Rural and Urban Parents Report on Access to Health Care for their Children with Medicaid Managed Care

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Rural and Urban Parents Report on Access to Health Care for their Children with Medicaid Managed Care

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EXECUTIVE SUMMARY

States have increasingly turned to managed care as a delivery system for their Medicaid programs. There are many barriers to the implementation of Medicaid managed care in rural areas, including provider resistance, the absence of commercial managed care, inadequate provider supply and lack of networks, limited beneficiaries across whom to spread risk, and lack of legislative or political will. Still, Medicaid managed care programs have been implemented in many more rural areas than some initially thought possible.

There has been little previous research on rural beneficiaries' perspectives on access to care under Medicaid managed care. The study reported here considers the perspective of the rural beneficiary in four states in order to broaden understanding of whether Medicaid managed care programs provide acceptable access to health care services. The study examines access to health care among rural children ages 0-17 who are enrolled in either fully capitated (New Mexico and Washington) or primary care case management (PCCM) Medicaid managed care plans (North Carolina and North Dakota), and compares this access to that of urban beneficiaries. Areas of focus include the ability to find a participating health care provider within a reasonable distance, coordination of care concerning services such as specialty care that are more likely to be located in urban areas, and use of the emergency room. A particular focus of the study is services such as dental and transportation, which are typically carved out of managed care programs but are particularly relevant to rural populations.

Children were classified as living in rural or urban areas by the county in which they reside. Using US Census data, counties were divided into quartiles depending on the "percent rurality" of the county, i.e., counties determined by the 2000 Census to be 76 to 100% rural were classified as mostly rural, those classified as 51 to 75% were partly rural. Similarly, counties 26 to 50% rural were designated as partly urban and those less than 26% rural were mostly urban. Five thousand children were randomly selected for the study, divided among the four county rurality groups. Parents of selected children were asked both closed-ended and open-ended questions.

The findings of this study provide both encouraging news for those who work to improve health care for poor rural residents as well as identifying areas that still need improvement. In the four states studied, access to primary care under Medicaid managed care is excellent. Almost all children, regardless of rurality of residence, have a provider who can meet their well care and acute care needs. Although the health department provides services for some, particularly those in rural areas and in certain states, rural parents report that they take their children to the health department because of convenience. Parents seldom mention that they use the health departments because they cannot find anywhere else to take their child.

Few parents, regardless of residence, reported unmet need for medical care. And when they did, the barriers they most often cited appeared to be provider-based, such as long waits for appointments or inconvenient hours. However, while these barriers are not directly attributable to the Medicaid managed care program, they may be exacerbated by

Medicaid policies which discourage provider participation and lead to overcrowding at the offices where Medicaid is accepted. If children need a specialist, their parents are likely to find it easy or at least not too hard to get the referral they need, although 11% of parents found it difficult or impossible to get a referral for their child. Again, there were no differences among rural/urban county groups.

Parents who lived in both the most rural and the most urban counties were significantly more likely to report that they want a different medical care provider for their child, usually one that is closer or one that they believe would provide better care. Those in fully capitated plans are more likely to want their previous doctor. The reasons parents were unable to switch their children's primary care provider differed by place of residence. Rural parents were more likely to face transportation barriers; urban parents were more likely to report that the desired provider did not accept Medicaid.

As might be expected, rural parents are less likely to report access to after hours care through their primary provider. Parents who felt their child needed after hours care might call their doctor or go to the ER but their choice of action did not differ by where they lived or by their type of managed care plan. Most parents who called their doctor, regardless of residence, were able to reach someone and get instructions. Although anecdotal reports suggest that many parents are routinely instructed that they should go to the ER when the office is closed, fewer than one-quarter did so when they needed after hours care and even fewer reported ever doing so. Again, this did not vary by rural/urban residence or managed care type.

Access to dental care remains a substantial problem for children covered by Medicaid and particularly for those in the most rural county groups, where 20% of children age five and older were reported to need a dental provider. Children in rural areas were also more likely to have had unmet need for dental care in the past six months, with lack of dentists who take Medicaid patients a major barrier. Another barrier frequently cited by all parents was a long wait for an appointment, a condition which, as noted above, may be exacerbated by Medicaid policies that discourage provider participation, leading to overcrowding at the offices where Medicaid is accepted. Almost three-quarters of the most rural children with unmet need for dental care needed acute care. The parents of rural children, on the other hand, were least likely to report that their children need routine dental care. However, past research has shown that in areas with historic lack of access, parents appear less aware of the need for preventive dental services, and so may not report lack of those services as an unmet need.

Transportation can be a problem for all poor people, but is particularly problematic in rural areas where long distances separate patients and their providers. Rural parents were significantly more likely to report missing an appointment due to transportation problems. Of interest to this report was the finding that rural residents were more likely to report that there was a Medicaid transportation program in their area but urban parents were more likely to report using it.

Overall, this study finds that parents of children living in the rural areas who are enrolled in a Medicaid managed care program are almost always able to get the medical care they need. Rural children who are Medicaid enrollees have primary care providers, their parents know how to access care when needed after hours, and although rural children sometimes use the ER, they do not rely on that source of care more than urban parents do.

Where barriers to medical care are reported, they are often consistent with those barriers reported for rural residents generally, and do not appear to be related to restrictions from managed care programs. Rural parents do face more challenges when it comes to some personal barriers to care such as transportation. Although many report that they are aware of Medicaid transportation, a knowledge that may arise from necessity as much as from Medicaid policy, it is not known why rural parents do not make more use of the service. It is possible that there are aspects of how Medicaid transportation services are operated that make them less useful in rural areas. Long waits for appointments is another barrier frequently reported regardless of where children with Medicaid live. This barrier might be partially mitigated by Medicaid policies that encourage provider participation in the program but will likely persist in areas where there are shortages of health care personnel.

Finally, access to dental services remains a substantial problem, not just for children in rural areas, but for all Medicaid enrollees. Regardless of managed care program type, there is work to be done for all Medicaid recipients to improve access.

INTRODUCTION

States have increasingly turned to managed care as a delivery system for their Medicaid programs. The use of managed care as a delivery system for Medicaid eligibles began in 1982 when Arizona instituted a statewide managed care program. A decade later (1991), 14% of Medicaid enrollees nationally were in some type of managed care plan (Highsmith and Somers, 2000). Medicaid managed care grew at an explosive rate in the 1990s, and by June 2004 almost 61% of eligibles nationally were enrolled in managed care (CMS, 2005).

There are many barriers to the implementation of Medicaid managed care in rural areas, including provider resistance, the absence of commercial managed care, inadequate provider supply and lack of networks, limited beneficiaries across whom to spread risk, and lack of legislative or political will (Felt et al., 1999). In many states where managed care programs have not been implemented statewide, participation in rural areas lags behind that of urban areas (Slifkin et al., 1998, Silberman et al., 2002). Still, Medicaid managed care programs have been implemented in many more rural areas than some initially thought possible.

States have chosen to implement managed care programs in rural communities for a number of reasons. For many states, the primary incentive for implementing Medicaid managed care was cost containment. Other states expressed interest in Medicaid managed care as a mechanism to improve health care quality or access to care, or as a means to provide the same program statewide (Slifkin et al., 1998). These state level decisions about whether and how to implement Medicaid managed care programs affect not only state budgets but also Medicaid beneficiaries, both directly and through effects on the rural health infrastructure.

There has been little previous research on rural beneficiaries' perspectives on access to care under Medicaid managed care. In a single study of beneficiaries in Minnesota, although there were cost savings from the implementation of Medicaid managed care, little impact was found on beneficiary access (Long et al., 2005). The study reported here considers the perspective of the rural beneficiary in other states in order to broaden understanding of whether Medicaid managed care programs provide acceptable access to health care services for them. This study examines access to health care among rural children ages 0-17 years who are enrolled in either fully capitated or primary care case management (PCCM) Medicaid managed care plans, and compares this access to that of urban beneficiaries.[1] Areas of focus include the ability to find a participating health care

[1] The two main types of managed care programs that are utilized in state Medicaid programs are primary care case management (PCCM) and fully capitated programs, although there are other variations, such as partially capitated programs, or combinations of the two program types. In fully capitated programs, an insuring organization receives a fixed payment per enrollee to provide Medicaid-covered services. If an individual enrollee has annual health care costs that exceed the capitated payment, the insuring organization must bear the loss, while if an enrollee has lower than expected costs, the organization keeps the profit. It should be noted, however, that although the insuring organization receives a capitated payment, they may contract with primary care providers who they reimburse on a fee-for-service basis. In PCCM programs, each enrollee in assigned (or chooses) a primary care provider, who serves as a gatekeeper and is responsible to managing that individual's care. The primary care provider is typically paid a monthly management fee,

provider within a reasonable distance, coordination of care concerning services such as specialty care that are more likely to be located in urban areas, and use of the emergency room. A particular focus of the study is services, such as dental and transportation, which are typically carved out of managed care programs but are particularly relevant to rural populations, to explore whether states' focus on program development has compromised access to services that have been separated from the managed care program.

METHODS

This is a cross-sectional study of access to care among children enrolled in Medicaid. A survey was mailed to the parents of Medicaid children in four states. The survey was designed to allow input from participating states to explore areas of particular relevance to their population, and so contained questions asked of all parents in all four states and state-specific questions. The study was reviewed and approved by the Committee for the Protection of the Rights of Human Subjects at the University of North Carolina School of Medicine.

Selection of Sample States – Four states were selected to represent different geographic areas, different ethnic populations, and different models of managed care. North Carolina and North Dakota agreed to participate and serve as examples of states with a primary care case management model of managed care for their Medicaid recipients. New Mexico and Washington were also willing to participate and represent full capitation models of managed care. The survey states were chosen to ensure representation of particular groups of interest, including Hispanic and Native American populations.

Selection of Sample Children – Children who had not yet reached their 18th birthday were eligible for the study. Further, the study was limited to children who qualified for Medicaid based on family income and did not include children who were medically needy, who were in foster care or who had been adopted, or children who were in institutions. Using Medicaid expiration dates, an attempt was made to survey parents of children who had been on Medicaid long enough to have used health care services but not those whose Medicaid was expiring soon.

The outcomes of interest were access to various types of care (described later) among children in rural areas compared to children in urban areas. Children were classified as living in rural or urban areas by the county in which they reside. Using US Census data from 2000, counties were divided into quartiles depending on the "percent rurality" of the county, i.e., counties determined by the Census to be 76 to 100% rural were classified as mostly rural, those classified as 51 to 75% were partly rural. Similarly, counties 26 to 50% rural were designated as partly urban and those less than 26% rural were mostly urban.

Lists of Medicaid enrollees were provided by each state's Medicaid office. Five thousand children were randomly selected for the study, divided among the four county rurality

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in addition to receiving fee-for-service payments for any care rendered. Unlike providers in full capitated managed care, providers in a PCCM program face no financial risk.

groups. The survey was conducted from mid-2003 to mid-2004 and sequentially fielded in the four states. Parents of selected children received a 12-page mailed survey that included close-ended and open-ended questions. For many questions, parents could write in their own response if the response categories listed did not match their situation. The following topics were covered:

- Primary care
  - acute and well care
  - use of the health department
  - changing health care providers
  - unmet need for care
  - access to specialty medical care
- After hours care
  - availability of care at primary provider
  - use of the emergency room
- Prescription medication
  - where obtained
  - sources of medication information
  - unmet need for prescription medication
- Dental care
  - availability
  - changing dental providers
  - unmet need for care
- Barriers to care
  - transportation
  - language
  - parental work schedule
- Satisfaction with care

A prepaid long distance telephone card was included in the survey mailing as a token of appreciation. Spanish language surveys were available and each survey packet included a prepaid postcard in Spanish that could be returned to request a Spanish survey. All nonrespondents received a postcard and two survey mailings in follow-up to the original mailing.

Twenty-five hundred and twenty-nine (2,529) surveys were received representing 50.6% of the four state combined sample. Response rates by state ranged from 46.4% to 54.0%. The response rate varied across rural/urban county groups (Table 1) with the best response coming from the partly rural group (53.1%) and the lowest response from the mostly urban group (48.6%). Parents in states with primary care case management models were more likely to respond. Thirty-eight percent (38%) of surveys were from parents of children under 5 years of age with the portion from parents of young children varying widely from state to state (27.0% to 56.1%).

Table 1: Response Rate						
	By Rurality				By MMC Type	
	Mostly Rural	Partly Rural	Partly Urban	Mostly Urban	PCCM	Full Cap
Number in Sample	1016	1484	1250	1250	2000	3000
Usable Surveys	499	788	635	607	1059	1470
Response Rate††	49.1	53.1	50.8	48.6	53.0	49.0

††Difference between managed care types is statistically significant at p<.01

RESULTS

Results of the survey are presented in the tables that follow. Each table includes six columns of results. The first four columns provide the findings for respondents by county rural/urban concentration from all four states combined. The final two columns present results for respondents as categorized by their type of Medicaid managed care (MMC) plan. The results are unweighted.

Differences among the four rural/urban county groups and between the types of managed care were tested for statistical significance using the chi-square test for categorical variables. Statistically significant differences among rural/urban county groups are indicated with asterisks (* for p values <.05 and ** for p values <.01). Values that differ significantly by type of managed care plan are noted with a single or double dagger (†) depending on the level of significance. Questions allowing multiple responses are noted and statistical testing for these questions was carried out to compare the percent of respondents who answered yes or no to each response option.

Description of Respondents

To gauge how experience with Medicaid might affect reported access, questions were included to assess length of Medicaid coverage and understanding of the program (Table 2). Respondents were asked how long they or any family member had been on Medicaid and how well they felt they understood how to get care for their child using Medicaid.

Table 2: Experience with Medicaid, Understanding of Medicaid, and Doctor Visits per Year						
	By Rurality				By MMC Type	
	Mostly Rural (N=499) %	Partly Rural (N=788) %	Partly Urban (N=635) %	Mostly Urban (N=607) %	PCCM (N=1059) %	Full Cap (N=1470) %
How long on Medicaid (any family member)††						
Less than 6 months	2.8	4.9	4.3	3.2	6.0	2.4
6 months to 1 year	14.4	11.9	11.9	14.5	20.5	7.5
More than 1 year	82.8	83.2	83.8	82.3	73.5	90.0
Understanding of Medicaid						
Understand it well	69.0	66.4	66.0	66.6	67.7	66.3
Some things are confusing	29.0	29.7	32.3	31.0	29.5	31.3
All hard to understand	2.0	3.9	1.7	2.4	2.8	2.5
Number of doctor visits for child each year††						
None	7.1	6.3	4.4	4.5	5.2	5.8
1 to 5	67.4	69.5	72.0	68.9	65.9	72.2
6 to 10	17.0	17.0	16.9	18.8	19.8	15.7
11 to 15	5.3	4.5	4.0	4.7	5.2	4.1
16 or more	3.2	2.7	2.7	3.2	4.0	2.1

††Difference between managed care types is statistically significant at p<.01

More than three-quarters of all respondents or a family member had been on Medicaid for more than one year with almost all respondents in fully capitated states reporting greater than one year's experience. There were not significant differences in experience among rural/urban county groups. Although respondents in PCCM states had less experience with Medicaid, they were as likely as those in fully capitated states to report that they understand Medicaid well.

Utilization as measured by number of visits for the sample child per year did not differ among rural/urban county groups. Children in fully capitated states, however, were reported by their parents to make fewer visits a year than those in PCCM states.

Primary Care

One goal of managed care is to assure access to a primary care provider who can meet the child's acute care and well care needs and coordinate needed care with specialist providers. Respondents were asked if they had a doctor's office or clinic to which they could take their child for acute care and if they could also go to that provider for well care. Those answering "yes" to both questions were considered to have a "medical home" for their child, recognizing that this definition represents only limited aspects of the American

Academy of Pediatrics' definition of medical home. Parents were also asked how easy it had been to get a specialist referral for their child, if one had been needed (Table 3).

Table 3: Access to Medical Care

	By Rurality				By MMC Type	
	Mostly Rural (N=499) %	Partly Rural (N=788) %	Partly Urban (N=635) %	Mostly Urban (N=607) %	PCCM (N=1059) %	Full Cap (N=1470) %
Child has a medical home (same provider for acute + well care)	97.6	98.7	97.3	97.8	98.0	97.9
Median travel time to primary provider in minutes (range)	18 (1-180)	15 (1-95)	15 (1-195)	15 (1-75)	15 (1-150)	15 (1-195)
Child Needed a Specialist	40.8	40.6	43.1	40.7	39.1	42.9
For those needing a specialist:	*N=201*	*N=317*	*N=271*	*N=245*	*N=409*	*N=625*
Easy to get referral	71.6	69.1	73.1	69.4	72.1	69.8
Not easy but not too hard	13.9	20.2	17.7	19.6	16.4	19.4
Very difficult to get referral	10.5	8.8	5.9	8.2	7.8	8.5
Impossible – Never got referral	4.0	1.9	3.3	2.9	3.7	2.4

The vast majority of parents, regardless of where they live or the type of managed care plan covering their child, reported that their child had one primary care provider to meet their well care and acute care needs. Around 40% reported that their child had needed a specialist and almost three-quarters of those needing a specialist reported that it was easy to get a referral to see one. On average, 11% of parents found it difficult or impossible to get a referral. There were no significant differences among rural/urban county groups or between managed care types in need for specialist care nor in the ease with which referral was obtained.

Public health departments (HD) have long provided safety net services for low income families and may be a familiar source of care for Medicaid recipients, particularly in rural areas. Respondents were asked if they ever used the health department or local public health office for check-ups, shots, or when the child was sick and, if so, why they went there. We also explored whether the health department was the child's medical home (Table 4).

Table 4: Use of the Health Department						
	By Rurality (all states)				By MMC Type	
	Mostly Rural (N=499) %	Partly Rural (N=788) %	Partly Urban (N=635) %	Mostly Urban (N=607) %	PCCM (N=1059) %	Full Cap (N=1470) %
Ever use the Health Department (HD)**††	35.7	21.8	26.1	22.1	32.4	20.9
Health Department is medical home**†† (same provider for acute + well care)	11.6	5.5	8.9	10.6	11.9	6.5
Of those who ever use the Health Department, why they go there: (multiple responses allowed)	*N=176*	*N=171*	*N=164*	*N=133*	*N=339*	*N=305*
Can't find another doctor**	4.3	3.1	3.3	11.6	5.4	5.0
HD is closer than other places*	26.4	18.2	13.3	20.7	20.1	19.2
HD speaks client's language*†	6.8	5.0	11.9	14.9	6.7	12.1
HD hours are convenient	10.4	13.2	15.2	18.2	13.4	14.6
HD isn't closer but is easier to get to	22.7	17.0	13.3	23.1	19.8	17.8
No appointment needed at HD	17.8	20.1	17.9	18.2	17.3	19.9
Only place can get some services	15.3	20.1	15.9	9.9	16.9	14.2
Other†	19.6	18.2	17.9	28.1	24.3	16.4

*Difference across rural/urban groups is statistically significant at p<.05
**Difference across rural/urban groups is statistically significant at p<.01
†Difference between MMC types is statistically significant at p<.05
††Difference between MMC types is statistically significant at p<.01

One-quarter of all respondents reported that they use the health department for health care for their child, with parents in the most rural areas as well as those in PCCM states more likely to report doing so. Among parents who identified the health department as their child's provider for both well and acute care, parents in both the mostly rural and the mostly urban county groups were more likely to do so. Parents in PCCM plans were also more likely to report using the health department for both acute and well care. Regardless of location or plan type, the health department was not the main source of care for the majority of children.

No one reason for using the health department predominated. Urban parents were more likely to report ever using the health department because they could not find another doctor and because health department staff speak their language. Rural parents were more likely to go there because it is closer. Among the reasons for using the health department that were frequently mentioned by parents under "other" were the cost of care at the health department, availability of the health department as back-up to their regular provider, general convenience, and a preference for the health department doctors, nurses and support staff.

Among only those parents who reported that the health department is their child's medical home, convenience factors such as location, hours, language, and appointment policy were the most frequently mentioned reasons for using the health department. Not being able to find another doctor was the least frequently mentioned reason for those parents' choice of the health department as their child's provider.

Parents were asked if there was any time in the previous six months that they felt their child needed to see a doctor or nurse but could not, and, if so, why their child was unable to receive needed care (Table 5).

Table 5: Unmet Need for Medical Care

	By Rurality (all states)				By MMC Type	
	Mostly Rural (N=499) %	Partly Rural (N=788) %	Partly Urban (N=635) %	Mostly Urban (N=607) %	PCCM (N=1059) %	Full Cap (N=1470) %
Child had unmet need for care in past 6 months	8.7	6.1	7.9	9.2	8.3	7.5
Of those who with unmet need, why they could not get care: (multiple responses allowed)	*N = 43*	*N = 47*	*N = 50*	*N = 55*	*N = 86*	*N = 109*
Medicaid would not pay for it	9.5	8.7	10.6	3.8	10.6	5.8
Health plan would not approve[§]	0.0	6.5	12.0	9.4	NA	7.8
Regular doctor would not send him/her	2.4	10.9	6.4	3.8	5.9	5.8
Couldn't find place that would take Medicaid	14.3	10.9	6.4	9.4	8.2	11.7
Wait for appointment was too long	45.2	37.0	53.2	50.9	49.4	44.7
Too far away or no transportation	31.0	21.7	10.6	20.8	24.7	17.5
Not open when child could go	21.4	10.9	10.6	17.0	17.7	12.6
Other	9.5	17.4	17.0	13.2	12.9	15.5

[§]This response option was only on surveys for states with full capitation plans

Fewer than 10% of parents reported that their child had an unmet need for care in the past six months. Barriers to care reported by parents did not differ significantly among rural/urban county groups or between plan types. Provider barriers (long wait for an appointment, inconvenient hours) were more commonly mentioned than were barriers imposed by the managed care plan. The most common "other" reason parents cited was a problem with their Medicaid certification.

Managed care seeks to improve health care by assuring that enrollees have a consistent source of care. Parents may feel that their choice of provider is limited as indeed it may be in areas where the provider supply is limited or where all providers do not accept Medicaid patients. Respondents were asked if they knew a provider they would rather go to and, if

they did, why they wanted to change. They were also asked why they thought they could not change to the other provider (Table 6).

Table 6: Wants a Different Office or Clinic						
	By Rurality (all states)				By MMC Type	
	Mostly Rural (N=499 %)	Partly Rural (N=788) %	Partly Urban (N=635) %	Mostly Urban (N=607) %	PCCM (N=1059) %	Full Cap (N=1470) %
Parent knows of an office or clinic s/he would rather use*	13.6	11.2	10.4	15.9	12.2	12.9
Of those who want a different provider, why they want to change: (multiple responses allowed)	*N=67*	*N=87*	*N=65*	*N=94*	*N=127*	*N=186*
Doctor is child/family's previous doctor†	15.4	12.1	17.5	14.1	9.2	18.0
Office is closer	36.9	28.9	31.8	30.4	26.7	35.0
Office isn't closer but easier to get to	4.6	2.4	4.8	5.4	5.0	3.8
Office has better office hours†	7.7	8.4	17.5	9.8	15.0	7.7
They speak client's language	4.6	8.4	6.4	4.4	5.0	6.6
Where other family members go	12.3	18.1	14.3	15.2	14.2	15.9
Other	49.2	53.0	42.9	48.9	52.5	46.5
Of those who want a different provider, why they can't change: (multiple responses allowed)	*N=67*	*N=87*	*N=65*	*N=94*	*N=127*	*N=186*
Not on list of allowable providers††	30.7	46.4	32.3	37.1	17.8	50.3
Provider won't take new Medicaid patients**	12.9	6.0	27.4	31.5	18.6	20.1
No way to get there*†	24.2	19.1	11.3	7.9	20.3	11.7
Hassle to change Medicaid doctor††	29.0	21.4	29.0	30.3	35.6	21.8
Doesn't know how to change Medicaid doctor	16.1	19.1	9.7	18.0	18.6	14.5
Other*†	24.2	9.5	17.7	7.9	19.5	10.1

*Difference across rural/urban groups is statistically significant at p<.05
**Difference across rural/urban groups is statistically significant at p<.01
†Difference between managed care types is statistically significant at p<.05
††Difference between managed care types is statistically significant at p<.01

Most parents did not want to change to a different provider but among those who did, urban parents were slightly more likely to express this desire. Parents in full capitation plans were more likely to want to change because the desired provider was the child or family's previous doctor. Parents in PCCM plans were more likely to have identified a

provider with better hours. For all parents, desire to use a closer office was the most frequently mentioned single reason for wanting to change. Almost half of respondents wrote in reasons under "other" which included wanting a better doctor, wanting a pediatrician rather than the physician available, wanting a better facility or nicer office staff, wanting a physician rather than a mid-level practitioner, or wanting one consistent provider.

Overall, 37% of all parents could not change because their preferred provider was not on the list of allowed providers. Parents in fully capitated states were much more likely to report this barrier than were PCCM parents. PCCM parents were more likely to report that they haven't changed because it is a hassle to change providers. Urban parents were more likely to report that the provider they want will not take new Medicaid patients, while rural parents cite transportation barriers more frequently than do other parents.

After Hours and Emergency Care

Managed care should ensure access to a care provider at any hour and should include information about how to obtain after hours care for those whose primary provider does not offer it. Parents in rural areas may have less access to after hours care with their primary provider. The survey asked specifically if the child's provider had evening or weekend hours. We also asked what parents had done if their child had needed care after hours in the past six months (Table 7).

Table 7: Access to After Hours Care						
	By Rurality (all states)				By MMC Type	
	Mostly Rural (N=499) %	Partly Rural (N=788) %	Partly Urban (N=635) %	Mostly Urban (N=607) %	PCCM (N=1059) %	Full Cap (N=1470) %
Primary doctor has evening or weekend hours**††						
Yes	26.9	27.0	35.7	35.7	34.6	28.8
No	59.8	57.2	48.8	46.7	48.7	56.3
Doesn't know	13.3	15.8	15.5	17.7	16.7	14.9
Needed care after hours in last 6 months	32.4	32.5	29.3	31.9	31.6	31.5
Of those who needed care, what did they do:	*N = 160*	*N = 254*	*N = 185*	*N = 189*	*N = 331*	*N = 457*
Called doctor's office	20.4	18.9	22.7	21.4	21.4	20.2
Went to ER without calling because it was emergency	28.7	30.1	30.9	24.7	29.4	28.3
Went to ER without calling because had been instructed to do so when office closed	24.8	24.9	21.0	19.8	23.5	22.2
Waited until next day to see how child was doing	17.8	16.5	15.5	18.7	15.5	18.2
Other	8.3	9.6	9.9	15.4	10.2	11.2
For those who called doctor, what happened?	*N = 32*	*N = 47*	*N = 41*	*N = 39*	*N = 69*	*N = 90*
Told to meet own doctor at ER	9.7	6.4	2.4	0.0	5.9	3.3
Told to go to ER and see whomever was there	29.0	38.3	22.0	20.5	25.0	30.0
Told to meet own doctor at office	16.1	2.1	9.8	10.3	8.8	8.9
Got advice on phone	29.0	48.9	51.2	51.3	48.5	44.4
Couldn't reach anyone	6.5	0.0	0.0	5.1	1.5	3.3
Other	9.7	4.3	14.6	12.8	10.3	10.0

**Difference across rural/urban groups is statistically significant at p<.01
††Difference between managed care types is statistically significant at p<.01

Overall, only 31% of parents reported that their child's primary doctor had weekend or evening hours, with parents in PCCM states and those in partly to mostly rural areas less likely to report the availability of such care. Thirty-two percent (32%) of all parents reported that in the past six months their child had been sick enough to need to see a doctor when the office was closed. Those parents were almost equally likely to have called the doctor or to have taken the child to the emergency room (ER) because the child's condition warranted it or because they had been told to do so in the event the office was closed. Parental response to the need for after hours care did not differ significantly among

rural/urban county groups or between plan types. Among parents who called their child's doctor, most received advice on the phone with the exception of families in the most rural areas. These families were more likely than others to be told to meet the doctor at the ER or at the doctor's office, and, along with parents in the mostly rural counties, were also more likely to be told to go to the ER and see whoever was there. These differences in instructions, although striking, were not statistically significant, probably due to the small number of parents who reported calling their child's doctor when they needed after hours care.

Even when it is not an emergency, parents of children on Medicaid may be told to use the ER after hours in places where there is no after hours primary care provider coverage (Table 8).

Table 8: Use of ER for Non-Emergencies

	By Rurality (all states)				By MMC Type	
	Mostly Rural (N=499) %	Partly Rural (N=788) %	Partly Urban (N=635) %	Mostly Urban (N=607) %	PCCM (N=1059) %	Full Cap (N=1470) %
Ever use ER when not an emergency	13.0	16.7	13.2	13.3	12.8	15.3
Of those who do, why: *(multiple responses allowed)*	*N = 64*	*N = 129*	*N = 83*	*N = 79*	*N = 133*	*N = 222*
Told to always go there when office closed	39.7	44.5	37.4	43.4	37.1	44.5
Easiest place to get to	11.1	10.2	7.2	7.9	9.9	8.7
Open all the time†	52.4	54.7	49.4	47.4	58.3	47.3
Know what to do to get child seen there†	7.9	6.3	3.6	6.6	9.9	3.7
Other††	12.7	14.1	19.3	17.1	9.1	19.7

†Difference between managed care types is statistically significant at p<.05
††Difference between managed care types is statistically significant at p<.01

Fewer than 15% of all parents reported that they used the ER when it was not an emergency and there were not significant differences among parents in different rural/urban county groups or between managed care types. Parents were more likely to go to the ER even if it is not an emergency because the ER is always open. Forty percent (40%) of all parents, however, do so because they have been told to, again with no significant differences by residence or plan type. Almost half of those in fully capitated plans who reported going to the ER for other reasons specifically noted that they go there when their regular doctor is too busy to fit in a patient without an appointment.

Pharmacy Services

Table 9 shows where parents fill their child's prescriptions and how long it takes them to get to the pharmacy.

Table 9: Access to Prescription Medication						
	By Rurality (all states)				By MMC Type	
	Mostly Rural (N=499) %	Partly Rural (N=788) %	Partly Urban (N=635) %	Mostly Urban (N=607) %	PCCM (N=1059) %	Full Cap (N=1470) %
Uses a regular local or chain drug store**††	70.7	68.8	63.9	62.8	74.2	60.9
Uses pharmacy at large grocery or discount store**††	25.1	36.6	36.1	29.5	19.1	42.1
Uses pharmacy at hospital or clinic**††	17.3	5.7	11.2	22.4	18.3	9.8
Hasn't needed prescription medication	2.2	1.5	1.6	2.1	1.9	1.8
Other	0.4	0.9	0.5	0.5	0.5	0.7
Median travel time to pharmacy in minutes (range)	15 (1-180)	13 (1-90)	10 (1-90)	10 (1-120)	10 (1-90)	10 (1-180)

**Difference across rural/urban groups is statistically significant at p<.01
††Difference between managed care types is statistically significant at p<.01

The type of pharmacy used by parents to obtain their child's prescriptions varied by both residence and plan type. Differences by plan type, however, likely reflect differences in the availability of different types of pharmacy providers in the states included in each plan type, rather than true differences associated with the type of managed care. Similarly, differences by rural/urban county groups may also be dictated by the distribution of pharmacy providers. Parents in rural areas were more likely to report using a regular local or chain drug store and less likely to report using a pharmacy at a large grocery or discount store, which is consistent with the geographic distribution of these two types of pharmacies. Parents in the most rural and most urban areas were more likely than others to use a pharmacy at a hospital or clinic. Travel time to a pharmacy increases as place of residence becomes more rural, although travel time differences are small.

Parents were asked if they could get the information they need if they have questions about their child's prescription medication (Table 10).

Table 10: Access to Information about Prescription Medication						
	By Rurality (all states)				By MMC Type	
	Mostly Rural (N=499) %	Partly Rural (N=788) %	Partly Urban (N=635) %	Mostly Urban (N=607) %	PCCM (N=1059) %	Full Cap (N=1470) %
Has not had questions	18.8	16.5	15.9	15.0	16.6	16.3
No one to ask	0.6	0.4	0.3	1.2	0.9	0.3
Can ask someone at drugstore or pharmacy	76.2	80.8	78.6	76.9	78.0	78.7
Can call doctor or nurse†	51.1	53.4	49.3	50.6	48.8	53.0
Has a number to call with medication questions	2.8	4.6	3.9	5.9	5.1	3.9
Other	1.0	1.5	1.6	1.8	1.7	1.4

†Difference between managed care types is statistically significant at p<.05

Most parents reported that there was someone they could ask if they had medication questions, and there were no significant differences across rurality groups. Parents in fully capitated plans were more likely to report that they could call their doctor or nurse although the difference between PCCM and fully capitated groups was not large.

One way managed care plans seek to control costs is by supporting the use of less expensive generic medications, restricting the list of medications that they will cover, or limiting the number of prescriptions that can be filled each month. Parents were asked if there was a time in the previous six months that they were unable to fill a needed prescription for their child and, if so, why (Table 11).

Table 11: Unmet Need for Prescription Medication						
	By Rurality (all states)				By MMC Type	
	Mostly Rural (N=499) %	Partly Rural (N=788) %	Partly Urban (N=635) %	Mostly Urban (N=607) %	PCCM (N=1059) %	Full Cap (N=1470) %
Had unmet need for prescription medication††	4.7	7.0	7.9	8.3	5.3	8.4
Of those who with unmet need, why they could not get Rx: *(multiple responses allowed)*	*N = 23*	*N = 55*	*N = 50*	*N = 50*	*N = 56*	*N = 122*
Due to Medicaid policies/procedures††	73.9	74.6	85.7	79.6	62.5	86.7
Due to pharmacy*††	34.8	38.2	14.3	24.5	42.9	20.0
Other	0.0	3.6	4.1	4.1	5.4	2.5

*Difference across rural/urban groups is statistically significant at p<.05
††Difference between managed care types is statistically significant at p<.01

Overall, 7% of parents reported that in the last six months they had not been able to fill a prescription that their child needed. This was a more common problem for parents of children in fully capitated plans and was most often due to Medicaid polices and procedures. The most common barrier to getting needed medication was that the plan would not pay for the particular drug, but occasionally the reported barrier was monthly limits on the number of prescriptions that could be filled. PCCM parents were more likely to list an "other" reason, most frequently that there had been a problem with their Medicaid card being late or invalid. Parents of children in more rural areas were significantly more likely to report that the unmet need for medication was due to a problem at the pharmacy, either that the pharmacy was out of the medication or that the pharmacy was closed.

Dental Care

Access to dental care is a well-known challenge for many Medicaid enrollees and lack of dentists in rural areas is likely to make the problem worse for rural residents. Table 12 displays parents' responses to a question asking if their child had a dentist. Analysis of access to and satisfaction with dental care is limited to children five years of age and older because of differing perceptions among parents of younger children as to when it is appropriate to begin dental care.

Table 12: Access to Dental Care for Children Five Years of Age and Older

	By Rurality (all states)				By MMC Type	
Does child have a dental care provider?*††	Mostly Rural (N=319) %	Partly Rural (N=498) %	Partly Urban (N=389) %	Mostly Urban (N=363) %	PCCM (N=511) %	Full Cap (N=1058) %
Has a provider for dental care	75.5	79.7	83.5	84.0	74.7	83.7
Too young for dental care	0.3	0.2	0.8	1.4	1.2	0.4
No, hasn't had dental problems	4.7	2.6	3.4	2.2	4.1	2.7
Needs a dental provider	19.5	17.5	12.4	12.4	20.0	13.3
Median travel time to dentist in minutes (range)	30 (1-180)	20 (1-150)	15 (2-240)	19 (2-90)	15 (2-240)	20 (1-180)

*Difference across rural/urban groups is statistically significant at p<.05
††Difference between managed care types is statistically significant at p<.01

Access to a dental provider differed significantly across rural/urban county groups with parents in rural areas less likely to report having a dentist for their child and more likely to report needing one. Reported travel times were also longer for rural residents. Dental access also varied by plan type. Like rural parents, parents in PCCM plans were less likely to report having a dentist and more likely to report needing one.

Lack of access to a dental provider can lead to unmet need for dental care. Parents were asked if their child had an unmet need for dental care in the past six months and, if so, why

she or he could not get the needed care. They were also asked to describe the care needed (Table 13).

Table 13: Unmet Need for Dental Care for Children Five Years of Age and Older						
	By Rurality (all states)				By MMC Type	
	Mostly Rural (N=319) %	Partly Rural (N=498) %	Partly Urban (N=389) %	Mostly Urban (N=363) %	PCCM (N=511) %	Full Cap (N=1058) %
Child had unmet need for dental care in past 6 months*	13.0	15.2	9.6	9.6	14.3	11.0
Of those who with unmet need, why they could not get care: (multiple responses allowed)	*N=41*	*N=75*	*N=37*	*N=34*	*N=72*	*N=115*
Dentist said child was too young	5.0	1.4	2.7	3.0	4.2	1.8
Could not find a dentist to take Medicaid*	42.5	61.6	37.8	36.4	52.1	45.5
Wait for appointment too long	50.0	32.9	46.0	30.3	39.4	38.4
No transportation	20.0	8.2	13.5	9.1	12.7	11.6
Dentist not open when could go*	17.5	4.1	0.0	6.1	4.2	8.0
Other	7.5	23.3	24.3	24.2	21.1	19.6
What kind of care was needed?	*N=41*	*N=75*	*N=37*	*N=34*	*N=72*	*N=115*
Routine check-up and/or cleaning*	19.5	33.3	51.4	32.4	41.7	28.7
Acute care including fillings and crowns	70.7	61.3	48.7	67.7	59.7	63.5
Orthodontia	12.2	10.7	21.6	17.7	12.5	15.7
Other or unspecified	7.3	6.7	5.4	5.9	4.2	7.8

*Difference across rural/urban groups is statistically significant at p<.05

Limited access to dental care for rural residents previously noted is also reflected in significantly greater unmet need reported by rural parents. Rural parents with a child with unmet need for dental care were more likely to report reasons for the unmet need that included not being able to find a dental provider to take Medicaid or that the dental office was not open when they could go. Long waits for appointments was a common problem regardless of residence or plan type. More than half of all children with who needed dental care were reported to need acute care that ranged from fillings to crowns. Rural parents were less likely than urban parents to report that their children needed routine check-ups and/or cleaning.

As with primary care providers, many parents would like to change dental providers and may know of a provider they would like to use but cannot (Table 14).

Table 14: Want a Different Dental Provider (Children Five Years of Age and Older)						
	By Rurality (all states)				By MMC Type	
	Mostly Rural (N=319) %	Partly Rural (N=498) %	Partly Urban (N=389) %	Mostly Urban (N=363) %	PCCM (N=511) %	Full Cap (N=1058) %
Would rather use a different dental provider	33.6	37.1	30.0	29.1	33.0	32.6
Of those who want to change, why they <u>can't</u> change: (multiple responses allowed)	*N = 103*	*N = 181*	*N = 115*	*N = 104*	*N = 164*	*N = 339*
Dentist wanted won't take Medicaid at all or wouldn't take more Medicaid patients	74.5	82.2	83.2	79.8	78.4	81.3
No way to get there	6.9	3.3	4.4	1.0	3.7	3.9
Don't know how to find a dentist	5.9	8.9	9.7	11.5	6.2	10.4
Other	21.6	16.1	14.2	16.4	19.1	15.7

One-third of all parents would like to use a different dental provider. By far the biggest barrier to changing providers was a lack of dentists who will accept any Medicaid patients or additional Medicaid patients. Neither the percentage of parents who want to change dental providers nor the reasons they cannot varied by residence or plan type.

Transportation to Care

In addition to the questions regarding barriers to care previously described, several questions were included in the survey to inquire about specific barriers known to affect access to care for low-income families. Table 15 describes how Medicaid families get to their doctor. Parents were also asked if Medicaid had a transportation program in their area and if Medicaid had ever arranged transportation for them or paid for transportation that the parent had arranged.

Table 15: Getting to the Doctor

	By Rurality (all states)				By MMC Type	
	Mostly Rural (N=499) %	Partly Rural (N=788) %	Partly Urban (N=635) %	Mostly Urban (N=607) %	PCCM (N=1059) %	Full Cap (N=1470) %
How do Medicaid clients get to the doctor? (multiple responses allowed)						
Their own car**††	85.8	90.9	91.7	87.0	84.8	92.2
Borrow a car or ask someone for a ride*††	16.0	12.9	10.1	14.3	17.4	10.1
Public transportation**	0.6	1.5	2.4	6.9	3.6	2.3
Walk	5.6	4.6	3.3	2.8	3.6	4.4
Use a van service	2.0	0.8	1.1	1.0	1.3	1.0
Other	1.2	1.5	0.9	1.2	1.4	1.1
Awareness of Medicaid Transportation						
Knows about Medicaid transportation in their area**††	43.9	29.4	32.0	35.5	40.2	30.2
Medicaid has arranged transportation**	6.4	4.4	6.6	9.5	7.5	5.9
Medicaid has paid for transportation patient arranged*	6.6	4.7	5.5	8.3	6.0	6.2

*Difference across rural/urban groups is statistically significant at p<.05
**Difference across rural/urban groups is statistically significant at p<.01
††Difference between managed care types is statistically significant at p<.01

The majority of parents report that they use their own car to get to health care appointments. Rural parents are slightly less likely to use their own car and more likely to rely on others for a ride. Parents in PCCM states and those in rural areas regardless of plan type are also more likely to report that they know about a Medicaid transportation program in their area. Parents in urban areas, however, are more likely to have used a Medicaid transportation program, either by using transportation arranged by Medicaid or transportation arranged by themselves but paid for by Medicaid. For all parents, regardless of residence or plan type, fewer than 10% reported using Medicaid transportation.

Even though almost 90% of all parents reported that they could use their own car to get to health care appointments, those with a car may not have a reliable car. Parents were asked

if they had ever missed a doctor or dentist appointment for their child because they could not get there, and if so, what was the nature of the transportation problem (Table 16).

Table 16: Missed Appointments Due to Transportation Problems

	By Rurality (all states)				By MMC Type	
	Mostly Rural (N=499) %	Partly Rural (N=788) %	Partly Urban (N=635) %	Mostly Urban (N=607) %	PCCM (N=1059) %	Full Cap (N=1470) %
Has missed doctor appointment due to transportation problems**	18.4	12.3	11.1	12.3	14.7	12.1
Of those who have missed appointments, why? (multiple responses allowed)	*N=91*	*N=96*	*N=70*	*N=74*	*N=154*	*N=177*
Could not find anyone to take them	45.1	42.7	48.6	45.2	48.1	42.6
Could not call for a ride far enough in advance	8.8	13.5	10.0	15.1	9.1	14.2
Ride was late to pick them up	19.8	13.5	10.0	11.0	15.6	12.5
Car broke down	46.2	52.1	37.1	39.7	40.3	48.3
Other	13.2	11.5	11.4	12.3	13.0	11.4
Has missed dental appointment due to transportation problems (limited to children 5 years of age and older)	10.5	9.2	6.4	8.7	8.9	8.5
Of those who have missed appointments, why? (multiple responses allowed)	*N=33*	*N=45*	*N=25*	*N=31*	*N=45*	*N=89*
Could not find anyone to take them	24.2	33.3	44.0	43.3	37.8	34.1
Could not call for a ride far enough in advance	0.0	8.9	8.0	16.7	6.7	9.1
Ride was late to pick them up*††	27.3	4.4	16.0	10.0	24.4	8.0
Car broke down	24.2	46.7	28.0	50.0	31.1	42.1
Other	27.3	28.9	24.0	10.0	20.0	25.0

*Difference across rural/urban groups is statistically significant at p<.05
**Difference across rural/urban groups is statistically significant at p<.01
††Difference between managed care types is statistically significant at p<.01

Overall, 13% of parents reported that their child had missed a doctor appointment due to transportation problems. Parents living in the most rural areas were more likely to report missing an appointment. Fewer parents reported missing dental appointments and there were no significant differences among rural/urban county groups or between plan types. The most frequently cited reasons for missing medical or dental appointments were that parents could not find a ride or that their car broke down. For residents of the most rural counties, their ride being late to pick them up was also a significant barrier. Barriers reported under "other" included weather.

Other Barriers

Other barriers queried in the survey included language differences and the parent's work schedule (Table 17).

Table 17: Other Barriers/Issues						
	By Rurality (all states)				By MMC Type	
	Mostly Rural (N=499) %	Partly Rural (N=788) %	Partly Urban (N=635) %	Mostly Urban (N=607) %	PCCM (N=1059) %	Full Cap (N=1470) %
Language differences make getting care difficult**	1.6	2.4	4.1	4.8	3.5	3.1
Parent's work schedule makes getting care difficult[§]	22.2	22.1	21.0	26.0	22.3	23.3

[§]This question was asked in 3 states only.
**Difference across rural/urban groups is statistically significant at p<.01

Parental work schedule was reported as a barrier to care by almost 25% of parents regardless of where they lived or the type of plan under which their child was covered. Language differences were less commonly reported but were more of a problem for parents in urban areas.

Parental Satisfaction with Health Care Services and their Medicaid Managed Care Plan

Parents were asked how satisfied they were with their child's medical care provider (doctor, nurse or clinic), dental care, pharmacy services, and their managed care plan in general (Table 18).

Table 18: Satisfaction with Services and Medicaid Managed Care[§]

	By Rurality (all states)				By MMC Type	
	Mostly Rural (N=499) %	Partly Rural (N=788) %	Partly Urban (N=635) %	Mostly Urban (N=607) %	PCCM (N=1059) %	Full Cap (N=1470) %
Satisfaction with Medical Care*[†]						
More than satisfied	67.2	70.8	75.8	68.8	70.1	71.6
Satisfied	23.4	22.6	19.3	22.5	23.8	19.8
Less than satisfied	9.5	6.7	5.0	8.8	6.1	8.6
Satisfaction with Dental Care (Children Five Years of Age and Older)						
More than satisfied	56.2	51.2	61.6	57.6	55.4	56.8
Satisfied	23.8	23.2	21.0	24.8	24.0	22.6
Less than satisfied	20.0	25.6	17.4	17.6	20.6	20.6
Satisfaction with Pharmacy Services						
More than satisfied	73.8	69.8	75.8	73.9	72.6	73.4
Satisfied	21.6	24.9	18.7	22.0	23.0	21.0
Less than satisfied	4.6	5.4	5.5	4.1	4.3	5.6
Satisfaction with Medicaid Managed Care Program*						
More than satisfied	65.1	67.4	71.4	63.3	67.8	66.1
Satisfied	25.2	25.3	20.7	25.0	22.3	25.9
Less than satisfied	9.7	7.3	7.9	11.8	9.9	7.9

[§]These questions were asked in 3 states only.
*Difference across rural/urban groups is statistically significant at p<.05
[†]Difference between managed care types is statistically significant at p<.05

More than 90% of all parents reported that they were satisfied or more than satisfied with their child's medical care. There were statistically significant differences across rural/urban county groups and between types of managed care plans but these differences were often not large and follow no clear geographic pattern. Dissatisfaction with dental care was more commonly reported with more than 20% of all parents reporting being less than satisfied. On the whole, prescription services were viewed positively by the vast majority of parents, regardless of residence of plan type. Finally, parents' overall satisfaction with their Medicaid managed care plan was high.

SUMMARY AND DISCUSSION

The findings of this study, based on responses from parents who have been on Medicaid for more than a year and who generally report that they understand Medicaid well, provide both encouraging news for those who work to improve health care for poor rural residents as well as identifying areas that still need improvement. In the four states studied, access to primary care under Medicaid managed care is excellent. Almost all children, regardless of rurality of residence, have a provider who can meet their well care and acute care needs. Although the health department provides services for some, particularly those in rural areas and in certain states, rural parents report that they take their children to the health department because of convenience. Parents seldom mention that they use the health departments because they cannot find anywhere else to take their child.

Few parents, regardless of residence, reported unmet need for medical care. And when they did, the barriers they most often cited appeared to be provider-based, such as long waits for appointments or inconvenient hours. Problems with Medicaid coverage or referrals were not the most common barriers cited. The main barriers cited, although not directly attributable to the Medicaid managed care program, may be exacerbated, however, by policies of the Medicaid program which discourage provider participation and lead to overcrowding at the offices where Medicaid is accepted.

If children need a specialist, their parents are likely to find it easy or at least not too hard to get the referral they need. Again, there were no differences among rural/urban county groups or between plan types. But, 11% of all parents found it very difficult or impossible to get a referral for their child. The extent to which this barrier existed due to Medicaid referral policies, due to a lack of agreement with the need or diligence on the part of the primary care provider, or due to an absolute lack of specialty providers or lack of those who will accept Medicaid patients cannot be determined.

Parents who lived in both the most rural and the most urban counties were significantly more likely to report that they want a different medical care provider for their child, usually one that is closer or one that they believe would provide better care. Those in fully capitated plans are more likely to want their previous doctor. The reasons parents were unable to switch their children's primary care provider differed by place of residence. Rural parents were more likely to face transportation barriers; urban parents were more likely to report that the desired provider did not accept Medicaid. Parents whose children are in fully capitated plans are more likely than those with children covered by PCCM plans to report that their choice of provider is limited, but PCCM parents face more bureaucratic barriers to change.

As might be expected, rural parents are less likely to report access to after hours care through their primary provider. Parents who felt their child needed after hours care might call their doctor or go to the ER but their choice of action did not differ by where they lived nor by their type of managed care plan. Most parents who called their doctor, regardless of residence, were able to reach someone and get instructions. Although anecdotal reports suggest that many parents are routinely instructed that they should go to

the ER when the office is closed, fewer than one-quarter did so when they needed after hours care and even fewer reported ever doing so. Again, this did not vary by rural/urban residence or managed care type.

Prescription medication is available for all children in Medicaid managed care plans regardless of residence and parents report having someone of whom they can ask questions about their child's medication. Barriers associated with Medicaid policies were most often reported particularly among those in fully capitated plans. Pharmacy barriers were also common, particularly among those in PCCM plans.

Access to dental care remains a problem for children covered by Medicaid and particularly for those in the most rural county groups, where 20% of children age five and older were reported to need a dental provider. In the states with PCCM programs dental access was more problematic but it is not possible to know if the barriers in those states are due to Medicaid policies, provider supply, or both. Children in rural areas were also more likely to have had unmet need for dental care in the past six months, with lack of dentists who take Medicaid patients a major barrier. Another barrier frequently cited by all parents was a long wait for an appointment, a condition which, as noted above, may be exacerbated by Medicaid policies that discourage provider participation, leading to overcrowding at the offices where Medicaid is accepted. Almost three-quarters of the most rural children with unmet need for dental care needed acute care. The parents of rural children, on the other hand, were least likely to report that their children need routine dental care. However, past research has shown that in areas with historic lack of access, parents appear less aware of the need for preventive dental services, and so may not report lack of those services as an unmet need (Mayer, et al., 2005).

Transportation can be a problem for all poor people, but is particularly problematic in rural areas where long distances separate patients and their providers. Although the majority of parents reported that they use their own car to get to health care appointments, those who missed appointments often noted that their car had broken down. Rural respondents were significantly more likely to report missing an appointment due to transportation problems. Of interest to this report was the finding that rural residents were more likely to report that there was a Medicaid transportation program in their area but urban parents were more likely to report using it.

Finally, most parents are satisfied or even more than satisfied with their child's medical care provider, with pharmacy services and with the Medicaid managed care plan overall. Parents were less likely to be satisfied with dental care. Although there were differences in levels of satisfaction across rural/urban areas there were not striking differences pointing to major issues for rural residents.

Overall, this study finds that parents of children living in the rural areas who are enrolled in a Medicaid managed care program are almost always able to get the medical care they need. Rural children who are Medicaid enrollees have primary care providers, their parents know how to access care when needed after hours, and although rural children sometimes use the ER, they do not rely on that source of care more than urban parents do.

Where barriers to medical care are reported, they are often consistent with those barriers reported for rural residents generally, and do not appear to be related to restrictions from managed care programs. Rural parents do face more challenges when it comes to some personal barriers to care such as transportation. Although many report that they are aware of Medicaid transportation, a knowledge that may arise from necessity as much as from Medicaid policy, it is not known why rural parents do not make more use of the service. It is possible that there are aspects of how Medicaid transportation services are operated that make them less useful in rural areas. Long waits for appointments is another barrier frequently reported regardless of where children with Medicaid live. This barrier might be partially mitigated by Medicaid policies that encourage provider participation in the program but will likely persist in areas where there are shortages of health care personnel.

Finally, access to dental services remains a substantial problem, not just for children in rural areas, but for all Medicaid enrollees. Regardless of managed care program type, there is work to be done for all Medicaid recipients to improve access.

LIMITATIONS

There are a number of limitations of the study that merit mentioning. First, as with all work assessing rural health conditions, classifications of place of residence are imprecise. The data in this report are also based on parental report. Questions based on parental perception of need or barriers to care cannot be verified by chart review or a detailed review of Medicaid policy. Need and barriers cited here could be overestimated or underestimated. Similarly, information was received from roughly half of the parents surveyed. The extent to which those who completed the survey are more or less happy with their child's health care as it relates to their Medicaid managed care plan compared to parents who did not respond cannot be determined.

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