Implications of Medicare Restructuring for Rural Areas

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As the American population ages, the Nation's health resources are bearing an increased burden. The elderly are the primary users of health care services, and as their numbers have increased so has spending for the Medicare program. Balanced budget legislation introduced many changes to the Medicare system in an attempt to curb spending. The legislation creates opportunities to improve the rural health delivery system, but low population density, limited managed care experience, and less access to health care providers in rural areas make market-based efficiencies and equity difficult to achieve in rural areas.

Medicare is the Federal health insurance program that in 2000 covered 34 million Americans age 65 and older and another 5 million persons under age 65 with permanent disabilities. The program was enacted in 1965 and went into operation on July 1, 1966, covering 19.1 million older persons. With the aging and growth of the U.S. population, the number of beneficiaries age 65 and older nearly doubled between 1966 and 2000 and is projected to double again by 2030.

Total Medicare spending (benefit payments and all other expenses) has steadily increased since the 1960s. In fiscal year 2001, Medicare benefit payments totaled $239 billion, accounting for 19 percent of national health expenditures (Henry J. Kaiser Family Foundation). The Balanced Budget Act (BBA) of 1997 set out to balance the Federal budget by the year 2002 and to curb Medicare expenditures. The BBA included many changes to the Medicare payment system, turning to the marketplace for managed care options and extending inpatient hospital prospective payment methods to nursing homes, home health care services, outpatient care, and ambulance services (see "Key Legislative Changes for Medicare," p. 39).

Over its history, Medicare has undergone several legislative changes that have redefined the population covered by the program, the benefits to which they are entitled, and the method of payment to physicians, hospitals, and skilled nursing facilities. Medicare has moved from reimbursing providers for their "usual, customary, and reasonable" costs to a series of payment formulas that prospectively set reimbursement levels for each use of a service. This article will examine recent legislative changes to the health care system and Medicare program and payment policies, and the impact of these changes on rural beneficiaries and communities. Overall, 23 percent of Medicare beneficiaries live in rural areas. Fourteen States have more than half of their Medicare populations living in rural areas, with the highest shares of rural beneficiaries in Montana (76 percent), South Dakota (74 percent), and Vermont (74 percent) (Henry J. Kaiser Foundation). Medicare is an important part of the Nation's health care financing system, but it is especially important to rural America because a larger share of the rural population is elderly.

Enrollment in Medicare + Choice Plans Remains Low in Rural Areas

The BBA made significant changes in a number of programs such as Medicare, with direct impacts on rural health care delivery systems. Overall, the legislation creates opportunities to improve the stability of rural delivery systems and for urban-based systems, to extend their influence into rural areas, but it also reduces traditional payment support.

Before the BBA, few nonmetro counties had Medicare + Choice (M + C) plans available. In 1996,

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Definitions

Capitation. A uniform payment payable on a per capita basis; an annual fee paid to a doctor or medical group for each participant enrolled under a health plan.

Risk contracts. Health plans with contracts accepting all insurance risk for enrolled beneficiaries; under such an arrangement, a plan agrees to provide all Medicare-covered services to enrolled beneficiaries for a fixed monthly capitation payment from Medicare.

Medicare. Medicare provides broad coverage of basic benefits, but does not cover outpatient prescription drugs or long-term care. Part A finances 45 percent of benefits and covers inpatient hospital services, skilled nursing facility (SNF) benefits, home health visits following a hospital or SNF stay, and hospice care. Part B accounts for 33 percent of Medicare benefit spending and covers physician and outpatient hospital services, annual mammography and other cancer screenings, and services such as laboratory procedures and medical equipment. Medicare + Choice plans (defined below) contract with Medicare to provide both Part A and B services to enrolled beneficiaries, accounting for about 18 percent of Medicare payments. Home health care is also funded under Parts A and B, accounting for 4 percent of Medicare spending.

Medicare + Choice Plans (M + C plans). The Medicare + Choice program began in 1998 and was intended to provide beneficiaries with a range of options from which to select the Medicare health plan of their preference. The choices include traditional fee-for-service Medicare; managed care plans (HMOs); provider-sponsored organizations (PSOs) and preferred provider organizations (PPOs); medical savings account plans (MSAs), and hybrids that combine fee-for-service payment to providers with capitation to Medicare and beneficiaries. M + C plans offer Medicare beneficiaries considerable benefits (prescription drugs, eye care, and preventive care) beyond the traditional fee-for-service Medicare program. The Medicare + Choice program, as written in the Balanced Budget Act, includes provisions intended to help spread the program into rural areas. These include capitated payment to plans that would retain a fee-for-service payment system for health care providers, contracting with provider-sponsored organizations (PSOs) as managed care plans, and establishing a floor payment for all counties.

Federally Qualified Health Centers (FQHCs). Urban or rural centers that provide comprehensive community-based primary care services to the medically underserved regardless of their ability to pay. FQHCs have two major revenue sources—Medicaid (34 percent) and Federal grant funds from the Health Resources and Services Administration (23 percent).

Rural Health Clinics (RHCs). Established in 1977 to provide primary care services in rural underserved areas, and may be operated either as independent clinics or as parts of larger organizations, such as hospitals. On average, RHCs receive approximately 25 percent of their revenue from Medicaid, and almost 60 percent of their revenue from Medicare and private insurance payments. RHCs operated as an independent practice have always been subject to a maximum cap on reimbursement per visit. The BBA extended the reimbursement cap to provider-based RHCs, exempting only those clinics owned by rural hospitals with fewer than 50 beds.

only 3 percent of nonmetro counties not adjacent to a metro county and 20 percent of nonmetro counties adjacent to metro counties had M + C plans available, compared with 95 percent of central metro and 45 percent of other metro counties (RUPRI, 2001b). Balanced budget legislation created financial incentives to offer M + C plans in rural counties, and increased Medicare payment rates to encourage managed care plans to offer products in areas that previously had low rates.

While enrollment in managed care by Medicare beneficiaries has increased considerably in recent years, it remains quite low in rural areas. And despite the higher payments, the availability of managed care for rural Medicare beneficiaries remains modest at best. In 1997, 22.5 percent of nonmetro counties adjacent to a metro county had an M + C plan available, but availability declined to 20.5 percent by 2000 (RUPRI, 2001b and c). About 4 percent of nonmetro counties not adjacent to metro counties had plans available in 1997, basically the same as in 2000 (RUPRI, 2001b). Many M + C plans either

dropped out of Medicare completely or reduced their service areas in 1999 through early 2001, and these nonrenewals disproportionately affected rural areas. In 2001, 68 percent of rural M + C enrollees in non-renewing plans (compared with 17 percent of urban enrollees) had no other M + C plans to choose from in their area (RUPRI, 2001c).

Under the BBA, provider-sponsored organizations (PSOs) are recognized as entities that may contract directly with the Federal Government to enroll Medicare beneficiaries and to offer M + C plans. PSOs are organizations of physicians, hospitals, and other providers that accept risk through such contracts. In effect, they function both as insurance organizations and providers. With as few as 500 Medicare beneficiaries enrolled and no private-pay enrollees, rural PSOs can contract with Medicare as a health maintenance organization (HMO) and receive capitated payments for those beneficiaries. If States resist licensing PSOs, the legislation allows the Federal Government to do so.

Balanced budget legislation has not dramatically increased the rural availability of M + C plans as intended, with low enrollment in managed care plans in rural counties. Although the rate of payment from Medicare to M + C plans is one factor affecting the availability of M + C plans, county and market characteristics also affect Medicare managed care enrollment. Nonmetro counties with larger Medicare populations, larger populations of "young old" people, higher population density, higher per capita income, and lower percentages of population employed in agriculture and manufacturing are more likely to be included in HMO service areas (McBride and Mueller). These

Key Legislative Changes for Medicare

Balanced Budget Act (BBA) of 1997:

- Influenced payment in the traditional Medicare program by restricting fee-for-service reimbursement;
- Encouraged initiatives to change to different payment systems;
- Created incentives for beneficiaries to enroll in capitated plans (presumably to enhance their insurance benefits);
- Encouraged changing the delivery system;
- Encouraged an emphasis on measuring quality of services;
- Established a National Bipartisan Commission on the future of Medicare, though with no assurance of rural representation.

Balanced Budget Refinement Act (BBRA) of 1999:

- Provided for additional payment to plans that enter underserved counties;
- Enabled plans to re-enter counties earlier than previously allowed.

Medicare, Medicaid, and State Children's Health Improvement Program (SCHIP) Benefits Improvement and Protection Act (BIPA) of 2000:

- Numerous provisions addressed the needs of rural health care providers;
- Replaced the requirement for cost-based reimbursement with a new prospective payment system (PPS), effective January 1, 2001. Under the PPS, the first year's payment is set at a FQHC's or RHC's average cost per visit for 1999 and 2000. Future years' payments are adjusted annually for inflation, and when necessary, for changes in the scope of services;
- Restored some portions of the cuts in growth of inpatient payment, outpatient payment, and payment for bad debt to hospitals. Fiscal relief was provided for sole community hospitals, and the Medicare-dependent hospital program was extended with some recalculation;
- Required that reimbursement to Critical Access Hospitals (CAH) for outpatient clinical diagnostic lab services be cost based. Also established payment for professional services based on 115 percent of the fee schedule;
- Reduced beneficiary copayment for outpatient services, addressing the disproportionate impact of increases in Medicare cost-sharing on rural beneficiaries;
- Provided additional payment for home health services delivered to rural beneficiaries. Changed the definition of the branch office by including technology to provide supervision, and also provided payment for services delivered using telehealth;
- Established a new floor payment of $475 in rural areas and $525 in urban areas for M + C plans, with an update in 2001 of 103 percent phase-in of risk adjustment. Payment in rural areas has been inadequate to induce offering of plans and enrollment in them;
- Provided bonus payments for entering markets where there were no plans previously, including where plans withdrew, and also allowed expansion of service areas during a contract year.

counties also have more community hospital beds and physicians per capita, more commercial managed care enrollment, and higher adjusted average per capita costs for Medicare. Late in 2000, Congress passed BIPA, which will have a significant impact on the payment to M + C plans (these rates went into effect in March 2001).

As health plans meet standards for access to services, rural systems may be strengthened. On the other hand, rural-based systems could be disadvantaged by requirements for open enrollment and disenrollment, and by requirements for information to meet quality assurance standards. Comprehensive quality assurance programs are expensive to develop and operate, and plans most capable of doing so tend to be large plans that can achieve economies of scale in operating expenses. The program of quality assurance, however, does not address questions of geographic access to services—such as distance from primary care, and time to specialty and hospital acute care—and rural inequities in access.

Payments to Medicare Risk Plans Will Increase, But Rural Payments Remain Below Urban Rates

Medicare risk plans or managed care plans have traditionally offered a richer benefit package or lower premiums. Prior to the BBA, Medicare risk plans received a monthly capitation payment based on the adjusted average per capita cost (AAPCC) of serving beneficiaries in the traditional fee-for-service sector. This was problematic for rural areas because payment rates generally fell below rates paid in urban counties, and rates were highly volatile from year to year. The low AAPCC in many rural areas has deterred the expansion of Medicare risk contracting in rural counties.

The BBA replaced the AAPCC payment rate with one in which each county's payment rate is the higher of a local-national blended rate, a national floor payment, or a 2-percent minimum update from the county's prior rate. Payments to health plans offering risk-based plans in rural areas will increase, in some instances substantially. The implementation of the new payment rate improves Medicare risk plan payments to the benefit of most rural areas, reducing the geographic disparities in risk plan payment rates and eliminating the possibility of payment decreases. Both changes should make rural markets more attractive to managed care plans serving Medicare beneficiaries. Rural areas and other areas with low payment rates and/or low Medicare HMO enrollment rates experienced large rate increases between 1997 and 1998 (Mueller et al.). Despite these gains, rural payments continue to fall below urban rates.

Although the BBA was generally perceived as favorable to M + C plans in rural areas, certain limitations became evident as it was implemented. These include limits on increases in payment to M + C plans, requirements for budget neutrality that resulted in delayed implementation of the blended payment formula, an inability to tailor benefits and premiums to segments of service areas, and a requirement to enroll all those who sign up (unless the capacity of the network providers in the plan is exceeded). The BBRA provides additional payments to plans that enter underserved counties and enables plans to re-enter counties earlier than previously allowed. Both of these legislative changes could benefit rural areas.

Prospective Payment Will Take Into Account Low Volume in Rural Health Care Facilities

The Medicare program is designed to make fair payments to providers by covering the costs of an efficient provider, and adjusting for factors beyond what the provider is accountable for. Low patient volume results in underpayment by Medicare to small rural hospitals. In 1998, Medicare payments to all hospitals totaled 2.6 percent over their Medicare costs (Atkinson). In contrast, Medicare payments to rural hospitals are 6.4 percent under their Medicare costs; payments to small rural hospitals (under 50 beds) are 11.1 percent under costs (Atkinson). A prospective payment system would take account of the impact of low volume (due to low population density) on the cost per unit of service where the service preserves access to care in the area.

The hospital flexibility program, introduced under the BBA, relaxes some Medicare rules to give hospitals flexibility in the delivery of health care services and to allow small rural hospitals to continue functioning as institutions eligible for Medicare cost-based reimbursement. The program is designed to encourage small hospitals (fewer than 15 acute care beds) to become Critical Access Hospitals (CAHs), patterned after existing rural primary care hospitals. CAHs would not be required to have the same staffing complement as full-service acute care hospitals.

Because Medicare payments to small rural providers are a fraction of total Medicare payments, payment inequities could be corrected at little cost to Medicare. First,

there is a long-recognized bias toward urban hospitals in the payments that Medicare makes to hospitals shouldering a disproportionate share of low-income patients, known as disproportionate-share hospitals (DSH). And second, Medicare's geographic wage adjustment, which is supposed to account for differences in urban and rural labor rates, undercompensates many rural hospitals. Adjustments in these two areas would have a minimal financial impact, as small, low-volume rural hospitals are reimbursed for the higher per-unit cost they incur in providing care under prospective payment.

A vast majority of Medicare payments will continue to flow through the traditional fee-for-service system, at least for the near future. Those payments are constrained in the balanced budget legislation in order to achieve budget savings by reducing the deficit and/or saving the Medicare trust fund. For the immediate and near-term future, Medicare payment to rural providers will continue to be through the existing rules, as fewer than 10 percent of rural beneficiaries are covered under any other arrangement.

Payment changes in Medicare can affect rural hospitals more dramatically than urban hospitals because rural hospital operating margins are lower, sometimes even negative. Changes that lower Medicare outpatient payments could lower operating margins further. Shortfalls in Medicare revenues for rural hospitals include payments for home health, skilled nursing care, bad debt, and post-acute transfers. Home health payments were reduced by the BBA, and nursing home payments will bundle previously separate payment for therapists into a single facility rate. These changes may lead to home health agencies avoiding high-cost patients or reducing services per user. Moreover, rural nursing homes may have difficulty recruiting physical therapists as employees.

New prospective payment systems to replace cost-based payment systems for outpatient care, skilled nursing, home health care, and ambulance services will profoundly affect rural providers because rural hospitals are more dependent on Medicare reimbursement than urban hospitals.

Medicare payment-to-cost ratios reported by the American Hospital Association's annual survey show the initial impact of prospective payment under the BBA. Overall, Medicare payments for rural hospitals were 6.4 percent less than their costs in 1998, down from their 3.9-percent loss in 1997. In contrast, Medicare payments for large urban hospitals exceeded their costs by 4 percent (Atkinson). The downward turn in 1998 for rural hospitals and Medicare revenues reflects only the leading edge of changes due under the BBA and the extension of prospective payment.

New prospective payment systems to replace cost-based payment systems for outpatient care, skilled nursing, home health care, and ambulance services will profoundly affect rural providers because rural hospitals are more dependent on Medicare reimbursement than urban hospitals. Medicare costs as a percentage of total hospital costs/patient expenses in 1999 accounted for 45 percent of rural patient care expenses, compared with 34 percent of urban hospitals (Wakefield). A rural provider infrastructure that is already thin could suffer under the expansion of prospective payment. Hospitals and other small rural providers are likely to lose revenue as the new prospective payment systems are implemented. However, balanced budget legislation (BBRA) may ameliorate some of these adverse effects. The BBRA protects hospitals up to 100 beds, or fully 82 percent of all rural hospitals, and BIPA provides some fiscal relief for certain hospitals and programs.

Rural Implications

Over the past three decades, health spending and hospital use increased more for the elderly than for persons under age 65. This greater spending may reflect legislative developments such as the fee-for-service nature of Medicare and/or changes in the health care delivery system such as the rapid growth in managed care enrollment among persons under age 65. Regardless, when the leading edge of the baby boom reaches age 65 in 2010, there will be increased needs in terms of health services, finances, housing, and social and psychological support for elders in poorer health.

Rural Medicare beneficiaries face greater income-related barriers to health care access. The rural elderly have lower per capita incomes and higher out-of-pocket

expenses than urban elderly beneficiaries. Rural beneficiaries have greater health care needs, use fewer preventive services, and are more ill at hospitalization. They are also burdened by fewer financing options and greater travel distances to health care, but the greatest barrier appears to be cost of care. Data from the 1995 Medicare Current Beneficiary Survey show that rural beneficiaries spend $2,700 out of pocket (23 percent of their income) on annual medical expenses while urban beneficiaries spend $2,540 (18 percent). Furthermore, the threat of hospital closures, fewer medical professionals, and lack of specialty services can confound access problems for rural Medicare beneficiaries. Because Medicare payments represent a substantial portion of the total revenues for many rural providers, changes in the Medicare program introduced by the BBA will have a significant impact on the financial well-being of small rural hospitals and the delivery and use of services in rural areas.

Balanced budget legislation provides new opportunities in Medicare programs and reimbursements for rural areas, but even with these changes, rural areas will not achieve equity with urban areas.

Rural characteristics such as low population density, limited managed care experience, limited access to health care providers, and poorer beneficiary health discourage managed care options in rural areas. In many rural areas, the number of persons and population density are not sufficient to support competition among several plans. In areas with few providers, HMOs and other health plans may have problems getting providers to contract with them. Even in rural areas where managed care plans are offered, beneficiaries may face a more limited menu of benefits.

Critical issues in rural health care include access to services, payment to providers, quality of services, and choices for beneficiaries. Remote rural beneficiaries are less likely to have access to certain types of care—timely electrocardiograms, timely gall bladder removal, timely followup after hospital discharge, and screening mammograms (RUPRI, 2001a). Quality of care is an issue for rural communities, and such factors as size and scope of facility/practice vary dramatically among rural communities and affect health care availability.

Reductions in Medicare payments threaten the financial viability of many rural providers, especially home health agencies and skilled nursing facilities that might reduce services and/or be selective in who they see. Most of the savings in the BBA resulted from changing reimbursement paid through the traditional Medicare program to limiting annual payment increases and converting cost-based reimbursement to prospective payment systems. Rural health care providers are likely to look increasingly to consolidation of service networks, including participating in urban-based systems.

Medicare provides significant health insurance at relatively little or no cost, but it offers very limited coverage of long-term care services—whether in the community or in a nursing home—and much of the cost is borne by older people and their families. The need for long-term care will most likely increase with the growth of the oldest segment of the older population. Rural communities are usually economically concentrated in a relatively small number of industrial sectors and are more limited in public sector capacity than urban areas, affecting the range of services available to older persons. Rural retirement areas have increasing populations and tax bases, putting them in a better position to meet the increasing demands for medical and social services than rural areas dependent on farming and mining.

Balanced budget legislation provides new opportunities in Medicare programs and reimbursements for rural areas, but even with these changes, rural areas will not achieve equity with urban areas. Studies of the impact of the BBA on rural health systems show low rural enrollment in M + C plans and lower reimbursement payments than in urban areas. Provisions of the BBRA and BIPA could help overcome some of the structural barriers to equity in rural health care systems. The challenge for rural health care providers, communities, and advocates is to be first in organizing and establishing rural-based health plans. Provisions in the balanced budget legislation for critical access hospitals, payment for services provided through telemedicine, and a grant program for network development support such work. The key is to support local development as opposed to large outside health plans (such as national companies that recently withdrew from rural markets under the new M + C experiment).

The most recent budget law—the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000—contains numerous provisions addressing the needs of rural health care providers. Yet, if significant shortfalls in Medicare funding occur, the underserved rural communities and populations could easily fall through the cracks. Ensuring that underserved rural communities and older people receive public funding for these services is critical for improving the capacity of the rural health care system to meet the growing needs of rural elders and their families. RA

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