

Issues in Rural Health

How Will Measures To Control Medicare Spending Affect Rural Communities?

Paul D. Frenzen

The Federal Medicare program provides subsidized health insurance for one in every seven Americans. Medicare covers a higher proportion of rural than urban residents because rural residents are more likely to be elderly or disabled persons entitled to benefits. The rapid growth of Medicare expenditures has prompted legislative proposals to control the increase in spending. The proposals may have a greater effect on rural than urban communities due to the higher proportion of Medicare beneficiaries in rural areas.

The Medicare program was established in 1965 to provide subsidized health insurance for the elderly aged 65 or older. The program was later expanded to include certain disabled persons under age 65, and the range of benefits was increased [see box, "The Medicare Program"]. By 1995, Medicare covered 14 percent of the U.S. population and paid for 20 percent of all personal health care expenses due to the higher health care costs of the elderly and disabled than other persons.

Real Federal Medicare expenditures have grown rapidly since the late 1980's, and have absorbed an increasing share of the Federal budget (fig. 1). Actuarial projections indicate that the Medicare Hospital Insurance Trust Fund will become insolvent by 2001 if present trends continue. The

rapid growth of Medicare expenditures has been due to several factors, including technological change in medical care, the expansion of benefits, increases in the per capita use of health services, medical price inflation in excess of general price inflation, and the growth and aging of the U.S. population.

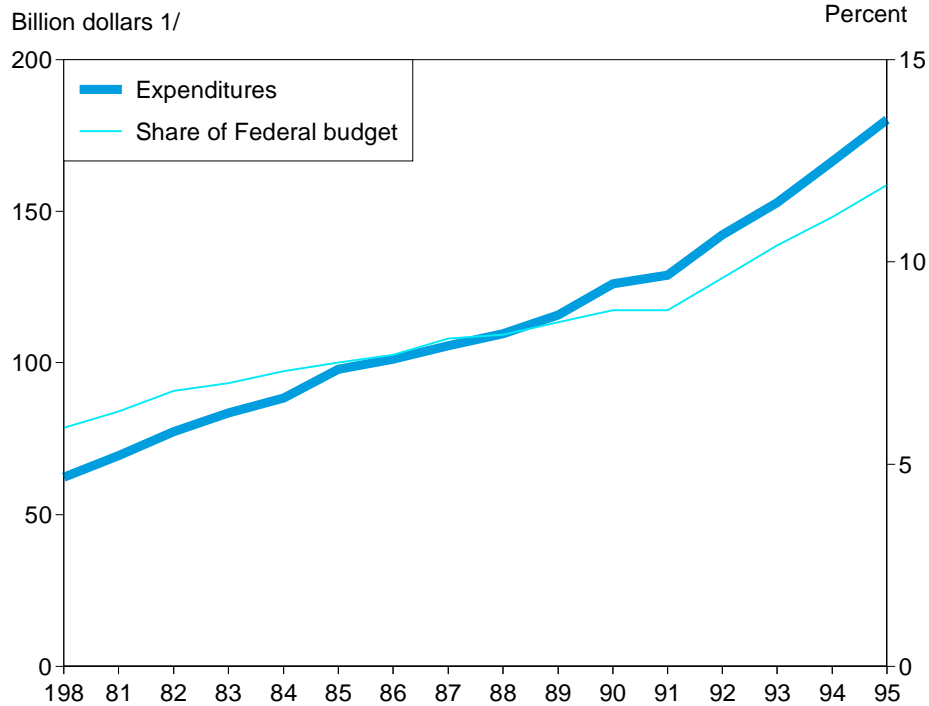
Concern about the effect of rising Medicare expenditures on the Federal budget has prompted proposals by Congress and the Clinton Administration to slow the growth of spending. These proposals may have a greater effect on rural than urban communities because rural residents and health care providers depend more on Medicare than their urban counterparts. The challenge for policymakers will be to control Medicare spending without disproportionately

The Medicare Program

Medicare is divided into two parts. Part A (Hospital Insurance) covers hospital, nursing home, hospice, and home health care. Part B (Supplementary Medical Insurance) covers physician services, laboratory and diagnostic tests, and other outpatient care. All Medicare beneficiaries receive Part A, and may voluntarily enroll in Part B. Part A is financed through the Hospital Insurance Trust Fund, which is funded by the Social Security Hospital Insurance payroll tax on workers and employers. Part B is financed by general Federal revenues and a monthly premium paid by enrollees, which is presently equal to 25 percent of the cost of Part B benefits. Beneficiaries are also liable for deductibles, copayments, and physician charges in excess of standard Medicare fees. The population entitled to Medicare includes elderly persons eligible for Social Security retirement benefits, nonelderly persons receiving Social Security or Railroad Retirement disability payments following a 2-year waiting period, and persons with chronic kidney disease. Elderly persons who are ineligible for Social Security can enroll in Part A if they pay the full cost of benefits. Most persons covered by Part A also choose to enroll in Part B.

Figure 1

Federal Medicare expenditures

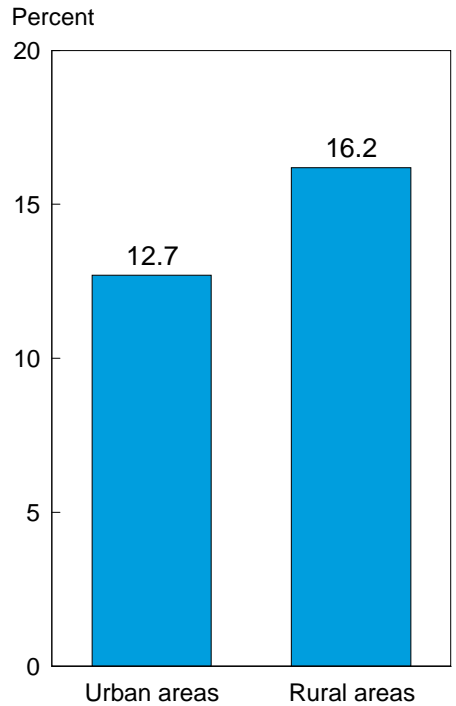


1/ Constant 1995 dollars.

Sources: Budget of the United States Government and Bureau of Economic Analysis.

Figure 2

Share of population with Medicare coverage, 1992



Source: Economic Research Service (ERS), based on Rural Policy Research Institute.

affecting rural Medicare beneficiaries or health care providers. This report describes the Medicare program in urban and rural areas, and assesses the potential impact of proposals to control spending on Medicare beneficiaries and health care providers.

Rural Communities Depend More on Medicare

Medicare is a more important source of health insurance and physician and hospital revenue in rural than urban areas, although Medicare spends less per beneficiary in rural areas [see box, “How Are Rural Areas Defined?”].

Medicare Covers a Higher Proportion of Rural Residents

Medicare covers a higher proportion of the population in rural than urban areas (fig. 2). The rural coverage rate

is higher because rural residents are more likely to be elderly or disabled than urban residents (table 1). The higher proportion of elderly in rural areas is due to the immigration of elderly retirees from urban areas and the simultaneous outmigration of young rural adults in search of urban jobs and educational opportunities. The causes of the higher disability rate in rural areas are less clear, but may include the higher level of employment in industries with high accident rates. Many nonelderly persons who report disabilities have not been officially certified as disabled and are not entitled to Medicare.

The areas of the country with the highest proportion of Medicare beneficiaries include parts of the rural Midwest and Great Plains (fig. 3). Only a few urban areas have comparably high proportions of beneficia-

ries, notably in Florida and Pennsylvania.

Rural Beneficiaries Have Lower Incomes and Poorer Health

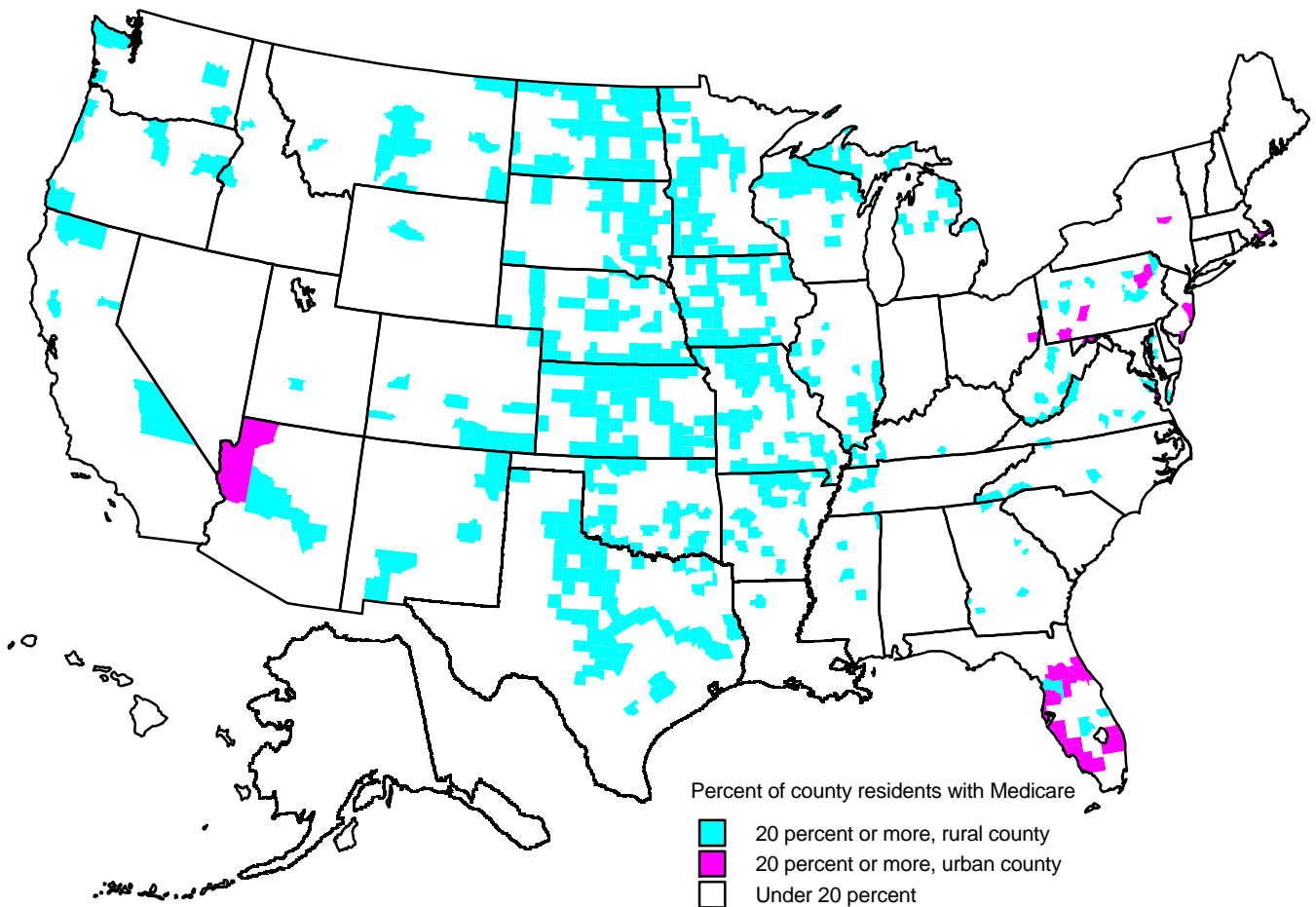
Rural Medicare beneficiaries have lower incomes and are more likely to fall below the poverty level than urban beneficiaries (table 2). The income difference is partly due to the lower wages in rural than urban areas, which reduce Social Security retirement benefits for rural workers.

Health surveys indicate that the health of rural Medicare beneficiaries is poorer than that of urban beneficiaries. In particular, rural beneficiaries are more likely to be chronically disabled than urban beneficiaries, and a higher proportion of rural beneficiaries are reported to be in only fair or poor health (table 2).

How Are Rural Areas Defined?

The definition of urban and rural areas used in this report is based on the official classification of metropolitan areas by the U.S. Office of Management and Budget (OMB). Urban areas include counties in metropolitan areas, and rural areas include nonmetropolitan counties. The OMB definition was updated in 1993 to reflect changes in urbanization since the last revision of the definition in 1983. The update reduced the proportion of the U.S. population in nonmetropolitan counties to 21 percent, but had little effect on other metropolitan-nonmetropolitan differences. Most of the information about urban and rural areas reported here is based on the 1983 OMB definition. Some information about recent Medicare expenditures is based on the 1993 OMB definition.

Figure 3
Share of Medicare beneficiaries by county, 1991



Source: Compiled by ERS based on data for the total population (including persons in institutions) from the Health Care Financing Administration and the U.S. Bureau of the Census.

Table 1—Elderly and disabled persons

| Item | Urban | Rural |
|--|----------------|-------|
| | <i>Percent</i> | |
| Elderly persons aged 65+, 1994 | 11.3 | 14.3 |
| Disability rate for persons aged 18-64, 1993 | 5.6 | 7.4 |

Note: Estimates for civilian noninstitutional population. Disability was assessed by survey respondents based on ability to work.

Source: Calculated by ERS using data from March 1995 Current Population Survey and 1993 Health Interview Survey.

Table 2—Income and health status of Medicare beneficiaries

| Item | Urban | Rural |
|--|----------------|--------|
| | <i>Percent</i> | |
| Income, 1994: | | |
| Below poverty level | 12.4 | 16.5 |
| \$50,000 or more | 12.3 | 6.4 |
| Median (dollars) | 17,960 | 15,547 |
| Health status, 1993: | | |
| Chronically disabled | 42.7 | 45.8 |
| Health only fair or poor | 29.7 | 35.1 |
| Health insurance, 1992: | | |
| Private retirement or medigap coverage | 79.9 | 73.6 |

Note: Estimates for civilian noninstitutional population. Health status was assessed by survey respondents.

Source: Calculated by ERS using data from March 1995 Current Population Survey and 1993 Health Interview Survey, and by Health Care Financing Administration using data from 1992 Medicare Current Beneficiary Survey.

Medicare Is a Valuable Benefit for Rural Beneficiaries

Medicare payments for health services averaged \$4,928 per beneficiary in 1995, making Medicare coverage a valuable noncash benefit. Medicare coverage may be more valuable for rural than urban beneficiaries because rural beneficiaries have less to spend on health care and experi-

ence poorer health. However, determining the cash value of Medicare coverage for beneficiaries is problematic because low-income individuals unable to meet basic food and housing needs may not be willing to pay the full market price for health insurance.

Medicare provides only partial protection against medical expenses

because most beneficiaries remain liable for deductibles, copayments, Part B premiums, and excess physician charges. The out-of-pocket costs of Medicare coverage averaged \$1,370 per beneficiary in 1995, and were potentially much higher for persons with serious health problems. Most beneficiaries are protected against high out-of-pocket costs by some type of supplemental health insurance, including retirement benefits from former employers, standardized private policies (known as “medigap” coverage), or Medicaid coverage for qualified low-income beneficiaries. Rural beneficiaries are less likely to have retirement or medigap coverage than urban beneficiaries, and consequently depend more on Medicaid or their own savings (table 2).

Medicare Spends Less on Rural Beneficiaries

The average Medicare expenditure per beneficiary was 20 percent lower in rural areas than urban areas in 1994. Medicare payments to health care providers are adjusted for geographic variations in medical input prices and are lower in rural areas, accounting for part of the difference in spending. The remainder of the difference reflects geographic variations in the use of health care.

A recent analysis by the Physician Payment Review Commission found that nearly half of the difference in average Medicare expenditures between urban and rural beneficiaries in 1993 was due to lower health care use by rural beneficiaries. Other evidence indicates that rural beneficiaries have less adequate access to health care and use fewer physician services than urban beneficiaries. However, it is unknown whether rural beneficiaries underuse health care or whether their health suffers as a result.

Medicare Provides Larger Share of Rural Physician and Hospital Revenue

Medicare payments represent a larger share of revenue for rural physicians (fig. 4) and hospitals (fig. 5) than their urban counterparts despite the lower Medicare payments per beneficiary in rural areas. The difference in revenue shares reflects the higher proportion of beneficiaries in rural areas.

Medicare plays an even greater role in funding local health care systems in parts of the rural Midwest and Great Plains with many elderly residents, where 45 percent or more of hospital net patient revenue is provided by Medicare payments (fig. 6).

Proposals To Control Medicare Spending Will Affect Rural Communities

Recent legislative proposals to slow the growth of Medicare spending have focused on reducing spending below projections for 1997-2002 in order to postpone the insolvency of the Hospital Insurance Trust Fund. The proposals include the following:

- Increasing the share of costs paid by Medicare beneficiaries.
- Slowing the growth of Medicare payments to physicians, hospitals, and other health care providers.
- Improving access to managed-care plans to encourage more beneficiaries to join plans.

The groups most likely to be affected by these proposals include low-income beneficiaries, health care providers with many Medicare patients, and communities served by less competitive providers.

Increasing the Share of Costs Paid by Beneficiaries

Medicare beneficiaries were liable for 24 percent of the total cost of

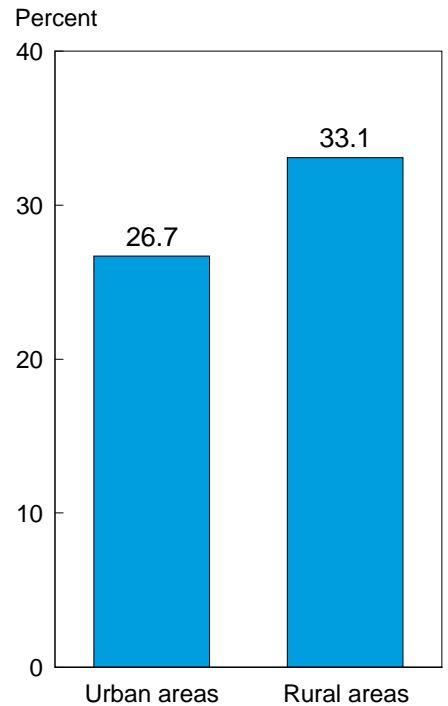
health services covered by Medicare in 1995, including deductibles, copayments, Part B premiums, and excess physician charges. Proposals to increase the share of Medicare costs paid by beneficiaries will reduce the corresponding Federal share of costs, but may have little effect on the demand for services or total expenditures.

Policy options to increase the share of Medicare costs paid by beneficiaries include (1) raising the monthly Part B premium (currently \$43.80) for all beneficiaries, (2) cutting the Federal subsidy of Part B benefits (now about \$1,577 per year) for high-income beneficiaries, and (3) raising Medicare deductibles or copayments (which include a \$760 deductible per hospital episode, a \$100 annual deductible and 20-percent copayment for physician and outpatient services, and copayments for extended hospital and nursing home stays ranging from \$95 to \$380 per day). Higher deductibles or copayments will affect beneficiaries with medigap policies as well as those who use health services because private insurers are likely to raise medigap premiums to cover the higher costs.

A general increase in Medicare premiums, deductibles, or copayments will have a relatively greater effect on rural than urban beneficiaries because rural beneficiaries have lower incomes. Conversely, cuts in the Federal subsidy of Part B benefits for high-income beneficiaries will probably affect a smaller proportion of rural than urban beneficiaries because fewer rural beneficiaries have high incomes (table 2).

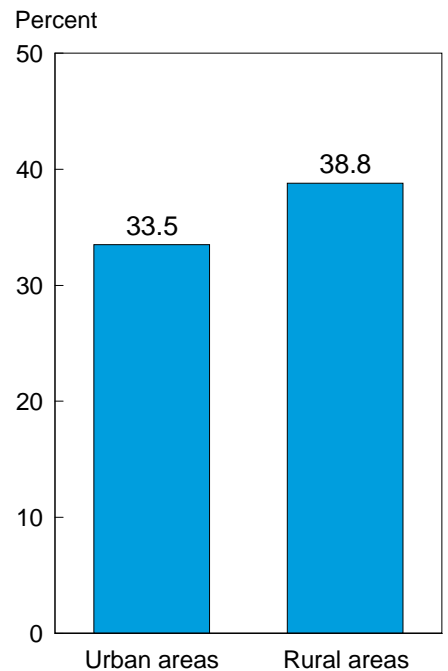
The effect of higher Medicare premiums, deductibles, or copayments on low-income beneficiaries will also depend on separate legislative proposals to control Federal Medicaid spending. Low-income beneficiaries entitled to Medicaid will face higher out-of-pocket Medicare costs unless

Figure 4
Share of physician gross practice revenue from Medicare, 1994



Source: Calculated by American Medical Association from 1994 survey of non-Federal patient care physicians.

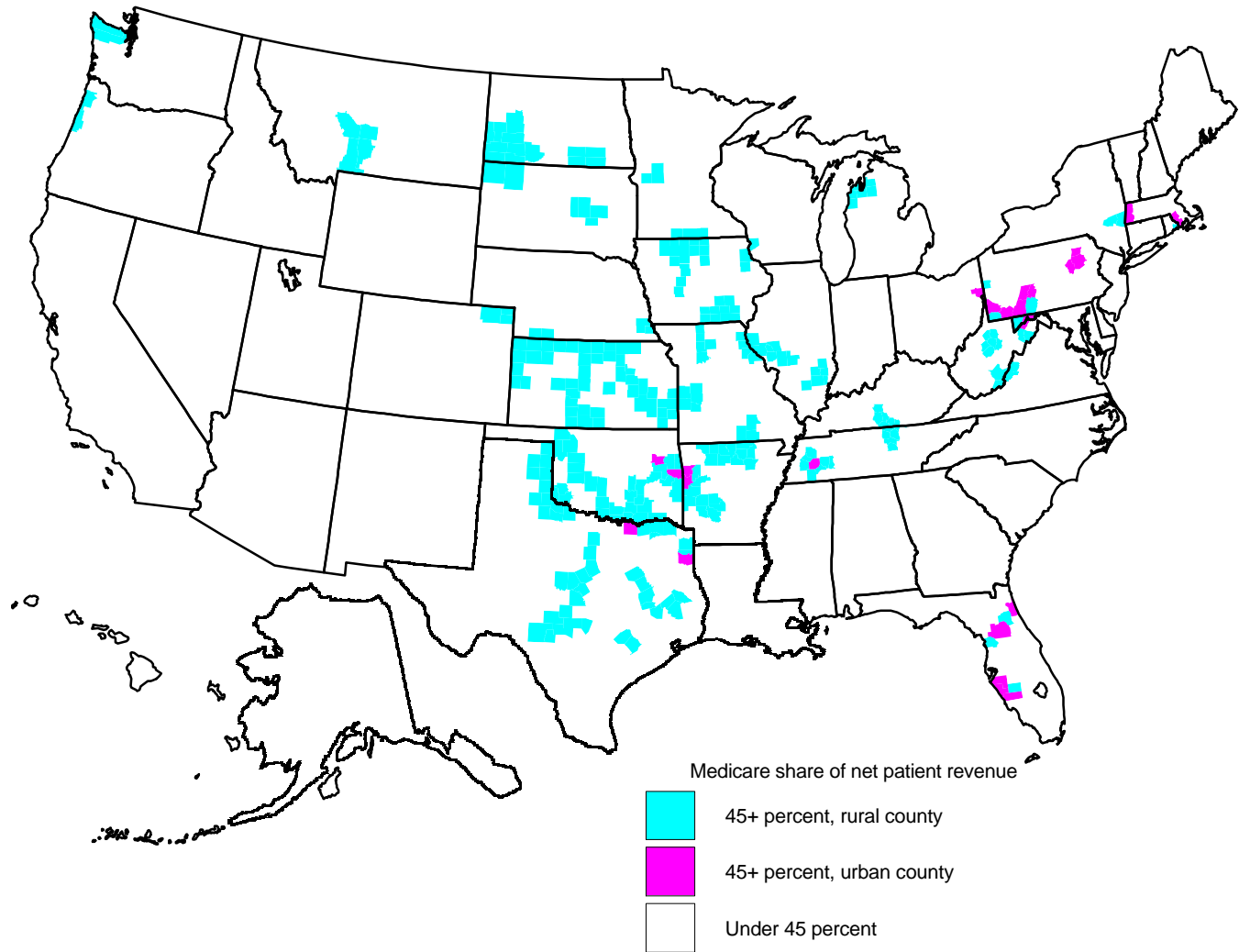
Figure 5
Share of community hospital net patient revenue from Medicare, 1993



Source: Calculated by American Hospital Association using data from 1993 Annual Survey of Hospitals.

Figure 6

Areas where Medicare provides a large share of community hospital revenue, 1993



Note: Counties are combined into areas with at least three hospitals.
 Source: Calculated by ERS from 1993 Annual Survey of Hospitals.

funding for Medicaid coverage of low-income beneficiaries is increased. Changes in Medicaid coverage are likely to affect a higher proportion of rural than urban beneficiaries due to the higher poverty rate among rural beneficiaries.

Many health care analysts think the present system of Medicare cost-sharing raises the demand for health services because beneficiaries with supplemental health insurance are largely insensitive to the actual cost

of services. Higher Medicare premiums, deductibles, or copayments may consequently have little effect on the demand for services because the out-of-pocket costs of Medicare coverage for most beneficiaries will remain unrelated to their own use of services.

Slowing the Growth of Medicare Payments for Health Care Providers

Medicare payments for health care providers are based on a system of

fee schedules updated annually for price inflation. Some categories of providers receive supplemental payments to support medical education programs and health care for poor and underserved populations. Important supplemental payment categories in rural areas include Sole Community Hospitals in rural places with only one hospital, Rural Referral Hospitals serving large health care markets, and physicians practicing in federally designated Health Professional Shortage Areas.

The growth of Medicare payments for health providers could be readily slowed by lowering the annual updates of fee schedules. Recent legislative proposals to control Medicare spending depend primarily on this policy option.

The effect of lower Medicare payment updates on health care providers is uncertain because the rapid expansion of managed-care plans is already forcing providers to cut costs and compete more vigorously for patients. The effect will also depend on how the reduction in projected payments is allocated among different categories of providers.

An across-the-board reduction in Medicare payment updates will have a relatively greater financial effect on rural than urban providers because Medicare payments represent a larger share of revenue for rural providers. The effect on rural providers could be mitigated by limiting the size of the reduction for providers with a high proportion of Medicare patients, or else increasing supplemental payments for categories of providers with many rural members.

Although health care markets are becoming more competitive, there is a risk that lower Medicare payment updates will reduce revenue from Medicare patients below the actual costs of care. Physicians can respond to inadequate Medicare fees by imposing excess charges (within prescribed limits), providing more services per patient, or else refusing Medicare patients. However, hospitals must treat Medicare patients and accept Medicare fees as payment in full.

The restrictions on hospital market behavior are important because Medicare payments for hospitals have fallen below hospital costs for treating Medicare patients since the

mid-1980's. The total payment shortfall declined to \$3 billion in 1994, but hospitals continue to shift unreimbursed Medicare costs to consumers in the form of higher charges for private patients. Under the current payment system, rural hospitals incur greater Medicare losses and charge relatively more for private patients than do urban hospitals (table 3).

The possible consequences of lower Medicare payment updates for hospitals are uncertain, but could include higher hospital losses on Medicare patients, an increase in hospital cost shifting to private patients, a rise in health insurance premiums as insurers respond to higher hospital charges for private patients, and the closure of less competitive hospitals. Many health care analysts expect that the increasing competition in health care markets will force relatively more rural than urban hospitals to close regardless of changes in Medicare payments because a higher proportion of rural hospitals have financial deficits (table 3). Hospital closures may tend to have a more adverse effect on access to care in rural than urban areas because the nearest alternative facility is likely to be further away in rural areas.

Improving Access to Managed-Care Plans

Most Medicare beneficiaries choose their own physician and obtain health care on a fee-for-service basis. Beneficiaries can also enroll in certain types of managed-care plans, but only 11 percent of beneficiaries were plan members in 1996. Participating plans are much less widespread in rural than urban areas (fig. 7). Few rural beneficiaries are consequently enrolled in plans (fig. 8).

The potential ability of managed-care plans to curb unnecessary use of health services and cut costs has attracted the attention of policymakers [see box, "How Managed-Care Plans Work"]. Recent legislative proposals to provide Medicare beneficiaries with better access to plans anticipate that plan enrollment will rise in response, slowing the growth of Medicare spending. Policy options to make plans more widely available include: (1) raising Medicare payments for managed care to attract more plans to serve beneficiaries, (2) relaxing antitrust restrictions on physician ownership of plans, and (3) changing Medicare program rules to allow more plans to enroll beneficiaries.

Table 3—Hospital Medicare losses and cost shifting

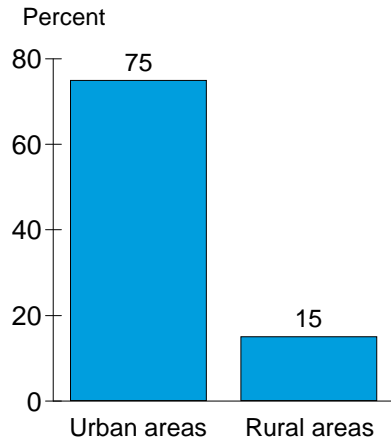
| Item | Urban | Rural |
|---|---------|-------|
| | Percent | |
| Losses from Medicare patients as share of total costs, 1994 | 2.5 | 3.7 |
| Payment-to-cost ratio for private patients, 1994 | 129.1 | 138.7 |
| Hospitals with negative total margins, 1994 | 19.5 | 25.1 |

Note: Data for non-Federal community hospitals. The total margin is the difference between total revenue and expenses expressed as a percentage of total revenue. Information on total margins is based on different reporting periods and excludes hospitals in Maryland.

Source: Calculated by Prospective Payment Assessment Commission using data from 1994 Annual Survey of Hospitals and Health Care Financing Administration.

Figure 7

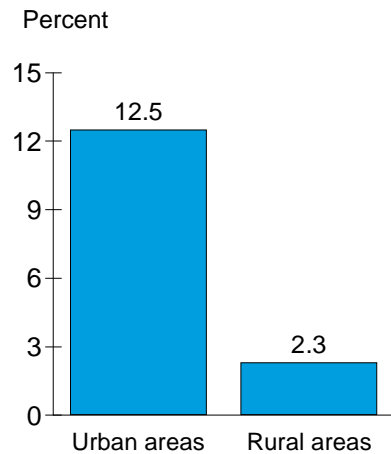
Proportion of Medicare beneficiaries in counties served by managed-care plans, 1994



Source: Calculated by Prospective Payment Assessment Commission using data from Health Care Financing Administration.

Figure 8

Proportion of Medicare beneficiaries enrolled in managed-care plans, 1995



Source: Calculated by Prospective Payment Assessment Commission using data from Health Care Financing Administration.

The effect of higher Medicare payments for managed care on the availability of managed-care plans will depend on the size and distribution of the payment increase. Under the current Medicare payment system, most participating plans receive a monthly payment for each Medicare

enrollee, risking losses if the average cost of care exceeds the payment. The monthly payment is based on Medicare fee-for-service costs in each county, adjusted for variations in medical input prices and the characteristics of beneficiaries. In 1995, the monthly payment ranged from \$177 in some rural areas to \$679 in New York City, and was 25 percent lower on average in rural areas (\$323) than urban areas (\$428). Plans consequently tend to serve urban areas with high payments and many beneficiaries and health care providers rather than other areas.

Medicare managed-care payments could be raised in areas without plans to encourage plans to enter less attractive health care markets, but the current payment system may need revision to avoid either overpaying or underpaying plans. Plans might require high payments to enter rural markets where shortages of health care providers, low population densities, or long travel times raise the costs of delivering comprehensive care. The cost of attracting plans to such areas could become an issue if the required payments exceed local Medicare fee-for-service costs.

Proposals to relax antitrust restrictions on physician ownership of managed-care plans could make plans more widely available by encouraging more physicians to participate in plans. Many physicians are reluctant to contract with plans owned by third parties who might interfere in medical decisions. Physicians also tend to be wary of payment arrangements involving financial risk. However, physician ownership of plans is restricted by current antitrust guidelines, which bar physician-owned plans from including more than 30 percent of local physicians in any specialty and require physician owners to assume significant financial risk. Changes in the guidelines could allow physicians in smaller markets to form indepen-

dent plans, particularly in rural communities with few physicians. Other legislative measures might be needed to provide effective oversight of physician-owned plans and prevent the establishment of local monopolies that reduce consumer choice.

Proposals to change Medicare program rules to allow more managed-care plans to serve beneficiaries could also increase the availability of plans. Current rules generally limit plan participation to Health Maintenance Organizations (HMO's), and exclude most other types of plans from the Medicare market. Rule changes permitting other types of plans to enroll beneficiaries could increase the number of participating plans in both urban and rural areas if other factors remain constant.

Questions About Managed Care

Some health care analysts doubt that managed-care plans will be able to enroll a high proportion of Medicare beneficiaries because many of the elderly are apprehensive about plan restrictions on their choice of physician. Many analysts also question whether higher plan enrollment will reduce Medicare spending because plans have financial incentives to selectively enroll healthy beneficiaries expected to incur lower health care costs, leaving ill and disabled beneficiaries in fee-for-service arrangements. Selective enrollment may be even more rewarding for plans in rural than urban areas because rural beneficiaries are less likely to be in good health than urban beneficiaries. The incentives for selective enrollment could be reduced by strengthening prohibitions against discriminatory plan marketing practices and improving the adjustment of plan payments for health differences among beneficiaries.

Analysts have raised other concerns about the effect of managed-care plans on rural communities. Plans

How Managed-Care Plans Work

Managed-care plans include a variety of organizational arrangements for providing comprehensive health care. Most plans impose some restrictions on the choice of health care providers by plan members. The best known types of plans are Health Maintenance Organizations (HMO's), which deliver care through a regular group of providers for a fixed monthly fee per enrollee, and Preferred Provider Organizations (PPO's), which offer lower charges for enrollees who use designated providers. Plans can provide care at lower cost than traditional fee-for-service arrangements by negotiating volume discounts from providers, offering financial incentives for providers to cut costs, controlling access to specialized care, substituting outpatient care for more expensive hospital inpatient care, and benefiting from administrative economies of scale. Plans have expanded rapidly in recent years, resulting in increased competition among providers for plan patients and slower growth in health care costs. Nearly 41 percent of the U.S. population were HMO or PPO members in 1993.

could benefit rural communities by improving local health facilities and making physician specialists more accessible for rural residents. However, plans could also harm rural communities by requiring plan members to use centrally located urban hospitals to cut costs, depriving rural hospitals of patients, and increasing travel times to care. The effect of plans on rural communities may need to be monitored to ensure that rural Medicare beneficiaries' access to health care is not reduced.

Medical Savings Accounts Are Another Option

Congress has proposed allowing Medicare beneficiaries to choose Medical Savings Accounts (MSA's) in lieu of fee-for-service or managed-care arrangements. Most versions of MSA's would provide beneficiaries with a private health insurance policy that had a high annual deductible, plus funds toward the cost of the deductible. Beneficiaries who spent less than the allotted funds would be allowed to keep part of the difference as a financial incentive to be more cost conscious when using health services.

It is unclear how many beneficiaries might choose MSA's, or whether MSA's would reduce Medicare spending. Many analysts think MSA's are likely to be most appealing to healthy beneficiaries who

anticipate little need for health services. This view of beneficiary preferences suggests that MSA's might increase Medicare spending by imposing new costs for private health insurance and financial incentives for healthy beneficiaries who choose MSA's. The increase in spending could reduce funds for ill and disabled beneficiaries, who represent a larger share of the beneficiary population in rural than urban areas.

Other Policy Options Exist

Other policy options to cope with the growth of Medicare spending are available. Some of these options may be needed to meet the rapid rise in demand for health services that will begin after 2010 when the members of the baby-boom generation start reaching age 65. These options include the following:

- Developing new payment methods that give health care providers greater incentives to cut costs.
- Revising the current system of Medicare cost-sharing and supplemental health insurance to make beneficiaries more cost conscious.
- Taxing the Federal subsidy of Medicare coverage to increase general Federal revenue.

- Raising the Hospital Insurance payroll tax on workers and employers to maintain the long-term solvency of the Hospital Insurance Trust Fund.
- Delaying the age of Medicare eligibility to 66 or 67 years to reduce the size of the population entitled to coverage.
- Reducing the range of benefits covered by Medicare to cut program costs.

Many of these policy options raise fundamental questions about public responsibility for the elderly and the equitable distribution of Federal taxes and benefits. Some options may also have a differential effect on urban and rural communities. For example, delaying the age of Medicare eligibility might affect relatively more rural than urban residents because a higher proportion of rural residents are currently aged 65 or 66. Similarly, taxing the Federal subsidy of Medicare benefits may have a greater financial effect on rural than urban beneficiaries because rural beneficiaries have lower incomes. As a result, the potential effect of each option on rural communities may need to be considered before deciding on the best approach to preserve the Medicare program.

Contacting the Author

Paul D. Frenzen
(202) 501-7925 (voice)
(202) 219-1191 (fax)
e-mail:pfrenzen@econ.ag.gov

Further Readings

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Acknowledgments

Pat Taylor, Linda Swanson, and Sheldon Weisgrau provided helpful comments on an earlier draft. Alma Young prepared the figures and maps in her usual expert and cheerful manner. Brenda Powell provided editorial assistance on the final draft.

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