RURAL HEALTH CARE IN MEDICARE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON WAYS AND MEANS
HOUSE OF REPRESENTATIVES

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TUESDAY, JUNE 12, 2001

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:10 a.m., in room 1100 Longworth House Office Building, Hon. Nancy Johnson (Chairwoman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HEALTH

FOR IMMEDIATE RELEASE
June 5, 2001
HL–8

CONTACT: (202) 225–3943

Johnson Announces Hearing on Rural Health Care in Medicare

Congresswoman Nancy L. Johnson (R–CT), Chairwoman, Subcommittee on Health of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on Rural Health Care: Provider and Beneficiary Issues. **The hearing will take place on Tuesday, June 12, 2001, in the main Committee hearing room, 1100 Longworth House Office Building, beginning at 10:00 am.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include the chairman of the Medicare Payment Advisory Commission (MedPAC) and rural health care experts. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

Rural health policy has an important place on the agenda of this Committee. In recent years, Congress has acted to ensure that rural beneficiaries have access to needed health care services. In the Balanced Budget Act of 1997, Congress created a new class of providers—Critical Access Hospitals—to ensure that the capacity for emergency and ambulatory services are protected in the most isolated rural areas while retaining a limited capacity for inpatient care. In the Balanced Budget Refinement Act (BBRA) and the Beneficiary Improvement and Protection Act (BIPA), Congress moved further to protect the delivery of emergency care for Critical Access providers by improving ambulance service payment and covering the costs of retaining physicians to provide on-call services to emergency rooms.

Further, the BBRA and BIPA increased Medicare payments for rural hospitals, above and beyond Balanced Budget Act corrections. Sole community hospitals will be paid based on updated information on the costs of providing services to patients in their community—the first significant change in the program since 1989. The eligibility for Medicare disproportionate share payments was equalized between urban and rural hospitals, correcting the disparity in who can receive these payments that has existed since 1990. Finally, the Medicare dependent hospital program was extended and the eligibility broadened to new hospitals.

Regardless, the demographic, social, cultural, and economic changes that affect rural populations are different in many respects than those for urban populations. Rural America is growing more slowly and its population is older than the rest of the nation. In *Rural Health in the United States*, researchers report that despite these differences the overall health status indicators for rural residents is similar to that of urban residents. Chairman Johnson stated: "Medicare policy must continue to ensure that the rural elderly and disabled have access to high quality care. The program should closely monitor their access and health status. Moreover, we may need to act to modernize the program when gaps are identified, for example, fewer rural beneficiaries have Medigap insurance and are more likely to have limited coverage."

FOCUS OF THE HEARING:

The hearing's first panel will report on the findings from the congressionally mandated MedPAC report on how Medicare is working for rural beneficiaries and recommendations for changes in Medicare. The second panel includes rural experts who will discuss access to services and the equity of the Medicare benefit structure. The panel will also discuss whether the many rural provider programs protect vulnerable rural communities.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Any person or organization wishing to submit a written statement for the printed record of the hearing should *submit six (6) single-spaced copies of their statement, along with an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, with their name, address, and hearing date noted on a label*, by the close of business, Tuesday, June 26, 2001, to Allison Giles, Chief of Staff, Committee on Ways and Means, U.S. House of Representatives, 1102 Longworth House Office Building, Washington, D.C. 20515. If those filing written statements wish to have their statements distributed to the press and interested public at the hearing, they may deliver 200 additional copies for this purpose to the Subcommittee on Health office, room 1136 Longworth House Office Building, by close of business the day before the hearing.

FORMATTING REQUIREMENTS

Each statement presented for printing to the Committee by a witness, any written statement or exhibit submitted for the printed record or any written comments in response to a request for written comments must conform to the guidelines listed below. Any statement or exhibit not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All statements and any accompanying exhibits for printing must be submitted on an IBM compatible 3.5-inch diskette in WordPerfect or MS Word format, typed in single space and may not exceed a total of 10 pages including attachments. **Witnesses are advised that the Committee will rely on electronic submissions for printing the official hearing record.**

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. A witness appearing at a public hearing, or submitting a statement for the record of a public hearing, or submitting written comments in response to a published request for comments by the Committee, must include on his statement or submission a list of all clients, persons, or organizations on whose behalf the witness appears.

4. A supplemental sheet must accompany each statement listing the name, company, address, telephone and fax numbers where the witness or the designated representative may be reached. This supplemental sheet will not be included in the printed record.

The above restrictions and limitations apply only to material being submitted for printing. Statements and exhibits or supplementary material submitted solely for distribution to the Members, the press, and the public during the course of a public hearing may be submitted in other forms.

Note: All Committee advisories and news releases are available on the World Wide Web at ″http://www.house.gov/ways__means/″.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Chairwoman JOHNSON. Good morning, everyone.

Today will be our first Subcommittee hearing this session on rural health care. In earlier hearings, we looked for new ideas on Medicare reform. We asked hospitals and physicians and other providers how to reduce the regulatory burden. We examined the adequacy and usefulness of the current definition of Medicare solvency. We laid the groundwork for a prescription drug benefit and examined ideas to modernize the fee-for-service program's beneficiary cost-sharing.

As I read through today's testimony, it is clear that the earlier hearings were also about the issues that are critical to rural seniors. For example, in our hearing on cost sharing, we reported that the design of Medicare beneficiary cost sharing in the fee-for-service program reflects outdated 1965 insurance practices. As such, more than 35 years later, beneficiaries are confronted with irrational and confusing cost sharing which does not reflect the current delivery of health care. Today, we will hear that as a result of this rural beneficiaries spend less but have higher cost sharing.

Similarly, at our prescription drug hearing, we found that many of the current supplemental prescription drug plans, such as Medigap, are expensive and generally inadequate. We also found that those without coverage have the least bargaining power and are therefore often paying the highest prescription drug prices. At the hearing today, we will hear that too many of those individuals with the least protection live in rural America.

Finally, we learned that health care providers spend a great deal of their time and energy on complying with Medicare rules. This Subcommittee will continue to work on easing these requirements so that these providers can once again focus on what is important to rural and urban beneficiaries alike, and that is patient care.

To protect rural beneficiaries, we have acted to solidify access to services in isolated areas. In the Balanced Budget Act of 1997, Congress created a new class of providers, critical access hospitals, to ensure that emergency services are protected in the most isolated rural areas while retaining a limited capacity for in-patient care. Recently, we have made the qualifications for critical access hospital designation more flexible. And last year this Subcommittee acted in the Beneficiary Improvement and Protection Act to strengthen access to ambulance services and cover the costs of retaining physicians to provide on-call emergency services in the remote communities served by critical access providers.

There is also a need to make sure that rural seniors have access to hospital services when needed. In the Balanced Budget Refinement Act and the Beneficiary Improvement and Protection Act, we increased Medicare payments for rural hospitals. Sole community hospitals will be able to be paid on their more recent information on cost, the first significant change in the program since 1989.

Most important, by equalizing the eligibility for Medicare disproportionate share payments between urban and rural hospitals, we were able to pump more than a billion dollars over 5 years into rural hospitals, which were legally being discriminated against under the law. Yet the payment formulas still-for Disproportionate Share Hospital (DSH) payments still are not fully equalized, and more needs to be done.

Additionally, rural hospitals are often dependent on outpatient skilled nursing and home health revenues. We added significant protections and additions to these services so that these services will continue to be available for seniors and rural hospitals are better shielded from any negative impact of the outpatient prospective payment system (PPS) until we can determine how they are affected by the PPS.

Skilled nursing units in rural hospitals benefit from the add-on payments to the resource utilization groups and from the 17-percent increase for the nursing component of the rate. The 15-percent reduction in home health services has also been delayed. These changes equally aided free-standing home health agencies and skilled nursing facilities in rural areas.

Finally, Congress made significant progress in eliminating the payment disparities in Medicare+Choice by enacting two payment floors, $475 for rural counties and $525 for counties with populations greater than 250,000.

Our goal is to ensure that Medicare beneficiaries get the care they need. The dust has far from settled from the positive changes we have made. In fact, most of these policies are only beginning to go into effect, starting into effect in April, and the impact of most are yet to be realized.

While we can count the dollars, it is too early to measure the differences we have made for rural providers. And while we have done much, I am still extremely concerned about the future of small providers in general and small rural providers in particular. In a joint letter to the Health Care Financing Administration, Mr. Stark and I have recommended a number of changes that should reduce the regulatory burden and put in place the technical assistance that small providers need to assure smooth cash flow in an extremely complicated billing system.

Then, of course, there is the senior citizen needing care. As long as it will take us to evaluate the effects of the changes that we have made in the last year and the year before that to law and regulatory law, it is going to be even more difficult to evaluate its impact on rural beneficiaries, the senior citizens who live in rural areas. I am concerned that seniors in these areas will still find cost barriers and receive less preventive care for flu shots, pap smears, screening mammographies and so on. Clearly, we must act to modernize Medicare so that the inequities faced by rural beneficiaries do not continue.

Today, we begin our examination of how rural beneficiaries as well as providers are surviving in the current distorted and complex Medicare Program. I am happy to host the first hearing in which our new chairman of MedPAC, the Medicare Payment Advisory Commission, will testify, Mr. Hackbarth; and I thank you for accepting this important job and being with us today. We are eager to hear what MedPAC's recommendations are to strengthen rural health care.

I would also like to at the same time note for the record my thanks to Gail Wilensky for her long and distinguished service to MedPAC and in the many ways in which she has served both the House and Senate over many years. I am sure that we will not lose

access to her experience and balanced analysis of problems, but I do here now recognize her extraordinary service to MedPAC.

Thank you, Mr. Hackbarth; and before I recognize you, I will recognize my colleague, Mr. Stark.

[The opening statement of Chairwoman Johnson follows:]

Opening Statement of the Hon. Nancy L. Johnson, M.C., Connecticut, and Chairwoman, Subcommittee on Health

Today will be our first Subcommittee hearing this session on rural health care. In earlier hearings, we looked for new ideas on Medicare reform, we asked hospitals and physicians and other providers how to reduce regulatory burden, we examined the adequacy and usefulness of the current definition of Medicare solvency, we laid the ground work for a prescription drug benefit and examined ideas to modernize the fee-for-service program's beneficiary cost-sharing.

As I read through today's testimony, it is clear that the earlier hearings were also about the issues that are critical to the rural seniors. For example, in our hearing on cost sharing, we reported that the design of Medicare beneficiary cost sharing in the fee-for-service program reflects outdated 1965 insurance practices. As such, more than 35 years later, beneficiaries are confronted with irrational and confusing cost-sharing which does not reflect the current delivery of health care. Today, we will hear that as a result of this rural beneficiaries spend less but have higher cost sharing.

Similarly, at our prescription drug hearing, we found that many of the current supplemental prescription drug plans, such as Medigap, are expensive and generally inadequate. We also found that those without coverage have the least bargaining power and are therefore often paying the highest prescription drug prices. At the hearing today, we will hear that too many of the individuals with the least protection are rural.

Finally, we learned that health care providers spend a great deal of their time and energy on complying with Medicare rules. Earlier this Spring, Representative Stark and I sent HCFA a detailed list of recommendations to make Medicare more workable and to relieve the regulatory burden on the providers, particularly the small providers, that serve Medicare beneficiaries. Those recommendations, when implemented will create a more collaborative relationship between HCFA and providers and allow health care professionals to devote more time to patient care.

Over the past several years we have acted to solidify access to services in isolated areas. In the Balanced Budget Act of 1997, Congress created a new class of providers, Critical Access Hospitals, to ensure that emergency services are protected in the most isolated rural areas while retaining a limited capacity for inpatient care. Recently, we have made the qualifications for Critical Access Hospital designation more flexible. And last year this subcommittee acted in the Beneficiary Improvement and Protection Act to strengthen access to ambulance services and cover the costs of retaining physicians to provide on-call emergency services in the remote communities served by Critical Access providers.

There is also a need to make sure that rural seniors have access to hospital services when needed. In the Balanced Budget Refinement Act and the Beneficiary Improvement and Protection Act, we increased Medicare payments for rural hospitals. Sole Community hospitals will be able to be paid on their more recent information on costs—the first significant change in the program since 1989. Most important, by equalizing the eligibility for Medicare disproportionate share payments between urban and rural hospitals, we were able to pump more than $1 billion over five years into rural hospitals, which were legally being discriminated against under the law. Yet the payment formulas for DSH payments still are not fully equalized and more needs to be done.

Additionally, rural hospitals are often dependent on outpatient, skilled nursing and home health revenues. We added significant protections and additions for these services. So that these services will continue to be available for the seniors, rural hospitals are shielded from any negative impact of the outpatient prospective payment system, until we can determine how they are affected by the PPS. Skilled nursing units in rural hospitals benefit from the add-on payments to the resource utilization groups and from the 17 percent increase for the nursing component of the rate. The 15 percent reduction for home health services was also delayed. These changes equally aided free-standing home health agencies and skilled nursing facilities in rural areas.

Finally, Congress made significant progress in eliminating the payment disparities in Medicare+Choice by enacting two payment floors: $475 for rural counties and $525 for counties with populations greater than 250,000.

Our goal is to assure that all Medicare beneficiaries get the care they need. The dust has far from settled from the positive changes that we made—in fact some of these policies only began in April and others are to come. While we can count the dollars, it is too early to measure the difference we made for rural providers.

And it is even more difficult to know if we made a difference for rural beneficiaries.

I am concerned that the rural beneficiaries sometimes find cost a barrier and receive less preventive care such as pap smears and screening mammography. Clearly, we must act to modernize Medicare so that the inequities faced by rural beneficiaries do not continue. Today, we begin our examination of how rural beneficiaries as well as providers are surviving in the current disjointed and complex Medicare program.

I am happy to host the first hearing in which our new chairman of the Medicare Payment Advisory Commission will testify. Mr. Hackbarth thank you for accepting this important job and for being here today. We are eager to hear from you MedPAC's recommendations to strengthen rural health care. I would also like to thank Gail Wilensky for her distinguished years of service and wish her best in her future endeavors.

Mr. STARK. Thank you, Madam Chair; and thank you for today's hearing.

Addressing the concerns of rural communities is an important part of the Medicare system, and I think MedPAC's recent very good analysis of rural issues makes a contribution to understanding the Medicare payment system. Unfortunately, most of the legislation that we have passed for rural health care has been highly political and rarely evidenced-based. I look forward to hearing the findings and recommendations in the new 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.

We do, however, continue to hear anecdotal evidence of rural area providers holding on by the skin of their teeth; and to the extent there are access problems, in particular rural areas, we will need to refine the payment system to target these areas. But, it is very expensive to do across-the-board increases that boost all rural providers or all providers in general, if we are just trying to deal with a very small percentage of the smallest providers.

The results of this MedPAC report also reinforce the reality that some areas are unlikely to ever be able to sustain managed care. I hope that Mr. Hackbarth will provide this information to the Health Care Finance Administration (HCFA) so that HCFA can take a careful look at this report when they develop their plans to increase the Medicare+Choice enrollment to 30 percent. I have trouble understanding why we would want to pour more money into managed care in rural areas, when there is little evidence that Medicare+Choice can even be sustained there.

According to the report, in more than 300 rural counties, the 2001 floor payment rate exceeds the fee-for-service spending for the average beneficiary by 130 bucks a month or about 40 percent. There are simply not enough beneficiaries to spread risk and not

enough providers to buildup a sufficient network for these plans to realize profits in isolated rural areas.

The plight of rural providers is not solely a function of Medicare and Medicaid payments. There are market forces that disproportionately affect rural areas, and rural areas must work harder to recruit and retain providers. Medicare payments are only a small piece of the puzzle in creating an efficient health infrastructure, and I hope the speakers on the second panel will help us better understand the problems of rural communities and how Federal programs can be refined and coordinated with local programs to help those communities in need.

I think that we should address, for example, the Medicare payment reforms as part of an overall strategy rather than in isolated area changes. MedPAC, I think, has advocated that Medicare payment policies be site neutral so that decisions on where a service is provided could be based on clinical factors rather than payment, and I hope the recommendations in this report further that policy approach.

At some point, there is a major concern. I don't know whether it is at 10 beds or 20 beds, but it must be a matter of medical practice to suggest that at some small minimum—it just isn't practical or efficient to try and maintain acute care service. It is probably a lot cheaper to have a helicopter pilot and a heliport to replace that kind of a facility.

And I think, politically, that is a terrible problem for us. Nobody on their watch wants to see the hospital in their hometown closed, particularly when it is named after your most substantial contributor to your campaign. It just is a very difficult thing. We have known that for years, and I hope that we can work together to find some way to build a statue to the contributors, convert the hospital to a useful purpose and perhaps make our whole system more efficient. I look forward to the witnesses' testimony to help us on that course. Thank you.

[The opening statement of Mr. Stark follows:]

Opening Statement of the Hon. Fortney Pete Stark, M.C., California

Madame Chairwoman, thank you for having this hearing today. Addressing the concerns of rural communities is always an important part of Medicare legislation, and MedPAC 's impartial analysis of rural issues makes a great contribution to our understanding of the Medicare payment system. It is unfortunate, however, that rural legislation is often highly political and rarely evidence based. I look forward to hearing more about the findings and recommendations included in the new MedPAC report.

My brief review of the report confirms what I have always thought to be the case—and what MedPAC has reported 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. But, we continue to hear anecdotal evidence of rural area providers holding on by a thread and the potential negative impact on beneficiary access. To the extent that there are access problems in particular rural areas, we will need to continue refining the payment systems to better target these areas. But, we need to be careful not to put more money into boosting all rural providers—or providers across the board— if there are more efficient ways to provide better quality care in those particular areas that are having trouble.

The results of the MedPAC report also reinforce the reality that some areas are unlikely to ever be able to sustain managed care. I hope that the new administrator of HCFA, Tom Scully, takes a careful look at this report when he develops his plan to increase Medicare+Choice enrollment to 30 percent. I don't understand why we would want to pour more money into managed care in rural areas when there is

little evidence that the M+C plans can even be maintained there. According to the report, in more than 300 rural counties the 2001 floor payment rate exceeds the fee-for-service spending for the average beneficiary by $130 per month—or about 40 percent! There are simply not enough beneficiaries to spread risk and not enough providers to build up a sufficient network for M+C plans to realize profits in isolated rural areas.

The plight of rural providers is not solely a function of Medicare and Medicaid payments. There are market forces that disproportionally affect rural areas, and rural areas must work harder to recruit and retain providers. Medicare payments are only a piece of the puzzle in creating an efficient health infrastructure. I hope that the speakers on the second panel will help us better understand the problems of rural communities, and how federal programs can be refined and coordinated with local programs to help the communities in need.

Thank you all for testifying before us today.

Chairwoman JOHNSON. I also want to welcome Jim Nussle especially to our Subcommittee hearing. He has long been very active in rural coalition and, of course, is the chairman of the budget Committee; and we appreciate his being here.

Chairwoman JOHNSON. Mr. Hackbarth, would you like to proceed?

STATEMENT OF GLENN M. HACKBARTH, J.D., CHAIRMAN, MEDICARE PAYMENT ADVISORY COMMISSION

Mr. HACKBARTH. Chairwoman Johnson, Mr. Stark, Members of the Subcommittee, thanks for the opportunity to discuss the Medicare Payment Advisory Commission recommendations.

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. We did that by reviewing a number of different measures, including beneficiary satisfaction, performance on certain clinical quality indicators in use of services. Overall, we have found that the services used in volume and quality are very similar to those used by urban Medicare 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.

Preserving access to quality care for the long run requires that we pay attention to the delivery system, including its financial needs. Here there is some reason for concern. As you well know, a substantial gap has opened between the financial performance of rural hospitals under the Medicare Program and the financial performance of urban hospitals. That is a relatively new development. It has happened over the last 10 years, but now the gap is quite substantial. On average, rural hospitals are losing money on their overall Medicare business, inpatient and outpatient.

As the chairman alluded to, Congress has already taken some steps to improve the financial performance of rural providers. For example, in the case of hospitals, a number of special payment categories have been adopted—rural referral centers, sole community hospitals, Medicare dependent hospitals and critical access hospitals.

We do see some indications that these special categories may be having a desired effect. For example, totally rural hospitals, that is, hospitals far-removed from urban areas, have higher Medicare

margins on average than any other category of rural hospitals at this point; and, also, fewer of them have negative margins.

In addition, the critical access program, which is relatively new, appears to be restoring access to some communities that had lost it. In other words, hospitals had closed and now have reopened under the critical access program.

We do have some concerns about the targeting of these special payment categories. In some cases, we think that the money is spread too broadly, benefiting hospitals that don't need the special assistance. Despite those concerns about targeting, though, we would continue the special payment categories until more targeted adjustments in the rates are developed and implemented and evaluated.

As has been true in the past, the standard that MedPAC uses in evaluating payment systems is to try to get Medicare payments to match the cost of efficient providers. We believe that Medicare can and should do a better job of targeting than it has in the past in the case of rural hospitals. We believe there are four factors that can contribute significantly to the poorer financial performance of rural hospitals. They are small size, a longer average length of stay, inaccuracies in the wage index, and unequal access to disproportionate share payments.

In developing the report to Congress, we examined 20 different options for dealing with these four issues. In this report, we make a number of recommendations that will address them in the short run. We also reiterate our support for some measures that cannot be implemented immediately but are crucial to the well-being of rural providers. For example, fixing the occupational mix in the wage index and equalizing access to disproportionate share payments.

Finally, we continue to study some other possible steps that could address the needs of rural providers, including an expanded transfer policy.

Our recommendations as we see it are not designed as aid to rural hospitals in particular. Rather, they are designed to improve the payment system and better match Medicare payments to the cost of efficient providers, for urban and rural hospitals alike.

As for the new prospective payment systems, those for outpatient services, home health services and skilled nursing services, there are a great many unanswered questions. As discussed in an earlier MedPAC report, this SNF, skilled nursing facility system, has troubling flaws for urban and rural providers alike.

We believe that the new outpatient and home health systems can be made to work effectively for rural providers, but it may take some refinement. There are some meaningful differences between the situation of rural providers and urban providers in these areas. Unfortunately, right now we simply don't have the data to either evaluate the impact or develop new refinements.

Fortunately, Congress included provisions in legislation that we think will buy us some time to do a proper evaluation. The outpatient system, as you know, includes a hold-harmless provision; and the home health system includes a special 10 percent add-on for rural providers.

Moving on now to the Medicare+Choice program, we believe that there are fundamental differences between urban and rural markets that make it unlikely that Medicare+Choice will work as well in rural areas as in urban areas. Moreover, we see some risk in the current efforts to try to make the Medicare+Choice program work in rural areas.

One final point on rural health. Rural America is really very, very diverse. Generalizations are, therefore, risky. In order to have a reasonable discussion, we talk a lot about averages in the report, recognizing that there are always exceptions to those averages. So if we make a statement about an average or a typical hospital that may not match exactly what happens in your district, please bear with us.

Finally, before closing, I would like to mention a non-rural issue. We are required by statute to review HCFA's estimate of the update to physician payments for 2002. We have reviewed HCFA's estimate and found it reasonable based on the information currently available. We do note, however, that the actual update could prove to be substantially different and possibly lower than the current estimate of a negative 1/10th of 1 percent change; and that difference could be significant. It depends on what happens with the growth in the economy and expenditures in the past year under the Medicare Program for physician services.

As you know, those are both factors in determining the Sustainable Growth Rate (SGR) cap. MedPAC has recommended eliminating the SGR system in the past out of concern that it could lead to a gap between the increase in cost that physicians experience and the payments they receive from Medicare. If that gap becomes large enough, it could threaten access to care.

In addition, since the system applies only to physician payments and not to outpatient department services, for example, there could become an incentive to switch services from physician offices to outpatient departments solely for payment reasons, which we think would be highly undesirable.

So that is my brief summary, and I would be happy to answer questions.

[The prepared statement of Mr. Hackbarth follows:]

Statement of Glenn M. Hackbarth, J.D., Chairman, Medicare Payment Advisory Commission

Chairman Johnson, Mr. Stark, Members of the Subcommittee. I am Glenn Hackbarth, chairman of the Medicare Payment Advisory Commission (MedPAC). I am pleased to be here this morning to discuss MedPAC's newly issued report on Medicare in rural America. This report responds to a set of requirements enacted in the Balanced Budget Refinement Act of 1999 directing MedPAC to assess Medicare's payment systems and policies in rural healthcare markets.

Bottom line

Medicare's most important objective is to ensure that beneficiaries have access to high-quality care. Because some rural communities face adverse economic conditions that may limit the ability of local providers to furnish a broad array of needed services, policymakers have been concerned that rural beneficiaries may not get the care they need. We were reassured to find, therefore, that Medicare beneficiaries living in rural areas are not facing widespread serious problems; with a few exceptions, data indicate that beneficiaries' access to care, use of care, and satisfaction with care are similar in rural and urban areas. This does not mean, of course, that rural beneficiaries in every county always get all of the care they need or the most appropriate and effective care; looking at averages can mask deficiencies. It does mean

that where problems exist, they may reflect something other than rural residence alone.

Preserving access to high-quality care over the long run requires attention to the well-being of the delivery system. Here, there is some reason for concern: a substantial gap has opened over the past decade in the financial performance under Medicare between rural hospitals—the locus of care in many communities—and urban hospitals. The Congress has already taken steps to shore up the rural delivery system and we see signs that some of those measures are making a difference. For example, the most isolated rural hospitals have higher Medicare margins than any other category of rural hospital and the critical access hospital (CAH) program even appears to be restoring access to some communities that had lost it. Other programs, such as the Medicare Incentive Program, which is intended to encourage physicians to practice in areas with limited numbers of primary care physicians, have been less effective.

MedPAC sees opportunities to refine Medicare's prospective payment system (PPS) for inpatient hospital services in ways that will make it more fair to rural hospitals—especially small ones—while preserving incentives for the efficient delivery of services. In combination, these incremental steps will improve the Medicare margins of many rural hospitals.

For example, implementing a low-volume adjustment, fully removing the salaries and hours of professionals paid under Medicare Part B from the wage index, and raising the cap on disproportionate share (DSH) payments would, on average, increase rural hospitals' inpatient payments by 1.8 percent. This increase would be on top of a 1.7 percent increase from the DSH payment changes enacted last year. In addition, although we did not quantify the impact, we can be reasonably sure that if the Health Care Financing Administration reviews the national labor share used in the wage index as we recommend, the resulting adjustment would on average modestly increase payments to rural hospitals and decrease them to urban hospitals.

Unlike some proposals currently being discussed—such as those to have a single base payment rate or to implement a wage index floor—MedPAC's proposals are targeted to take into account factors affecting rural hospitals' costs. Targeting payments allows the Congress to get dollars where they are needed most.

For the prospective payment systems that are being phased in for services in hospital outpatient departments (OPDs), home health care, and skilled nursing facilities (SNFs), there are many unanswered questions. We believe the OPD PPS and the PPS for home care can be made to work for rural providers, but the available data are inadequate to assess their impact properly. Steps taken by the Congress—enacting hold-harmless provisions for the OPD PPS and temporary payment increases for rural home care agencies—give policymakers time to make an assessment. In the case of skilled nursing care, MedPAC has previously noted that the new prospective payment system has troubling flaws that affect urban and rural providers alike. Until these more fundamental difficulties are addressed, we cannot assess whether there are issues that affect rural SNFs separately.

Because of differences between urban and rural health care markets, the Medicare+Choice program is unlikely to succeed in bringing coordinated care plans to rural areas. In our March report, MedPAC noted that efforts to overcome barriers to managed care, such as introducing floors under payment rates, may increase Medicare spending with no guarantee that the higher spending will yield additional benefits for Medicare beneficiaries. We recommended in that report that the Secretary examine variation in fee-for-service spending across the country to address the more fundamental problem.

The diversity of rural America means that there will undoubtedly be exceptions to every generalization we make. Without some generalization, however, policymaking becomes almost impossible. MedPAC will continue to monitor how well the Medicare program works in rural areas generally, as well as to watch for specific problems.

Overview of rural health care markets

Many rural communities face market conditions that may depress demand or supply and potentially decrease access to and use of health care services among Medicare beneficiaries and other residents. Depending on the community, these factors include:

- a small population,
- a declining and disproportionately older population,
- low household incomes, relatively high unemployment rates, and high poverty rates,

- a high proportion of the population lacking health insurance or with limited coverage,
- physical isolation, with long distances to urban centers for specialty care, and
- weak or restrictive state polices (such as in Medicaid eligibility and payment policies or certificate of need laws).

To examine where these factors operate and the extent to which they interact, MedPAC contracted with researchers at the Cecil G. Sheps Center for Health Services Research, UNC-Chapel Hill, who mapped demographic characteristics to hospital markets. Using the hospital market data, we analyzed the variation in many of these factors across market areas and geographic regions. We also explored the relationship between market characteristics and hospitals' financial performance. Although our analysis has only begun to scratch the surface, two preliminary conclusions emerge (see Table 1). First, economic conditions vary widely among rural markets. Second, rural markets in the West have different sets of risk factors than those in the East. For example, the main risk factors affecting rural Western hospital markets are small populations, declining populations, and disproportionate numbers of residents aged 65 and older. By contrast, the main risk factors affecting rural Eastern hospital markets are low household incomes, high unemployment rates, and disproportionate numbers of racial and ethnic minorities (who are more likely to lack health insurance).

These risk factors raise three policy questions:

- Are these factors affecting access to, use of, or quality of services?
- Can prospective payment work in rural areas?
- Can Medicare+Choice work in rural areas?

Access to care, use of services, and quality of care

Rural areas of the country often have fewer providers and longer distances between beneficiaries and providers than do urban areas, potentially hindering access to care. Further, rural quality of care issues have received little attention in Medicare policymaking. Our research on access to care, use of services, and quality of care is largely reassuring. The experience of rural Medicare beneficiaries appears generally similar to that of urban beneficiaries, suggesting that they are largely able to overcome the risk factors noted previously.

Access to care

Data from the Medicare Current Beneficiary Survey (MCBS) indicate that rural beneficiaries are generally satisfied with the availability of care, including specialty care; their satisfaction rates are generally similar to those of urban beneficiaries (see Table 2). This finding holds for rural areas in general as well as for the most remote rural areas.

The MCBS data do show differences on questions relating to the affordability of health care. A smaller percentage of rural than urban beneficiaries reported being satisfied with the costs of medical care, and in the more remote rural areas a larger fraction reported delaying care because of cost considerations. These differences may reflect rural beneficiaries' lower likelihood of having supplemental coverage for cost-sharing and services not covered by Medicare. Accordingly, MedPAC recommends that the Secretary identify strategies to increase rural beneficiaries' participation in government programs that cover all or some of Medicare's cost-sharing requirements. These programs include Medicaid, the qualified Medicare beneficiary program, and the specified low-income beneficiary program.

Use of services

Similarities in access are reflected in rural and urban beneficiaries' use of health care services. Although policymakers and rural health care advocates have often argued that rural residents are disadvantaged in obtaining needed care compared with urban residents, we found that urban and rural Medicare beneficiaries use similar amounts of care, on average, both nationally and within regions (see Figure 1).[1] Similar rates of service use do not imply that all beneficiaries are equally well served. At the same time, we would expect serious access problems to show up in lower use.

Although overall use was similar, the mix differed; rural beneficiaries used fewer physician and post-acute care services and more hospital inpatient and outpatient

[1] We measured per capita use of 11 type of services: short—and long-term hospital inpatient care, rehabilitation hospital, psychiatric hospital, skilled nursing facility, home health care, swing bed, outpatient hospital, physician, ambulatory surgical center, and rural health clinic.

services than did their urban counterparts (see Table 3). Rural beneficiaries were about as likely as urban ones to have any physician visit, but had fewer total visits.

Quality of care

Assessing differences in quality of care between rural and urban areas is difficult, but two measures we examined—use of recommended services for patients with particular conditions and satisfaction with care as reported by beneficiaries—are reassuring.

Quality of care is often measured by the extent to which patients receive recommended services—including preventive services and services for acute and chronic illnesses—and the outcomes of that care. To compare quality in rural and urban areas, MedPAC contracted with Direct Research LLC to analyze Medicare claims data. The researchers examined two measures: 40 indicators of necessary care (which reflect minimum standards of recommended care) and 6 indicators of avoidable outcomes (which represent potentially avoidable emergency or urgent care). The results suggest that the provision of necessary care and the occurrence of potentially avoidable outcomes is roughly comparable between rural and urban beneficiaries. After weighting each of the indicators equally and adjusting for differences in the age and sex composition of rural and urban populations, researchers found that the receipt of necessary care varied from 72 to 74 percent of rural beneficiaries, compared with 73 percent of urban beneficiaries.

These results are mirrored by the subjective assessment of Medicare beneficiaries. Among respondents to the MCBS, over 90 percent of rural beneficiaries reported agreeing or strongly agreeing that their physician checks everything and that they had great confidence in their physician. These responses are virtually identical to those of urban beneficiaries.

Nonetheless, Medicare's systems for improving and assuring quality could be strengthened to deal more effectively with issues in rural areas, and we recommend that the Secretary include rural populations and providers when carrying out Medicare's quality improvement activities. We also recommend that the Secretary address a critical problem with Medicare's system for safeguarding quality in rural areas by requiring more frequent surveying of providers to ensure the care they deliver meets minimal standards for quality and safety.

Medicare's payments for services in the traditional program

In the traditional fee-for-service program, Medicare generally relies on prospective payment systems. Two of these systems—the PPS for inpatient hospital care and the physician fee schedule—are mature (in the sense that they have been in place for over a decade). New systems are being phased in for outpatient hospital services, home health care, and SNFs.

To ensure access to care for Medicare beneficiaries without imposing undue costs on taxpayers, Medicare's payments should approximate the costs that an efficient provider would incur in furnishing care. In general, this means accounting directly in the payment system for factors that are beyond the control of providers and that have substantial and systematic cost effects. Some factors can be easily identified and addressed (at least conceptually). For example, the diagnosis related groups (DRGs) that Medicare uses to pay for inpatient hospital services distinguishes cases according to their clinical similarity and resource cost, raising payments for relatively expensive cases and reducing them for relatively less expensive cases. Similarly, Medicare's application of a wage index adjustment to a portion of operating payments—raising payments in high-wage markets and lowering them in low-wage markets—allows the program to account for systematic differences among markets in the wages providers must pay to remain competitive.

How to account for other factors is less clear. Prospective payment systems are based on averages, and some providers may be significantly different from average (and unable to do anything about it). For example, a hospital in a remote area with a small patient volume may not be able to achieve the same economies of scale and scope that a large hospital located in an urban area can. Hospitals may also face different kinds of costs depending on their location. For example, some people argue that travel costs are not properly taken into account for home care provided in rural areas where distances are long.

These examples underlie the congressional interest in how well the current payment systems work in rural areas for inpatient hospital services and whether the new payment systems for hospital outpatient services and home care are likely to be appropriate.

Prospective payment for inpatient hospital services

Rural hospitals had lower Medicare inpatient margins than urban hospitals throughout the 1990s, and the gap has been widening. By 1999, the disparity had

grown to 10 percentage points (see Table 4). The growing imbalance in financial performance under Medicare has occurred despite special payment provisions for rural hospitals whose value is almost as high as that of provisions that primarily affect urban hospitals. Although some of the difference in performance may be within hospitals' control, the size of the gap suggests that the payment system does not recognize factors that have an important effect on the costs of rural hospitals.

MedPAC identified four aspects of Medicare's inpatient payment system that may inhibit the appropriate distribution of payments and that together play a substantial role in rural hospitals' lower margins. They are:

- failure to account directly for small scale of operation,
- failure to account for longer lengths of stay,
- limitations in the measurement of input prices, and
- unequal disproportionate share (DSH) payments.

The first three issues concern systematic differences in costs; the fourth issue involves differences among hospitals in the volume of services they provide to low-income patients. In each case, Medicare's current payment system—together with a variety of special payment categories for rural referral centers, sole community hospitals, small rural Medicare-dependent hospitals and critical access hospitals—either does not address the underlying differences or appears to address them in ways that work against rural hospitals. We therefore recommend changes, discussed below, that would make payments better targeted and preserve, as much as possible, the incentives for efficiency embodied in the PPS. We recommend retaining the special categories until the proposed changes are implemented and evaluated.

Low volume

Patient volume, particularly in small and isolated communities, is largely beyond hospitals' control and may cause their per-unit costs to be higher than average. The current PPS rates do not account directly for the relationship between cost and volume, potentially putting smaller providers at a financial disadvantage relative to other facilities. We found a statistically significant inverse relationship between discharge volume and Medicare costs per case (holding other factors recognized by the payment system constant). The volume and cost relationship was most pronounced for facilities with fewer than 200 discharges per year (see Figure 2).

The current special payment categories do not target low-volume hospitals well. Although 10 percent of hospitals—most of them rural—have fewer than 500 discharges, over one-third of low-volume hospitals are not in any of the categories. MedPAC recommends that the Congress direct the Secretary to develop a graduated adjustment to base payment rates for hospitals with few discharges. So as not to encourage more care in low-volume settings than is necessary, we recommend that in defining this adjustment, the distance between facilities providing inpatient care be taken into account.

Longer length of stay

Substitution of post-acute services for the latter days of inpatient stays was a key factor in reducing Medicare's acute care length of stay 33 percent since 1989. Length of stay fell less for rural providers generally (25 percent) and much less for the most rural providers (13 percent). As a result, rural hospitals have longer lengths of stay than urban hospitals given the mix of cases they receive, in part because they are less able to transfer patients to post-acute settings. MedPAC will continue to examine this issue and possible policy responses.

Input prices

Medicare's prospective payment systems for inpatient (and other facility) services include input-price adjustments that raise or lower payment rates to reflect the hourly wages of health care workers in each local market. Making accurate adjustments for differences in market wages is important for two reasons. First, problems could arise for beneficiaries and taxpayers if Medicare's payment rates differ from efficient providers' costs. Second, hospitals' reported wage rates vary substantially among labor market areas.

MedPAC and others have identified four problems with the wage index Medicare uses to adjust for input prices. First is the so-called occupational mix problem, where differences among areas in the types of workers employed is confounded with differences in their wages. Second is that market areas as defined by Medicare often encompass distinct health care labor markets. Third, the wage data that underlie the adjustment are four years old. Finally, the share of the payment to which the input price adjustment is made—about 71 percent for inpatient hospital services—may include cost components that are not locally purchased (and therefore whose price should not vary with local market wages).

Addressing the occupational mix problem directly will require data that HCFA has begun to collect only recently. In the meantime, MedPAC recommends that Secretary accelerate the planned phase-in of excluding from the hospital wage index the salaries and hours of teaching physicians, residents, and certified registered nurse anesthetists. Although the impact would not be large, the policy would improve the distribution of payments.

We also recommend that the Secretary reevaluate current assumptions about the proportions of providers' costs that reflect resources purchased in local and national markets. Some rural health care advocates have argued that the current labor share overstates the proportion of costs that rural hospitals devote to labor and other locally purchased inputs. The inputs included in the labor share were originally designated in 1983, and many of these are still largely purchased in local markets. However, other inputs may be purchased wholly or partly in national markets; applying an input price adjustment to such inputs leads to underpayment in low-wage areas and over-payment in high-wage areas.

The flaws associated with the hospital wage index have led some advocates to propose that a floor be put under the index. This would raise payments in market areas with low hospital wage rates (and, if done budget neutrally, lower them in areas with high wage rates), but it would do so in an arbitrary fashion. Moreover, if the objective is to help rural hospitals with poor financial performance, a wage index floor is a poor way to do so because it would raise payments to both low—and high-margin hospitals. Our analysis shows that there is no correlation between hospitals' Medicare inpatient margins and the wage index; hospitals with low margins are just as likely to be in areas with a high wage index as a low wage index.

Disproportionate share payments

Medicare's DSH adjustment for hospital inpatient services is designed to offset the financial pressure of uncompensated care and inadequate payment from Medicaid and other indigent care programs. However, despite improvement in the DSH payment system implemented through the Benefits Improvement and Protection Act of 2000 (BIPA), the current system still provides substantially smaller payment add-ons for rural facilities.

The Commission believes that policy changes are needed to ameliorate two key problems inherent in the existing DSH payment system. First, the current measure of care provided to low-income patients excludes uncompensated care. The BBRA mandated that HCFA collect this information beginning in 2001.

Second, the current system has separate payment rates for 10 specific hospital groups, with the least favorable rates being given to most rural facilities and urban facilities with fewer than 100 beds. The BIPA improved the equity of DSH payments by applying to all hospitals the same minimum low-income share needed to qualify for an adjustment. However, the legislation capped the adjustment for rural hospitals at 5.25 percent; no such cap applies to urban hospitals. MedPAC recommends raising the cap to 10 percent to improve the equity of payments. However, we do not believe the cap should be eliminated, in part because that could lead to large increases in DSH payments now followed by reductions later if a new payment formula were enacted.

Physician fee schedule

Although 20 percent of the U.S. population lives in rural areas, only about 10 percent of physicians practice in rural communities. Because of concerns that some areas were underserved, the Medicare Incentive Payment (MIP) program was enacted in 1989 in an effort to entice more physicians to Health Professional Shortage Areas (which include urban areas). The MIP pays a 10 percent bonus for physicians' services.

The MIP program is limited in two ways. First, the bonus payments may be insufficient to attract physicians. Second, MIP payments may be inappropriately targeted. Nurse practitioners and physician assistants—who provide a significant share of primary care in rural areas—are not eligible for payments. In addition, payments may be inappropriately targeted because specialists and certain other health professionals are not counted when an area is designated as a shortage area.

Prospective payment for services in hospital outpatient departments

In August 2000, HCFA implemented a new prospective payment system for hospital outpatient services. Rural hospitals have been concerned that the new payment system will not adequately cover their costs of providing care because it is based on median costs for all hospitals. Essentially, the question is the same as that discussed above for inpatient services: does a payment system based on averages penalize low-volume facilities? The OPD PPS may present additional risks for rural hospitals because of their greater dependence on Medicare—which accounted for 45

percent of total costs in rural hospitals, compared with 34 percent in urban hospitals—and on outpatient services.

Our analysis suggests that rural hospitals, particularly small ones, may have higher unit costs, be more vulnerable to the financial risks inherent in prospective payment, and be less able to adapt to the new payment systems. However, our assessment of the applicability of the new PPS is hampered by a lack of experience and data under the new system. Fortunately, the current policy has a hold-harmless provision for rural hospitals with 100 or fewer beds. This provision protects more than 80 percent of rural hospitals and all of the small rural hospitals that appear to be most vulnerable, and provides time to gather data and undertake analyses that can better inform future policy decisions regarding the treatment of rural hospitals under the outpatient PPS.

Prospective payment for home health services

In October 2000, HCFA implemented a new prospective payment system for home health services. Movement to prospective payment has generally been viewed positively, but some advocates and policymakers have been concerned about access to home health services in rural areas. They are concerned about the effects of closures of home health agencies in rural areas and that the PPS may not adequately account for the costs of providing care in rural areas. MedPAC concludes that the new PPS should work equally well in rural and urban areas and that the Congress should not exempt rural home health services from the PPS.

An appropriate payment amount should cover the costs that an efficient provider would incur in furnishing care. We identified two factors that could distinguish rural from urban areas: travel costs and volume of services. Traveling to serve sparse or remote populations may increase the costs (relative to urban settings) of providing services to rural patients. Rural providers may also be at a cost disadvantage if they have a low volume of services and cannot spread fixed costs over a large number of episodes.

Significant data limitations restrict our ability to analyze the impact of these factors fully. The first cost reports under the new payment system will not be available until September 2003, and we are concerned that the quality of the information they provide may not be good. Accordingly, we recommend that the Secretary study a sample of home health providers to evaluate the impact of the new payment system, evaluate costs that may affect the adequacy of prospective payments, and find ways to improve all cost reports. As with outpatient services, legislative protections—in this case a 10 percent increase in payments for the next 2 years—should help to ensure access while we evaluate the system.

Will Medicare+Choice work in rural areas?

Policymakers have sought to bring to rural areas the generous benefit packages and low premiums enjoyed by some beneficiaries in urban areas who have enrolled in Medicare managed care plans. Two aspects of the Medicare+Choice program were designed to help accomplish this. First, payments in lower-paid counties, which includes most rural areas, were increased by creating a floor rate. Second, plans other than health maintenance organizations (HMOs) were allowed to participate in the program.

Even though the floor under payments has been increased substantially (to $475 monthly), coordinated care Medicare+Choice plans offering generous benefit packages at little or no cost have not entered rural areas. We see three reasons for this. First, coordinated care plans rely on provider networks, which are difficult to establish in rural areas. This difficulty arises because rural providers who face little competition have no incentive to accept reduced payments and because there are fewer so-called intermediate entities, such as independent practice associations, willing to accept financial risk. Second, the small populations in many rural areas provide too small an enrollment base over which to spread fixed costs. Third, because relatively few rural areas consume large amounts of health care, there is less scope to achieve efficiency gains.

The floor payments have made entry attractive to private fee-for-service plans. Under Medicare+Choice, such plans take full risk for beneficiaries' health care, but need not manage care or establish networks of providers. If Medicare+Choice payments were substantially equal to risk-adjusted spending in traditional Medicare (as MedPAC recommended in March), private fee-for-service plans could provide a desirable option to beneficiaries without presenting a financial quandary for the Medicare program. Under current law, however, Medicare spending will rise above what it would otherwise have been, and the increased spending will not necessarily yield extra benefits for beneficiaries. Instead, some of the higher spending may be used for additional profit, higher administrative costs, or higher payments to providers.

What should policymakers do? The efficiency gains and provider discounts that Medicare HMOs in urban areas use to fund additional benefits are unlikely to be achievable in rural areas. Although other alternatives to the current system should be explored—such as risk sharing through partial capitation or split capitation—rural beneficiaries are unlikely to see more generous benefits without an explicit or implicit subsidy.

1. We measured per capita use of 11 type of services: short- and long-term hospital inpatient care, rehabilitation hospital, psychiatric hospital, skilled nursing facility, home health care, swing bed, outpatient hospital, physician, ambulatory surgical center, and rural health clinic.

Table 1.—Percentage Of Rural Hosptial Markets With Selected Characteristics, By Region

Market/hospital characteristic	All markets			Markets with small population		
	All	East	West	All	East	West
Small population	25.0%	6.0%	40.0%	100.0%	100.0%	100.0%
Declining population ..	24.3	14.6	32.1	49.6	28.3	52.1
Declining population and disproportionately aged	10.3	1.7	17.3	32.4	8.3	35.3
Low household income	44.7	45.5	44.1	48.7	65.0	46.7
High unemployment ..	30.2	35.1	26.2	21.1	55.0	17.0
Isolated location	18.5	7.3	27.6	34.3	18.3	36.3
Low volume	21.7	8.1	33.2	65.6	54.5	67.0

Note: East and West regions are divided by the Mississippi river; East includes New England, Middle Atlantic, South Atlantic, East South Central, and East North Central census divisions, while West includes West South Central, West North Central, Mountain, and Pacific Divisions. Small population = fewer than 11,900 people; declining population = average annual population change from 1990 to 1999 of at least &0.1 percent; disproportionately aged = at least 20 percent of the population in the market ZIP codes is age 65 or older; low household income = median household income of the market area is <$28,100; high unemployment = percent of workforce that is not employed is greater than 8.1 percent; isolated location = air-mile distance to nearest short-term acute care hospital is $ 25 miles; low volume = 500 or fewer acute inpatient discharges in 1997.

Source: Analysis of Claritas Corp. estimates based on 1990 census by Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

Table 2.—Beneficiary Satisfaction With and Access to Care, by Location of County, 1999

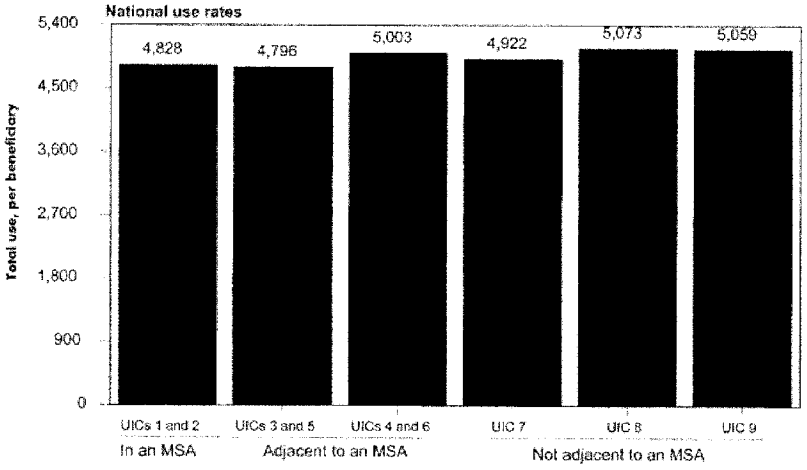
Characteristics	Urban in an MSA (UIC 1,2)	Rural total	Adjacent to an MSA		Not adjacent to an MSA	
			Includes a town with at least 10,000 people (UIC 3, 5)	Does not include a town with at last 10,000 people (UIC 4, 6)	Includes a town with at least 10,000 people (UIC 7)	Does not include a town with at least 10,000 people (UIC 8 (UIC 8, 9))
Very satisfied/satisfied						
Availability of medical care	93.6%	93.6%	94.3%	93.0%	94.9%	92.9%
Overall quality of care	96.0	96.0	95.4	96.3	96.4	96.2
Ease of getting to doctor	94.9	92.4	95.0	90.7**	94.6	90.3*
Costs of medical care	87.6	82.4*	83.3*	82.8**	82.7	79.6**
Specialist care	96.4	95.6	97.4	95.6	93.9	94.0
Had trouble getting care	4.0	3.3**	2.2**	4.1	2.0**	4.1
Delayed care due to cost	6.6	9.9	8.7	10.5**	11.3**	9.8**
No office visit this year [1]	18.3	20.2	16.1	20.5	12.4**	31.0**

Note: UIC (urban influence code, as defined by the U.S. Department of Agriculture), MSA (metropolitan statistical area, as defined by the U.S. Office of Management and budget).

[1] Office visits only pertain to beneficiaries enrolled in traditional Medicare, and not Medicare+Choice. The Medicare Current Beneficiary Survey bases office visits on claims data, and providers do not submit claims for Medicare+Choice enrollees.

*Difference between urban and rural subgroups is statistically significant at the 0.05 level.
**Difference between urban and rural subgroups is statistically significant at the 0.01 level.
Source: MedPAC analysis of 1999 Medicare Current Beneficiary Survey Access to Care file.

Figure 1. Urban and rural beneficiaries use similar amounts of services, but rates differ among regions



Regional Use Rates

Location of county (UIC)	Region				
	Nation	Northeast	South	Midwest	West
Urban, in an MSA (1, 2)	4,828	4,650	5,092	4,827	4,532
Adjacent to an MSA and includes a town with at least 10,000 people (3, 5)	4,796*	4,396*	5,111	4,718	4,527
Not adjacent to an MSA but includes a town with at least 10,000 people (7)	4,922*	4,339	5,395*	4,750	4,503
Adjacent to an MSA but does not include a town with at least 10,000 people (4, 6)	5,003*	4,541	5,213*	4,867	4,480
Not adjacent to an MSA but includes a town with between 2,500 and 10,000 people (8)	5,073*	4,601	5,469*	4,787	4,688
Not adjacent to an MSA and does not include a town with at least 2,500 people (9)	5,059*	5,504	5,372*	4,815	4,586
All beneficiaries	4,864	4,627	5,156	4,813	4,537

Note: UIC (urban influence code, as defined by the U.S. Department of Agriculture), MSA (metropolitan statistical area, as defined by the U.S. Office of Management and budget). Use is the sum of the services from 11 service types, evaluated at nationally standardized payment rates and adjusted for individual differences in health status. These results include beneficiaries in traditional Medicare and exclude beneficiaries in Medicare+Choice, who make up 21 percent of the Medicare population in urban counties and 4 percent of the population in the five non-urban categories. Northeast includes New England and Middle Atlantic census divisions; South includes South Atlantic, East South Central, and West South Central census divisions; Midwest includes East North Central and West North Central census divisions; West includes Mountain and Pacific census divisions.

*Indicates statistically different from urban value in same region (5 percent level).

Source: MedPAC analysis of claims from 1999 for a 5 percent random sample of Medicare Beneficiaries.

Table 3.—Per Capita Use of Services by Beneficiaries in Traditional Medicare, by Type of Service and Location of County, 1999

Service type		Location of county (UIC)				
		Adjacent to an MSA		Not adjacent to an MSA		
	Urban, In an MSA (1, 2)	Includes a town with at least 10,000 people(3, 5)	Does not include a town with at least 10,000 people (4, 6)	Includes a town with at, least 10,000 people (7)	Includes a town with between 2,500 and 10,000 people (8)	Does not include a town with at least 2,500 people (9)
Physician	1,276	1,188*	1,186*	1,195*	1,139**	1,117*
Physician+RHC	1,280	1,214*	1,246*	1,231*	1,212*	1,230*
Hospital outpatient	541	616*	625*	642*	664*	690*
Hospital inpatient	2,185	2,250*	2,363*	2,319*	2,473*	2,452*
Post acute**	684	602*	653*	628*	623*	593**
SNF+Home health	502	461*	467*	478*	453*	426**
Swing beds	1	8*	24*	13*	30*	49*
Other	138	114	116	103	101	94
Total	4,828	4,796	5,003*	4,922*	5,073*	5,059

Note: UIC (urban influence code, as defined by the U.S. Department of Agriculture, MSA (metropolitan statistical area, as defined by the U.S. Office of Management and budget), RHC (rural health clinic), SNF (skilled nursing facility). Hospital inpatient combines short-term and critical access hospitals. "Other" combines ambulatory surgical center and psychiatric hospital services. Use is services evaluated at nationally standardized payment rates and adjusted for individual differences in health status. These results include beneficiaries in traditional Medicare and exclude beneficiaries in Medicare+Choice, who make up 21 percent of the Medicare population urban counties and 4 percent of the population in the five non-urban categories.

*Indicates statistically different from urban value (5 percent level).

**Post acute also includes two categories (not shown) for rehabilitation and long-term hospital services.

Source: MedPAC analysis of claims from 1999 for a 5 percent random sample of Medicare Beneficiaries.

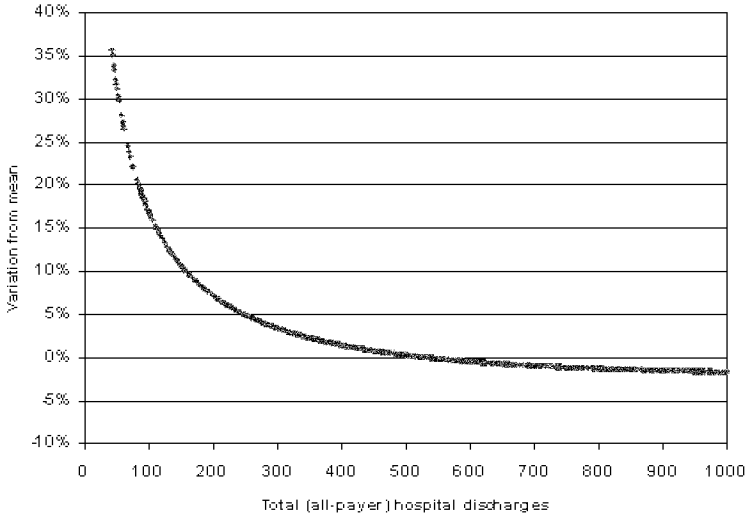
Table 4.—Hospital Financial Performance, By Urban and Rural Location, 1999

Hospital location (UIC)	Medicare inpatient margin	Overall Medicare margin	Total margin
Urban, in an MSA (1, 2)	13.5%	6.9%	2.9%
Rural			
Adjacent to MSA and includes a town with at least 10,000 people (3, 5)	3.1	−3.2	4.5
Adjacent to an MSA but does not include a town with at least 10,000 people (4, 6)	6.0	−2.2	3.9
Not adjacent to an MSA but includes a town with at least 2,500 people (7, 8)	4.5	−2.7	5.3
Not adjacent to an MSA and does not include a town with at least 2,500 people (9)	8.4	−0.1	−0.4

Note: UIC (urban influence code, as defined by the U.S. Department of Agriculture), MSA (metropolitan statistical area, as defined by the U.S. Office of Management and budget). Data are preliminary; the inpatient and total (all sources of revenue) margins are based on two-thirds of hospitals covered by prospective payment, while the overall Medicare margin is based on one-half of hospitals covered by prospective payment.

Source: MedPAC analysis of Medicare Cost Report data from HCFA.

Figure 2. Relationship between hospital discharge volume and costs per case, 1997



Source: MedPAC analysis of data from HCFA.

Chairwoman JOHNSON. Thank you very much, Mr. Hackbarth.

I thought your testimony was very useful in the way it went through kind of the unique aspects of reimbursing rural hospitals and the way common factors don't play out as clearly or as accurately for small hospitals that tend to have lower usage.

You comment that patient volume, particularly in small and isolated communities, is largely beyond hospitals' control and may cause their per-unit costs to be higher than average. The current PPS rates do not account directly for the relationship between cost and volume, potentially putting smaller providers at a financial disadvantage relative to other facilities. I think that is a very significant problem. I don't know how we deal with it, but it is an equally significant problem at the other end.

When you visit some of the big medical centers in the urban areas where they are running at a hundred percent of capacity and sometimes over a hundred percent and their hospitals are under this constant pressure of full usage and their staff are under that strain and their rest rooms and everything, we don't account well for that either. In fact, I am wondering if you are giving any thought at MedPAC to the fact that the PPS system worked very well when we brought the system of the seventies into the eighties and nineties but may not be working so well right now. In other words, it works well when there is fat in the system and there is flexibility. Now that we have pressed down on length of stay and that can't change much and costs stay about the same, I am finding that this concept of average payment is not as valid a concept as it was when we first adopted it in the eighties.

I agree that it seems to work very directly against rural hospitals, because you allocate the overhead over fewer patients. So it works equally badly against the really hundred-percent capacity hospitals, too.

I would like you to comment on that, but also I would like you to take just a few minutes and go into a little further explanation of how the factors vary, that rural hospitals almost inevitably have a longer length of stay because of the dearth of other facilities and so on with the input prices. I thought that was very interesting, and I think you need to be on the record a little bit more specific about how the very formula that we rely on doesn't work when you apply it to the rural institutions.

Mr. HACKBARTH. OK.

Chairwoman JOHNSON. Thank you.

Mr. HACKBARTH. Well, let me begin with the low volume issue. One of our recommendations is that we add a low volume adjustment to the prospective payment system, and it would apply to hospitals with fewer than 500 total discharges. We arrived at that figure by looking at the data and looking at the relationship between average cost per case and volume and found that, below the 500 level, there were significant increases in the cost per case.

We think that volume is an issue that can be outside the control of a provider. I say "can be" because you wouldn't want to make payment adjustments for multiple low volume hospitals that are in close geographic proximity to one another. So, our proposal is to

make an adjustment for hospitals that are further than some reasonable distance from other providers.

Chairwoman JOHNSON. I do think the distance consideration is very important. Otherwise, we will be funding lots of little hospitals——

Mr. HACKBARTH. Exactly.

Chairwoman JOHNSON. In every little town.

Mr. HACKBARTH. So, in our report, we did not choose a particular mileage figure. We have recommended that the Secretary look at that. The analysis that we did was based on the 15-mile distance. There obviously is no right answer to the exact distance, but that was how we did the analysis.

Chairwoman JOHNSON. But when you say 10 percent of the hospitals, fewer than 500 discharges, that 10 percent was derived from hospitals that are—were less than 15 miles apart?

Mr. HACKBARTH. About 11 percent of the hospitals have fewer than 500 discharges. The number that are more than 15 miles apart will be somewhat lower than that. I don't know that number off the top of my head. Because we are talking about very small hospitals, the overall financial affect of this adjustment to Medicare as a whole is quite small, but for the individual hospital, it could be quite important.

Chairwoman JOHNSON. And how much do we know about those hospitals in the sense that do they provide sort of a community clinic capability? Many of the small hospitals in my part of the country have done that. Where there are emergency rooms, they provide emergency care. But they also provide just sort of—like a general practice office.

Mr. HACKBARTH. Well, there is a fair amount of variability in terms of the services they provide. Obviously, a concern is that a very small hospital like that not try to provide services that are beyond the scope of what can be done well in a small institution.

Chairwoman JOHNSON. How much of the reimbursement problem that we are seeing in rural America results from the fact that rural providers experienced only a 25 percent drop in length of stay, whereas on average in the Medicare system there was a 33 percent drop since 1989? Certainly if you had a very much lower drop of length of stay, you would have higher costs for the same PPS.

Mr. HACKBARTH. Yes. In 1992, the average Medicare margins of rural hospitals were just about the same as urban hospitals. So the gap that exists today has opened up over the last 10 years. A principal factor in the development of that gap is the fact that rural hospitals have not been able to reduce the average length of stay by the same amount as urban hospitals, and their cost per case increases have therefore been larger. We think that one factor of that is a lack of alternatives for post acute care and for sophisticated ambulatory care. And, therefore, since those factors are beyond the control of the individual rural hospital, we think that those are factors that ought to be taken into account.

Chairwoman JOHNSON. Have you done any looking to see whether or not we could provide step-down beds, allow step-down beds in those rural facilities so we could reimburse them less, the patients would cost us less and the institution would be reimbursed more fairly in their acute bed section?

Mr. HACKBARTH. We did not look at step-down beds as a particular option, at least not since I have been on the Commission. That is something that we could take a look at.

Chairwoman JOHNSON. Well, I just—I am going to move on, because I don't—there are plenty of questions that could be asked, but we have a lot of members here really interested in rural health.

I would just say that I know there are a lot of barriers in looking at step-down beds. On the other hand, the whole world is looking at continuity of care and those issues much differently. So, that is one thing that I think we do need to look at with MedPAC. In some areas they have done it by integrating home health agencies in nursing homes with hospitals. But in rural areas we should be looking I think more seriously at what these relationships are and what they could provide us with.

Mr. Stark.

Mr. STARK. Thank you, Mr. Hackbarth, and congratulations.

Mr. HACKBARTH. Thank you.

Mr. STARK. I hope you find this an exciting, challenging job.

First, on this question of extra days, my guess would be that an extra day, if it is a 3-day Diagnosis Related Group (DRG), would have a lower marginal cost than the first couple of days. Is that a reasonable assumption?

Mr. HACKBARTH. Typically, the services provided on the later days are somewhat less expensive than the early days.

Mr. STARK. And, second, most of these hospitals have swing beds?

Mr. HACKBARTH. Yes.

Mr. STARK. So, they could move the beneficiaries within the hospital to a swing bed and get a second cut at the apple, couldn't they? I mean, they not only get the full DRG, but then they could hop over and get some money for transferring the patient into a swing bed. It would be in the hospital's interest to keep them and move them into swing bed status. It seems to me there is almost an incentive for the hospitals to keep them there, because they make a little extra money, but maybe I misread that.

Mr. HACKBARTH. Well, there is an opportunity to move patients from inpatient into swing beds.

Mr. STARK. And get a second fee, which you wouldn't get if you just kept them in the extra day of the DRG.

Mr. HACKBARTH. That is correct. They have an incentive in the same sense that any provider has an incentive to use the facilities.

Mr. STARK. And in a 10-bed hospital, that isn't a very big move. I mean, that is from one end of the hall to the other?

Mr. HACKBARTH. Right.

Mr. STARK. A couple of things in your report. You recommend that the Secretary identify strategies to increase the enrollment of rural beneficiaries for Qualified Medicare Beneficiaries (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) cost sharing.

Mr. HACKBARTH. Right.

Mr. STARK. Would you have any objection or would you think it is a good idea for us to do that for all low-income beneficiaries everywhere? Would that be a fair request to ask about suggesting that?

Mr. HACKBARTH. Well, we certainly think that all beneficiaries ought to have access to what they are entitled to under the law.

We focused on rural beneficiaries here for a couple reasons. One, we found that an important issue in rural beneficiaries is the cost of care. I say that at the outset that rural beneficiaries were generally as satisfied with their care as urban beneficiaries. One of the exceptions to that is around the cost of care.

Mr. STARK. What about——

Mr. HACKBARTH. Oh, I am sorry——

Mr. STARK. What about having the providers qualify people, particularly in rural communities where they may be farther away from the welfare office to provide information on QMB and SLMB, than they are from the hospital. Would you see anything wrong with letting the providers have a qualification program?

Mr. HACKBARTH. Mr. Stark, that is really beyond my personal knowledge and expertise.

Mr. STARK. One other problem that I see coming up here, just recently the Secretary announced that HCFA would discontinue collecting encounter data from the Medicare+Choice plans. And I wonder about your thoughts on that. My thought is that MedPAC has always supported risk adjustment, and I presume MedPAC still does. It would seem to me that you need to have that encounter data to begin to get at any kind of basis for risk adjustment. Would you feel that it would be in the best interest of HCFA to continue collecting that encounter data, or do we have something that we can substitute for it?

Mr. HACKBARTH. Well, we believe that risk adjustment is critically important for the Medicare+Choice program, and the tool that has been under development for several years depends on that data. I have not had a chance to talk to Mr. Scully about what alternatives he sees, so I am not sure what his thinking is about.

Mr. STARK. Would you have any source for data? I mean, wouldn't that hurt your studies if you didn't have this encounter data?

Mr. HACKBARTH. It is those data that allow us to evaluate what is going on. You may have an alternative I am not privy to at this point.

Mr. STARK. I wanted to commend you. I know of nobody else in this town, except myself, who is diplomatic and gentle enough to suggest that the fee-for-service Medicare+Choice plans are like stealing money from Medicare. That is the kind of phrase I like. And how are you going to know if they are stealing money if you don't have the encounter data? So, thank you, and we will help you get the data.

Mr. HACKBARTH. OK. Could I just address that for a second?

Chairwoman JOHNSON. If you could address that, Mr. Hackbarth.

Mr. HACKBARTH. I have real concerns about the use of floors in the Medicare+Choice program. The Medicare Payment Advisory Commission as a whole has concerns about that. And what I said in the comment that you referred to, Mr. Stark, is that by creating these floors—I fear we have given a license for people to steal from the Medicare Program. The problem is not with the insurers that are moving in, but I think with the policy—the underlying policy.

For reasons that have to do with the nature of rural health care, I don't think managed care is going to work very well in rural America for Medicare. It hasn't on the private side. There isn't a lot of private managed care in rural America. And by artificially increasing the payment rates by the underlying fee-for-service costs, we create a substantial gap that could be used for higher profit, higher administrative costs, higher payment for providers, and I think it could be a very expensive way to try to get added benefits to rural beneficiaries. And that is my concern about it. Thank you.

Mr. STARK. Thank you.

Chairwoman JOHNSON. Just on the issue of the data, would you care to comment on MedPAC's position on aggregate data versus encounter data?

Mr. HACKBARTH. For Medicare+Choice?

Chairwoman JOHNSON. Well, for risk adjusting.

Mr. HACKBARTH. Yes. For risk adjusting, we have not looked extensively at a proposal for use of aggregate data. Our analysis has been based on and favored the use of beneficiary-specific data. I don't want to rule out that Mr. Scully has a better idea until I learn more about it, but all of our focus has been on beneficiary-specific adjustment.

Chairwoman JOHNSON. We will be looking at that, because there are areas—there is some seasoned experience with aggregate data. Mr. Camp.

Mr. CAMP. Thank you, Madam Chairman. I have a couple of questions.

I think most of the hospitals in my district are over 10 beds but probably under a hundred and so would fit into a category of hospital that I think is essential in a rural area, and I have a question particularly about the financial performance. You mentioned the gap in your report, rural hospitals having about a 3.4 percent Medicare in-patient margin compared with 13.4 percent for urban hospitals; and you testified today that that gap has opened up over the last 10 years, I believe. And one of the causes being length of stay. But my question is, do you think that rural hospitals then are being paid too little and that urban hospital margins are too high?

Mr. HACKBARTH. Well, the focus of this report has been on the adequacy of payment to rural hospitals, and we see areas where we don't think the payments are adequate. Specifically, we haven't adjusted for factors that are beyond the control of rural hospitals. So, yes, we think that that needs to be changed and would result, on average, in increased payments.

Mr. CAMP. Do you think the fact that rural hospitals are losing money overall in the Medicare system, and given your background at HCFA over the last few years, what do you think the intent of Congress was in creating the prospective payment system in relation to that problem?

Mr. HACKBARTH. Well, certainly the intent was not for any large category of hospitals to lose money continuously. That is a sign that we haven't properly matched payments to efficient costs. So that needs to be addressed.

When the PPS system was developed in the early eighties, there was not a specific target rate of profitability that was set as a

guide. That has always been a much looser discussion. There is not a specific number.

Mr. CAMP. On the disproportionate share payment issue, you know, it was created by Medicare to—by care of some uncompensated areas and the financial pressure that results from that. In your testimony you mention there is a couple of problems, one being that the specific hospital groups' ratings really gives the least favorable rate to rural hospitals.

Mr. HACKBARTH. Right.

Mr. CAMP. And how do you think—with fewer than a hundred beds. How do you think that could be improved?

Mr. HACKBARTH. Well, disproportionate share we believe should be equally available to urban and rural hospitals alike. It was initially developed with an eye toward inner city hospitals with a high share of low-income patients and often relatively low shares of Medicare patients. Now the rationale has been expanded, and we advocate taking into account all types of uncompensated care and expanding the eligibility equally to hospitals.

In order to do that completely, we need to get some additional data, which is now being collected on uncompensated care burdens, and the information to make a uniform adjustment and recalculate the formula will be available in about 2 years. So what we have advocated as an interim step is to lift the cap that was imposed last year from 5.25 percent up to 10 percent, and that would substantially help many rural hospitals. We do not advocate removing the cap at this point, because using the old formula that was developed for urban hospitals, it would result in windfall payments for many rural hospitals. And rather than have a windfall that then has to be taken back when we have the right formula, we want to take an interim step and then implement the new formula.

Mr. CAMP. OK. Thank you very much. Thank you, Madam Chairman.

Chairwoman JOHNSON. Thank you. Congresswoman Thurman.

Mrs. THURMAN. Thank you, Madam Chairman.

I want to go into a little bit of the disproportionate share, too, because that seems to be a real issue for some of our rural hospitals, and I think that something that—I would like to know if we have looked at any of this data. Since the welfare reform took place and as people got into the system and started coming off of the system, have you seen any increases, particularly in the rural areas where unemployment is higher, less opportunity for jobs, probably, you know, sort of issues going on there? Has that taken place when you look at the disproportionate share and why maybe some of this has gone up in these areas and why rural hospitals are concerned with it?

Mr. HACKBARTH. Well, certainly the overall economic conditions in rural communities are a factor in the financial problems facing rural hospitals. The nature of the problems vary a little bit as you move across the country, but there clearly are areas where there is just general economic distress that has an adverse impact.

As to its effect specifically on the disproportionate share adjustment, I don't have any specific numbers to share with you there. But to the extent that there are more people without insurance and more uncompensated care, it would mean higher disproportionate

share payments once we go to a new formula that is now under development.

Mrs. THURMAN. With that—I mean, in your recommendations you talked about there should be a 10 percent add-on for disproportionate share, if I read and understood that correctly. How did you get to that? What kind of data and what kind of analysis was done, or is it just kind of this is what we ought to do? I mean, why would we not put the same system in rural areas as we have in urban areas?

Mr. HACKBARTH. Right now the problem is that we don't have the data necessary to revamp the whole disproportionate share system. We strongly advocate that. The data to allow a revamping of the system are now being collected, and we hope that the new system can be in place in a couple years.

Mrs. THURMAN. But based on that recommendation, then, it is just kind of arbitrary 10 percent——

Mr. HACKBARTH. Yes. Elevating the cap from 5 and a quarter to 10 percent, there is no magic about 10 percent, but we wanted to take a meaningful step in the right direction without getting in a situation where we would have payments that have to be taken back when we have the new formula in place.

Mrs. THURMAN. OK. And then the standardized payment issue, because that is another issue that has been brought up with our rural hospitals about the base payment, at those over one million population would receive about 1.3 percent. Why wouldn't we equalize that for everybody?

Mr. HACKBARTH. When we analyzed that—again, what we try to do is compare payment rates to costs, and in fact the costs of rural providers on average are lower than urban providers. So increasing the payments by 1.6 percent across the board would not be a very targeted solution. It would go to hospitals that need it and don't need it alike. Our preference is always to identify particular problems with the payment system and address those through targeted adjustments, like low volume, for example.

Mrs. THURMAN. We are going to hear some testimony from rural hospitals in a little while, and one of my concerns in all of this and one of the things that they point out is that, you know, we keep talking about making these changes and these things are going to happen and this is what we did in BBA and this is what we did in 1999 and this is what we did in 2000, but the fact of the matter is money of this has been put in place, and so we have got some real lag time here. At the same time, as you have mentioned, we have got the disparity between the urban and rurals now. I mean, what comfort can you give to some of our rural institutions that these things absolutely are going to happen? Because they live from day-to-day thinking this is going to happen, and this is going to be put into place, and it is a real concern for them.

Mr. HACKBARTH. Yeah. Well, we share your sense of urgency about this. It is not enough to talk about possible solutions or future solutions. They need to come quickly.

Some things have happened. For example, last year making rural hospitals eligible for disproportionate share payments even with the cap is a major step in the right direction. It will increase pay-

ments on average to rural hospitals by about 1.4 percent. That is meaningful money.

The steps that we advocate in this report, the low volume adjustment, lifting the cap on disproportionate share and so on, would on average increase payments to rural hospitals about 1.8 percent on top of last year's.

Mrs. THURMAN. Because they have a larger indigent population?

Mr. HACKBARTH. Right, in terms of—not necessarily a larger but certainly they do have an indigent population that needs to be recognized. Then changes that are now under development having to do with disproportionate share still again and with the wage index would still further improve payments to rural hospitals and tend to increase their average margins. We absolutely share your sense of urgency and urge the Secretary to work as quickly as possible on these issues.

Mrs. THURMAN. Madam Chairman, will we have another round?

Chairwoman JOHNSON. Probably not with Mr. Hackbarth, because we need to get to the next panel.

Mrs. THURMAN. Can I ask one more question, just based on a little of the conversation that was going on here as to access outside of the hospital setting? Because, as noted, we have this problem with the fact that we don't have potentially home health care as readily accessible. We don't have critical nursing, skilled nursing needs. And yet one of the things that is going to happen in October is we are actually going to lose this 15 percent that we have been given. We are going to actually lose that.

Can you offer any suggestions? I mean, my feeling is that we should not do this until we get everything in place, because I think it is just going to exascerbate some of the situations that we have been talking about.

Mr. HACKBARTH. Well, the new prospective payment systems for home health and outpatient services are tricky. There are some differences—meaningful differences between rural providers and urban providers that need to be taken into account. We would not advocate a 15-percent reduction at this point in the home health payments. We think it is wise to keep that on hold.

We also support the 10 percent add-ons for rural home health providers that were included in the legislation. We think that money buys us some time to evaluate the impact of the system and make appropriate adjustments. It is time that we need.

Mrs. THURMAN. Thank you.

Chairwoman JOHNSON. Then to just clarify for the record from your earlier statements, that you do not support wage floors as a policy and you do not support the sort of arbitrary increase in the wage index that some are looking to strengthen rural providers but that you do support some adjustments that retain the relationship between costs and reimbursement——

Mr. HACKBARTH. Yes.

Chairwoman JOHNSON. But will result in higher payments?

Mr. HACKBARTH. Yes.

Chairwoman JOHNSON. Thank you.

Mr. HACKBARTH. On the wage index, what we support in this report is looking at the so-called labor share of the prospective payment rate. Currently, about 71 percent of the rate is adjusted for

local wages. There has been concern among rural providers that that number is too high, and since their wage indexes are less than one, they lose money in the process.

Chairwoman JOHNSON. In other words, many things that they buy that are called inputs they have to buy from the same general market that everybody buys.

Mr. HACKBARTH. Exactly.

Chairwoman JOHNSON. And so they get penalized, I guess? Thank you.

Mr. HACKBARTH. Yeah. So the issue is, is 71 percent the right number or is it 69 or some other figure?

Chairwoman JOHNSON. I do think that your testimony was very useful in going into some of those specifics. Let me move on to Mr. Nussle.

Mr. NUSSLE. Thank you, Madam Chairwoman; and let me compliment you on calling this hearing and talking about this very important subject. I appreciate that. My constituents who live in very rural area appreciate that.

I wanted to start off, Mr. Hackbarth. I am fascinated by your testimony in the way you begin on Page 1, and this is just—let me read this, and then I want to discuss this. It is fascinating.

"Medicare's most important objective is to ensure that beneficiaries have access to high-quality care. Because some rural communities face adverse economic conditions that may limit the ability of local providers to furnish the broad array of needed services, policymakers have been concerned that rural beneficiaries may not get the care they need."

Because some rural communities face adverse economic conditions that limit the ability to provide these services—what economic conditions are you talking about?

Mr. HACKBARTH. There are two levels. One is that the general economic situation, which may be high rates of unemployment, a lot of people without health insurance, factors that are not specific to the Medicare Program, that can cause some financial distress for providers.

Then there are factors obviously specific to the Medicare payment formulas and the like that we have been talking about that we have concerns are not appropriate for rural providers.

Mr. NUSSLE. In your first part, you talk about many rural communities face these market conditions—this is on Page 4—that may depress demand or supply, a small population, declining and disproportionately older population, low household incomes, high proportion lacking health insurance, physical isolation, weak and restrictive State policies, and so forth, and so forth.

Basically, what I see you saying there are two things. One is that—and you said this—I believe you have said it a couple of times, although I can't find the quote—that there is an inadequacy between the payments to rural and urban areas. That is number one. And, number two, because of that they can't transfer those costs to anyplace else, which is really number two. Isn't that what you are getting at here, that Medicare payments are inadequate, number one? And because they are inadequate and they are inadequate for many hospitals, what they do is they look around and they say, where can I put these costs. And urban areas have the

ability to transfer those costs to other places, but rural areas don't? Isn't that what you are basically saying?

Mr. HACKBARTH. Well, we are concerned about specific failures in the Medicare system, failures to account for differences in the situation that rural providers face.

I would note, though, that if you look not just at the Medicare margins but the overall financial performance of rural hospitals versus urban hospitals, the average total margin—which includes not just Medicare but all payers—is higher among rural hospitals on average than among urban hospitals. The reason for that, we believe, is that, yes, there are some specific rural hospitals in economically depressed communities that have problems. But in many rural communities there are relatively high levels of insurance, relatively good economic conditions, and there is not as much competition for those rural providers. Unlike an urban institution that faces lots of close-by competitors and has to deal with managed care plans trying to negotiate them all down, the rural providers have much more leverage in dealing with private payers. And so, as a result of that, we have this seemingly anomalous situation where rural providers have lower Medicare margins but higher total margins than urban providers.

Mr. NUSSLE. Well, I don't know what hospitals you are talking about. I mean, I have gone and looked at the books in my district, in my rural area. And I know that you may be trapped in what you told me not to do, and that is, don't generalize. So, I am not going to hold you to that. But I will just tell you, I don't know what you are talking about. I don't know what hospitals you are looking at.

Because the bottom line—I mean, how can you have on the one instance low health care coverage, high unemployment, all of those things you said and these hospitals are still able to provide a much higher margin? Now, part of it may be that they are more efficient. And if that is the case, that flies in the face of the other argument that was made, and that is that really you didn't see a difference between the efficiencies.

Mr. HACKBARTH. Well, Mr. Nussle, I really do think that the reconciliation of these statements is in the diversity. I happen to come from a rural community. I live in a rural community in Oregon, Bend Oregon. Our——

Mr. NUSSLE. How many people?

Mr. HACKBARTH. Fifty thousand people.

Mr. NUSSLE. Fifty thousand?

Mr. HACKBARTH. But we are rural.

Mr. NUSSLE. Let me just share with you, Mr. Hackbarth, that that ain't rural—with all due respect. There are places that we are talking about that are rural, that 50,000 people—well, let me just close with something, because I—there is never enough time to discuss this. And I just—I am very frustrated about this. But I will ask you one thing that I think you can probably answer.

The people in the rural areas pay the same taxes as the people in the urban areas. So people in your 50,000 town pay the same as my 5,000 town, don't they? I mean, why is it that one size does not fit all when you are talking about it from the analysis standpoint, but from the policy standpoint, we constantly try and find a one-size-fits-all solution to the Medicare reforms that we put in

line, and it never treats any of these providers that you say is the—you know, the frontline of providing high-quality care. But we don't provide them the kind of fairness in the system that they deserve so that these taxpaying beneficiaries who have paid taxes into Medicare their entire life get the same kind of opportunities throughout the country. And let the market decide. If they want to buy a helicopter, buy a helicopter. If they don't, then name it after a big contributor and, yeah, build a hospital if that is what they want to do.

But the folks—I will just tell you, and, you know, you can analyze this all you want, but the folks in my area are starting to see this as an issue of clout and who has had the clout to be able to get their voice across. And if it is a matter of clout, the rural areas will stand up and fight for it. We can do that. We have been trying to deal with it as best we can.

But I am very frustrated that we are getting nickeled and dimed over this issue, and in your very first statement you say that they face adverse economic conditions. I will tell you, the mother of all adverse economic conditions in this is the fact that they don't get the same reimbursement. They don't even get anywhere close. That is totally and completely unfair, and we are going to have to change that system if we are going to get the kind of care that you say we deserve.

I would be glad to have you come out to a rural area, which has a lot less than 50,000 people, so you can see what some of those bottom lines are all about.

Mr. HACKBARTH. Chairman Johnson, could I just spend 1 minute on this? Because I think this is a really critical point in the discussion.

Chairwoman JOHNSON. Yes, sir.

Mr. HACKBARTH. I recognize that the community that I live in is atypical, atypical in a lot of ways, and my point is not to hold it out as a typical rural community but in fact to emphasize that it is different. Yet the categories that we use in Medicare are so broad that my town is categorized as rural, just like some very small town in Iowa with very different economic resources and health care resources.

To the extent that we use these big categories and say that we want to increase the base rate for every rural hospital, hospitals like the one in my community that may not need it are going to get money, just like everybody else. That is why we so strongly advocate targeted solutions and not across-the-board solutions. We want to identify particular problems and address those and not just spread money across the board to all rural hospitals. Rural America is too diverse for that to be a proper solution.

Mr. NUSSLE. Well, I will just tell you, we will take the opposite deal. We will let you target the urban areas, and we will take the opposite deal. From a tax fairness, from a beneficiary standpoint, I don't know how you can advocate—I mean, I appreciate the fact that the news you have made today is that there is an inadequacy between urban and rural. I appreciate that. I am glad that MedPAC has finally come forward and made that kind a very grandiose statement. But I would suggest to you that your solutions lack a basis in reality that need to be there in order for us to solve

this problem, and I would invite you out to real rural areas so that you can examine this further.

Chairwoman JOHNSON. Mr. Hackbarth, I think that MedPAC needs to help us on this issue.

Your testimony, I would point out to Mr. Nussle—I am going to recognize Mr. Pomeroy in a minute. But this issue of the impact of low volume on rates, the issue of the impact of the longer length of stay on costs in the face of rates, the impact of input prices are very significant, honest differences in the relationship between cost and payment, between cost—just a minute, Pete, let me just—very important and honest differences between the way our payment formula and the real cost of these small institutions that are interfaced—we need to look at that, and we need to look at how much of that—how much of correcting that problem so we have a more honest relationship between cost and payment, which is what Medicare ought to be able to do, and how much of the problem is the fact that the bigger issue that you mentioned under disproportionate share, that has to do with the fact that Medicare as matter of policy does not reimburse for disproportionate share for uncompensated care, unless it is an uncompensated care Medicaid person or Medicare.

So there is a whole group of uncompensated care people, the uninsured, that tend to be a very big group. They are not as poor as Medicaid, and they are not in a public program, and they are not seniors. So to what extent are they the cause of the problems in the rural group?

When you look at averages, I am glad to hear that, on average, totally, they are doing pretty well, but I face this in the urban area, too. You know, on average doesn't help your hospital that is failing and it is failing because you are not reimbursing the costs.

So we do need to look at the specific things, see how much of the problem that absorbs, that will address, and then we need to look at how much is the burden of uncompensated care that in the past the government hasn't paid for. Because you do recommend and you are collecting the data so that next year we would be able to make some specific response to that burden? In the urban areas we make a very, very small partial response under the medical education reimbursement rates, but even that really doesn't recognize the same problem in urban areas.

So, I think if we can still continue to pursue costs and payments but also look at what is causing the disparities beyond that. So if you can give us back some better information about who is in that hundred-bed hospital group. You know, how many of the rural hospitals that are not showing healthy margins are in that hundred-bed group? How many are we not going to reach if we don't address that issue?

So, we need more detailed data to see who is not doing well, what kind of institution they are and how much they would be affected by the specific cost items that you address. Mr.——

Mr. NUSSLE. Would the chairwoman yield?

Chairwoman JOHNSON. Yes, I would be happy.

Mr. NUSSLE. You were much more eloquent in saying what I was trying to say.

Chairwoman JOHNSON. No, I appreciate your——

Mr. NUSSLE. What I was trying to say is I don't see myself—I don't see my district or any of my facilities in the averages that are being discussed here. I just don't see it. And that is what concerns me, is that I don't know what you are describing as rural, because it ain't here. And when I don't see it, then I am worried about the results of the report. When you say there is a discrepancy or a disparity or whatever, irregularity, amen. Thank you.

Mr. NUSSLE. But I don't see myself in the averages, and that is what really concerns me.

Chairwoman JOHNSON. That is why I am very pleased that actually you do go into some of the specific ways in which the formula doesn't work in rural areas, because years ago in the eighties I went through this very same problem with hospitals in my district that are rural. You know, two-thirds of my towns have less than 3,000 population, so I have what are rural hospitals, but because of the nature of New England, they designated themselves as urban because they have to pay the same wages as the urban areas. Now they are suffering the problems of the rural hospital under an inappropriate payment system, and we did make some adjustment, very modest. There is a formula, and when you put this formula across the country, it was all in New England, Tennessee and southern Illinois.

But the problem with a national formula is that it is very hard to make a national one-size-fits-all policy actually fit the extraordinary variety of institutions that not only our seniors depend on, but, remember, every age group depends on these institutions. So the—on average the policymaking process is a problem, which is exactly why we need to strengthen Managed Care+Choice because it has a different ability to negotiate with every single plan.

But, I want to recognize Mr. Pomeroy. He has a deadline and wants to make a brief statement.

Mr. POMEROY. Madam Chair, thank you, and thank you for allowing me to sit in on part of this hearing. For 8 years I was the State's insurance commissioner and tracked the health of our rural hospitals very closely. For the last 8 years I have been in Congress, and I have continued to track. Over this period of time, I have seen substantial decline in the financial condition of these facilities.

I guess I ascribe myself closely with the frustration voiced by Congressman Nussle, who has done excellent work in trying to get some of these reimbursement issues addressed, but we are not there yet.

I am pleased with the forthright acknowledgment of some of the issues in the MedPAC report, but have concern that the prescription doesn't match the diagnosis. I mean, you diagnose, for example, relative to rural hospitals in the West. Where I come from, the main risk factors affecting Western hospital markets are small populations, declining populations, disproportionate numbers of residents age 65 and older. I would add to that two conditions that are really threatening facilities, and that is the ability to staff and ability to recover cost of providing services, as the Chairwoman just referenced.

Again, back to this, you said that is the diagnosis, but your prescriptions in terms of a little more tinkering here and a little more tinkering there I am not sure is going to be aggressive enough

without having the face of health care delivery change very significantly. You indicate that right now we are able to match services, and Medicare recipients are reasonably satisfied. I think you don't have to look forward very far and see a very different situation. It is kind of like someone with an internal hemorrhage have a doctor say, well, you look good now; your situation is about to change very significantly based on things that maybe aren't readily apparent or captured in a patient safety.

That concludes my observation, Madam Chair, and I appreciate——

Chairwoman JOHNSON. Well, I am appreciative of your attendance.

Earl is a new Member of the Way and Means Committee. He is not a Member of this Subcommittee, but he and I have worked on a lot of issues together, and his experience in insurance will help us.

But I do want you to go back in the detail of the testimony so that you can see how the factors in the formula just don't fit, and if we adjust that, we should at least be able to deal with it honestly, you know, and we need to try to stick to a formula that has a fact-based structure, the problem your hospitals face with getting properly reimbursed.

I am very concerned about this nursing issue and the fact that it is going to hit very hard, very fast, and earlier in Mr. Hackbarth's testimony he mentioned that one of the problems in the wage area was that the data is 4 years old.

So we will be working on those issues, but I hope we will have the benefit of your expertise in the details. Mrs. Thurman.

Mrs. THURMAN. Madam Chairman, just to the nursing issue and to some of the whole health care provider issues in rural, and something I know you and I have worked on, and certainly something we probably, and hopefully States, are working on as well, but what my students are telling me at the University of Florida is part of this is the whole issue on loans and what it costs them. They can't afford to go in many of these rural areas.

Chairwoman JOHNSON. We do hope to get into another hearing on the nursing issue.

Mrs. THURMAN. And we have hospitals now going overseas looking for nurses.

Chairwoman JOHNSON. Right, in large numbers.

Thank you very much, Mr. Hackbarth. I didn't get a chance to ask you to comment on the presence of Sterling, which is a fee-for-service service Choice plan out there now in the rural communities. Just in a word, do you know much about it, and do you think it is doing well?

Mr. HACKBARTH. Well, I don't know much about Sterling in particular. I do have the concerns that I described earlier about the system of floors and Medicare+Choice and the opportunities they present.

Chairwoman JOHNSON. We will be talking with you more about that because it is the first Choice plan that has penetrated the rural areas, and we need to know more about how it is doing and whether it is impacting some of these problems. Thank you very much, appreciate it.

And would then the panel come forward. Kathleen Dalton and Curt Mueller and Keith Mueller. Kathleen Dalton is a Fellow at the Cecil Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. Curt Mueller is with Project HOPE, the Walsh Center for Rural Health Analysis. And Keith Mueller is the director of RUPRI Center for Rural Health Policy Analysis in Omaha, Nebraska.

We welcome you and appreciate your presence here and your help in understanding these issues. Dr. Dalton, if you will proceed.

STATEMENT OF KATHLEEN DALTON, PH.D., RESEARCH FACULTY MEMBER, CECIL G. SHEPS CENTER FOR HEALTH SERVICES RESEARCH, UNIVERSITY OF NORTH CAROLINA AT CHAPEL HILL

Dr. DALTON. Madam Chairman and members of the Committee, my name is Kathleen Dalton. I am a faculty member at the University of North Carolina where my field is health care finance. I have been asked to report on our research regarding specific Medicare prospective payment issues as they affect the rural hospitals.

Medicare's inpatient payments historically have been more generous to urban than to rural hospitals. This is evident in the longstanding differences in their respective average payment-to-cost ratios. We find, however, that these differences are due primarily to the disproportionate share and the indirect medical education addons to the prospective payment rates rather than problems in the underlying rate structure. Among hospitals not eligible for either of these special adjustments, Medicare's inpatient payments average about 5 percent above cost for both the rural and the urban facilities.

The wage index has often been identified as one of the chief problems facing rural hospitals under prospective payment, but our research thus far has found little evidence that the index is a contributing factor in poor rural margins. We have concluded that while the index is not perfect, it has improved over time, and it is an adequate instrument to accomplish the purpose for which it is designed. The rural labor markets as now defined actually serve to protect the margins of hospitals in the very smallest and most rural communities by grouping them with higher-wage facilities.

The gap in the urban and rural PPS margins appears to be more a reflection of Federal policy, in this case one of directing additional resources to safety net and teaching providers, than an indication that rural hospitals as a group are unable to compete under the discipline of the prospective payment system.

The disproportionate share adjustment, or DSH, is now recognized as the vehicle through which the Medicare Program shares in the cost of indigent care, just as other payers share when uncompensated care costs are factored into hospital price structures. DSH adjustments are an add-on to the payment rates. They are proportional to the hospital's share of low-income payments, but the formulas, as you have heard, are not equally applied across rural and urban hospitals. If we want to close the gap between rural and urban Medicare margins, then parity in the DSH formulas is the first change that should be considered rather than changes in the wage index or in the base payment rates.

MedPAC has already recommended reducing the differences in the DSH formulas across hospitals. If their recommendations were implemented, the rural and urban Medicare margins would be closer, though the rurals margins would always be somewhat lower because the overall indigent care burden is not as high in rural areas. But if the objective of the DSH adjustment really is to allow Medicare to shoulder its share of indigent care costs, then the DSH adjustment should be made available to all safety net providers, including critical access hospitals and other hospitals outside of the PPS system, and it should be made available for outpatient care.

Our research does not show that special payment considerations need to be given to all small rural hospitals. Nevertheless, there are some groups of rural facilities, particularly very small, low-volume or isolated facilities, that struggle to cover their costs under the inpatient payment rates. Many of these already qualify for a variety of special payment exceptions or have opted for cost-based reimbursement as critical access hospitals. The newly converted cost-based hospitals are generally receiving much-needed increases to their reimbursement, but only at a price, by giving up a possibility that Medicare services will ever contribute to their needed reserves.

An expanded disproportionate share adjustment will help many of these same hospitals by targeting assistance to rural safety net providers, but there may still be a class of vulnerable hospitals that are essential to their communities and that will need extra help if Congress wants to assure continued and stable access to services for all rural beneficiaries. For this class, perhaps a simpler and more effective way to address their payment problems might be by retaining their participation in prospective payment, but offering a cost-based payment floor. This would be a commitment that the Medicare program would never pay less than the essential providers' cost of delivering services.

These hospitals have very small operations to begin with, so even if many facilities were deemed to be essential, the total budget impact would probably be very small. A cost floor, we believe, would be better suited than the current proliferation of special add-ons and permanent cost-based alternatives to target help only to those institutions that need it and only during those years when they need it, without losing the inherently beneficial incentives of a prospective payment system.

This concludes my remarks. Thank you very much.

Chairwoman JOHNSON. Thank you very much, Dr. Dalton.

[The prepared statement of Dr. Dalton follows:]

Statement of Kathleen Dalton, Ph.D., Research Faculty Member, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill

Madame Chairman and members of the committee, thank you for inviting me to speak to you today. My name is Kathleen Dalton and I am a research faculty member at the University of North Carolina, where my field is health care finance. In recent years I have participated in several funded research projects that investigate rural hospital cost and reimbursement issues. I have been asked to describe some of our findings to you, focusing specifically on the role of Medicare payment policies in addressing special financial problems faced by rural health care institutions.

Rural providers and constituent groups are alarmed at the deteriorating Medicare and overall financial margins of their health care providers over the past three

years. Several advocacy groups are examining specific components of Medicare's prospective payment formulas to identify ways in which to obtain some regulatory or legislative relief. To help in assessing some of the specific issues with regard to Medicare's payments, my remarks will cover the following topics: (1) The hospital area wage index; (2) the Medicare disproportionate share adjustment to hospital prospective payment rates; (3) the gap between rural and urban Medicare payment ratios; and (4) special payments for categories of rural hospitals, particularly the expansion of cost-based reimbursement alternatives.

Hospital Area Wage Index. The wage index is used to adjust PPS rates for regional differences in the cost of labor. Many rural providers and advocates believe that the wage index penalizes rural hospitals because it overstates average wage differences and is based on poorly defined labor markets. Our studies have led us to conclude that the index does *not* overstate regional differences in average labor costs. In our research, in fact, we find little evidence that the wage index contributes to low Medicare margins. The rural labor markets as currently defined are too large and appear to incorporate multiple market areas. Yet we found that this deficiency has the effect of *protecting* hospitals in the very smallest and most rural communities because they are grouped with higher-wage areas. In earlier years there was some evidence that hospitals in the larger rural communities were penalized by the broad rural market definitions, but by the mid-1990's many of these hospitals were allowed to be reclassified into neighboring urban labor markets, without bringing down the index values of the markets from which they transferred.

Any set of labor market boundaries will create individual cases where there are arbitrary differences between facilities on either side of a boundary. The existing exceptions process, however, allows for geographic reclassification to regroup cases to neighboring markets if they can meet certain criteria. Reclassification cannot fix all boundary problems, but we believe we have demonstrated that, for rural hospitals as a group, the exceptions process has substantially improved the equity of the wage index. Last year's legislative and regulatory changes to the reclassification rules will improve the index further.

The hospital wage index is now used to adjust prospective payment rates for home health and skill nursing services in addition to hospitals, but without the benefit of the geographic reclassification rules. The reclassification provisions were critically important to our findings, and we conclude that the wage index adjustments to these non-hospital rates will not be equitable unless similar reclassification provisions are available. If reclassification continues to be decided at the individual institution level this process could add considerable administrative burden to the new payment systems. If this is unacceptable, it should be possible to design a provision where the skilled nursing and home health facilities in a given county are paid under the same reclassified index values of that county's hospitals, wherever a majority of its hospitals have already proven that the reclassified labor market is more appropriate.

Disproportionate Share Adjustments (DSH). The stated purpose of Medicare's DSH adjustment has changed over the years since it was first adopted. We now appear to have a consensus that the DSH policy objective is to permit the Medicare program to share in the cost of indigent care, similar to the way in which other payers share when uncompensated care costs are factored into hospital price structures. Under this approach, additional DSH payments are not intended to reflect the higher costs of delivering care to Medicare patients, but rather, the distributed costs of delivering care to other, uninsured patients. DSH is thus acknowledged as a policy-driven, rather than a cost-driven, adjustment to the national standard rates under PPS. This underlying premise has been the justification for MedPAC's DSH-related recommendations over the past several years. MedPAC has recommended parity in the DSH formulas across all hospitals, and that HCFA should develop an improved measure to use a proxy for each hospital's indigent care burden. The Benefits Improvement and Protection Act of 2000 gave rural hospitals parity in eligibility for DSH adjustments, but not in the formulas that govern the size of the proportional adjustment.

If Congress accepts the premise that DSH adjustments should underwrite Medicare's share of indigent care, then several payment policy changes flow logically from this position that go beyond MedPAC's recommendations for formula parity.

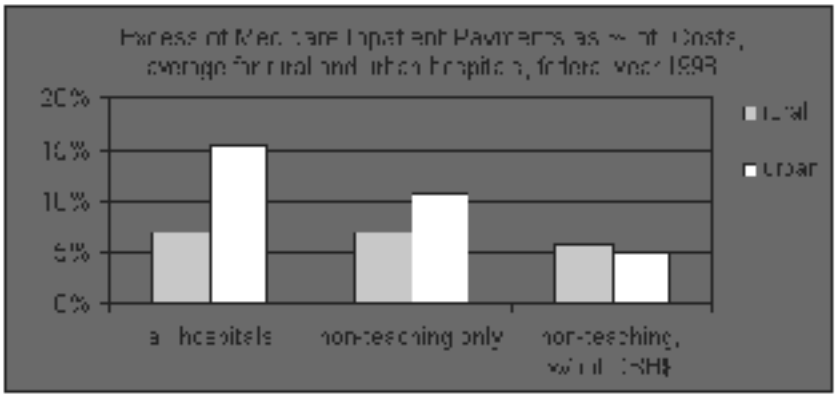
- DSH adjustments should be available regardless of the particular Medicare payment system under which the facility is paid. Under current law this adjustment applies only to inpatient PPS services. Cost-based and exempt (TEFRA-based) facilities also provide indigent care, and should be eligible for similar policy adjustments based upon their individual indigent care loads.

• DSH should be applicable to other hospital services, clinics, if their indigent care needs are similar. HCFA's proposed regulations for prospective inpatient rehab services include DSH provisions, but hospital outpatient PPS and clinic per-visit rates do not, even though indigent care burdens are at least as great, or greater, in these settings.

• DSH adjustments should not be implemented as "budget neutral" changes, where the extra payments are funded by reducing the base rates for all providers. Budget neutral DSH adjustments would redistribute the burden, but would not allow the Medicare program to underwrite its share relative to other payers.

Medicare payment ratios. Medicare's inpatient payments historically have been more generous to urban hospitals than to rural hospitals. This is evident in the long-standing differences in their respective average payment-to-cost ratios. When we analyze payment ratios from recent years we find that nearly all of the differential can be attributed to two of the special policy adjustments that Congress has created—the disproportionate share and the indirect medical education (IME) add-ons to the per-case payment rates.[1]

In fiscal 1998, for example (the last year for which complete hospital data were available from HCFA, and the first year in which the effects of the Balanced Budget Act of 1997 were felt) Medicare's inpatient PPS payments averaged 15.1% above costs among urban hospitals, but 6.9% above costs among rural hospitals. Among non-teaching hospitals the gap is much smaller (10.4% compared to 6.8%). If we remove the DSH payments from the calculation, the payment ratios are quite similar for both groups (close to 5%, though actually slightly higher for rural); if we look only at rural and urban hospitals that qualify for neither adjustment, we find that their average payment-to-cost ratios are also about 5%. Thus, the gap in urban and rural PPS margins appears to be more a reflection of federal policy than an indication that rural hospitals, as a group, are unable to compete under the discipline of the prospective payment system.



[1] The IME adjustment is theoretically cost-based, but the formula intentionally computes an adjustment that is greater than the expected cost differences in teaching hospitals. The portion of the IME add-on rate that is attributable to this intentional increase (we estimate it at 30%—40% in the FY 1998 data) is viewed as a policy adjustment.

Recent changes in the DSH policy will make more rural hospitals eligible for these payments, which will reduce the difference in margins between rural and urban non-teaching facilities. If MedPAC's other recommendations regarding the DSH formulas are implemented, the gap will narrow even further. We could not expect the gap to be eliminated, however, because the policy objectives being met by these two payments address needs that are unequally distributed between rural and urban communities. Teaching hospitals are predominantly located in urban areas, and urban hospitals have proportionally higher indigent care loads, so even under identical DSH formulas they would tend to have higher DSH adjustment rates.

Even without the effects of policy adjustments, similarities in average payment-to-cost ratios across groups still mask real differences in their distributions. The proportion of hospitals receiving Medicare PPS payments that are below their cost of delivering services is always greater for rural than for urban facilities. A subgroup of very small rural facilities has always struggled to cover costs under the PPS rate structure. Many of these have adapted by becoming cost-based Critical Access Hospitals (CAH). If the facilities that are struggling are important to protect in order to maintain rural beneficiaries' access to care, then the task of lawmakers is to identify whether and how to address the problems of these sub-groups with further payment policy adjustments.

Special rural payment exceptions and the expansion of cost-based alternatives. The various Medicare prospective payment systems already define several categories of rural health care providers that are eligible for special payments or exemptions from rate limits. These categories target different groups of facilities with varying levels of success. Some provide only small supplemental payments to groups that are in need of substantially more relief, while others provider substantial payments to facilities that qualify on the basis of a geographic characteristic, yet may not demonstrate any financial need. Much attention recently has focused on Critical Access Hospital (CAH) status, which allows very small, isolated hospitals to withdraw from prospective payment systems altogether for inpatient, outpatient and swing bed services, and receive cost-based reimbursement. Proposals to expand cost-based alternatives to other rural hospitals have been circulating among rural advocacy groups; at the same time, MedPAC is proposing a new low-volume adjustment to the inpatient PPS rates, in order to provide an alternative to cost-based payments for the smallest providers.

The proliferation of special exceptions and protected status makes it difficult for providers, analysts and lawmakers alike, to evaluate the adequacy of Medicare payments in rural settings. Our analyses of the economic and related health-delivery problems of rural communities have revealed great geographic variation. Severe isolation and sparse populations predominate in the west, while low-volume but only moderately isolated providers predominate in the mid-west. In the southeast and Appalachian regions we find multiple proximate hospitals, with low average census figures and very low average occupancy, but they serve communities that have very low incomes, poor employment and high levels of indigent care.

When we examine the Medicare margins as well as the overall finances of rural hospitals over periods of several years, we are struck by two characteristics in particular. First, even among those located in the most disadvantaged of rural markets, some facilities manage to earn good margins on Medicare and/or other patient services. Thus any Medicare policy offering automatic payment adjustments based on geographic criteria without a demonstration of financial need is potentially misdirected. Second, the margins for any one institution are unstable from year to year, particularly in the smaller providers. Hospitals that opt for cost-based alternatives to Medicare PPS are guaranteeing that they will not have to deliver Medicare services at a loss during bad years, but they are also giving up the possibility of ever earning a surplus during better times. In an uncertain environment where many providers are able to earn a surplus on some PPS services in some years, the expansion of cost-based reimbursement should be a last resort alternative.

We think that a well-designed DSH policy can alleviate many of the problems of rural providers located in very poor areas, without over-committing Part A trust fund support. Many of these communities may continue to need additional local and state-level public support, or even a different level of federal support, but those needs should be considered over and above Medicare's share of the burden.

Apart from the DSH adjustment, the underlying justification for special exemptions, payment add-ons or other subsidies should relate back to the Medicare beneficiaries and the need to provide adequate access. There is a certain

class of rural provider that should be protected, if there is evidence that the loss of these providers could jeopardize beneficiaries' access to care. That class may be difficult to identify, but we think that the criteria should relate to characteristics of the community (or beneficiaries) rather than to the financial condition of the individual institution. The class should certainly include very isolated providers, but it may also include providers that are not isolated, possibly are underutilized, but that serve as an important focal point of a poor community's health infrastructure (for example, where the loss of the hospital would jeopardize the town's ability to retain physicians, pharmacists or emergency medical personnel). Even if the class is broadly defined in terms of the number of qualifying providers, that group is not likely to represent a very large share of total Medicare payments. Whether Congress chooses a broad or narrow definition of the group, the question remains, what is a better way for Medicare to support it that would not overwhelm the system with multiple options, yet would still target only those institutions in need??

Many of the special payment provisions now in place could be rationalized by simply making a single commitment to this class of protected health care providers: that the Medicare program will never pay less than cost for the care of its beneficiaries, in any year. Paying everyone under the PPS rules but setting a cost-based floor (while excluding the DSH payments from the payment-to-cost ratio calculations) could provide consistent help to marginal hospitals, periodic help to providers suffering from temporary shifts in demand, and would avoid unnecessary subsidies to providers that are able to operate successfully within the discipline of the various PPS systems. The incremental Medicare payments from such a policy are likely to be very low (based on our historical estimates from the inpatient component), and the administrative burdens would probably be less than those required to support the current system.

In summary, my points are as follows:

- Our research indicates that the wage index is not a contributing factor to the gap between rural and urban Medicare payment margins. We find that the wage index does an adequate job in adjusting hospital payments for regional wage differences; however, opportunities for geographic reclassification must be extended to the home health and skilled nursing prospective payment system rules for the same index to be equitable in these areas.
- If Congress' objective in designing the disproportionate share adjustment is, in fact, to allow the Medicare program to share in the costs of indigent care, then the DSH adjustments as now computed are arbitrary and incomplete. The formulas should be made consistent not only across all types of PPS hospitals, but across non-PPS hospitals as well. They should also be developed for outpatient services, clinics, or other Medicare institutional providers that care for significant numbers of poor or uninsured patients.
- If the DSH adjustments were to be modified in this way, it is my opinion that the simplest way to address the problems of communities and/or providers at risk under prospective payment would be to pay all providers under the appropriate PPS rules, but to promise a minimum cost "floor" to those identified as essential institutions. The evidence does not show that special payment considerations need to be given to all small rural hospitals, but there is a class of essential providers that should be protected. A cost floor approach would target help where and when it is needed, without disrupting the incentives for efficient care provision that are built into all prospective payment systems.

Chairwoman JOHNSON. Dr. Mueller.

STATEMENT OF CURT D. MUELLER, PH.D., DIRECTOR, PROJECT HOPE WALSH CENTER FOR RURAL HEALTH ANALYSIS, BETHESDA, MARYLAND

Dr. CURT MUELLER. Good morning, Madam Chairwoman Johnson and other Members of the Subcommittee. I am Curt Mueller, and I direct the Project HOPE Walsh Center for Rural Health Analysis. I am very pleased to be here to discuss access to care issues pertaining to rural Medicare beneficiaries.

My bottom line is that although there is some good news to report, recent evidence suggests that rural beneficiaries do face access problems, and equity of the Medicare Program is compromised. At the same time, there are policy approaches that would help address these problems.

I will briefly summarize the written statement I have submitted. First let's turn to the evidence.

The good news is that the access to care among rural and urban Medicare beneficiaries is comparable in many respects. This is true if you look both at a number of the traditional measures of access, and it is also true if you look at more sophisticated measures of access. Evidence from a recent analysis of more than a quarter of a million program beneficiaries indicates that rural residents are just as likely to receive much of the necessary care also received by urban beneficiaries.

No important rural versus urban differences were found for 27 of 46 necessary care indicators, but there are some differences between rural and urban areas. Some rural beneficiaries do face access problems as there were real deficiencies for 19 of the 46 necessary care indicators in the study I just referred to. According to the study, rural populations are significantly less likely to receive timely EKGs for congestive heart failure, follow-up care after hospitalization for diabetes, timely gall bladder removal for symptomatic gall stones, and screening mammography. It is also important to note that these access deficiencies are most severe in the most rural of rural areas.

Rural access deficiencies are also important from the perspective of program equity. In spite of these access differences, medical care expenditures by urban beneficiaries are considerably greater than for rural beneficiaries. In 1996, per capita expenditures for the noninstitutionalized Medicare beneficiary without any supplemental coverage was 37 percent greater in urban areas than in rural areas. This difference is larger than what could be explained by differences in geographic—geographic differences in the cost of care alone.

It is important to emphasize that equity with respect to rural versus urban residents does not necessarily require that per capita program expenditures be equal. Some of the expenditure differences may reflect differences in taste, differences in provider style, but there are program actions that—policy actions that could, by helping to eliminate these differentials, improve equity of the program.

First, policies that increase the supply of health care resources in rural areas should improve access. I believe that access would be improved by work force policies that provide additional incentives for physicians to locate and maintain practices in rural areas and by payment policies that assist rural providers and help ensure their financial viability. An example is the new Rural Hospital Flexibility Program, which appears to be helping small rural hospitals overcome financial problems associated with low volume. In the same way, payments to physicians under traditional Medicare in historically low-cost, underserved areas could be increased. This might be accomplished, for example, either through the current bonus payment mechanism or by increasing the work component of

the Medicare fee schedule for these physicians. Over time such adjustments should improve access by helping to direct physicians to the areas of greatest need.

Second, policies that improve rural beneficiaries' access to expanded benefits should help improve access in rural areas. Currently rural residents are less likely than their urban counterparts to have drug coverage, for example, because they have less access to employer-sponsored supplemental coverage, Medicare HMOs and Medicare Choice plans. I support additional attempts to improve choice in rural areas.

In the short run cost-sharing under Medicare could be tied to the level of program expenditures per capita. For example, the Medicare premium could be reduced in areas with lower per capita program expenditures. Beneficiaries would be expected to pay a premium equal to 25 percent of program expenditures in rural areas of the State or region, for example. The difference between the national and local premiums could then be applied to subsidize the purchase of more benefits through a supplemental plan that offers additional benefits.

One final note, although the primary focus of this statement is on access to care among rural beneficiaries, monetary barriers of access for the nonelderly are more severe in rural areas than in urban areas because of a lack of insurance. There is no Medicare for these people. Because the Medicare population is relatively larger in rural than in urban areas, policies designed to improve access to care among the elderly are likely to strengthen the rural health infrastructure as a whole, which in turn should improve access for the entire rural population. Thank you.

Chairwoman JOHNSON. Thank you very much, Dr. Mueller.

[The prepared statement of Dr. Curt Mueller follows:]

Statement of Curt D. Mueller, Ph.D., Director, Project HOPE Walsh Center for Rural Health Analysis, Bethesda, Maryland

Good morning, Madam Chairwoman Johnson, Mr. Stark, and other members of the Subcommittee. I am Curt Mueller, Director of the Project HOPE Walsh Center for Rural Health Analysis. The Walsh Center is one of several research and policy centers funded in part by the federal Office of Rural Health Policy (ORHP). My testimony today reflects my views as an economist and health policy analyst; my views should not be regarded as representing the positions of Project HOPE, the Walsh Center, or ORHP.

I am very pleased to be here to discuss access to care issues pertaining to Medicare beneficiaries. My bottom line is that although there is some good news to report, recent evidence suggests that rural residents face access to care problems. Equity of the Medicare program is compromised. At the same time, there are policy approaches that would help address these problems.

What Does "Access" Mean?

Access to care refers to the potential *and* actual entry by an individual or population group into the health care system (Aday, Andersen, Fleming 1980). At the outset, it is important to recognize that access is not always realized: not every one, for various reasons, experiences actual access to care during a defined period of time. But access is difficult to measure when defined in this way. Among the most widely used measures of access are measures of actual use, or utilization. These include simple counts, e.g., the average, per capita number of physician visits per year, and the percent of the population with at least one hospital stay during the year. These measures, although frequently used, may not take into account differences in the clinical need for care or health status of the population that is being studied, differences in attitudes toward use of the medical care system, differences in practice style of providers, and other factors.

With the recent availability of large, claims-and patient-level data bases and advances in data handling, more sophisticated measures of utilization that account for medical need can be studied for large populations. Examples include measures of the percent of the elderly, diabetic population receiving an annual eye exam, and the percent of women in various cohorts, e.g., defined by age and medical need, who have received a mammogram during the previous year.

Finally, access has been measured in other ways, some of which were designed in attempts to measure the extent to which persons do not achieve access to services and reasons why. Survey respondents, for example, have been asked whether care was recently needed but not obtained due to cost or other reasons (Schur and Franco 1999; Mueller, Schur, Paramore 1998). Researchers have also studied satisfaction with various components of the health care delivery system, arguing that satisfaction is an important dimension of access. A battery of questions that separately assess satisfaction with cost, quality, and other dimensions of utilization are routinely asked as part of the HCFA-sponsored Medicare Current Beneficiary Survey.

Factors that affect access to care—by affecting *both* whether any care is actually received, *and* the level or intensity of services received—include those that health services researchers refer to as determinants of ability-to-pay, need, and availability. For the Medicare beneficiary, these factors include: family income; whether the beneficiary has insurance that supplements Medicare and the nature of the supplemental coverage (e.g., benefits, cost-sharing); health status; attitudes regarding relationships between personal health and the health care delivery system; the supply of providers in the beneficiary's community; practice style of community providers; and the non-monetary "costs" of care, including travel time and expenses.

It is often argued that rural beneficiaries tend to be poorer, which—by limiting ability to pay for care—reduces access. Relatively more persons in non-metropolitan areas have *individually purchased* supplemental coverage than in metropolitan areas where supplemental coverage is relatively more likely to be *subsidized by a previous employer*.[1] Individually purchased coverage is often less generous with respect to benefits than employer-subsidized coverage. Beneficiary coverage of prescription drugs, for example, is more common in urban than in rural areas because employer subsidized coverage is more common and more likely to include a drug benefit (Mueller and Schur 2001). Finally, the importance of travel and time costs in rural areas should not be underestimated. The distance traveled to providers of care and associated time and travel costs can be very high in rural areas, which reduces access measures by reducing patient demand and utilization.

Access to care among rural and urban Medicare beneficiaries is comparable in many respects.

The good news is that access among rural and urban beneficiaries is comparable in many respects. Access indicators for rural and urban populations are similar for a number of dimensions of care. Rural beneficiaries are as likely to see a physician during the year as their urban counterparts (Mueller, Schoenman, Dorish 1999). Differences in the average annual number of physician visits between urban and rural beneficiaries exhibit some variation, depending on the definition of "rural," are usually small (NCHS, 2000b; Mueller, Schoenman, Dorosh 1999; Coburn and Bolda 1999; Krauss, Machlin, Kass 1999; Clark and Dellasega 1998).

Evidence from a recent analysis of Medicare claims submitted on behalf of more than a quarter million program beneficiaries indicates that rural residents are just as likely to receive much of the *necessary care* received by urban beneficiaries (Hogan 2001). The author of this analysis defines *necessary care* as care for which benefits are expected to be substantial and outweigh associated risks, and care, which if not provided, was viewed as inappropriate by a panel of physician experts. For example, one necessary care indicator is whether a mammogram is performed annually for patients with a history of breast cancer. The author examines to what extent 46 necessary care components are met in five different types of rural and in urban areas. With respect to mammography, the exam was received by 69 percent of the female population with a history of breast cancer in urban counties, and by between 68 and 69 percent of the populations in rural counties, depending on the extent of "rurality." No important rural-versus-urban differences were found for 27 of the 46 indicators studied, and "for the typical indicator, most geographic areas

[1] Supplemental coverage comes from a variety of sources. Private supplemental, or Medigap coverage, is either purchased directly by the beneficiary or is obtained through an employer. The term, "supplemental coverage" also includes Medicaid, for those Medicare beneficiaries who are eligible.

differ by just a few percentage points" (Hogan 2001).[2] Finally, rural access deficiencies tend to be most severe in the least populated, most-rural of rural areas.[3]

Data also suggest that Medicare beneficiaries in rural and urban areas are satisfied with certain dimensions of access to care. In 1996, most beneficiaries (96 percent) indicated satisfaction with the overall quality of care, and little variation existed within and across residents of rural and urban counties (Mueller, Schoenman, Dorosh 1999). Contrary to expectations, rural beneficiaries are not less satisfied with the availability of care on nights and weekends. While fewer elderly in the most remote rural counties are satisfied with the ease of commuting (92 percent in remote counties, versus 94 percent in the largest metropolitan counties), the difference is small and not statistically significant (Mueller, Schoenman, Dorosh 1999).

But rural beneficiaries face access problems.

The importance of rural deficiencies in access to necessary care identified by Hogan (2001) should not be understated. For example, rural populations are significantly less likely to receive timely EKGs for congestive heart failure and transient ischemic attack, follow-up care after hospitalizations for diabetes and gastrointestinal bleeding, timely gall bladder removal for symptomatic gallstones, and screening mammography (Hogan 2001). Once again, these deficiencies are for care deemed medically necessary.

It is also important to observe that these access deficiencies are most severe in the most rural of rural areas. Although this is not surprising, given the lack of providers in these areas, this point is very important to emphasize because much of the research on access to date does not thoroughly address the extent to which access differences vary *within* rural areas. Part of the reason is that national databases that have traditionally been used to research access to care issues do not have enough data on rural populations to generate reliable estimates for the variety of rural settings that often get lumped together under the label, "non-metropolitan."

Evidence from a number of other studies also indicates that rural beneficiaries have less access to care than their urban counterparts. Rural Medicare beneficiaries are less likely than urban beneficiaries to: receive pap smears (Stearns, Slifkin, Edin 2000); have an emergency department visit during the year (NCHS 2000a; Lishner, et al. 2000; Miller, Holahan, Welch 1995); and use auxiliary home health services, including physical therapy and medical social services (Sutton 2000; Kenney, 1993). Rural residents are less likely to have access to specialty physician services, and the average physician visit for rural residents is less resource-intensive than for metropolitan area beneficiaries (Sutton 2000; Miller, Holahan, Welch 1995).

How access to care that requires an inpatient stay varies between rural and urban beneficiaries is unclear. Recent findings indicate that the rural elderly are slightly more likely to be hospitalized during the year and that their lengths of stay tend to be shorter than in urban areas (NCHS 2000a; Schur and Franco 1999; Krauss, Machlin, Kass 1999). In thinking about what these findings say about access, it is important to remember that use of hospitals is not a "complete" picture of the illness episode. Payment system incentives often encourage shorter lengths of stay and discharge to a "lower level" of care. Complete episodes of illness for the elderly often involve skilled nursing care (either in a skilled nursing facility bed or at home), home health services, or both after the patient's discharge for an acute care hospital. We know that rural residents receive more skilled nursing facility care (Coward, Netzer, Mullens 1996; Coward, Horne, Peek 1995), that receipt of this care appears to vary indirectly with the availability of home health services (Dubay, 1993) and directly with the supply of skilled nursing facilities in rural areas (Coburn and Bolda, 1999). While these findings are consistent with the substitutability of certain kinds of services, currently available access measures do not address the *mix* of care received during the entire episode. Additional study on the use of post-acute care services in rural versus urban areas is needed before we can say more about access to care that requires an inpatient hospital stay.

Do these differences matter?

The evidence cited above suggests that rural residents have less access to certain types of care than urban residents. These differences are important for at least two

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[2] Other examples of necessary care indicators are: gastrointestinal work-up for patients with iron deficiency anemia; follow-up visits for hospitalization within one week of initial diagnosis of unstable angina; chest x-ray within three months of initial diagnosis of congestive heart failure; and visit within two weeks following discharge of a patient hospitalized for depression.

[3] Rural deficiencies are statistically significant and the divergence from the corresponding urban value is 10 percent or greater in the most-rural areas for 15 of the 19 indicators for which rural deficiencies are observed.

reasons. First, these differences are of at least some clinical significance. Although there is often disagreement among medical experts in defining medical need and exact prescriptions of what constitutes optimal levels of services for rural versus urban populations, some of the observed differences are large enough to be of concern to clinicians, e.g., the large differences in access to types of services *that clinicians have deemed necessary*.

Second, these differences are important from an equity perspective. A basic objective of the Medicare program is that beneficiaries—regardless of geographic location—should have equitable access to adequate medical care. Rural residents should have adequate access to basic preventive, primary care, and emergency medical services. But as access differentials do exist, especially for residents in the most rural of rural areas, medical care expenditures by urban beneficiaries are considerably greater than for rural beneficiaries. In 1996, per capita personal health care expenditures for non-institutionalized Medicare beneficiaries residing in metropolitan areas was $6,901 and $5,901 for non-metropolitan beneficiaries (Liu et al. 2000). Differences are even larger after controlling for differences in supplemental coverage across beneficiaries. Per capita expenditures for the populations of beneficiaries without any supplemental coverage—that is, with only Medicare coverage—were $5,248 in metropolitan and $3,860 in non-metropolitan areas (Liu et al. 2000). This difference, 37 percent, is an amount larger than could possibly be accounted for by geographic differences in the costs of providing care.

It is important to emphasize that equity with respect to rural versus urban residence does not necessarily require that per capita program expenditures be equal. A variety of factors determine per capita expenditures on medical care, just as a variety of factors affect access. For example, expenditure differences reflect differences in practice style and in the prices of care. By definition, expenditures will be larger in areas with higher Medicare payment rates and in areas where service mix is relatively resource-intensive. Thus, because payments under the Medicare Fee Schedule have tended to be lower in rural areas and service mix tends to be less resource-intensive, per capita expenditures will be greater in urban areas. On the other hand, removing access to care barriers faced by rural residents will certainly increase rural expenditures relative to urban expenditures, and improve equity of the Medicare program.

What policies might improve access among rural beneficiaries?

Several policy responses might be considered as we think about Medicare reform and restructuring. First, policies that increase the supply of health care resources in rural areas should help improve access. At present, relative supplies of physicians and hospital resources are larger in urban than in rural areas because markets—in terms of numbers of people—are larger. The number of specialist physicians per capita is larger in urban areas, so access to specialty care is easier to obtain. A corollary is that certain "fixed" costs will be lower in more-populated markets, so hospitals will be relatively scarce and more costly to operate in rural areas. Personal preferences of providers also constrain supply in some areas. Some rural markets have difficulties attracting and retaining physicians and other providers. Access indicators for these areas will differ from measures for areas where effective supplies of providers are larger.

Supply in rural areas would be enhanced by workforce policies that provide additional incentives for physicians to locate and maintain practices in rural areas, and by payment policies that assist rural providers and help ensure their financial viability in rural areas. An example is the Rural Hospital Flexibility Program, which has granted cost-based reimbursement to many of the smallest rural hospitals. This program appears to be helping these facilities overcome financial problems associated with low volume and allowing them to continue help meet community needs.

Second, policies that improve rural beneficiaries' access to expanded benefits should help improve access in rural areas. For example, rural access will improve with a Medicare drug benefit so long as rural residents can obtain coverage from a plan that provide drug coverage. Currently, rural residents are less likely than their urban counterparts to have this coverage because they have less access to employer-sponsored private supplemental coverage, Medicare HMOs, and Medicare+Choice plans that offer a drug benefit. Furthermore, rural residents tend to be poorer and less able to afford an individually purchased supplemental plan with drug coverage. For these reasons, federal subsidization of a drug benefit based on income will likely improve access in rural relative to urban areas.

To the extent that these policy approaches improve access in rural areas, equity of the program from the rural perspective would improve because real utilization in rural relative to urban areas would increase. In the short run, other policy options that would reduce rural inequity by reducing rural beneficiaries' share of pro-

gram expenses might be studied. One approach is to tie cost sharing to program expenditures per capita. For example, the Medicare premium could be reduced in lower cost (mainly rural) areas. Beneficiaries would be expected to pay a premium equal to 25 percent of program expenditures in rural areas of the state or region, for example. Another possibility is to increase program payment rates to providers under traditional Medicare in historically low-cost, under-served areas. This might be accomplished, for example, either through the current bonus payment mechanism that targets the bonus to physicians in shortage-designated areas, or through the work component of the Medicare Fee Schedule. The premium adjustment would benefit rural beneficiaries directly, whereas adjustments in payment rates might affect improvements in access over time by helping to direct physicians to areas with the greatest need for physicians.

One final note. Although the primary focus of this statement is on access to care among rural Medicare beneficiaries, it is important to note that the Medicare program has been very successful at reducing monetary barriers of access to care. Data indicate that access differentials, like those noted above, also distinguish the rural non-elderly from the urban non-elderly, but that monetary barriers are more severe because of the lack of insurance among the non-elderly and that this problem is relatively more severe in rural than in urban areas. Because the Medicare population is relatively larger in rural than in urban areas, policies designed to improve access to care among the elderly are likely to strengthen the rural health infrastructure as a whole, which in turn should improve access for the entire rural population.

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Chairwoman JOHNSON. Dr. Mueller.
Dr. KEITH MUELLER. Also Dr. Mueller.
Chairwoman JOHNSON. Oh, is it also Dr. Mueller.

STATEMENT OF KEITH J. MUELLER, PH.D., DIRECTOR, RURAL POLICY RESEARCH INSTITUTE CENTER FOR RURAL HEALTH POLICY ANALYSIS, UNIVERSITY OF NEBRASKA MEDICAL CENTER, OMAHA, NEBRASKA

Dr. KEITH MUELLER. Thank you, Madam Chairwoman.

The Rural Policy Research Institute Center for Rural Health Policy Analysis that I direct focuses its attention, analysis and research on the special circumstances of sustaining service delivery in rural communities. Why then the focus on Medicare policy?

The current Medicare policies and payment are creating financial stress for many small rural hospitals. In 1998, the total Medicare margin for rural hospitals was a negative 2.1 percent and in 1999 a negative 2.9 percent. In 1999, the small rural hospitals under 50 beds who were not already part of some special payment category experienced negative margins aggregating the 5.6 percent negative, and 54½ percent of them had negative margins.

How do we change that situation in current Medicare policies? Medicare payment policies are designed for Medicare to be an efficient payer of efficient providers, as you heard earlier. Therefore, trying to address the needs, special needs, of small rural providers requires adjustments to formulas to try to increase the bottom line or maybe wrinkles in the system, such as a low-volume cost adjuster or perhaps what I call policies by exceptions, creating categories that would be deemed eligible for cost-based reimbursement.

What are the results of that kind of an approach? One result is imperfect targeting. As you have heard throughout this morning's discussion already, each attempt to do this by adjusting a formula creates a payment bonus, if you will, for a broad category of providers, not necessarily those located in those small, isolated communities most in need of assistance. To reach them we end up reaching many. We also create a system of administrative complexity, because one has to turn, then, attention to, well, how do I adjust my cost reporting system to comply with the new payment system intended to benefit me.

We also create a system with constantly changing regulations and all of the time lines that are associated with changing regulations, the publication of proposed rules, final rules, then the implementation of those rules. That combination of administrative complexity and constantly changing regulations can overwhelm the systems that we have in place. It certainly overwhelms those small rural hospitals like the critical access hospital I visited recently in

northern California that is doing its best to take advantage of every single opportunity to enhance its bottom line, but has to add on administrative personnel in order to do that.

It also overwhelms our own government administrative system, an issue that I know this Subcommittee has addressed in the recent letter Chairwoman Johnson mentioned earlier to the Health Care Financing Administration. Now, all of that can mean cash flow crises for the small rural hospitals that can't adjust quickly enough or have experienced regulations that aren't adjusted quickly enough to deal with changes that we intend to do in 1 month, but don't actually occur until 9 or 12 months later.

What is a better way out of this? What we are looking at now at the RUPRI Center as a way of identifying communities rather than focusing on providers. By using demographic, economic and geographic data, we are working on identifying those communities in which it would be nearly or absolutely impossible to sustain service delivery based on operating revenues alone, that some additional flow of dollars would be needed in those communities.

If communities are identified, then we can look, as Representative Stark said earlier, a holistic view of what is the package of policies that we would use to help providers in those communities: National policies, including payment policies, but also including targeted technical assistance in grant programs; State policies, including the same combination; and local policies, including local tax revenues, local foundations. We could be looking at other provider-based and population-based programs to be serving those small communities. If we engage in that kind of a dialog, we may do a better job of sustaining those services in the rural communities where today they are experiencing a great deal of difficulty.

Thank you.

Chairwoman JOHNSON. Thank you very much, Dr. Mueller. I guess is it Mueller, or is it Mueller?

Dr. KEITH MUELLER. Mueller.

[The prepared statement of Dr. Keith Mueller follows:]

Statement of Keith J. Mueller, Ph.D., Director, Rural Policy Research Institute, Center for Rural Health Policy Analysis, University of Nebraska Medical Center, Omaha, Nebraska

Chairwoman Johnson, Representative Stark, members of the Subcommittee, thank you for the opportunity to share some thinking about reasons to change Medicare payment policies and a new framework for making appropriate changes. The Rural Policy Research Institute is committed to completing analysis that helps develop policies that address the needs of people in the rural places where they live. This reflects a belief that there are differences in *place* that ought to be recognized in public policies, including Medicare, with policy choices directed to the *places* where people live. I will conclude this testimony describing a policy choice for Medicare payment policy that does just that. Before reaching that conclusion I will use the current conceptualization of policy to make three points: (1) health care providers in small, remote rural communities continue to struggle to survive financially; (2) the existing policy framework forces the use of incremental changes to payment formulas that were not designed to address the fundamental problem of delivering services where operating revenue will not sustain services; and (3) the approach of payment policies has led to accumulating technical changes that overwhelm the systems used in payment.

THE CURRENT FINANCIAL STRUGGLE OF RURAL PROVIDERS

While not a perfect indicator of the financial condition of providers in the small, remote communities that are the focus of my testimony, the plight of small rural hospitals is a good proxy indicator. In its March, 2001 report, the Medicare Payment

Advisory Commission (MedPAC) presented data showing that rural hospitals experienced negative margins on their total Medicare business,-2.1% in 1998 and-2.9% in 1999 (Figure 5–8). The picture is especially bleak for rural hospitals with fewer than 50 beds that are not included in any special payment category, 54.5% of those institutions experienced negative margins in 1999 (Table B–5), and their aggregated overall Medicare margin was-5.6% (Table B–10). Losses generated in serving Medicare beneficiaries might be offset by other sources, including local taxes and foundations and/or payment from other insurers, but not in all of hospitals in this group. In the aggregate, the total margin reported by MedPAC for those hospitals in1999 was 2.1%, much less than the overall 4.9% reported for all hospitals (Table B–15). In its December 14, 2000 report of hospital margins, MedPAC presented data reflecting improvement in hospital margins, but even so, 34% of hospitals, mostly rural, had negative total Medicare margins.

The National Advisory Committee on Rural Health, on which I serve, recently learned of the plight of small hospitals in some of the most remote territory I have seen, in Northern California. The 72 rural hospitals in that state averaged a-2.2% patient-operating margin in 1999, and 74% of them lost money on their operations in 1999. We visited one rural hospital that recently converted to Critical Access status, after being very near bankruptcy. Its most recent fiscal year showed a slight loss on operations, but thanks to an aggressive plan to expand services available in the community, it is on a path to recovery, albeit with continued very narrow margins. Two images were burned in my mind in that visit. First, that hospital is only barely surviving financially, because even though it is doing everything a good consultant would recommend, it suffers the natural disadvantage of being located in a remote mountainous area. Second, as difficult as the struggle is for that hospital, it is planning to affiliate or merge with a neighboring (28 miles away in an area that can receive as much as 20 feet of snow in the winter) hospital that is literally bankrupt. This is a tale of difficulty about which aggregate data can only give us hints. For me, this demonstrated the value of combining case study data with aggregate data in our research, giving you a better sense of the range of circumstances that exist in rural America.

The example of Northern California is repeated elsewhere in rural areas—providers that are in precarious financial condition but finding ways to continue providing services. The access to services they provide today is assured only if they are able to continue to balance operating losses with other sources of revenue, and doing everything possible to reduce those losses.

CURRENT POLICY FRAMEWORK

Current policies present imperfect choices to address the needs of rural communities. Medicare payment policies are designed, as summarized by MedPAC, to create a system of efficient payment for services delivered to beneficiaries, not to recognize needs caused by environments in which providers cannot survive under financial models assuming constant gains in efficiency. Yet those policies are the tools available to address the needs of a unique group of providers serving the small, remote rural communities. Therefore, proposals such as setting a floor payment in the wage index, or equalizing the base payment in the prospective payment system, appeal to the providers and their associations who can calculate an improvement in revenue that may "stop the bleeding." Other suggestions, such as adjusting payment systems to increase per case payment in situations where the number of cases are few (low-volume adjustment) are intended to bring the operating margin closer to, if not in balance. But because there are multiple payment streams to multiple providers in the same communities, the incremental approach would need to apply to all of those payment systems. This is the nature of the segmentation inherent in decisions that track with the type of service and category of provider.

It should not be surprising that another approach to this problem gains favor; that of creating a separate, cost-based payment system for vulnerable providers. This would seem to be the most certain means of meeting the needs of providers in target communities, since it would neutralize the effect of Medicare payment on the financial condition of those providers. However, two problems remain. First, even cost-based payment may not be sufficient if "allowable" costs are not inclusive and if there is no possibility to build up reserves needed to maintain quality services. Second, the policy is still linked to providers, which presents complications in trying to be sure the definition of provider matches with communities that need those particular providers (the concept of "essential provider"). Despite these problems, this approach would appear to be succeeding, for the most part, in the designation of Critical Access Hospitals, 91% of which are located in counties designated as Health Profession Shortage or Medically Underserved Areas, 65% are the

only hospital in their county, and nearly 83% are located in counties with higher than state averages of persons aged 65 or over.

Assuming the special financial needs of certain rural providers are met, the remaining objective of payment systems fairness. No class of provider should be disadvantaged vis a vis another class because of differential payment. Any difference in payment must be related to a difference in the actual cost of the specific service.

UNINTENDED CONSEQUENCES OF MULTIPLE, SEGMENTED TECHNICAL SOLUTIONS

The legacy of numerous incremental attempts to address the special financial circumstances of rural providers, combined with repeated efforts to refine and establish prospective payment systems, has overwhelmed the capacity of administrative systems. The numbers of providers in different categories is some indication of the complexity being created: as of 1997 there were 1804 independent rural health clinics (RHCs) and 1525 provider-based RHCs; the most recent PPS update identified 165 Rural Referral Centers, 667 Sole Community Hospitals, and 328 Medicare Dependent Hospitals. None of these classifications are necessarily inappropriate, but the mere existence of separate provider types necessitates at least different applications of payment systems and regulations, if not completely separate regulations.

The inherent strain of multiple policies is most apparent when new policies are enacted. For example, not all provisions of the Balanced Budget Act of 1997 have been implemented through publication and application of final rules. Issues have arisen in the implementation of new systems to certify and reimburse Critical Access Hospitals, resulting in legislative amendment in 1999 and 2000. Implementation of prospective payment for outpatient services has been slow, affecting timely completion of cost reports and therefore delaying fiscal year end reconciliation, and forcing new policies based on cost report data to start late or use old data.

Frequent and multiple "fixes" to payment systems can easily outpace the ability to use appropriate data, both for developing systems and for measuring their impacts. The delays in cost report data described earlier means wage data (including occupational mix) used in prospective payment formulas are reliable only as of some years prior to the payment. Recent increases in wage scales and mix of employees (due to changes in medical practice and/or new regulations) will not be reflected in the payment.

Delays in implementing new systems might be only bumps in the road were it not for the effects on the small, financially vulnerable providers that are the focus of this testimony. A seven month delay in reconciliation based on the year-end cost report could result in a serious, even crippling, cash flow problem for a provider expecting a positive result. Problems in implementing legislation that initially does not include the specific authority intended (for example, cost-based payment for lab services provided by CAHs) can be resolved, and retroactively (as was the case in CAH lab payment). But, again, that means a delay in receiving expected revenue.

The resolution to this pattern of ever-increasing complexity is not "administrative simplification," since that only makes each regulation simpler and does not slow down the increase in volume every time a payment system is altered. A completely different approach would offer a better solution.

PAYMENT BASED ON COMMUNITY

With access to locally-based services as an objective of public policy, a new framework would identify those communities within which any provider would be unable to sustain services based on operating revenue. The RUPRI Center is currently developing a means of designating "vulnerable communities" as an alternative to designating specific types of health care providers. Our aspiration is to use information that can be obtained from Census data and other public sources in a formula that accounts for low expected patient-based revenue. We have begun by mapping areas based on population aggregation, to at least 1500 persons in a "community" (town and surrounding census tracts). Within each community, in addition to total population, variables expected to be related to operating revenues are: household income, percent of population enrolled in Medicaid, percent of population enrolled in Medicare, percent of the population at or below federal poverty level in income; percent of workforce unemployed, and population per square mile. Population per square mile is one measure of isolation, but physical terrain will need to be operationalized and either incorporated into a formula or used as second-level criteria.

By building the definition of community using census tracts rather than county boundaries, this approach can deal with the problems of having small isolated communities within very large counties that include areas that are well-served. This is a problem in western counties, like the ones the National Advisory Committee on Rural Health toured last week. We are currently testing the early phases of our

modeling with data regarding communities in Nebraska, and so far our thinking passes the "face validity test" of identifying communities we know have difficulty recruiting and retaining health care practitioners and sustaining institutional providers.

Once communities are identified as "vulnerable" policies devised at the federal, state, and local levels of government can be used to maintain the economic viability of providers based in those communities. For the federal government the policies can be a combination of payment from Medicare and availability of grant funding for special needs such as capital investment or conversion of information systems to develop new systems of quality improvement. From state governments the policies can include special payment from Medicaid and direct financial assistance. Local policies can include access to a tax base (which may be broader than the single community), direct assistance, and/or help in organizing community-based foundations.

Hospital financial data indicate, to at least some degree, communities who are self-identified as "vulnerable." Small rural hospitals (under 50 beds) with substantial income from government subsidies and non-patient revenue are financing care through these means. Of the types of hospitals as classified by MedPAC, the category with the highest percent gain from "other government payers and subsidies" are the small rural hospitals. For those hospitals, a loss of non-patient revenues would have resulted in net losses in 1999 (Table B–15). Of course, those are aggregate numbers, and the reason to develop a community-based policy is target resources effectively within clusters of hospitals, or any other health care providers.

If this or some other means of identifying communities is found to be effective, non-payment policies, including special grant programs and flexibility in meeting conditions of participation, can be targeted to specific places. The same is true for grant programs, including technical assistance and promoting innovative means of meeting local needs, such as developing networks.

I am suggesting a framework for considering policies targeted to issues of access to care in rural areas. The focus of this framework is *place*, not *provider*. Short of finding acceptable means of imposing this framework, policies targeting providers should be based on underlying assumptions about the communities they serve.

Chairwoman JOHNSON. OK. Two questions, Dr. Mueller on my right. Do you support the wage base, just the arbitrary increase in the wage adjustment for rural hospitals?

Dr. KEITH MUELLER. You are speaking about creating the floor payment of .9 or whatever it might be?

Chairwoman JOHNSON. Yeah.

Dr. KEITH MUELLER. That would be inconsistent with the idea of looking at a more holistic change. So, no, in an analytical sense, no, that can't be supported.

Chairwoman JOHNSON. I do think your comments about a more holistic approach are very, very interesting. You heard the questions that I asked Mr. Hackbarth earlier, and any comments you may have in looking at those hundred-bed or, you know, the different categories of rural hospitals, which does go to the point you are raising about let's look at the community, would certainly be of interest to us. I would remark that it isn't just the small hospitals that are now having cash flow crises because the banking institutions are seeing the health providers as poor risks, and even larger hospitals are having great difficulty if the payment system breaks down, which it is now quite frequently.

I did want to just ask Dr. Mueller in the center, your comment about reducing premiums where costs are lower and the barrier that income places on access to care in rural areas, is that an idea that you have developed to any degree?

Dr. CURT MUELLER. There is a considerable amount of health services research which indicates that income and insurance are

significant determinants of access to care, both among—well, among the population in general, but also among Medicare beneficiaries.

Chairwoman JOHNSON. Certainly access, those with Medigap insurance that covers much of the co-pay and deductible responsibility of seniors does make access much easier, and it is more difficult—is it difficult for seniors in rural areas to get because it is not available or because they can't afford it?

Dr. CURT MUELLER. My suspicion is that, well, fewer rural beneficiaries have Medicare supplemental coverage than beneficiaries that live in urban areas, and it is actually a combination of both. You can either obtain privately purchased supplemental coverage, which I think in rural areas it is about the percentage covered with privately purchased. It is about the same as in urban areas. The big differences, though, are that employer-subsidized supplemental insurance is much more common in urban areas than in rural areas.

Chairwoman JOHNSON. And have you given any thought to going to a single deductible, a more sort of modern structure of Medicare, and whether that would increase access in rural areas?

Dr. CURT MUELLER. A single deductible?

Chairwoman JOHNSON. Yes.

Dr. CURT MUELLER. Well, there has been a lot of interest in reforming the nature of supplemental insurance coverage. Right now the supplemental insurance—some of the supplemental insurance plans provide first dollar coverage, which has been criticized as encouraging more use than might otherwise be appropriate.

Chairwoman JOHNSON. I guess let me take it from a little different angle. MedPAC testified that rural beneficiary cost-sharing is higher, and you have testified that costs are an impediment to access. Could you walk us through policies—and you can all contribute to this if you want. What policies contribute to high cost-sharing, and what are the implications for cross-subsidies from the rural elderly to the urban elderly? Is there any difference? Is the urban elderly person with no Medigap insurance in exactly the same position as the rural elderly person with no Medigap insurance?

Dr. CURT MUELLER. No. Expenditures for the urban elderly with no Medigap, it is on a per capita basis, total expenditures are higher. In fact, in 1996, one of the statistics in my statement is that among those with no supplemental insurance at all, the urban expenditure per capita is 37 percent higher than in rural areas.

Chairwoman JOHNSON. For the same income elderly?

Dr. CURT MUELLER. Well, for persons with Medicare only, with no supplemental coverage. I don't know what their income level is. My suspicion is it is lower since in general incomes tend to be lower in rural areas.

Chairwoman JOHNSON. It would be helpful if you could look at that for us, because while certainly incomes tend to be lower in rural areas, the group that have no supplemental in the cities are often just above the Medicaid income levels also. So, I don't know whether they are getting more services because the urban institutions are more accustomed to providing services for uncompensated

care, or they have access to a community health center that can provide those services at an income-related cost.

So what I hear you saying, and I assume that you all agree on this, is that we don't know much about why seniors with no auxiliary insurance experience a 37 percent higher utilization rate than rural seniors. So we don't know how much of that is lack of availability of services and how much of that is availability of services at lower cost in the urban structure.

Dr. CURT MUELLER. Yes. It is important to emphasize you raise a very good point, that there are a number of factors that could explain parts of that difference. Income is certainly one of them.

Chairwoman JOHNSON. Congresswoman Thurman.

Mrs. THURMAN. Thank you, Madam Chairman.

Dr. Curt Mueller, something else in your testimony, especially with the debate that is going on in Congress right now, that was kind of alarming to me, and I am just—maybe you can expand on it. Maybe I shouldn't ask this question because I may not know the answer, but you talked about the idea that Federal subsidization of drug benefit based on income will likely improve access in rural relative to urban areas. I mean, there is a large—high debate going on here about whether it should be under a helping hand or rather it should just be a Medicaid benefit, but just based on this exchange, with a lack of ability for insurance, the lack of Medicare+Choice programs, the lack of, you know, all of these things that rural areas can't get, why would you just do it to low-income and not to look at that whole population out there?

Dr. CURT MUELLER. I wouldn't necessarily limit it just to low-income Medicare beneficiaries, but that certainly is one of the options that is being considered. I personally—my personal view is that it should be offered to all Medicare beneficiaries.

Mrs. THURMAN. Thank you.

And Dr. Keith Mueller then, let me—you know, we sometimes go into our districts, we bring our staffs, we have them go through the hospital, situation very similar to what you did in your study, and I was interested in your comment particularly on the administrative part of it because you talked about the lack of administration to handle some of the complicated issues, or even keeping up with what is going on. What we found in a small rural area of ours, there was about three people in the whole—two were consultants and one was actually staff—in trying to do this.

What I am curious about is that as you know, our Chairwoman and Mr. Stark submitted to HCFA a letter that looked at some administrative procedures that could be put in place to try to get rid of some of this paperwork and cumbersome issues, and I am curious to know if you have had an opportunity to look at that, and if so, do you have any comment; and if not, I would love to give you a copy of it so that you could have an opportunity to review it and see if in any way that helps us in the rural areas.

Dr. KEITH MUELLER. No. I have not had the opportunity to look at that letter and would welcome the opportunity to do so. I would like to comment, though, that it is a—when you talk about the administrative complexity and the burden that it imposes, it is a combination of two factors. One that you mentioned is trying to simplify the administrative rules that we have in place now and proce-

dures that we have in place, but the other that I was also addressing in my testimony is that by trying to continue to resolve issues of payment and sustaining services by tweaking and changing payment formulas, we are structurally contributing to administrative complexities. So that is not under the control just of the administrative agency itself.

Mrs. THURMAN. Dr. Dalton, on the last page, on page 5 in your very last bullet point, you talk about DSH adjustments and saying that that would be certainly something that would be helpful to the rural health community. I understood that. But particularly after MedPAC testified, you actually talk about targeted help in those urban or those rural areas. Can you give us some idea of how you would target so that it didn't become unbalanced then or imbalanced with the rest of the community in the rural health? I am just interested in what kinds of things you would look at to make those targeted areas receive additional dollars.

Dr. DALTON. Well, with respect to the disproportionate share expansion, I think by itself it targets it appropriately because it is related to indigent care, or should be. My thought about offering a cost floor was that this sort of arrangement would automatically target hospitals in bad years that are having difficulty if they qualify as an essential provider on the assumption that that definition of essential provider is something like Dr. Mueller's community-based characteristic. It is a community at risk for one reason or another.

Not all hospitals in these communities at risk need the help. My thought was that a cost floor is able automatically to target the hospitals to help only those hospitals that do. We have also noticed that these very small hospitals are very—their financial position is unstable. Some years they actually can do all right on a prospective payment, and then in other years they won't. It usually has to do with rapid changes in utilization. When you only have 10 beds, the difference between 6 and 12 patients is rather large. The advantage of a cost floor would be that in a bad year it is there to help you, but in a good year you don't need any—you might not need any extra money, and in a good year you might be able to accumulate some surplus, put it away to your reserve, and be able to use that for the purposes to which all organizations need their reserves.

Mrs. THURMAN. Thank you.

Chairwoman JOHNSON. Actually that is a very interesting point you made, Dr. Dalton, that even if we create new categories within those categories, there may not be a—sort of in a sense a stable demand. So what you are really suggesting is that we need—because we have tried to do this with sole providers, and we have categories that have gone directly to the issue we are discussing here, and what you are really suggesting is that we need a sort of a loose category through which hospitals can be heard.

And we know this flies in the face of Dr. Keith Mueller's comments about the need for stability and predictability and simplicity, but I don't know how we match this need of small rural providers for exceptional consideration and communities that need an exceptional view with the need for the system to stop churning change.

I did want to ask any of you if you know how the small providers deal with some of the—particularly the small hospitals—some of the extraordinarily complex changes we have sent down. I had one person who had a lot of experience in the rural areas say they just put the pile of the regulations in the corner, and, you know, when there is a hitch in their payment system, somebody tries to explain to them what the problem is, but they literally don't have the technical capability to review all that stuff, nor the time, nor the resources, nor the programs.

What percentage of the situation—of the facilities deal with some of these—at least some of these administrative directives that way, or do they take everything we say to heart?

Dr. KEITH MUELLER. The percentage that deal with it in the way you describe, Ms. Johnson, is probably higher than we would like to admit. A lot of the small rural hospitals, though, turn to either their association at the State level, especially if it is responsive in particular to rural hospitals, or to consultants, the accounting firm that may handle their books, other consultants that come out. That kind of technical assistance, though, doesn't take care of how do I maintain my records on a daily basis so that when the accountant comes in, the records are ready for he or she to deal with appropriately. And I think that is the level at which we have a real problem.

Chairwoman JOHNSON. You will notice in the letter that Karen referred to is that one of the recommendations is that we be able to provide technical assistance. We do that in other sectors of the economy, and if you will look at that section, all three of you, and see if you have any suggestions for us, we will be interested in that.

The goal is provide better tools to the small providers so that they aren't just trying to make it up as they go along, both in terms of technical advice on equipment and technical advice on systems management.

Mr. ENGLISH. No questions, OK.

The last point I want to raise that—incidentally, I appreciate how detailed your testimony is and how much good information it does give us, and while we can't bring all of that out at the hearing, it will be very useful to us.

On this last issue about the prescription drug bill, you know, the access—and that is why anything you can do to help us shed light on how much of the utilization rate, the very utilization rate between the urban uninsured that is to be on Medicare and the rural uninsured be on Medicare, would be very helpful, because if the barrier is primarily cost and the lack of available, you know, sort of subsidized facilities like community health centers, we need to know that. But also the prescription drug bills, and this is a nonpartisan statement, all of the prescription drug bills on the table involve an additional premium, and 50 percent of the cost of prescriptions. Now, they also are almost likely to be involved this year because of the increased projections in costs for a deductible. So how useful is this going to be to these rural seniors? Again, how do we look at that from a sort of community systems point of view?

We need as much information as you can get us about the access issue, and try to break it down a little bit more and think it

through as to whether we can even deal with it through a reimbursement mechanism that is institution-specific and cost-specific, or whether we really need to try to find a way to look more holistically.

Well, thank you very much for your testimony here and for the thought and care you put into writing it, and if you have follow-up information you want to provide us with, we are always happy to receive it.

Chairwoman JOHNSON. Thank you very much. The hearing is adjourned.

[Whereupon, at 11:55 a.m., the hearing was adjourned.]

[Submissions for the record follows:]

Statement of the American Association of Homes and Services for the Aging

The American Association of Homes and Services for the Aging (AAHSA) appreciates the opportunity to submit this statement for the record of the Subcommittee's hearing on June 12, 2001 on special issues confronting health care providers and consumers in rural areas.

AAHSA is a national organization whose more than 5,600 not-for-profit providers serve over 1,000,000 individuals on a daily basis. Approximately seventy-five percent of AAHSA members are affiliated with religious organizations; others are sponsored by private foundations, fraternal organizations, government agencies, and community groups. Our members include not only nursing facilities, but also independent senior housing, assisted living, continuing care retirement communities, and providers of home health care, adult day care, respite care, meals on wheels, and other services. AAHSA members are characterized by long-standing ties to their communities and a firm commitment to quality.

Providing health care and social services in rural areas present special challenges. According to the Medicare Payment Advisory Commission (MedPAC)'s recent study, "Medicare in Rural America", rural communities share several factors that may affect the supply of medical services to their residents: small and disproportionately older populations, relatively low incomes and less health insurance coverage, physical isolation, and weak or restrictive state health policies.[1] The report also noted that these problems are more severe for providers and consumers in rural areas that are farthest from an urban area.

The rural populations AAHSA members serve are dispersed over large geographic areas, making travel time a significant factor in home- and community-based services. For example, one home care agency in a rural area of New York State is the only health care provider within 5,000 square miles. Its employees routinely travel a total of 7,000 miles every day to serve its widely scattered clientele. The recent escalation in gasoline prices has added enormously to the agency's cost of providing service, but these costs are not reflected in the reimbursement the agency receives, since the payment is based on the projected cost of a one-hour visit.

Rural providers have difficulty attracting health professionals to serve in non-urban settings. In addition, local populations from which rural providers can recruit staff are much smaller than in urban areas, making it that much more difficult for them to recruit and retain the staff they need to provide high-quality care. Health care facilities in rural areas tend to be smaller than average and have less access to sophisticated computer equipment, which makes it more difficult for them to comply with rapidly multiplying federal regulations. Medicare policies do not always give adequate consideration to these factors, making it more difficult for rural providers to meet the needs of their elderly residents and clients.

An overriding problem for health care providers in rural areas is that they simply do not have the volume of patients that can make prospective payment systems work. Prospective payment systems are based on the assumption that higher-than-average cost cases will be balanced by those costing less than the average, allowing the provider to at least break even. When a provider serves a low volume of patients, however, a few costly cases can completely overwhelm the provider's financial situation. In more urban areas, some small health care providers have been able to consolidate with other facilities in order to achieve economies of scale to cope with

[1] Medicare Payment Advisory Commission. Report to Congress: Medicare in Rural America. June 2001, p. 8.

prospective payment systems. Rural health care providers most often do not have this option, since they frequently are the only health care facility in their region. If they close their doors, consumers have no alternative source of health care.

Another factor to consider is that a rural health care provider frequently is not only the sole source of health care for consumers in the area, but often is the largest employer as well. Residents of rural areas typically have few employment alternatives. The closure of a local health care facility, besides throwing many people out of work, can have a major impact on other local businesses and on the local tax base.

AAHSA supports legislation that has been introduced in the House and Senate to resolve Medicare payment inequities toward hospitals in rural areas. However, these measures do not take into account the problems that also face rural nursing homes and home care providers. AAHSA recommends the following additional initiatives to enhance long-term care providers' ability to serve consumers in rural areas:

Eliminate the impending 15% cut in Medicare spending on home health: Home health care fills an especially important place in rural areas, where it often is extremely difficult for consumers with disabilities to access other forms of health care. In addition, the MedPAC report on "Medicare in Rural America" points out two special challenges facing rural home care providers: travel time and low volume. MedPAC noted that "Traveling to serve sparse or remote populations may increase the costs of providing services to rural beneficiaries." In addition, "Because rural HHAs generally deliver fewer visits than their urban counterparts, their low volume could lead to higher per episode costs." The report went on to recommend that CMS study further the impact of the prospective payment system on rural home care providers.[2]

Home health agencies are trying to recover from the financial devastation of the Balanced Budget Act's interim payment system. The new prospective payment system has solved some reimbursement problems. However, an additional 15 percent reduction would cause many more home health agencies to close, which will cause serious access and availability problems for Medicare beneficiaries. Furthermore, the BBA's restrictions on eligibility for Medicare-covered home health services have caused total Medicare spending on home health to fall far below the levels that were projected in 1997, making the additional 15% cut unnecessary. The FY2002 budget resolution passed by Congress sets aside funding availability for the elimination of this spending cut, and AAHSA urges passage of the necessary legislation

Incentives for recruitment and retention of staff: While staffing is a serious problem throughout the long-term care field, it is particularly urgent in rural areas, which have smaller and generally less-educated labor pools. AAHSA strongly supports legislation that has been introduced by Rep. Lois Capps, Senator John Kerry, and Senator Tim Hutchinson to provide a variety of incentives for the recruitment, training, and retention of nursing staff at all levels. These measures include a new program of scholarships for individuals to obtain nursing education in exchange for serving for at least two years in areas with nursing shortages, an enhanced federal Medicaid match for nursing homes' cost of training certified nursing assistants, and grants to meet the costs of child care and transportation for nursing students. It is particularly important that these bills cover staff recruitment, training, and retention for long-term care providers as well as for hospitals and that they provide these incentives for certified nursing assistants and other nursing staff as well as for registered nurses. This legislation would go a long way toward solving the health care staffing crisis, and we urge its passage by Congress.

Single task workers: Because of the difficulty of hiring sufficient numbers of certified nursing assistants, nursing homes in many areas maximized the efficiency of their staffs by training non-nursing staff to help residents with specific tasks such as eating and drinking. Last year, the Health Care Financing Administration, now CMS, notified nursing homes that they would be cited for care deficiencies if they continued this practice. Current law defines a nursing assistant as "any individual providing nursing or nursing-related services to residents in a skilled nursing facility or a nursing facility." The statute requires that nurse aides successfully complete a training and competency evaluation program. The law does not define which specific tasks are considered to be "nursing or nursing-related"; CMS has determined, under its State Operations Manual, which tasks should be so designated. According to the State Operations Manual, assisting residents with eating or drinking is considered to be a nursing-related task.

In the nursing home environment, many employees who are neither nurse aides nor licensed health professionals also have frequent and regular contact with resi-

[2] Ibid, p. 107–110

dents. Permitting these individuals to be trained to help residents at mealtime can offer partial relief to the nurse aide shortage and provide more individual attention to residents. Allowing specially trained non-nursing staff to assist residents who may need only a little help frees certified nursing assistants to help other residents who have more complex needs. This kind of relief is especially important in rural areas, where it is particularly difficult for nursing homes to hire sufficient staff.

AAHSA strongly supports legislation that has been introduced by Rep. Paul Ryan and Senator Herb Kohl to permit nursing facilities to train non-nursing personnel to assist residents with eating and drinking. These employees would augment, but not replace existing staff and would be trained specifically to help with eating and drinking without having to complete the full nurse aide training and competency evaluation program. The interdisciplinary team responsible for the care of the resident would determine resident appropriateness and employee competence and ability to perform these tasks, and the training programs would be reviewed and approved by the state regulatory authority.

Need for regulatory relief: Regulatory requirements that are costly for most long-term care providers become almost insurmountable burdens for providers in rural areas. For example, nursing homes now are supposed to have one full-time compliance officer to ensure that the facility is not violating Medicare payment policies and another full-time employee to monitor the facility's compliance with the privacy requirements under the Health Insurance Portability and Accountability Act of 1996. For small facilities with few administrative staff, devoting two full-time positions to this kind of regulatory compliance is an inefficient use of scarce resources. AAHSA strongly supports the work your subcommittee is doing this year to review the regulatory requirements for health care providers and modify or eliminate those that are non-essential.

Another example of unnecessary regulation that is particularly burdensome for rural nursing homes is the requirement in Section 941 of the Benefits Improvement and Protection Act, that nursing facilities post daily for each shift the current number of licensed and unlicensed nursing staff, in a uniform manner to be designated by HCFA and in a clearly visible place. Again, for nursing homes that have few administrative staff, little computerization, and a shortage of nursing staff, this requirement will take resources away from essential patient care. Furthermore, posting of staffing levels is of little value and is potentially misleading to consumers, since without any reference to the acuity of the residents being served, or an established criterion for appropriate staffing levels based on resident acuity, simple staff numbers are meaningless. AAHSA urges the repeal of this provision.

Regulatory relief for "swing beds": Current law allows small, rural hospitals to enter into agreements under which the hospital can use its beds to provide either acute or skilled nursing care, according to patients' needs. A hospital bed becomes a swing bed when a patient no longer needs acute care but still needs subacute care. Rather than transferring the patient to a different facility, the hospital keeps the patient and is reimbursed at the subacute level. Swing beds may provide access to subacute care for Medicare beneficiaries in many rural areas where there are few other providers of this kind of care. Swing bed patients typically have relatively short stays, averaging approximately nine days.

CMS is beginning to implement provisions of the Balanced Budget Act that will bring swing beds under the skilled nursing facility prospective payment system (SNF PPS). In turn, the SNF PPS is based on a full assessment of a skilled nursing facility resident's condition that is done upon entry and at specific intervals thereafter, recorded on the minimum data set (MDS). CMS has determined that the assessment for payment purposes must be done according to the full MDS, rather than just according to the specific treatments for which reimbursement is claimed.

The full MDS is a detailed and time-consuming process, as it should be. The current requirements are such that skilled nursing facilities with average Medicare volume are forced, as a practical matter, to dedicate the equivalent of a full-time RN to completing assessments rather than providing care if the facilities are to get all of the paperwork completed and submitted on the time schedule required. This requirement is particularly onerous for rural hospitals, which have little experience with OBRA requirements for skilled nursing facilities and which have limited administrative and nursing staffs. It also makes little sense to require rural hospitals to complete the full MDS process for patients who generally will occupy a swing bed for only a few days.

Last year's Medicare and Medicaid Benefits Improvement and Protection Act (BIPA) exempted critical care facilities in rural areas from the requirements of the prospective payment system. AAHSA recommends that a similar approach be taken toward swing beds in rural hospitals, exempting them from completing the full MDS and from the skilled nursing facility prospective payment system. Hospitals could

then be reimbursed for care given to swing bed patients according to the current cost-related basis, which combines a calculated rate and a retrospective component.

Nursing assistant training lockout: Medicare and Medicaid prohibit nurse aide training by or in a nursing facility if the facility within the last two years has: (1) operated under a (staffing) waiver; (2) has been subject to an extended or partial extended survey; (3) has been assessed a civil money penalty of $5000 or more; or (4) has been subject to certain remedies (i.e., denial of payment for new admissions, or temporary management, termination of provider agreement due to a finding of immediate jeopardy, and/or closure of a facility, transfer of residents, or both). These provisions are severely restricting the ability of nursing facilities to train nurse aides and have proved counterproductive to improving quality of care.

There is little argument for approval of a nurse aide training program by a facility that is providing substandard quality of care. However, the prohibition on training once compliance has been achieved and demonstrated is completely arbitrary and poses problems for providers and residents alike. The two-year duration of the nurse aide training "lock-out" severely impedes the facility's ability to recruit and retain adequate and qualified staff, and to assure provision of quality care.

Opportunities to access alternative training programs are frequently limited and many facilities, even after achieving and demonstrating compliance, find it difficult, if not impossible, to secure training for their aides. This problem is particularly severe in rural areas, where the nearest alternative training site may be at a great distance from the facility. The end result can be either new compromises to quality of care or a recurrence of the problems that caused the disqualification from training. The effect of this particular sanction is counterproductive to the improvement of quality, and to the intent of the law that facilities achieve and maintain sustained compliance.

AAHSA urges the elimination of the present two-year prohibition on nurse aide training by or in nursing facilities that are found to be out of compliance with certain federal long term care requirements [Section(s) 1819 and 1919(f)(2)(B)(iii)(I)(b) of the Social Security Act]. Once facilities have corrected their deficiencies and demonstrated compliance, they should be permitted to resume their nurse-aide training programs.

Medicare wage index: Hospitals in rural areas have the option of using the urban wage index in filing reimbursement claims if they can show that they must compete with urban areas in recruiting staff. This option should be extended to rural nursing homes, which also must often compete with urban facilities in recruiting staff.

Telemedicine in long-term care: Telemedicine is a promising new use of technology that holds the potential for greatly improving access to quality health care in rural areas. Section 223 of last year's Benefit Improvement and Protection Act, which expanded Medicare payments for telehealth services provided to rural beneficiaries, did not authorize nursing homes as potential sites, although it did give CMS two years to study additional settings for telehealth services. Nursing homes located in rural areas are often central elements of their communities, familiar to and easily accessed by beneficiaries, and providing ready access to skilled professional services. Including nursing homes as originating sites for telehealth services will benefit not only the community at large, but also the frail elderly population residing in these facilities by improving the breadth and quality of medical services potentially available to them. AAHSA recommends that nursing homes be authorized as telemedicine sites without the additional delay of waiting for the CMS study.

Conclusion: Medicare regulations and payment policies that are problematic for long-term care providers generally can become almost insurmountable for rural providers, who must cope with the special challenges of small patient populations and labor pools and lengthy travel times to serve home care clients. AAHSA looks forward to working with the subcommittee on reforms that will provide essential relief to rural nursing homes and home care agencies and enhance their ability to give the highest-quality health care.

Statement of the Federation of American Hospitals

Madam Chairwoman,

The Federation of American Hospitals would like to thank Chairwoman Nancy Johnson (R–CT), Ranking Member Pete Stark (D–CA), and other Members of the Subcommittee for their attention to rural health care. The House Ways and Means Committee, under your leadership, has remained committed to the needs of rural providers—recently helping to mitigate a number of rural reimbursement problems

through the Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid and SCHIP Benefits Improvements and Protection Act of 2000 (BIPA).

The Federation of American Hospitals (FAH) represents nearly 1,700 privately owned and managed community hospitals across the United States, including over 400 rural facilities. On a daily basis, our doctors and nurses face the daunting task of trying to provide the best and most affordable care to rural communities—all with fewer dollars. This is not a recent development. The communities in which we serve have historically suffered under inequitable Medicare reimbursement rates.

Rural hospitals serve a critical role in the health and well-being of our nation's seniors. With nearly one-in-four Medicare beneficiaries living in rural America, the Federation believes it is vital that Congress more fully understand the unique challenges that these hospitals face. Specifically, hospitals in rural communities: (1) tend to have higher per unit costs; (2) are more dependent on Medicare revenues than are urban hospitals; (3) are often the only provider of the services they render (i.e., when such facilities close, it can affect beneficiaries for miles in all directions); and (4) often have difficulty recruiting physicians and nurses as well as maintaining their patient base.

As you will hear from the Medicare Payment Advisory Commission (MedPAC) today, despite modest legislative adjustments over the past several years, Medicare continues to reimburse rural America far below their urban counterparts. This is despite the fact that rural providers are expected to provide the same standard and level of quality care to their community. The Federation is delighted that MedPAC has made some proactive recommendations, some of which would certainly improve the delivery of care in rural America. However, FAH is concerned that some of these provisions continue to remain too targeted.

In fact, the Federation believes that Congress should look at broader solutions. In particular, we would like to see as part of any rural hospital legislation enacted this year: (1) full Medicare Disproportionate Share (DSH) equity and (2) a Medicare Hospital base payment increase, both with new monies.

Medicare DSH payments are distributed through a hospital-specific percentage add-on applied to the basic DRG payments rates. The intent of these payments is to reimburse facilities for the high cost of treating poor patients. BIPA made some important changes to Medicare DSH payments; most notably, it extended the eligibility threshold of 15% low income share (previously enjoyed by only urban hospitals with 100 or more beds), and increased the DSH cap for rural or small urban to 5.25%

While the Federation appreciates Congress' efforts last year to address the issue of Medicare DSH equity, we would like Congress to take another step forward in correcting this inequity and ensure full Medicare DSH equity. In short, a rural hospital or small urban currently receives a Medicare DSH add-on to each DRG payment—the add-on is limited under current law to 5.25% above the DRG. FAH believes that the 5.25% is arbitrary and artificial, and *if new money were to be used*, the Federation would support eliminating the cap altogether.

The Federation would also like to see Congress once and for all address the Medicare base payment rate—an unequal and inequitable payment difference with no justification in policy. Medicare payment for inpatient care in hospitals is determined by a formula based on a dollar amount known as the base payment. That amount is multiplied by the DRG to reflect the costs of the treatment the patient receives for a particular diagnosis, and adjusted by the relevant wage index, DSH, IME, transfer, etc. There are currently two separate base rates for inpatient payments—one for large urban areas with a population greater than one million ($4,197), and a second encompassing rural and urban areas less than one million ($4,130). The base payment for large urban areas is 1.6% higher. The intent of this rate is to reimburse for the cost of a typical Medicare patient.

The Federation would like to establish one base payment rate at the level of large urban areas. We believe that increasing the standardized amount for the rural and small urban hospitals to the rate of the large urban areas would not only bring more equity to the table, but it would also help these hospitals attract and retain critical hospital labor. The standards of care are the same regardless of location. Whether a patient is being treated in a rural or urban setting, the standards of care the physician employ are the same and should, therefore, be reimbursed the same rate as the large urban areas.

The Federation believes that any comprehensive solution to rural health care should also address the uninsured in rural America. The Federation remains concerned about the health and well-being of those who forego essential health coverage. Clearly, the absence of coverage is a significant contributor to poor health, and delaying or not receiving treatment can lead to more serious illness and avoidable health problems. America's hospitals have and will continue to do their part

to treat the uninsured and indigent in their communities; because every American deserves access to basic and affordable health care services—services that provide the right care, in the right setting, at the right time.

We certainly hope that this testimony sheds some light on what we believe to be constructive solutions to health care delivery in rural America. Thank you and we look forward to working with all Members to address these concerns.

Statement of Hon. Jim Nussle, a Representative in Congress from the State of Iowa

I appreciate this opportunity to express my continued views to the Subcommittee about the need to address the disparities in federal health policy for rural beneficiaries and health care providers.

My home state of Iowa ranks 8th best in the nation for health quality. However, Iowa ranks 48th worst in the nation for overall Medicare reimbursements. The reimbursement levels are not fair to Iowa seniors who rely on Medicare for health coverage, to Iowa taxpayers who pay as much into the system as taxpayers in other states, and to Iowa health care providers who are forced to provide quality care with less than adequate resources.

The disparities in Medicare reimbursement across the country are a result of outdated, complex and burdensome Medicare policies that when written, did not take into consideration the uniqueness of delivering health care in rural states such as Iowa. There lies a distinct rural-urban disparity in the Medicare reimbursement system that has been in existence since the program was created in 1965. The Medicare program has not kept pace with modern medicine and it needs to be modernized.

As Co-chairman of the House Rural Health Care Coalition during the 105th and 106th Congresses, I worked with the Committee to address the unintended consequences of the Balanced Budget Act of 1997 (BBA) on rural health care providers. The Balanced Budget Refinement Act of 1999 (BBRA) and the Medicare, Medicaid, SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) included several provisions for rural beneficiaries and providers such as improved the Critical Access Hospital (CAH) program, provided increased payments to Sole Community hospitals, equalized eligibility under the Medicare Disproportionate Share Hospital (DSH) program, and expanded access to telemedicine services.

The BBRA and BIPA provided much needed, immediate relief to beneficiaries and providers across the country. Congress now needs to address overall access to benefits for rural seniors and policy disparities for rural providers within comprehensive Medicare modernization.

I recently had an opportunity to host a forum with health care providers in my congressional district and representatives from the Health Care Financing Administration (HCFA). The forum proved to be constructive and beneficial to all participants. The health providers pointed to specific areas in Medicare policy that need to be modernized.

First of all, the Medicare hospital inpatient wage index needs to be reformed. It is unfair to all hospitals that the current wage index for fiscal year (FY) 2001 be calculated according to FY 1997 data. I do not know any other labor market that has to compete for qualified professionals with wages based on the market four years prior. Coupled with the questionable calculation that states that 71% of all hospitals' budgets are comprised of wage expenses and outdated methodology for arbitrarily defining hospital labor market areas, hospitals in rural states like Iowa are struggling to obtain and retain qualified professionals.

BIPA required HCFA to collect occupational mix data every three years by FY 2004 and implement a new methodology for using this data by FY 2005. While this is a step in the right direction, there needs to be action taken now to ensure hospitals have the resources available to employ qualified health professionals while keeping their doors open for our seniors until a new methodology can implemented.

Secondly, the national standardized payment rate for hospital inpatient services needs to be reformed. I do not believe there should be two separate inpatient payment base rates——one for rural hospitals and one for urban hospitals that is 1.3% higher. The playing field should be level for the Medicare national standardized payment rate.

Additionally, the CAH program needs to be refined and expanded to include those rural hospitals over 25 beds that are ineligible for the program but need the safety net in order to keep their doors open. I am very pleased with the progress and re-

sults of the CAH thus far. I believe rural beneficiaries can continue to have access to their hometown hospital by expanding CAH eligibility.

Lastly, health providers continue to be bogged down with paperwork and regulatory burdens. During the forum, I was presented with the paperwork requirement for one Medicare beneficiary's home health care incident that, when taped end to end, was 52 feet long. It was a very striking example of the federal government over medicating our health providers with paperwork.

I look forward to continuing to work with Chairwoman Johnson and the Committee to ensure our rural seniors have access to local, quality health care as Congress considers Medicare modernization.

VOLCANO PRESS
Volcano, California 95689–0270
June 15, 2001

Alison Giles, Chief of Staff
Ways & Means Committee
U.S. House of Representatives
1162 Longworth House Office Bldg.
Washington, DC 20515

Dear Alison Giles:

Attached please find a copy of a letter sent to Kaiser Permanente, a major HMO provider in rural California. Let me start by stating that we have never received an answer.

In the letter the Agency on Aging Advisory Council of Area 12 (five rural counties adjacent to Sacramento, CA) asks Kaiser to discuss the issue of many of its members being "red lined" by zip code.

We understand that this is happening as a result of the inequality in capitation rates between urban and rural areas.

We also understand that this problem was created in the Balanced Budget Act of 1997 which instructed HMO's to drop members outside their "service centers".

Please include this correspondence as part of "written statements" for the hearing on Rural Health Care Provider and Beneficiary Issues which took place on June 12, 2001.

Sincerely,

RUTH GOTTSTEIN

AREA 12 AGENCY ON AGING
Sonora, California 95370
March 16, 2001

Lisa Koltun
KAISER PERMANENTE
1800 Harrison Street,
9th floor
Oakland, CA 94612

Dear Ms. Koltun:

The undersigned is a newly formed Health Care Committee for the Area 12 Advisory Council to the Agency on Aging. Area 12 includes five counties: Amador, Alpine, Calaveras, Mariposa and Tuolumne.

This letter also carries the endorsement of the Amador Commission on Aging (see attached).

We would like to meet with representatives of Kaiser Permanente to discuss the problems and impact of being outside the service areas. For seniors, many of whom have been members of Kaiser for over 50 years, this is a tragedy.

Many of us have received notices stating that a decision, based on zip codes, will result in our memberships being terminated. For example, Amador county will be divided by this decision.

At the same time, we constantly see full-page, full-color ads recruiting new members in the Sacramento Bee. We are also aware that Kaiser will be expanding to Elk Grove, Roseville and Folsom, which are nearby communities, and will be lowering members' monthly premiums in Fresno, Kings, Madera, Mariposa and Tulare counties.

Our purpose in meeting will be to discover whether there are ways in which our HMO and we can work together to find solutions to our problems, as we value our many years of excellent services from Kaiser.

We propose that the meeting take place in Amador county, and that once the time and place has been set, we can invite legislators, the California Department of Managed Care, and the media to attend.

We thank you in advance for your consideration in responding to our invitation.

Sincerely,

RUTH GOTTSTEIN
Chair, Health Care Committee, Area 12 Advisory Council

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