate if the risk-adjustment methodology is accurate. Existing risk-adjustment methods are notoriously incomplete predictors of health care needs and typically rely on current utilization to assess risk. This leads to a biased conclusion if rural residents are less likely than urban residents to use health care services because services are less accessible. Previous studies have demonstrated that rural populations have lower socioeconomic status, greater disability, more chronic disease, and are older than their urban counterparts. Therefore, it is counterintuitive that MedPAC would find that "urban beneficiaries in our sample had higher average risk scores (worse health) than rural ones" (p. 15), especially given that even MedPAC concludes that rural beneficiaries report lower health status (p. 27). Since MedPAC finds that "rural beneficiaries' risk-adjusted use rates also may be overstated somewhat if they use relatively few services given their health status" (p. 15), some rural beneficiaries in need of health care services may never receive them.

Table 1. Comparison of MedPAC Conclusions on Differences in Utilization Between Urban and Rural Medicare Beneficiaries

MedPAC Report Analysis	**General Conclusion**	**% Difference**
Figure 1-10, p. 16	Urban ≅ rural utilization	Urban 0% to 4.83% *lower* than rural
Figure 1-10, footnote (9), p. 16 (not risk adjusted for health status differences)	Urban > rural utilization	Urban 2.3% to 6.6% *higher* than rural
Validation: using AAPCC, p. 18 (price and health adjusted)	Urban > rural utilization	Urban 6.1% *higher* than rural
Validation: using AAPCC, p. 18 (price adjusted only)	Urban > rural utilization	Urban 4.1% *higher* than rural

2. Exclusion of M+C Recipients. M+C utilization was not included in the MedPAC calculation of use rates reported in Figure 1-10 (p. 16) and Table 1-4 (p. 19). Since reimbursements to M+C plans in urban areas greatly exceed payments to rural plans, and because penetration of M+C plans is much higher in urban areas than in rural areas, a significant urban-rural disparity in utilization may have been overlooked. To assess whether this is true, and the extent to which this would alter conclusions about access, the Panel analyzed Medicare spending on M+C, across urban and rural areas, after adjusting for price differences across these areas. The results are presented in Table 2, which mimics Figure 1-10 from the Report and starts from the MedPAC findings on Medicare FFS spending. However, the results show that spending on behalf of rural Medicare beneficiaries is 10% lower than spending on behalf of urban beneficiaries, a difference of

approximately $600 annually in 1999 (Table 2, columns b and e).[3] When this spending is added to Medicare FFS spending, note that overall spending on Medicare (combining FFS and M+C spending) is 2.3% *lower* in rural areas, as compared to urban areas.

3. Validation. Further doubt is raised about MedPAC's conclusion on aggregate utilization being higher in rural areas from analysis of AAPCC rates to validate their findings on utilization. The results from using AAPCC rates conclude that urban utilization rates are in fact *higher*–6.1% if risk adjusted and 4.1% if not (see Table 1).

4. Several Methods Point to a Rural Access Problem. It is worth noting that MedPAC reports four sets of results on utilization differences, and three of these lead to the conclusion that urban utilization exceeds rural utilization (see Table 1). In addition, the analysis of M+C spending reported on the preceding page shows yet another method for analyzing utilization data, which would lead to the conclusion that urban utilization exceeds rural utilization. Given these findings, there is significant evidence to cast doubt on MedPAC's conclusion that "rural beneficiaries do not seem to be measurably disadvantaged compared with urban beneficiaries" (p. xv).

While the differences in rural and urban utilization may seem small, ranging from 0% to 6.6% depending on the analytical approach used, they are significant in the context of all the points raised in this paper and by the Report for several reasons. First, small differences in overall utilization could reflect large and significant differences for certain rural beneficiaries (e.g., those in areas nonadjacent to MSAs or those in some regions of the country). Second, MedPAC concludes that there is evidence to suggest that some rural persons face problems in accessing health care, especially in remote rural areas. Small differences in utilization measured using expenditure data are likely to understate differences in access to services. Finally, risk-adjustment techniques that measure risk by assessing prior utilization will be overstated for individuals who had greater access to health care. The results will tend to minimize the differences in expenditures when comparing urban to rural beneficiaries.

[3]There are some significant caveats to the analysis presented here. First, M+C payments are not risk adjusted, as the FFS payments reported in the Report are. It is impossible to risk adjust the M+C payments because individual level data on enrollment in M+C plans is not available. Second, actual payment made to M+C plans differs from the county M+C payment rate because payment is adjusted by the risk adjustment before payment is made to plans. Thus, plans are likely to be paid less than is shown here because M+C recipients are favorably selected. Third, this analysis depends on the price index used to adjust M+C spending across the U.S. However, the price index used here is the official input price index specified in the Balanced Budget Act for determining M+C payment rates, so this is probably the best available price adjustment that could be made to M+C payment rates. Fourth, the estimates here do not remove graduate medical education and disproportionate share hospital payments from the M+C payment. Including those expenditures tends to bias the urban M+C spending figures up, relative to rural M+C spending, because graduate medical education and disproportionate share hospital expenditures are higher in urban areas. Despite these caveats, the findings presented here illustrate the point that exclusion of M+C utilization may bias the conclusions drawn by MedPAC. Further analysis of this issue is warranted.

Table 2.
Medicare Expenditures Per Beneficiary, Comparison of Urban to Rural, Including Medicare+Choice Spending

County Type (and Urban Influence Codes [UIC])	Average Indexed FFS Spending, 1999	Average Indexed M+C Spending, 1999	Average Indexed Spending, FFS and M+C, 1999	Average Indexed FFS Spending, relative to urban, 1999	Average Indexed M+C Spending, relative to urban, 1999	Average Indexed Spending, FFS and M+C, relative to urban, 1999	Total Medicare Eligibles (Thousands)	Total M+C Enrollees (Thousands)
	(a)	(b)	(c)	(d)	(e)	(f)	(g)	(h)
Urban, in an MSA (UIC 1&2)	**$4,828**	**$6,239**	**$5,081**	**100.0%**	**100.0%**	**100.0%**	**24,269.1**	**4,359.0**
All rural counties	**$4,945**	**$5,615**	**$4,962**	**102.4%**	**90.0%**	**97.7%**	**7,679.0**	**198.5**
Adjacent to MSA and includes town of at least 10,000 people (UIC 3 & 5)	$4,796	$5,525	$4,824	99.3%	88.6%	94.9%	1,918.6	73.2
Not adjacent to MSA but includes town of at least 10,000 people (UIC 7)	$4,922	$5,286	$4,933	101.9%	84.7%	97.1%	2,301.3	66.9
Adjacent to MSA but does not include town of at least 10,000 people (UIC 4 & 6)	$5,003	$6,023	$5,020	103.6%	96.5%	98.8%	1,372.3	23.3
Not adjacent to MSA but does not include town of 2,500-10,000 people (UIC 8)	$5,073	$6,136	$5,094	105.1%	98.4%	100.2%	1,516.5	29.5
Not adjacent to MSA and does not include a town of at least 2,500 people (UIC 9)	$5,059	$6,283	$5,071	104.8%	100.7%	99.8%	570.3	5.5
National Average	$4,864	$6,212	$5,053	100.7%	99.6%	99.4%	31,948.0	4,557

SOURCES:

a. MedPAC, "Report to the Congress: Medicare in Rural America," Figure 1-10, page 16.
b. RUPRI analysis of Medicare+Choice spending, adjusted by input price index.
c. Total of columns (a) and (b) weighted by number of eligibles in FFS Medicare and Medicare+Choice.
d. Ratio of FFS spending in column (a) to spending in urban counties in column (a).
e. Ratio of Medicare+Choice spending in column (b) to spending in urban counties in column (b).
f. Ratio of total spending in column (c) to spending in urban counties in column (c).
g. Total number of Medicare eligibles in counties, from CMS Medicare+Choice data.
h. Total number of Medicare+Choice enrollees, from CMS Medicare+Choice enrollment data.

Chapter 3: "Quality of care in rural areas"
RUPRI Panel Comments

The MedPAC recommendation (3A, p. 46) that peer review organizations (PROs) should include rural populations and providers when fulfilling quality improvement directives will greatly benefit rural providers and populations if the Medicare program's responses are sufficiently sensitive to unique rural characteristics and requirements.

Currently, there is a significant disincentive for PROs to focus efforts on rural health care quality improvement. By targeting their efforts to large, urban providers, PROs can demonstrate more significant performance improvement (measured as lives affected) if the programs are successful. Furthermore, not all PROs have expertise in quality improvement in rural facilities. PROs should receive additional funding to enable them to overcome the distance and methodological barriers to working with rural providers and to avoid having to divert funds from quality improvement (QI) efforts in urban areas. PROs with established expertise in rural QI initiatives (e.g., Arkansas, North Dakota, Nebraska) should be used as technical assistance resources for those PROs without such expertise. Also, a toolbox of relevant QI tools and approaches should be developed for all PROs to use with rural providers.

In providing objectives to guide PROs in performing QI projects in the next scope of work as promulgated by the Centers for Medicare and Medicaid Services (CMS), the Secretary could direct PROs to work with local providers to identify quality concerns, encourage use of the national clinical topics whenever feasible, and establish state-level PRO rural performance goals.

Rural service settings differ in the demography in which they are located as well as the size and service mix of health care facilities and their degree of affiliation with other rural and urban provider organizations. Because rural service settings vary and user buy-in is important in establishing QI systems, PROs should work with local providers (and networks of providers) in identifying QI projects. Also, to the extent that the national health improvement clinical topics and performance indicators are relevant to health status and delivery system characteristics in rural areas (e.g., outpatient diabetes, breast cancer, pneumonia for rural primary care, and inpatient pneumonia or AMI for rural hospitals), PROs and the rural providers with whom they work should be encouraged to develop related projects that would allow for urban-rural and across-rural comparisons. The measure of PRO success in rural QI should recognize that characteristics such as low volume, distance to tertiary care facilities, etc., may impact performance measurement and related findings.

Given the human, financial, and information systems limitations in many rural facilities, financial incentives for rural providers to conduct QI activities should be considered.

Financial incentives would allow hardware and software upgrades and installations needed to move from paper (manual) QI protocols, increasingly used by many rural providers, to computerized systems. Such systems would increase efficiency and accuracy in data collection

and analysis, allow rural provider organizations to address a wider range of health issues (e.g., diabetes, asthma, preventive, and other services), and enable rural provider organizations to perform a variety of analyses and reporting to improve patient care processes. In addition, implementation of affordable and appropriate information technology would set the stage for establishing centralized patient databases to track chronic disease and preventive services delivered to individual patients in different (primary, secondary, and tertiary care) settings and to begin to concentrate data on similar provider organizations to start benchmarking and examining outcome measurement.

MedPAC's recommendation (3B, p. 49) that at least one-third of each facility type should be surveyed annually to certify compliance with Medicare's Conditions of Participation is important to ensuring adequate public oversight of all types of rural health care facilities.

However, it is equally important to avoid regulatory and financial burdens associated with increased survey frequency, particularly for those facility categories with negative overall Medicare margins. MedPAC appropriately expresses concern about the need for the federal government to adequately fund state survey and certification activities – activities that are used much more extensively by rural providers than by urban providers. When Medicare revises the Conditions of Participation, rural health experts should participate in the process to ensure that the established standards are appropriate for rural as well as urban health care entities. To enhance flexibility for rural facilities and providers, the Conditions of Participation should permit variation in structure and processes when comparable outcomes are achievable.

Caution should be exercised in generalizing volume-outcome findings from urban to rural settings.

The Report raises concerns about rural providers treating fewer patients for some types of services for which evidence exists indicating a relationship between some low service volumes and poorer patient outcomes. While these concerns merit attention, the majority of services where this association has been made are not routinely provided in many rural facilities (e.g., coronary artery bypass graft surgery). Furthermore, it is likely that rural health care is characterized by a higher volume of certain primary and ambulatory care interventions and the treatment of more common conditions. Consequently, research should include a focus on quality measures of the types of care commonly rendered by rural providers. Where the low volume of procedures is found to be related to poorer patient outcomes, interventions should be studied that could improve outcomes for those procedures.

While MedPAC asserts that quality of care is "roughly comparable" for urban and rural beneficiaries based on a set of 46 indicators, some very important differences were noted for beneficiaries living in remote rural counties. Also, certain types of "potentially avoidable care" were higher for beneficiaries in remote rural counties, including multiple emergency room visits for angina and admissions for pulmonary disease. The Report notes that the study from which these findings were drawn cannot distinguish differences that result from poorer quality of care

versus poorer access to care. Attention should be given to assuring the availability of essential services including primary, preventive, and chronic care management for rural beneficiaries.

MedPAC's conclusion that rural providers have fewer incentives to perform QI activities than their urban counterparts is questionable.

While MedPAC suggests links between QI incentives and the presence of managed care or purchasing coalitions, such links are a recent and quite limited phenomenon. In spite of the fact that managed care is markedly limited in rural areas, rural providers are likely to lose market share if local residents perceive health care quality problems. Already operating at low volume, many rural facilities are especially sensitive to the loss of even a very small percent of their patient population. In fact, such outmigration may drive providers to try to create evidence for quality so that patient populations are not lost to urban areas. Rural facilities can experience market pressure from neighboring urban areas, including those that set up clinics in some proximity to rural providers, resulting in a threat to market share and hence, operating margins. Establishing QI programs and providing evidence to the public of the quality of care delivered are activities being included in several state rural hospital flexibility programs. This is further substantiation of the self-perceived need of rural hospitals to focus on quality.

Chapter 4: "Improving payment for inpatient hospital care in rural areas"
RUPRI Panel Comments

In general, the recommendations made by MedPAC regarding inpatient hospital Medicare reimbursement are positive and a step in the right direction for rural hospitals. However, these recommendations are incremental reforms that do not fully address the financial reality facing the small rural hospital.

Given the purpose of the wage index, MedPAC's recommendation (4A, p. 62) that rural referral centers' wages must exceed the average wage in their area to qualify for geographic reclassification is reasonable.

The intent of the wage index is to adjust payments under the prospective payment system (PPS) for factors that are beyond the individual hospital's control, in this case, the labor market conditions that the hospital faces. The reasoning behind allowing rural referral hospitals that meet certain minimal criteria to reclassify to an urban rate was that the referral hospital required a staffing mix that more closely resembled the staff hired in urban hospitals, rather than closer rural institutions, and therefore competed with urban hospitals for labor. If this is in fact the case, the requirement in recommendation 4A (p. 62) will not pose a problem, as rural referral centers that have wages and a staffing mix comparable to urban hospitals will still receive geographic reclassification. Rural referral centers with wages that do not exceed the average wage in their rural geographic labor market will lose the ability to reclassify (and therefore will also see decreased PPS reimbursements), but this is appropriate under the intent of the PPS payment system. If these institutions need financial relief for other reasons, or if there is a policy objective to support these institutions, the integrity of the PPS payment system is better maintained through the use of some other mechanism to provide financial relief. However, such a mechanism should be in place before rural referral centers lose the ability to automatically reclassify.

MedPAC's recommendation (4B, p. 67) to develop an adjustment for low volume in the inpatient payment system is an incremental step that will improve Medicare margins for some rural providers.

MedPAC recommends that a graduated adjustment be developed for low-volume rural hospitals. Simulations of the impact of a low-volume adjustment, which MedPAC presents in Table 4-7 (p. 69), show only minimal relief. In fact, 57.7% of low volume hospitals (up to 200 discharges per year) will still have negative inpatient Medicare margins after implementation of the proposed adjustment, although the average negative margin improves from -16.4% to -8.5% (p. 69). In order to most effectively target the rural hospitals that face financial constraints not accounted for in PPS, more research needs to be conducted to fully understand the factors that contribute to the differential in margins between rural and urban hospitals.

It is important to note that MedPAC reports dollar-weighted margins (in other words, the numerators and denominators are each individually summed across all hospitals). This means

that hospitals with more revenue and more costs will have a greater effect on the reported aggregate average margin than will hospitals with less financial activity. Average margins that are computed by averaging each individual hospital's margin are generally lower than the margins reported in the Report.

MedPAC's recommendation (4C, p. 76) that "In fiscal year 2002, the Secretary should implement fully the policy of excluding from the hospital wage index salaries and hours for teaching physicians, residents, and certified registered nurse anesthetists" would improve the payment system.

Likewise, MedPAC's recommendation (4D, p. 80) would provide data needed to improve the application of the hospital wage index: "To ensure accurate input-price adjustments in Medicare's prospective payment systems, the Secretary should reevaluate current assumptions about the proportions of providers' costs that reflect resources purchased in local and national markets."

MedPAC's recommendation (in earlier reports) to raise the cap on the disproportionate share hospital (DSH) add-on for rural hospitals to 10%, which will increase rural hospitals' share of DSH payments to 9.8%, is a step in the right direction (p. 80). However, given the intent of DSH payments to compensate for the costs of Medicaid and uncompensated care, the inequity of DSH payments between urban and rural hospitals should be completely eliminated, and rural hospitals' DSH share should be equal to the share of care provided.

As noted by MedPAC, "Rural hospitals were responsible for 12.8% of the care provided to Medicaid and uncompensated care patients nationally in 1999…[in] 2000, only 3.1% of (DSH) payments went to rural facilities" (p. 80). MedPAC's justification for not recommending complete removal of the cap rests in part on anticipation that new data on uncompensated care, available in about two years, will result in a redistribution of DSH payments. Under the current payment formulas, the amount of care provided to Medicaid enrollees is used as a proxy for uncompensated care. Implicit in MedPAC's reasoning is that the relationship between the amounts of Medicaid and uncompensated care delivered differs between urban and rural hospitals. However, without data on uncompensated care, and lacking analysis of the relationship between that care and care to Medicaid eligibles, it is impossible to evaluate whether, when DSH payments are based on a formula that explicitly accounts for uncompensated care, there will be a larger distributional shift in DSH payments among rural hospitals as compared to urban ones. Additionally, although the necessary data will have been collected and will be ready to form the basis for such redistribution, "Congress will have to legislate a new distribution formula or provide guidelines to HCFA for developing the formula" (p. 80) before the new data is used in calculations of DSH payments. Thus, it is by no means certain that redistribution will occur in two years.

Recognizing gaps in current knowledge about the impact of PPSs on use of hospital swing beds and general problems with the PPS for skilled nursing facilities, MedPAC "is concerned about

bringing these stays under the PPS" (p. 70). Therefore, a deliberate pace of implementation is a wise course of action.

Policies affecting payment for swing beds have considerable implications for rural hospitals, two-thirds of which have approved swing beds. One example of the effect of considering rural hospitals' special circumstances before wholesale adoption of PPS is that a low-volume adjustment may be appropriate, as suggested by MedPAC (p. 70).

Chapter 5: "Assessing payment for outpatient hospital care in rural areas"
RUPRI Panel Comments

The June 2001 MedPAC report, and previous MedPAC reports, identify two critical realities about the impact of outpatient PPS in rural areas.

1. The implementation of prospective payment for outpatient services has a disproportionate impact on the financial well being of small rural hospitals.

Rural hospitals are more dependent on Medicare outpatient payment than their urban counterparts. In 1999 Medicare costs were:

45.4% of total costs for rural hospitals; and
34.0% of total costs for urban hospitals (p. 91).

Outpatient costs were:

21.8% of total Medicare costs for rural hospitals;
24.2% of total Medicare costs for rural hospitals with 100 or fewer beds; and
16.1% of total Medicare costs for all urban hospitals (p. 91).

In 1999, the margin for Medicare outpatient payment, excluding graduate medical education, was lower for rural hospitals (-16.0%) than urban hospitals (-15.2%), and lowest for small rural hospitals (-19.4 for Medicare dependent hospitals, -19.3% for rural hospitals with fewer than 50 beds that were not a special payment category) (MedPAC, March 2001, p. 175).

2. Rural beneficiaries face increases in their coinsurance payments as a result of implementing prospective payment for outpatient services.

Beneficiaries are liable for 20% of hospital *charges* for most outpatient services. Prior to prospective payment, that share was calculated based on the *particular hospital's* charges. In that system, beneficiary payment was generally lower for care provided by rural hospitals because their charges are usually lower than urban hospitals for the same test. In the new system, the beneficiary percentage is based on *the historical national median charge*. This is true regardless of the actual charge by a specific hospital. Therefore, beneficiary payment will be higher for hospitals that had charged below the median and lower for hospitals that had charged above the median. To illustrate:

Hospital Charge	Old Beneficiary Payment	New Beneficiary Payment
$3,000	$600	$800
$5,000	$1,000	$800

This problem would be corrected with full implementation of a limit on coinsurance of 20% of *payment (not charges)*, which MedPAC, in its March 2001 report, recommended be fully implemented by 2001.

MedPAC's recommendation to "revisit outpatient payments to rural hospitals when better information...is available" should include a proviso that the current hold harmless provision not be lifted until that analysis is completed.

Over 80% of rural hospitals (p. 90) are eligible for hold-harmless payments (equivalent to pre-PPS payments), a provision that expires January 1, 2004.[4] Although pre-PPS reimbursements are less than actual costs, for some institutions, they are more favorable than the new PPS system (which includes a wage index adjustment using the inpatient hospital wage index).

Appropriate and equitable use of PPS for outpatient payment is a function of the validity and reliability of the data used in reimbursement calculations. If implemented before data systems are fully developed (including a history of proper coding that will begin when hospitals have implemented new billing systems), a new payment system could result in some services being discontinued because of poor payment as compared to costs. To guard against *possible* adverse impacts on access because PPS payments force service reductions, analysis should be completed in time to make any appropriate adjustments to PPS payments for small rural hospitals.

[4]Pre-PPS payments are not the equivalent of reimbursement for full costs. They were calculated using a cost-to-payment ratio that reduced payment below costs by an adjustment factor of approximately 6.5% (combination of capital and non-capital adjustments), and for some categories (ambulatory surgical procedures, radiology, and other diagnostic) blended cost-based payment with a fee schedule. Under current provisions, the payment-to-cost ratio based on 1996 cost reports is applied to the current cost-to-charge ratio to calculate payment. An important exception is that payments for lab services are based on a fee schedule.

Chapter 6: "Prospective payment for home health services in rural areas"
RUPRI Panel Comments

MedPAC's recommendation (6A, p. 110) that rural home health services should not be exempt from the prospective system is reasonable, at least in the short term, given that the impacts of the new system are not yet known.

A more important short-term issue is the pending 15% reduction in the PPS payment for home health. As MedPAC found, many rural home health agencies operate at low volumes and have less sophisticated management systems. Therefore, they are likely to have smaller margins and be less able to adjust to the "shock" of a 15% reduction in payment. The 15% reduction should be repealed. The intent was for PPS to be at 85% of IPS, but IPS was much more draconian than expected, so savings have been achieved without a further reduction.

MedPAC's recommendation to study rural home health providers (6B, p. 110) is well founded and imperative. In addition to the three specifics identified by MedPAC (impact of prospective payment on home health in rural areas, costs that may affect adequacy of prospective payments, and ways to improve all cost reports), such a study should include:

1. Examination of the difference in the mix of services available to and used by rural and urban beneficiaries and whether or not prospective payment changes that mix.

2. Examination of different types of rural home health agencies in different regions of the country, especially as related to volume, size of the agency, and characteristics of the agency's service area.

3. Examination of problems in maintaining a work force for long-term care nursing units and home health, and the impact of those problems on availability and cost of home health in rural areas.

4. Examination of travel time associated with rural home health agency visits compared to urban travel times.

A thorough, relevant study requires participation of health services researchers specializing in rural health care issues.

Chapter 7: "Bringing Medicare+Choice to rural America"
RUPRI Panel Comments

The Report correctly concludes that "the basic market characteristics shared by many rural areas...will likely continue to frustrate these efforts" (p. 115) to expand access to M+C in rural America.

Enrollment in M+C plans offers Medicare beneficiaries considerable benefits beyond what is offered in traditional fee-for-service Medicare (e.g., some coverage of prescription drugs, eye care, and preventive care). For this reason, the availability of M+C in rural areas is a crucial concern for rural persons, and this point was addressed previously, in the comments on Chapters 1 and 2 of the Report. Previous work completed by the Panel and others also shows that M+C plans face significant impediments in rural areas (Penrod, McBride, & Mueller, 2001; McBride, Penrod, Mueller, Andrews, & Hughes, 2001).

Given the lack of access to M+C plans for the vast majority of rural Americans, MedPAC appropriately concludes that "rural beneficiaries are unlikely to see more generous benefits without an explicit or implicit subsidy" (p. 122).

Policymakers will need to be mindful of this conclusion if their goal is to ensure equity for Medicare beneficiaries regardless of geographic location.

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RUPRI Rural Health Panel

Andrew F. Coburn, Ph.D., is the Director of the Institute for Health Policy and Professor of Health Policy and Management in the Edmund S. Muskie School of Public Service at the University of Southern Maine. Dr. Coburn is also Director of the Maine Rural Health Research Center. He has published extensively on rural health issues related to health insurance coverage and long-term care. He is a contributing author of the recent book, *Rural Health in the United States* published in 1999 by the Oxford University Press.

Charles W. (Chuck) Fluharty, M.Div., is the Director of the Rural Policy Research Institute. He also currently serves as Interim Director of the Missouri Institute of Public Policy, and holds Adjunct Faculty Appointments in the University of Missouri Graduate School of Public Affairs and Department of Rural Sociology. He was the recipient of the 1999 Friend and Partner Award from the National Association of Counties Rural Action Caucus, the 1999 National Rural Development Partnership Recognition Award, the 1998 Distinguished Service Award from the National Association of Counties, and the 1998 Recognition Award from the National Organization of State Offices of Rural Health. He received his M.Div. from Yale University Divinity School, and has focused his career upon service to rural people, primarily within the public policy arena.

J. Patrick Hart, Ph.D., is an Associate Professor and the Deputy Director of the RUPRI Center for Rural Health Policy Analysis, University of Nebraska Medical Center. Before assuming his current responsibilities, Dr. Hart served as President of Hart and Associates in Larimore, North Dakota. He has held faculty positions in Public Health, Allied Health, and Medicine, and worked with rural organizations, communities, and networks in the United States, Pakistan, and Honduras providing consultation in community and organization development, information systems, program evaluation and training design. Dr. Hart is past President of the Board of Directors of the National Rural Health Association, past Chair of the Rural Health Committee of the American Public Health Association, and served on the National Advisory Committee of the Robert Wood Johnson Foundation Program on Improving the Health of Native Americans. He received his M.S. in Social Psychology and his Ph.D. in Human Ecology from the University of Oklahoma.

A. Clinton MacKinney, M.D., M.S., is a board-certified family physician. He is currently practicing with HealthPartners Central Minnesota Clinics in St. Cloud, Minnesota. He earned his medical degree at Medical College of Ohio and completed residency training at the Mayo-St. Francis Family Practice Residency. His MS degree is in Administrative Medicine, University of Wisconsin. He has lectured and published articles regarding rural health, and has served on committees for the American Medical Association, the American Academy of Family Physicians, the Robert Wood Johnson Foundation, and the National Rural Health Association.

Timothy D. McBride, Ph.D., is an Associate Professor of Economics, Public Policy and Gerontology at the University of Missouri-St. Louis. Dr. McBride's research focuses on public economics, with special emphasis on the economics of aging and health. In the health policy area, Dr. McBride's research has focused on Medicare policy reform, the uninsured, long-term care, and health care reform. He is the author of over twenty research articles and co-author of a monograph titled *The Needs of the Elderly in the 21st Century*. Dr. McBride joined the Department of Economics in 1991 at the University of Missouri- St. Louis after spending four years at the Urban Institute in Washington, D.C.

Keith J. Mueller, Ph.D., is a Professor and the Director of the RUPRI Center for Rural Health Policy Analysis, University of Nebraska Medical Center. Dr. Mueller is also the Director of the Nebraska Center for Rural Health Research. He was the 1996-97 President of the National Rural Health Association, and the recipient of the Association's Distinguished Rural Health Researcher Award in 1998. He is the author of a University of Nebraska Press book, *Health Care Policy in the United States*, and has published articles on health planning, access to care for vulnerable populations, rural health, and access to care among the uninsured. He is a member of the Secretary's National Advisory Committee on Rural Health. Dr. Mueller's expert testimony has been solicited by Committees of the U.S. Congress, the Medicare Payment Advisory Commission, and the Bipartisan Commission on the future of Medicare.

Rebecca T. Slifkin, Ph.D., is the Director of the North Carolina Rural Health Research and Policy Analysis Center, one of six centers funded by the federal Office of Rural Health Policy. She is also Director of the Program on Heath Care Economics and Finance at the Cecil G. Sheps Center for Health Services Research at the University of North Carolina at Chapel Hill, and a Research Assistant Professor in the Department of Social Medicine in the Medical School. Her work has spanned a broad array of topics, including Medicare Graduate Medical Education payments, Medicaid managed care, Critical Access Hospitals, and access to care for rural minorities.

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Can Payment Policies Attract M+C Plans to Rural Areas? May 2001. (PB2001-8)

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