THE EXPERIENCE AND CONSEQUENCES OF MEDICAID MANAGED CARE FOR RURAL POPULATIONS

LITERATURE SYNTHESIS

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INTRODUCTION

States have been faced with steep health care cost increases over the last ten years. Medicaid was one of the fastest growing state expenditures—increasing by an average of 22% between 1988 and 1992 (Physician Payment Review Commission, 1997; Winterbottom, 1995). There were several reasons for the large increases in the states' Medicaid budgets between 1988 and 1992, including expanded eligibility, general medical price inflation, increased utilization, higher provider reimbursement, and the states' use of disproportionate share hospital (DSH) payments to creatively finance Medicaid expansions (Physician Payment Review Commission, 1996).

After 1992, the annual increases in Medicaid expenditures began to slowdown. Between 1992 and 1995, Medicaid expenditures increased by approximately 9.5% on an annual basis (Physician Payment Review Commission, 1997). Despite the slowdown in growth, Medicaid accounted for 19.2% of state expenditures in 1995 and was the second largest category of state spending after education (Physician Payment Review Commission, 1996). The more recent decline in the growth rate, estimated at 3.3% in 1995-96 and a 7.7% growth rate between 1997 and 2002, is attributed to a number of factors, including the limitation on the use of DSH payments, increased use of managed care and slower enrollment growth (Physician Payment Review Commission, 1997). Although the increased use of managed care is only one of the factors which have slowed the growth in expenditures, states continue to look towards managed care programs as a means of controlling rising Medicaid costs.

The number of recipients enrolled in Medicaid managed care programs has grown from 750,000 beneficiaries (3% of the Medicaid population) in 1983 to 7.8 million people in June 1994 (23% of the Medicaid population) (Rowland, 1995). As of June 30 1996, there were 13.3 million Medicaid beneficiaries in 48 states enrolled in managed care plans (35% of the Medicaid population) (Health Care Financing Administration, 1997c).

Although the continuing effort to enroll more Medicaid recipients in managed care appears inevitable, there has been concern that the delivery systems which are appropriate in urban areas will function less well in rural ones. Rural communities face different challenges than those experienced in urban settings. Rural communities, by definition, have lower population densities. They also have higher percentages of older adults, lower per capita income and lower rates of private insurance than do urban communities (Office of Technology Assessment, 1995). Individuals who have insurance in rural communities are more likely to have individual coverage or be publicly insured than those living in urban communities. As a general rule, rural areas have fewer providers; in 1992, there were 106 US counties with a combined population of 300,000 people that had no physicians.

The purpose of this working paper is to synthesize the current knowledge of Medicaid managed care in rural areas. The literature analysis begins with a general overview of Medicaid managed care. Then, to place the rural Medicaid managed care issues into a broader context, the literature analysis summarizes the experience implementing managed care in rural areas for the commercial populations. This summary of rural managed care for the commercial population is based, in large part, on prior literature reviews on the subject, including a recent literature synthesis of rural managed care written by Ricketts et. al. for an AHCPR delivery order (Ricketts, 1997; RUPRI, 1995; Wellever, 1994; Christianson, 1989; Christianson, 1986). The literature about the impact of Medicaid managed care in rural areas is then described. Specifically, the review focuses around three broad questions: first, how has Medicaid managed care been implemented in rural areas; second, what lessons can be learned from states' experiences to date with rural Medicaid managed care implementation; and finally, what effect are Medicaid managed care programs having on rural safety net and traditional rural providers? An annotated bibliography summarizing the available literature about Medicaid managed care in rural areas is available from the authors upon request.

OVERVIEW OF MEDICAID MANAGED CARE:

There are three basic types of Medicaid managed care systems— primary care case management systems, partial capitation programs, and comprehensive risk contracting plans—although many variations are found within each prototype (Lewin, 1995). These managed care systems differ in the amount and type of risk transferred from the state Medicaid agency to the plans or providers. In a primary care case management system (PCCM) the Medicaid agency pays a primary care provider ("gatekeeper") a monthly management fee to manage the patient's care, but all of the services are paid on a fee-for-service basis. The primary care physician bears no financial risk for any part of the patient's care. Under a partial capitation program the state contracts with a group of providers or clinics to assume the financial risk for some of the recipient's health care needs. These arrangements are sometimes referred to as "prepaid health plans," although the concept of prepaid health plans also includes plans that offer a comprehensive array of services on a non-risk basis (Health Care Financing Administration, 1997c). Common forms of partial capitation programs include primary care capitation programs[1] in which the providers assume financial risk for primary care services only, or special service capitation programs (such as mental health or maternity "carve-outs").

Comprehensive risk programs generally fall into two categories: health maintenance organizations (HMOs) or health insuring organizations (HIOs). Both HMOs and HIOs create networks of providers and assume the risk for a comprehensive list of services. One of the major differences between HMOs and HIOs is whether risk is passed onto the providers. In many HMOs, providers are at risk for some or all of the patient's care (through capitation payments, withholds or financial incentives). HIOs, on the other hand, generally operate like private Medicaid agencies. The HIO receives a fixed payment from the state for most of the care, but then pays providers at the state determined rate (Lewin, 1995). Of the 13.3 million Medicaid recipients enrolled in managed care in 1996, 18% were enrolled in prepaid health plans, 26% were enrolled in primary care case management systems, 52% were enrolled in HMOs, and 3% were enrolled in HIOs (Health Care Financing Administration, 1997c).[2]

The extent to which the state can mandate that Medicaid recipients enroll in a managed care system depends, in part, on whether the state obtains a waiver of sections of the Medicaid statute which guarantees recipients a choice of providers. Absent a waiver, states can offer recipients an opportunity to enroll in a managed care plan, but cannot force the recipient to do so. HMOs that meet certain federal statutory requirements can participate in the Medicaid program. Examples of these requirements include: ordinarily no more than 75% of the enrollees in a given plan can be receiving Medicaid or Medicare (HCFA allows specific exceptions to this rule);[3] the plan must make services available for Medicaid recipients to the same extent as for non-Medicaid enrollees; and plans are prohibited from discriminating against enrollees on the basis of health status, need for services, race, sex, national origin, age, or disability.[4]

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[1] Some states label their primary care partially capitated systems a "PCCM" system. For purposes of this review, these programs have been categorized as partial capitation systems—not PCCMs. In this document, PCCM programs are limited to those systems that pay primary care providers a monthly management fee, but pay for the services on a fee-for-service basis.

[2] This calculation was based on HCFA's National Summary of Medicaid managed care programs and enrollment for June 30, 1996. The number of enrollees included individuals enrolled in more than one managed care plan and individuals enrolled in a state health reform program that expanded eligibility beyond traditional eligibility standards.

[3] New HMOs, public HMOs, and federally qualified HMOs operating in medically underserved areas are exempted from the 75% rule for up to three years if they show progress towards meeting the goal. 42 U.S.C. 1396b(m).

[4] The statutory provisions describing the Medicaid HMO requirements are found at: 42 U.S.C 1396b(m); 1396e. Community health centers, and nonprofit primary health care entities located in rural areas are exempt from most of these statutory provisions.

With waivers, states have two other mechanisms for enrolling recipients into managed care plans:

1) States can mandate that recipients enroll in a managed care program through a 1915(b) "freedom-of-choice" program waiver. Under 1915(b) waivers, states can mandate participation in managed care and restrict choice of providers, but may not expand eligibles, modify the benefits package, restrict access to family planning services or federally qualified health centers (FQHCs), or cover services provided by HMOs which do not meet the federal Medicaid HMO requirements listed above (Rotwein, 1995). 1915(b) waivers are granted for renewable two year periods.[5]

2) States can more extensively redesign their Medicaid program and mandate that recipients enroll in an HMO or other managed care program through an 1115 "comprehensive health care reform demonstration" waiver (Rotwein, 1995). The Secretary of the U.S. Department of Health and Human Services has the authority to waive most Medicaid provisions through an 1115 waiver. States may expand eligibles to cover more of the uninsured, may modify the Medicaid benefits package, and may restrict access or payments to certain providers. Managed care organizations may receive Medicaid payments even if the HMOs do not comply with the statutory provisions listed above (for example, states can waive the 75% rule to contract with Medicaid-only HMOs). Even with a waiver, however, states may not force recipients to enroll in an HMO unless there is a choice of at least two HMOs or two managed care plans operating in the area (i.e, an HMO and PCCM program).

1915(b) waivers are the most prevalent form of managed care waivers. The Health Care Financing Administration reported 93 active "freedom of choice" waivers in the first quarter of 1997. Sixteen new waivers and 39 modifications were pending review (Health Care Financing Administration, First Quarter, 1997b). Forty-one states have obtained a 1915(b) waivers to operate a Medicaid managed care program. Most of these waivers require AFDC and SSI recipients to enroll in either a primary care case management or a fully capitated HMO plan. Many states operate a number of different Medicaid managed care programs—varying by geographic region, services covered, type of program, and type of fee structure.

In addition to the freedom of choice waivers, there have been 16 comprehensive health care reform demonstrations (1115 waivers) approved. Ten plans have been implemented and operational for more than one year (Arizona, Delaware, Hawaii, Minnesota, Ohio, Oklahoma, Oregon, Rhode Island, Tennessee and Vermont)[6] (Center for Health Policy Research, 1996; Health Care Financing Administration, 1997a). Another nine proposals are under review.

COMMERCIAL MANAGED CARE PENETRATION IN RURAL AREAS:

The market penetration of managed care is lower in rural areas than urban ones (Ricketts, 1995). Even when managed care moves into rural areas, the growth is slower than in the urban areas (Ricketts, 1995; Serrato, 1995; RUPRI, 1995). However, between 1994 and 1995, the percentage of rural counties included in an HMO service area increased from 59.6% to 82.3% (Moscovice, 1997). Because an HMO claims to cover a rural area in its service area does not mean that the HMO enrolls substantial numbers of rural residents. Moscovice and his colleagues "observed numerous instances in which the service area expansion was in name only, i.e., the HMO had little or no enrollment in the service area" (Moscovice, 1997 at p. 5).

Almost all of the HMOs serving rural areas also serve urban counties. Ricketts and his colleagues examined the service areas of all the

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[5] 42 U.S.C. 1396n(b).

[6] These programs were all implemented on or before July 1, 1996.

HMOs operating around the country in 1995 and found, for example, that 59% of the HMOs served both rural and urban counties, but less than 1% served only rural counties (Ricketts, 1995). Moscovice found that less than 3% of all HMOs had their headquarters in rural counties (Moscovice, 1997). In a study of Medicare HMOs, Serrato et al. found that only 18 of the 592 HMOs offered Medicare risk plans in rural areas (Serrato, 1995). Seventeen of the plans served both urban and rural areas (primarily urban areas). Only one Medicare risk HMO was exclusively rural.

Rural areas that had a participating HMO were substantially different than the rural counties in which no HMO was present (Moscovice, 1997; Ricketts, 1995; Serrato, 1995; Wellever, 1994). The following features distinguish rural counties that have attracted managed care from those that have not:

- The average population was almost twice as large, the population density was more than twice as large;
- The average AAPCC rates were $30/month higher (13% higher);[7]
- The supply of physicians was about one-third larger;
- The number of hospital beds per capita was lower while occupancy rates were higher;
- The nursing home bed ratio was 25% higher;
- The proportion of minorities was lower;
- The percentage of the population employed in manufacturing was higher and the percentage employed in agriculture was lower;
- Unemployment rates were higher, per capita income was lower and the percentage of college educated people was lower;
- Rural areas with the Health Professional Shortage Area (HPSA) designation were more likely to be served by an HMO;
- Rural areas that were adjacent to metropolitan areas were more likely to be included in a HMO's service area.

Researchers have suggested numerous reasons for the differential HMO penetration rates in urban and rural areas. Rural areas, for example, have lower rates of private health insurance coverage, making these areas less attractive to managed care companies (Ricketts, 1997). Similarly, rural areas lack large employers who can spur the development of managed care organizations (RUPRI, 1995; Wellever, 1994). Rural residents typically use less services, making it harder for managed care companies to cut unnecessary utilization (Serrato, 1995), and the lack of primary care services makes it difficult to substitute primary care for more expensive levels of care (Wysong, 1997). Also, managed care organizations have difficulty negotiating discounts in physician fees in return for patient volume, since many rural physicians are already operating at capacity (RUPRI, 1995; Serrato, 1995; Wellever, 1994), and rural physicians are resistant to managed care (Wellever, 1994). Ricketts and his colleagues suggested that rural areas lack providers with sophistication in business, contracting, marketing, and knowledge of management information systems necessary to successfully participate in managed care arrangements (Ricketts, 1997). Researchers have also suggested that it is more difficult to reduce hospital stays given the lack of available community alternatives such as home health or nursing homes (McCarthy, 1995; Wellever, 1994).

IPA model plans are more likely to be operating in rural areas than group or staff model HMOs, possibly because this type of HMO requires less capital and organizational structure (Ricketts, 1995). Mixed-model HMOs increased their presence in rural areas between 1988 and 1995, as did HMOs sponsored by insurers and other major non-HMO firms (Moscovice, 1997). In addition, more profitable HMOs were more likely to be participating in rural areas, suggesting

[7] A recent GAO report noted that in addition to the level of AAPCC payment rates, several other factors play a key, and sometimes, dominant role in enrollment in Medicare risk HMOs. These factors include the presence of HMOs, number of Medicare beneficiaries, and employers' policies towards retiree health benefits (GAO, 1997).

an ability to cost shift profits from urban areas to more rural ones (Ricketts, 1995). Older HMOs are more likely to include non-metropolitan counties in their services area, suggesting that urban based HMOs spread into adjacent rural counties over time.

MEDICAID MANAGED CARE AND RURAL AREAS:

Numerous articles and reports have been written which describe how states have implemented Medicaid managed care programs and the impact these programs have had on quality, access, and overall program costs. Horvath (1997) and her colleagues, for example, have produced a compendium of information about state Medicaid managed care programs, describing in great detail the program requirements. Rosenbaum (1997) and her colleagues studied and reported the details of all of the Medicaid managed care contracts in use around the states. In addition, Rowland (1995) and her colleagues, wrote an extensive literature review of Medicaid managed care research findings. However, neither the Horvath, Rosenbaum or Rowland reports, nor most of the prior Medicaid managed care literature focused on the experiences that states, managed care organizations, safety net providers or recipients have had with Medicaid managed care programs that have been implemented in rural areas. For example, there has been little prior research to explain why some states have been able to successfully implement Medicaid managed care in rural areas while others have not. There is a similar dearth of research about the impact of Medicaid managed care programs on safety net providers in rural areas.

This section of the literature review analyzes all the relevant literature on these topics. Most of the literature is drawn from case studies documenting how a particular state or series of states implemented Medicaid managed care. The impact on rural areas or rural providers was typically not the focus of these studies. Further, most of the research was qualitative rather than quantitative, drawn from a series of key informant interviews and focus groups.

1. Implementing Medicaid managed care in rural areas

In 1994, 30 states were operating Medicaid managed care programs in rural areas (Mark, 1995; Horwitz, 1994). Twenty-four of the 30 states were operating PCCM programs in rural areas (Horwitz, 1994; RUPRI, 1995); PCCM programs have been popular in states with limited penetration of commercial managed care, and in rural states where few integrated systems exist (Freund, 1995; Gold, 1996a).

Horwitz (1994) reported that in 14 states, either urban HMOs had expanded to reach rural areas or rural based HMOs had emerged. Most of the development was in the eastern and western regions of the country, paralleling areas of high penetration of commercial managed care. By 1995-96, 22 states had some rural Medicaid recipients enrolled in an HMO or prepaid health plan, including Arizona, Colorado, Connecticut, Delaware, Florida, Hawaii, Indiana, Iowa, Maryland, Massachusetts, Michigan, Minnesota, Missouri, New Hampshire, New York, Ohio, Oregon, Pennsylvania, Tennessee, Utah, Virginia, and Washington (Moscovice, 1997).[8] Approximately 10.5% of rural Medicaid recipients (more than 700,000), were enrolled in HMOs or prepaid health plans, compared to 27.1% (6.5 million) urban Medicaid recipients. Most of the rural enrollment in Medicaid managed care plans in 1995-96 were in five states that implemented Medicaid managed care plans statewide—Tennessee, Arizona, Hawaii, Oregon, and Washington (Moscovice, 1997). These states together accounted for 86% of the rural Medicaid managed care enrollment in fully capitated plans. In most of the remainder of the states, capitated

[8] Florida, Indiana, Iowa, Michigan, Minnesota, New Hampshire, New York, Ohio, Pennsylvania, Utah, and Virginia had less than 10% of rural Medicaid recipients enrolled in HMOs or Prepaid Health Plans.

managed care programs have been implemented selectively in rural areas (RUPRI, 1995; Gold, 1996a). Some research suggests that programs based on fully capitated health plans may be more workable in areas with high commercial managed care penetration (Lewin, 1995), or in counties adjacent to urban counties (Horwitz, 1994).

a. Implementation approaches:

States have used a variety of approaches to implement fully capitated managed care in rural areas, including implementing a fully capitated managed care program statewide, allowing plan variation in rural areas, or transitioning to fully capitated managed care plans over time. Hawaii, for example, moved directly from fee-for-service systems with limited or no Medicaid managed care experience to fully capitated Medicaid managed care plans statewide. QUEST, Hawaii's program, was the first exposure of many independent doctors to a gatekeeper role or structured provider networks (Wooldridge, 1996).

Tennessee also moved directly to capitated plans from a fee-for-service system even though the state had a much lower HMO penetration in the commercial market than the national average. Tennessee's managed care penetration for the public and privately insured increased from 5.7% in 1993 to 14% in 1994, as a result of enrolling almost all Medicaid recipients into its Medicaid managed care program, TennCare (Wooldridge, 1996). Tennessee allowed both Preferred Provider Organizations (PPOs) and HMOs to operate in TennCare to achieve its goal of implementing Medicaid managed care statewide. The largest managed care organization with over 50% of Medicaid enrollment statewide, for example, was a PPO that did not initially utilize gatekeepers. PPOs participating in TennCare were given three years to establish a gatekeeper system.

Other states that relied heavily on fully capitated managed care plans have allowed different managed care models to operate in rural areas. Partial capitation has been seen by some providers as a way to ease into prepayment, and for some Medicaid agencies, as a way to shift some of the financial risk to providers (Freund, 1995). States use acute care partial capitation programs for three main reasons: when full-risk plans are not available, to give recipients choice of more than one plan, or when the available providers are poorly positioned to accept risk (Lewin, 1995; Gold, 1996a).

Oregon has the most explicit policy in this area. The state's long-term goal is to enroll all Medicaid recipients in fully capitated health plans. However, the state recognized that some counties might not have the necessary infrastructure to support full capitation or a provider network ready to accept risk. The state assessed each county's ability to accept full capitation. If the county was unable to support a fully capitated model, then a mix of fully and partially capitated models or primary care case management was used. This most often occurred in isolated rural counties (Gold, 1996a).

Other states, such as Florida, implemented HMO and PCCM programs simultaneously, with the understanding that at least initially, rural areas were more likely to participate in the PCCM program (Gold, 1996b). Similarly, New York, Oklahoma and Texas also included special provisions for rural areas, allowing them to rely on primary care case management programs or partially capitated primary care plans with the long-term goal of developing fully capitated plans (Sparer, 1996a; Center for Health Policy Research, 1996; Wooldridge, 1996; Gold, 1997).

Another approach used to phase in Medicaid managed care in rural areas is to delay implementation in rural areas until the state has had more experience in urban communities. New York had an explicit policy in this regard. The state initially had a three year phase-in for Medicaid managed care, with the rural counties concentrated in the second and third rounds (Horwitz, 1994). Similarly, when Arizona's Medicaid managed care program, Arizona Health Care Cost Containment System (AHCCCS) started in 1982, the state contracted with managed care plans in urban areas, but paid providers on a fee-for-service basis in the rural areas. Now rural areas are also being served by fully capitated managed care plans

(Office of Technology Assessment, 1995). In Minnesota, with the exception of one rural county, state officials decided to slowly expand Medicaid managed care to rural areas, delaying implementation until integrated service networks were formed (Sparer, 1996d).

b. Strategies to encourage Medicaid managed care in rural areas:

Several states provided incentives to encourage the development of Medicaid managed care in rural areas or had specific strategies to address barriers to implementation in rural areas. Imposing mandates on HMOs or financial incentives to expand coverage to rural communities, expanding care to the uninsured or limiting the number of participating plans (to have a larger enrollment base in rural areas), increasing the capitation payment rates in rural areas, relaxing program requirements and sharing risk to enable rural providers to become plan participants, allowing counties flexibility in program design, and designing a continuum of managed care possibilities for providers in rural areas with little managed care experience were all methods used to encourage providers and plans to participate in Medicaid managed care and stimulate the formation of plans covering rural communities (Office of Technology Assessment, 1995; Developing Rural Managed Care Demonstration Projects, 1995). Arizona, for example, initially had difficulty enticing commercial HMOs to develop prepaid managed care plans in the rural counties; however, local physicians and hospitals were interested. To encourage plan development in the rural communities, the state relaxed commercial HMO licensure requirements and facilitated the purchase of reinsurance to enable rural physician/hospital sponsored plans to participate in Medicaid managed care (Developing Rural Managed Care Demonstration Projects, 1995). In addition, Arizona specifically limited the number of plans per county to encourage competition while ensuring that the plans had a sufficient number of enrollees.

New York tried another approach when it enacted a law in 1992 which required HMOs to pay higher hospital rates for commercial enrollees. The tax was waived or reduced to the extent that the HMOs met specific Medicaid enrollment targets within a service area (including both rural and urban areas). Before enactment of the HMO legislation, HMOs were reluctant to enter into markets with low populations or physician supply. After the tax was enacted, HMOs showed an interest in the rural market (Horwitz, 1994; Bliss, 1996; Sparer, 1996b). In addition, New York raised the capitation rates in rural areas to counter low HMO penetration rates in these areas, negotiated rates separately with each plan, and established a specific rural managed care coalition to facilitate the development of Medicaid managed care plans (Bliss, 1996; Sparer, 1996c, Wysong, 1994). The coalition discussed common problems, provided technical assistance to communities, served as a communication link to local providers, and helped influence New York's Medicaid managed care policies for rural areas.

At least two states have given counties greater flexibility in designing their own Medicaid managed care programs. New York had an explicit policy, from 1991 to 1995, to allow county Departments of Social Services (DSS) to design managed care programs within broad parameters suggested by the state (Bliss, 1996; Sparer, 1996c). Local flexibility turned out to be both beneficial and detrimental to the goals of developing managed care plans in rural areas (Bliss, 1996). Local DSS planners lacked the knowledge and sophistication to be able to easily design managed care arrangements, and therefore, it took more than two-and-a-half years to develop managed care arrangements in some rural communities. However, local planners were especially sensitive to the needs of rural practitioners, and tried to design the managed care models to meet the needs of the rural communities.

California also allowed variation in plan implementation. The state recognized that differences in provider networks, the ways that patients seek care and political philosophies meant that the same managed care model would not work in all counties. As a result, California allowed counties the flexibility to operate within one of three

different models.[9] In addition, rural communities were encouraged to operate fee-for-service managed care systems (PCCM) starting in 1994, when the state started to expand its Medicaid managed care initiative (Sparer, 1996b; Orloff, 1995). In Minnesota, one county (Itasca) took on the responsibility of developing its own managed care organization. The county became the risk bearing organization and contracts directly with doctors and dentists who share the financial risk (Riley, 1990; Sparer, 1996d).[10]

c. Participation incentives which might have a spillover effect in rural areas:

While some of the states' incentives to encourage the development of Medicaid managed care were targeted specifically at rural areas, most incentives were more generic. The effect of these more generic policies on rural providers and HMOs willingness to enroll rural Medicaid recipients is an interesting issue yet to be studied. For example, Oregon eased the regulatory requirements to participate in Medicaid managed care by giving providers the authority to establish partially capitated plans (PCOs) and Medicaid-only plans not under the Department of Insurance's regulatory oversight (Gold, 1995b). This policy was developed in 1983, when the state tried to encourage provider participation in Oregon's former Medicaid managed care program. Although not established specifically to help rural communities, three rural counties relied on a combination of fully capitated health plans and partially capitated plans (PCOs), and providers in other rural areas have formed Medicaid-only plans (Gold, 1995b).

Florida required all commercial HMOs to apply for a Medicaid contract and enroll Medicaid recipients until the recipients reached 5% of the plan's total enrollment (Mark, 1995). The state also relaxed its marketing and oversight of prepaid health plans in order to encourage plans to participate in Medicaid managed care. For example, plans were allowed to enroll Medicaid recipients through door-to-door marketing, and had the authority to operate for up to three years without meeting the financial or quality standards required of commercial carriers (Gold, 1996b). Whether as a result of these policies, or natural growth in the HMO industry, the number of counties served by HMOs in the Medicaid market grew from five in 1990 to 48 in 1995 (Gold, 1996b). Several of these counties are rural. The marketing and enrollment requirements and oversight of Medicaid HMO plans were eventually made more stringent, as widespread abuses in the Medicaid managed care program were uncovered.

Some states have used stop-loss reinsurance arrangements to limit a plan's risk or have agreed to share risk with the plans (Riley, 1990; Wysong, 1994; Developing Rural Managed Care Demonstration Projects, 1995). While not limited to rural areas, these risk sharing arrangements may be especially important for rural providers wishing to establish managed care organizations when the enrollee population base is not large enough to spread the risk. Other states have set up specific initiatives and provided state funding to assist providers seeking to establish managed care organizations (Mark, 1995; Orloff, 1995).

All states that have approved or pending 1115 waivers allow the use of Medicaid-only HMOs (Center for Health Policy Research, 1996). While not restricted to rural areas, this practice may enable some rural areas to establish prepaid plans where no commercial plans are willing to operate (Gold, 1996a). For example, in Oregon providers in some rural areas created a Medicaid-only plan to begin the intro-

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[9] Currently, Medicaid managed care plans are only operating in metropolitan statistical areas; however, many of the counties are geographically large and include rural communities.

[10] Minnesota also implemented a rural managed care strategy that did not initially target Medicaid enrollment. Minnesota tried to encourage the growth of integrated service networks in rural areas (called community integrated service networks, "CISN"). CISNs operate much like HMOs in providing a comprehensive benefit package, but have lower financial solvency requirements and are exempt from other HMO filing requirements (Sparer, 1996d). However, CISNs were not required to accept Medicaid patients during their first year of operation.

duction of managed care into their locales (Gold, 1995b).

The threat of future legislative or policy initiative has also been successful in encouraging the development of Medicaid managed care. In New York, for example, there was a large increase in Medicaid managed care enrollment (214,000 enrollees in seven months) when New York first submitted its 1115 waiver (Sparer, 1996a). This enrollment increase was attributed to the health plans' desire to expand their market share before the Medicaid managed care program was made mandatory statewide. California proposed legislation which would have required all HMOs to serve at least 5% Medi-Cal patients (Sparer, 1996b). To ward off the proposed legislation, HMOs voluntarily enrolled Medicaid patients. Once in the market, the HMOs realized they could make a profit. In addition, the increased patient volume gave the HMOs greater negotiating leverage with providers. Again, it is not clear from the literature whether either of these initiatives had a differential impact in rural areas.

d. Other statewide policies with the potential to assist rural areas:

A number of states implemented statewide policies that may have a differential impact in rural areas. Several states, for example, have imposed access requirements, including provider-to-patient ratios and maximum travel distances, which are arguably more important in rural areas because it could force plans to contract with rural physicians or recruit new providers into medically underserved areas. Maximum travel distances could also help reduce the distances rural residents often have to travel to see a provider. On the other hand, strict access standards could also deter plans from covering rural areas. States varied in how they tried to assure provider availability, ranging from strict provider-to-patient ratios to more general oversight of network adequacy.

Twenty-five states had a maximum primary care enrollee-to-provider ratio in their Medicaid contract with participating managed care organizations (e.g., no more than 2,000 enrollees per primary care provider)(Rosenbaum, 1997).[11] Nine states used specialty care provider-to-patient ratios in their contracts. Massachusetts and Florida have provider-to-patient ratios for primary care physicians (Mark, 1995); Florida also requires plans to have at least one general surgeon and OB/GYN, and to assure the availability of major types of specialists. New York has a provider-to-patient ratio for primary care physicians and specialists, although it allows adjustments for rural areas (Mark, 1995). Oregon, on the other hand, does not require that each county have a specified provider-to-patient ratio, but plans must maintain a provider panel with sufficient capacity to provide required services. Plans are required to submit an access plan to the state which describes how the capacity is determined, the physician-to-population ratios for each rural county, and how the plan will monitor compliance with its internal standards, although no specific standard is required (Gold, 1995a; Office of Technology Assessment, 1995). Fourteen states also examined whether the managed care organization has attracted new providers into the Medicaid program (Horvath, 1997).

Twenty-four states have established maximum travel times or distances for primary care providers,[12] states have travel/distance standards for specialty or inpatient care providers, and 15 states have travel/time standards for other benefits or services such as pharmacy (Rosenbaum, 1997).[12] While, many states permit variation from these standards for rural areas, Arizona, Delaware, Minnesota, New York and Massachusetts have established rigid standards (Rosenbaum, 1997; Mark, 1995). Minnesota, for example, mandates that primary care providers be within 30 miles travel distance or 30 minutes

[11] Horvath (1997) and her colleagues reported that 31 states had maximum primary care enrollee-to-provider ratios in their Medicaid risk-based contracting programs for the AFDC population.

[12] Horvath and her colleagues reported that 29 states had some type of maximum travel times or distance standards for the risk-based contracting systems for the AFDC populations (Horvath, 1997).

travel time from plan members. New York has more extensive requirements: the maximum travel time for primary care visits is 30 minutes. Primary care providers should be no more than 20 miles away using primary roads, no more than 15 miles away in mountainous or flat areas using secondary roads only; and no more than 25 miles away in flat areas or areas connected by interstate highways. Further, specialists must be "geographically accessible." Oregon, in contrast, has a more flexible standard, understanding that in some areas of the state, all of the people in the community typically travel long distances to obtain care.[13] Oregon requires that the maximum travel time for Medicaid managed care enrollees be consistent with community standards for at least 90% of a plan's members (Mark, 1995). This standard attempts to ensure that access for Medicaid patients is basically the same as for other residents in their community; HMOs are not required to establish higher standards for the Medicaid population. Florida sets a maximum travel time of 30 minutes to obtain care from a primary care provider, but waives the requirement for rural areas. Tennessee requires participating plans to meet availability, time and distance standards, although the specific requirements were not discussed in the literature (Gold, 1995a). In addition, some HMOs used more stringent accessibility standards than those imposed by the state (Mark, 1995).

Some states require plans to provide bilingual materials or offer interpreters, which may be particularly useful in rural areas with a large migrant population (Mark, 1995; Rosenbaum, 1997). Nearly half of the states include provisions that written plan materials be provided in other languages in their contracts with full-risk managed care organizations (Rosenbaum, 1997). Ten states require plans to have a multilingual provider in the network, 20 states require carriers to produce materials in other languages or in a form useful to people with disabilities, 22 states require services for persons whose primary language is not English (such as professional interpreters), and 19 have a cultural competence requirement (Rosenbaum, 1997; Mark, 1995).

Under federal Medicaid law, states must pay for transportation to obtain medical services.[14] Often states shift the requirement to provide transportation for emergency care to the managed care organization (Mark, 1995). Although states do not usually require plans to pay for non-emergency transportation, they are sometimes required to help enrollees access non-emergency transportation when needed. Some plans have reported offering relatively extensive transportation assistance.

Some organizations or states conditioned the providers participation in commercial managed care contracts on their willingness to treat Medicaid managed care patients. Tennessee's largest managed care organization, Blue Cross Blue Shield, had a "cram-down" provision which required physicians who wanted to participate in the state employee's health plan to also participate in the TennCare program (Wooldridge, 1996; Gold, 1995a; Gold 1996a). It is unclear from the literature whether the cram-down provision had a differential impact on rural providers. Similarly, Minnesota enacted legislation requiring providers and plans that compete for public employees to accept a "fair share" of Medicaid clients (Sparer, 1996d).[15]

2. Lessons Learned

a. In rural areas, factors linked to successful implementation of Medicaid managed care are similar to those linked to implementation of commercial managed care:

A number of factors have been linked to the successful implementation of Medicaid managed care in rural areas, including high private sector

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[13] Based on a personal conversation with Brenda Goldstein, Managed Care Coordinator, Oregon Office of Medical Assistance Programs, February 25, 1997.

[14] 42 CFR 431.53, 440.170.

[15] Rhode Island, largely a urban state, had a more extensive mainstreaming requirement. To participate in the commercial managed care market, HMOs were required to open their commercial provider panel to Medicaid recipients (Wooldridge, 1996). This type of policy would only help a rural area to the extent that it has a commercial managed care presence.

HMO enrollment, adjacency to urban areas, allowing counties the flexibility to design plans to meet local needs, and state policy initiatives. Conversely, a number of factors have been suggested as reasons why states have been unsuccessful or less successful in implementing Medicaid managed care in rural areas, including provider resistance, low capitation payments, population demographics, unyielding program rules that failed to adjust for specific problems encountered in rural areas, and insufficient time to develop rural provider networks.

Lewin found that "about 30% of the variation among the states in the percent of the Medicaid population enrolled in HMOs is explained by variation among states in private sector HMO enrollment" (Lewin, 1995). Further, states with a greater number of participating HMOs had higher Medicaid managed care enrollment. The authors suggest that greater competition may make the Medicaid population more attractive, or may reflect the greater ease of establishing fully capitated Medicaid managed care plans where commercial HMOs already exist.

While the Lewin study did not specifically examine the differences in urban and rural areas, the study suggests that Medicaid managed care may be easier to implement in rural areas with a significant commercial managed care enrollment. However commercial penetration need not be a precursor to successful implementation of Medicaid managed care. Gold noted that one of the spillover effects of implementing Medicaid managed care in the rural areas in Tennessee, Oregon and Minnesota has been the growth of the commercial sector, especially where commercial managed care penetration was once low (Gold, 1996a; Wellever, 1994). In many rural areas, Medicaid is the first managed care system implemented, stimulating rural network development.

In New York, rural areas that were adjacent to urban areas had better Medicaid managed care penetration and greater choice of plans than rural, non-adjacent areas (Wysong, 1996). Flexibility in designing managed care arrangements in rural areas was also seen as a key to success. A phased-in approach such as was used in Oregon and New York, first using partial capitation under local control may be perceived as a less intrusive way to ease into full capitation (Rosenthal, 1996). Providing technical assistance to providers in rural areas has also been linked to successful program implementation (Wysong, 1994; Bliss, 1996), as were specific policies intended to encourage the development of Medicaid managed care in rural areas such as the New York hospital assessment for HMOs (Bliss, 1996).

Wysong and his colleagues (1996) examined the extent to which Medicaid managed care plan availability and penetration in rural New York was linked to population characteristics (such as the percent of professionals in the workforce, percent with high annual incomes, number of businesses in the county, percent minority, percent without a high school education or receiving public assistance), and health system characteristics (such as the number of primary care physicians per 100,000 population, the percent of physicians in solo practice or group practice, and the hospital beds per 100,000). They compared the relative importance of these factors to geographic location alone. They found that the differences in the population and health systems characteristics explained up to 86% of the difference in managed care plan availability and penetration among rural, urban-suburban, and urban areas.

In addition to some of the factors which have led to successful implementation of rural Medicaid managed care programs in other parts of the country, plan and program administrators in Arizona identified a number of program elements which contributed to Arizona's success in implementing fully capitated Medicaid managed care plans in rural areas (Developing Rural Managed Care Demonstration Projects, 1995; Arizona Health Care Cost Containment System, no date). In Arizona the number of contractors were limited in rural areas to ensure that plans had sufficient numbers of enrollees; the state paid fair capitation rates that reflected what utilization should be (rather than historical usage); rural provider networks were linked with experienced managed care entities to provide management and admin-

istrative services; rural providers were involved in the development and governance of the health plans; the state was flexible in contracting with different types of organizations; and plans built upon the local provider base.

Researchers have also documented certain factors which make it more difficult to implement Medicaid managed care in these communities. In the late 1980s, for example, some states experienced significant problems in implementing Medicaid managed care, some of which were specific to rural areas. Riley (1990), for example, noted that HMOs had not had much success in developing provider networks in rural areas and areas where there was little competition for patients. As a result, states were unable to develop managed care contracts in these areas. Another problem encountered in rural areas was the low capitation rate. Since most states establish capitation rates based on the historical fee-for-service costs, rural communities, which have historically underutilized health care services, were artificially disadvantaged (Riley, 1990; Freund, 1995).

Inflexible program rules have also led to difficulties implementing Medicaid managed care in rural areas. For example, in New York, the state initially required hospital clinics to provide or arrange for all ambulatory services to clients under a full capitation reimbursement (Horwitz, 1994). This rule essentially precluded rural hospitals from participating in Medicaid managed care arrangements because they did not offer tertiary care and were reluctant to assume the financial risk for specialty services that they could not provide.

The fast implementation of Medicaid managed care, along with provider resistance, seemed to cause network adequacy problems in some rural areas. For example, Gold (1995a) reported that Tennessee, which implemented its statewide Medicaid managed care program two months after its waiver was approved, did not have adequate provider networks in all service areas. This was particularly an issue when there was only one alternative plan available—a feature common to rural areas. There were other network-related problems reported in Gold's paper, including gaps in particular specialty services and poorly designed networks. Although these problems seemed more widespread in rural communities, they also occurred in some urban areas.

b. There is little evidence available about the impact of Medicaid managed care on access and costs in rural areas:

There is relatively little literature about the comparative effects of Medicaid managed care in rural areas; most reports note the dearth of data about the impact of rural based managed care initiatives (Freund, 1995; Wellever, 1994; James, 1993). The literature that does exist is mixed. In isolated communities, there have been some reports that Medicaid managed care has helped to increase the availability of providers.[16] For example, in Oregon prepaid health plans have helped finance the recruitment of physicians into certain rural areas (Kitzhaber, 1996). The expansion of coverage to the uninsured through the 1115 waiver also may have contributed to the providers' willingness to move into underserved areas. Nonetheless, access to services was still poorer in

[16] Most of the literature examined provider participation in the state as a whole. There is less information available about whether Medicaid managed care has improved or decreased provider participation in rural areas. TennCare, for example, helped stimulate an increase in primary care supply, both by generating an increased demand for services and by creating the pressure to enact legislation to expand the role of nurse practitioners and physician assistants (Gold, 1995a). As a result of new legislation, there were more mid-level providers available to serve as primary care providers. Florida also reported increased provider participation, although it is not clear how much of the increase was due to changes in fees versus implementation of the HMO and PCCM programs (Gold, 1996b). Minnesota and Rhode Island also reported increased access to providers overall and to some services not available under the fee-for-service system; however, both states experience with Medicaid managed care has been largely in urban areas (Sparer, 1996d; Wooldridge, 1996). On the other hand, Wooldridge and her colleagues thought there were fewer physicians participating in the Hawaii Medicaid program after implementation of the statewide managed care program (Wooldridge, 1996).

rural versus urban areas after the Medicaid managed care program was implemented because of limited provider availability or reluctance to participate in Medicaid (Gold, 1995b). In Rensselaer County, New York, which is considered rural by the state,[17] four health plans were able to increase Medicaid provider participation (Sparer, 1996a). Arizona generally reported improved access to care with the advent of the state's prepaid health plan; however, rural respondents initially reported greater barriers to obtaining pediatric care than did their urban counterparts (Kirkman-Liff, 1986). Further, Arizona did not have a Medicaid program prior to the advent of its statewide managed care system; thus this study was likely comparing access under the Arizona managed care system to access for individuals who were previously uninsured.

Some researchers note that current market forces (i.e., increased use of managed care in the commercial, Medicaid and Medicare populations) have improved access to specialty consultations. This has occurred in some rural areas through visiting specialty clinics and telemedicine linkages. Some urban based integrated delivery systems have opened new rural clinics, and some urban providers have moved into rural areas to avoid managed care (RUPRI, 1995; Lipson, 1996). In general, however, market forces have not changed the availability of health services in rural areas (RUPRI, 1995; Gold, 1996).

The literature is more sparse on the question of cost savings in rural areas. In the second year evaluation of the Virginia PCCM program ("Medallion"), researchers found that in urban areas, the program helped reduce hospital outpatient visits, and more care was provided by primary care physicians. These same impacts were not experienced in rural areas. The researchers posited that there were fewer savings in the rural areas because the limited number of primary care providers meant that these providers were already acting as de facto case managers/gatekeepers for their patients before the advent of the Medallion program (Final Report of the Second Year Evaluation of the Medallion Program, 1994). These findings were similar to those suggested by other researchers (Freund, 1995).

Utah, in the evaluation of its 1915(b) mental health managed care program, Utah Prepaid Mental Health Plan (PMHP), examined whether PMHP had any impact on utilization of services, costs or patient satisfaction in comparison to the traditional fee-for-service delivery system (Utah Department of Health, 1996). From the moment of the program's implementation, greater reductions in utilization of inpatient psychiatric care, length of stay and overall costs were experienced by the rural PMHP recipients when compared to those Medicaid clients still receiving FFS care. By the third year of the program, however, the annual difference between the FFS clients and PMHP clients in rural areas has greatly diminished. There were slightly greater cost savings among PMHP clients ($.14 per enrollee), but in most other areas, including utilization rates, length of stay and client satisfaction, the differences had been negated. The researchers posited that providers in the FFS areas changed their practices in response to the introduction of managed care into their operating environment (a "spillover" effect). The study also looked at the differences between urban and rural PMHP sites and found that overall, rural areas showed a more significant reduction in adult inpatient psychiatric admissions than the urban areas. Both the urban and rural PMHP areas significantly reduced the number of children placed in a hospital setting. Rural areas, both PMHP and FFS, showed a more dramatic decline in outpatient utilization than did urban areas. The authors suggested that this may be due to PMHP contractors and fee-for-service providers having to develop more efficient patterns of care as the number of recipients across the state increased.

The Maine Rural Health Research Center is currently examining the impact of Medicaid managed care mental health carve-outs on the rural

[17] Reported in telephone conversation by Faith Baker, Bureau of Program Planning, Office of Managed Care, NYS Dept. of Health. February 27, 1997.

mental health delivery system in five case study states (Maine Rural Health Research Center, 1997). The study will address the impact of mental health carve-outs on the integration of mental health and primary care services, access to mental health specialty providers, and administrative burdens on primary care and mental health service providers in rural areas.

3. Impact of Medicaid Managed Care on Rural Safety Net and Traditional Providers.

Most of the information about the impact of managed care on safety net providers has been generic, without a specific urban or rural focus. Because of the relative dearth of research focusing on the impact of Medicaid managed care on rural safety net providers, this section discusses selected published literature about the effects of managed care on safety net providers. To the extent that information is available about rural safety net providers, this information is highlighted.

a. Community and Migrant Health Centers:

Community health centers have been forced to participate in Medicaid managed care programs because Medicaid revenues constitute a large percentage of total clinic revenues, and the centers want to be able to continue to provide care to their patients. In 1993, about 20% of the community health centers' (CHC) publicly insured patients were enrolled in a prepaid Medicaid plan, although the rural CHCs were much less likely to have publicly insured patients enrolled in prepaid plans than urban CHCs (11% rural vs. 24% urban) (Kiedrowski, 1993). The GAO, in its study of the impact of managed care on ten community health centers between 1989 and 1993 (one of which was rural), noted that Medicaid constituted between 17 and 50% of health center revenues (GAO, 1995). Providers who do not form contractual relationships with managed care organizations or join large integrated delivery systems may be excluded from participation in the Medicaid system (Schauffler, 1996).

Initially, many of the community health centers or traditional clinics serving Medicaid patients and the uninsured lacked the infrastructure and skills needed to be able to successfully participate in managed care contracts (Schauffler, 1996; GAO, 1995). These clinics needed staff members with strong financial management and marketing skills to promote clinics to HMOs and the Medicaid population; data systems to track revenues, patient utilization and provider performance; skills to measure and improve client satisfaction; assistance in determining costs to establish capitation or negotiated rates with managed care organizations; and knowledge about managed care contracting. Involvement in Medicaid managed care has forced some community health centers to change their internal management processes. As the amount of risk assumed in Medicaid managed care arrangements increased, community health centers were more likely to take a proactive role in primary care coordination, utilization review systems, and risk management (Abrams, 1995; Lewin, 1994). The greater the risk, the greater the penetration of Medicaid managed care, the more sophisticated the centers have become in rate negotiations and management capacity.

A review of the literature suggests that the impact of Medicaid managed care on the financial viability of community health centers has been mixed, although few of these studies look specifically at the impact on rural CHCs (RUPRI, 1995). Historically, the Medicaid statute required states to cover services received at federally qualified health centers (which are typically community health centers) or rural health clinics (RHC). Only sixteen of the 35 states and District of Columbia that contract with full-risk managed care plans include provisions in their contracts requiring plans to cover the services provided by FQHCs or RHCs. However, these states do not define the scope of the covered benefit in the contract (Rosenbaum, 1997). In addition, the Medicaid statute normally requires states to provide cost-based reimbursement to FQHCs and RHCs, but this requirement has been waived by many of the states which have implemented 1115 waivers (Center for Health Policy Research, 1996; Rosenbaum, 1995). Several other states, including Minnesota, are in the

process of transitioning away from cost-based reimbursement (Center for Health Policy Research, 1996; Sparer, 1996d). Another study by Mark (1995) of six HMOs which had contracts with FQHCs showed that none of the plans provided full cost reimbursement to federally qualified health centers. Most of the CHCs were paid capitation payments, although some were paid a negotiated discounted fee-for-service rate.

Overall, managed care organizations appeared willing to enter into contracts with community health centers and other federally qualified health centers (Lipson, 1996; Gold, 1995a; Mark, 1995). The number of community health centers participating in Medicaid managed care arrangements has grown rapidly in the last few years, with a 30% increase between 1993 and 1994. By 1994, about one-quarter of all community and migrant health centers participated in managed care arrangements that served 566,000 enrollees (Henderson, 1996; GAO, 1995). Approximately three-quarters of those involved in managed care have either full or partial capitation contracts (Henderson, 1996). In 1996, FQHCs were involved in risk contracting programs in 30 states, which was an increase from 19 states in 1994 (Horvath, 1997). Among all the safety net providers, including CHCs, those with strong links to the Medicaid population and those with primary care providers in communities with physician shortages have a particular competitive advantage.

In addition, in some states CHCs have formed their own managed care organizations. In 1994, at least seven centers had established HMOs in order to continue serving their traditional populations (Pope, 1994). By 1996 there were 24 licensed managed care plans owned in whole or in part by community health centers operating in Connecticut, Massachusetts, Rhode Island, New York, Maryland, Pennsylvania, Florida, Ohio, Michigan, Missouri, Colorado, Hawaii, California, Oregon and Washington (Abrams, 1997; Henderson, 1996; Maryland Health Resources Planning Commission, 1996; Gold, 1996b). Seven of the plans operated statewide while the remainder operated in more limited urban areas (Abrams, 1997). These plans have been successful in competing in the Medicaid managed care market, with a nearly 50% increase in enrollment from 418,000 in June 1995 to 610,000 in February 1997 (Abrams, 1997). Together, CHC plans rank first in Medicaid market share in six states, and the majority of CHC plans rank within the top four in Medicaid market share within their respective service areas.

Although most of the community health centers appeared to be able to participate in Medicaid managed care arrangements, either as subcontractors or as plans, several studies reported anecdotal information that CHCs were losing revenues from managed care contracts (National Association of Community Health Centers, 1997; Gold, 1995b; Henderson, 1996). CHCs also reported losing patients with auto assignment when their former patients failed to select the CHC as their primary care provider (National Association of Community Health Centers, 1997). GAO, in the only available study which examined the financial impact of Medicaid managed care arrangements on CHCs, reported that the earnings from the prepaid Medicaid contracts were modest and did not significantly support the provision of enabling services or uncompensated care (GAO, 1995). Three of the ten centers examined lost money on the prepaid Medicaid contracts; although all of the centers improved their financial position through other revenue sources. While all of the centers studied were financial viable, none met the Bureau of Primary Health Care's benchmark of 60 days cash on hand, and certain centers, especially those that relied heavily on Medicaid prepaid managed care capitation plans, were especially vulnerable.

b. Public Hospitals

Public hospitals and other hospitals that serve a disproportionate share of Medicaid and uninsured patients share many of the same issues as those facing Community Health Centers. Historically, these institutions received enhanced reimbursement through Medicaid disproportionate share hospital payments (DSH). Three of the eight states that had implemented their 1115 waivers as of July 1996 had eliminated or reduced

DSH payments to hospitals (Center for Health Policy Research, 1996). Ten states incorporated DSH payments into managed care payment rates (Horvath, 1997).

Despite the elimination of DSH payments, the experience of public hospitals with Medicaid managed care contracts has been mixed. A study which surveyed Medicaid managed care contractors in eight states showed that almost all the plans have contracts with public hospitals and children's hospitals (Mark, 1995). Some of the hospitals, especially those in states which expanded Medicaid eligibility to cover some of the uninsured, reported better financial results from reduction in the numbers of emergency room visits and drop in uncompensated care (Gold, 1995b, Gold 1995a). Urban hospitals in Tennessee that were able to establish parallel outpatient clinics to serve Medicaid patients reportedly fared very well (Gold, 1995a). However, the rural hospitals reportedly fared poorly because they were more dependent on TennCare revenues and had less ability to cost shift to other providers. In contrast, some of the larger urban hospitals in other states have experienced a decrease in the number of paid emergency room visits, but an increase in the number of unreimbursed visits as the clients continue to seek non-urgent care in the emergency rooms (Sparer, 1996a; Gold, 1995a). Because rural hospitals typically offer less comprehensive emergency room services and are less conveniently located than those in urban areas (Freund, 1995), it is unclear whether rural hospitals will have the same experience under Medicaid managed care as the urban based hospitals.

The movement of managed care into rural areas is forcing some rural hospitals into new delivery systems. In a survey of 233 rural hospital CEOs in 1995, Hudson (1995) found that 85% thought that their hospitals' survival would be jeopardized without close links to doctors. Nearly half (45%) of the CEOs said that they were employing primary care doctors, and about a quarter noted employing physician assistants (27%) or nurse practitioners (20%). Further, more than half (54%) of the CEOs thought they needed close links with another hospital or hospital system to survive. Of these, 47% had formal contractual affiliations with another hospital or health system. Hospitals entered into these formal linkages to increase managed care opportunities or capabilities (77%), improve or expand clinical services (51%), and improve doctor recruitment or staffing (46%). However, the CEOs noted some drawbacks to these arrangements, including loss of power (32%), board and medical staff resistance (32% and 31% respectively). Among those hospitals without formal affiliations, 38% were planning to complete an affiliation agreement that year.

c. Public health departments:

Public health departments appear, from the research, to be most at risk with the advent of managed care arrangements, as their primary care services are typically less comprehensive and their ability to negotiate with managed care organizations are hampered by bureaucracy (Lipson, 1996). Despite the limited array of services offered by most health departments, Horvath (1997) reported that local health departments participated as contractors or subcontractors in 25 states' Medicaid managed care programs in 1996, an increase of 11 states since 1994.

The impact of Medicaid managed care on local public health departments appears to vary, depending on the type of managed care program and array of services offered by the health department (Hurley, 1997). PCCM programs, which typically required 24 hour/day and 7 days/week coverage, caused some initial problems for local health departments. Some of the smaller rural health departments in Virginia, for example, were initially unable to participate in the Medicaid PCCM program because they were unable to meet program requirements (Final Report of the Second Year Evaluation of the Medallion Program, 1994). However, many local health departments made the necessary changes to meet the PCCM program requirements; and in some instances, states were willing to make exceptions to certain programmatic requirements to enable local health departments to participate (Hurley, 1997).

Local health departments have experienced more difficulties in communities dominated by

fully capitated Medicaid managed care plans. The health departments that provide a full array of primary care services are more likely to obtain contracts with managed care organizations than those offering a more limited array of services. For example, the public health departments in Tennessee that provided direct primary care services were able to contract with the plans as primary care providers (Wooldridge, 1996; Gold, 1995a). Although these local health departments reported revenues in the first year of TennCare that were similar to the year prior, counties lost discretionary funding because they could only bill for the specific services provided and could not accumulate the savings needed to start special program initiatives (Gold, 1995a).

Those health departments that offered less than a full array of primary care services, and in some states, even the health departments that offered a full array of primary care services, seemed to be adversely affected by the advent of Medicaid managed care. In Arizona, for example, some Medicaid recipients continued to seek care from local health departments because they were more conveniently located than plan providers, even though the health departments were not part of the plan's provider network (Greenberg, 1995). This problem was compounded because of a state law which required local health departments[18] to provide certain clinical preventive services for free, even though few had contracts with Arizona Health Care Cost Containment System (AHCCCS) health plans. Unpublished 1992 data from Maricopa county found that 25% of TB patients referred to the county were AHCCCS clients, 3% of immunization clients in Coconino county, 19% in Pima and 37% in Gila county were AHCCCS clients.[19] Rural public health agencies were forced to drop more services than their urban counterparts because of a loss in revenues. Health departments in Oregon reported losing revenues while at the same time being asked to provide the same or more care for the uninsured (Gold, 1995b). A Florida study suggested that Medicaid managed care has forced some of the county health departments[20] to close their primary care clinics, as they were faced with increased competition from the private sector (Gold, 1996b).

Hurley (1997), in an article examining the impact of Medicaid managed care on public health entities, suggests that local public health departments will be faced with one of three choices in response to the growth of fully capitated Medicaid managed care arrangements. First, public health agencies with sophisticated delivery systems can become plan providers—they may be able to subcontract with multiple plans (especially when the choice of other providers is limited). Their ability to participate in Medicaid managed care arrangements over longer time periods will be directly related to their ability to negotiate adequate rates; as a public agency, their ability to add profitable services or shed unprofitable ones is limited. Second, local health departments may find a role providing "wrap-around" services for special needs populations which HMOs are not prepared to handle. Third, public health officials may move out of the provision of personal health services, and assume a greater role in the assessment and assurance functions; for example, in assessing the impact of Medicaid managed care on the enrollees or on aggregate community health indicators.

d. Community mental health centers:

Community mental health centers (CMHC) are increasingly entering into Medicaid risk arrangements (Horvath, 1997). By 1996, mental

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[18] Most public health departments provided some personal care services, but not a comprehensive array of primary care services (Greenberg, 1995).

[19] Maricopa and Pima were MSAs, Coconino and Gila were non-MSAs at the time of this study.

[20] Most public health departments in Florida provided maternal and child health clinical services; but fewer provided a full array of primary care services. In Florida, the legislature committed $30 million to provide primary care services through health departments, but competition from HMOs and MediPass (PCCM) relegated county public health clinics to more traditional public health functions (Gold, 1995b).

health centers were participating in risk networks in 25 states, a significant increase since 1994 when only four states reported involving mental health centers in risk networks. Most of the literature examining the impact of Medicaid managed care on community mental health centers reported concerns that mental health services would be "mainstreamed" into the HMOs' capitation payments. The fear raised by community mental health providers was that HMOs would place more emphasis on physical health than mental health services and consequently, mental health services would be underfunded. According to the American Managed Behavioral Healthcare Association (1995), "HMOs spend 3-5% of their budgets on behavioral health services, while mental health spending within healthcare overall totals 10%." Christianson (1994) also suggested that HMOs have had little experience treating individuals who have severe, chronic mental illness and little awareness of community-based treatment programs, so the quality of care and financial viability of these community based services might suffer. While several articles discussed the potential impact that Medicaid managed care may have on the financial viability of community mental health providers, there was little data to actually measure this impact.

e. Other traditional providers:

The literature suggests that managed care could have either a positive or negative impact on fragile rural health infrastructures. While there were several articles discussing the potential impact of managed care on rural health infrastructure, there was little research that documented actual effects. The literature suggested that managed care could help to lower costs through gatekeepers who coordinate care, improve the quality of care by providing patients with a medical home, and reduce the isolation of rural practitioners through utilization review and quality assurance activities (National Rural Health Association, 1995; Wysong, 1997). If managed care organizations contracted with rural providers, the community might retain more of the local health dollars in the community. On the other hand, the literature also pointed out that rural managed care arrangements could reduce the quality of care if the plan included strong financial incentives to limit referrals or reduce the time spent with patients. Rural hospitals could be threatened if patients were referred to urban centers, and local practitioners might be threatened if they were not in the network. Patients might be subject to longer travel distances. Further, some commentators expressed the fear that managed care and multi-provider delivery systems could subsume the providers in the rural areas, only to abandon the area if it later turned out not to be profitable (Office of Technology Assessment, 1995; National Rural Health Association, 1995; Wysong, 1997).

Medicaid managed care has also reportedly cut into the sales of pharmacies because the plans have been able to negotiate lower reimbursement rates. This loss in revenues could potentially have an adverse impact on the availability of pharmaceutical providers in rural areas. Last year, Medicaid sales as a percentage of pharmaceutical marketplace were lowest in the states where most Medicaid beneficiaries enrolled in Medicaid managed care (Muirhead, 1996a; 1996b). Also, states have the flexibility, under a waiver, to restrict the pharmaceutical network to a limited number of providers, potentially eliminating some pharmacists from participating in the Medicaid program (Muirhead, 1996b).

f. Initiatives to protect safety net providers:

States have employed a variety of policies to protect safety net providers; in rural areas, these strategies have focused on rural network development. Twenty-nine states, for example, are involved in more comprehensive efforts to develop or implement rural health networks. Of these, 17 states have provided assistance to rural networks to help them function in managed care environments (Orloff, 1995). States have also provided technical assistance to rural providers to help them prepare for managed care (Bliss, 1996; Schauffler, 1996).

In addition, some states have required plans to contract with certain defined "safety net

providers," or have given plans that contract with safety-net providers greater consideration in the competitive bidding process. Some states have supplemented the contractual rates negotiated between the HMOs and the safety net providers, and others have created special funding pools to smooth the transition to managed care for certain providers. States have also relaxed program rules (such as reserve requirements) to allow community providers to establish prepaid health plans.

Overall, about one-third of the state contracts with managed care organizations required these plans to include one or more classes of safety net providers in their provider networks (Rosenbaum, 1997; Horvath, 1997). A number of states have included provisions in their approved 1115 waivers requiring managed care organizations to contract with certain safety net providers, such as federally qualified health centers, rural health centers, public health departments, regional perinatal intensive care centers, publicly funded mental health and substance abuse agencies, or school-based clinics. This requirement may be waived if the plans could demonstrate reasonable access without these contracts (Center for Health Policy Research, 1996; Horvath, 1997; Mark, 1995). If direct contracting was not required, some states gave HMOs that contracted with safety net providers extra points in the contract bidding process (Mark, 1995).

Other states specifically exempted certain categories of eligibles or services from the Medicaid managed care program in order to protect certain providers. Five states, for example, have carved out pharmaceutical benefits (Muirhead, 1996b), and Florida exempted children with special needs from mandatory HMO or PCCM participation so that they could continue obtaining services from the Children's Medical Services network (Gold, 1996b).

Some states have established separate funding mechanisms to protect certain safety-net providers. Several states gave FQHCs the option to continue to be reimbursed at reasonable cost, either by the state through supplemental payments, or by the HMOs (Rosenbaum, 1997; Gold, 1997; Wooldridge, 1996; Henderson, 1996; Sparer, 1996a; Gold, 1995a).

Some states have permitted safety-net providers to develop their own HMOs to serve Medicaid recipients only (Medicaid-only HMOs) (Gold, 1996a). In at least one state, the performance bond requirements were relaxed to enable a CHC-owned HMO to participate in the Medicaid managed care program (Wooldridge, 1996). In addition, the federal government has also provided funding to help community health centers develop their own networks and has offered training, consultation and review of managed care contracts (GAO, 1995; Schauffler, 1996).

FUTURE DIRECTIONS

A number of suggestions have been made about how public policies can be changed to better support the operation of Medicaid managed care in rural communities. These ideas include, for example, mechanisms to involve the community in program design, mandating contracts with certain rural providers, and setting standards for the amount of risk that should be shifted to rural providers and networks. Both Wysong and the National Rural Health Association (NRHA) suggested that managed care systems include community representation so that the programs could be designed to accommodate the unique challenges in rural areas (National Rural Health Association, 1995; Wysong, 1997). Wysong also argued that states should encourage the formation of rural health coalitions to help implement Medicaid managed care in rural areas, involve the state Office of Rural Health in evaluating the impact of Medicaid managed care on the stability and strength of rural delivery systems, and require managed care plans to partner with local providers and invest in health professional recruitment into rural areas (Wysong, 1997). NRHA also recommended that managed care organizations be required to cover adjacent rural areas and enroll Medicaid recipients; that providers be allowed to participate in more than one plan (i.e., no exclusive contracting allowed); and that any willing provider laws be used to sustain the health care delivery system in rural areas.

Kuder (1996) argued that public policy should permit flexible approaches in rural areas rather than prescribing particular models because so little is known about the effects of managed care in rural areas. Government has a broader role than that of payer, and as such should set reasonable rules to ensure that the advent of managed care does not harm a fragile provider infrastructure.

The Rural Policy Research Institute (RUPRI) made several other recommendations in a Congressional briefing in 1995 (RUPRI, 1995). Specifically, RUPRI suggested that specific standards be established to determine the appropriate level of risk for small providers and networks; that the federal and state governments should provide stop loss coverage and reinsurance to providers with limited capacity for assuming financial risk; and that the state help involve and educate rural providers and consumers in the Medicaid managed care waiver process.

Many of these ideas have been tried by states seeking to implement Medicaid managed care in rural areas. States, for example, have attempted special recruitment efforts targeted to rural providers, enacted policies or legislation to mandate and/or encourage HMO coverage in rural areas, offered risk-sharing arrangements with HMOs or provider groups, relaxed HMO licensure requirements, provided funding and technical assistance to rural and/or safety net providers to prepare them for the managed care environment, required HMOs to contract with certain safety-net providers, gave local communities flexibility in designing their managed care initiatives, and eased rural communities into fully capitated plans by first implementing PCCM or partially capitated plans in the community. The extent of any particular state's success appears to be associated in the research to several factors, including the availability of health care resources, the providers' willingness to enter into managed care contracts, the extent of commercial managed care penetration in the community, the willingness of health plans to participate in Medicaid managed care arrangements, the level of capitation payments, the extent to which the state is willing to allow plan flexibility to accommodate provider or community concerns, and the state's determination to promote Medicaid managed care programs in rural areas. As McCall (1996) noted, in one of her studies of the Arizona Health Care Cost Containment System, states may need to take an active role in helping potential bidders get organized, especially for traditional safety-net providers. As the Medicaid managed care system evolves over time, it may go through stages where HMO interest in participation in the plan is weak and stages where interest is strong. "States must take an active role in attempting to make their market place more competitive by encouraging potential entrants and sharing information. They also should assess their market potential before each bidding cycle, and carefully develop a strategy in tune with their market assessment. Stimulating a competitive market is an ongoing process which requires a substantial state commitment to collection and use of data" (McCall, 1996 at p. 23).

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