Future Rural Managed Care Issues

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The six managed care organizations (MCOs) described in the preceding case studies faced similar challenges in their efforts to continue to serve rural areas. During the formative stages of their rural market development, most of the MCOs did not compete with other MCOs to serve rural areas. In the future, however, they all will face increased competition from other MCOs. All of the MCOs, except Medical Associates HMO, are in the midst of efforts to expand their geographic market areas. Likely changes in Medicare and Medicaid policy will induce more MCOs to serve rural areas, encouraging greater use of managed care by rural residents eligible for these programs. These market and policy changes raise many questions.

- How are rural providers and consumers likely to be affected by an increase in MCO competition in rural areas?
- What are the consequences for rural providers and consumers of MCO expansion into new, previously unserved rural areas?
- Will MCOs develop new products designed to meet the particular needs of rural populations?
- What are the likely effects on rural areas of Medicare and Medicaid policies intended to increase the use of managed care?

Competition

The increased competition among MCOs in rural areas is likely to affect physicians, but exactly how rural physicians will be affected is less clear. Increased competition could result in greater risk sharing with physicians (or more forceful management of service utilization) in an attempt to lower costs and premiums. MCOs may accelerate their acquisitions and management of rural practices in an attempt to more directly control the behavior of physicians. Alternatively, competition among MCOs may create a more favorable negotiating climate for rural providers. To ensure rural physician participation in their networks, MCOs may be willing to make payment concessions and to offer greater practice support.

If their communities are served by multiple MCOs, rural physicians in the future probably will participate in multiple provider networks to maintain or expand the number of patients treated by their practices. To the extent that the care management, referral arrangements, and payment policies of the MCOs differ substantially, participation in multiple health plans may increase the complexity and cost of medical practice. If the proportion of patients enrolled in multiple MCOs with conflicting policies is significant, it could promote the demise of solo and small independent medical practices in rural areas as rural physicians coalesce to share practice management expertise, benefit from economies of scale, and spread risk among a larger number of patients and providers. Some rural physicians may remove themselves altogether from practice management issues by selling their practices and accepting salaried employment by a hospital, clinic, or health plan.

Conversely, small rural practices may adapt to the policies and procedures of MCOs in the same way they have adapted to other prominent changes in health insurance during the past 50 years (e.g., the advent of

indemnity health insurance, the introduction of Medicare and Medicaid, Peer-review Organizations, diagnosis-related groups, and Resource-based Relative Value Scales). Rather than being a watershed event, the introduction to a rural area of multiple competing MCOs could be viewed by rural providers as merely a cost of doing business.

Rural hospitals, too, could become either the beneficiaries or the victims of increased MCO competition. Rural hospitals may see their bargaining power increase as multiple MCOs compete for access to low-cost "workshops" for their rural physicians. On the other hand, those hospitals may be squeezed by the greater cost cutting associated with competition (e.g., more effective utilization management programs). It is not in the interest of MCOs, however, to reduce payments to rural hospitals to such a degree as to threaten their fiscal viability. Although the role of rural hospitals is changing, they are likely to remain an integral component of the rural health delivery system.

Rural employers and employees could benefit in the short run from increased competition among MCOs if lower premium rates, better service, and more expansive benefits result. It is uncertain how many MCO competitors can be sustained in rural markets, although it is likely that some of these competitors will eventually be driven from the field. Those MCOs most vulnerable to failure are likely to be small plans located in, or currently serving, predominantly rural areas. Larger MCOs will have more staying power in competitive markets.

As the number of rural enrollees grows, what effect will a smaller number of MCOs serving rural areas have on rural consumers? Will the benefits of competition be exhausted by the time the rural MCO market matures? Theoretically, the threat of MCO entry should continue to discipline the rural managed care market, but this potential effect may be limited in practice if the costs of entering a rural market dominated by an existing MCO are high, especially if antitrust law is interpreted to permit the dominance of one MCO in the rural segment of a larger geographic market.

Expansion

The MCOs that currently serve rural areas have been successful to date in part because they show a "local face" to both providers and consumers. These MCOs are either locally operated or decentralized into regional offices. Will MCOs that expand into new rural territories mimic the strategies of these successful MCOs, or will they manage provider and customer relations from central offices in major metropolitan areas? How satisfied will rural providers and customers be with MCOs that are managed by staff located in a remote, urban location? What are the current and possible future roles of local insurance agents and brokers in regard to MCO expansion and management?

Five of the six MCOs studied reported that they plan to expand into new geographic areas. Some reported that they plan to maintain personal relations with rural providers and employers in the future by establishing new regional offices. Will these MCOs be able to maintain local offices as competition intensifies, or will such amenities be sacrificed to cost-cutting measures? How will the providers and consumers currently served by local MCOs react if these personal relations are severed?

Medicare

To date, the low adjusted average per capita cost (AAPCC) in many rural areas has deterred the expansion of Medicare risk contracting in rural counties. It is not clear what will happen in rural areas now that this barrier has been lowered by the establishment of a national AAPCC minimum amount. In rural areas where the current AAPCC is well below the AAPCC floor, one might expect MCOs to enter the market. These MCOs may compete on the basis of no-cost benefit expansions (e.g., drugs, eye care) if the new AAPCC exceeds their costs.

In rural areas where the current AAPCC is close to the floor or above it, the effect of the policy change on enrollment in Medicare risk plans is not clear. Many rural counties that currently have an AAPCC greater than the proposed floor are not served by Medicare risk contractors. Clearly, the AAPCC amount itself does not constitute the sole consideration in an MCO's decision to serve an area (Serratto, et al., 1995).

Because many rural areas have limited exposure to MCOs, marketing Medicare risk plans to the rural elderly will present MCOs with special challenges. MCO marketers will need to educate rural Medicare beneficiaries and overcome negative attitudes about MCOs that result from national news stories. Little is known about how rural Medicare beneficiaries learn

about health insurance options or about what criteria they use to make their selections. In part, this is because most Medicare beneficiaries do not currently have many options from which to choose.

Medicare reform allows provider service organizations (PSOs) to contract directly with Medicare as at-risk entities. These physician and hospital-controlled organizations will compete with other MCOs for Medicare risk contracts. Although small, local PSOs may be established in some rural areas in an effort to spread risk, in other cases, several rural areas may come together to form a larger rural PSO. Alternately, rural areas may be subsumed in PSOs composed primarily of urban providers. Urban-based PSOs that contain rural providers may or may not be any more sensitive to the concerns of rural providers than urban-based MCOs.

Medicaid

The expansion of Medicaid managed care into rural areas has been made possible by various waivers of the Social Security Act, particularly Section 1115 waivers. In the two areas studied where rural Medicaid managed care programs exist (Colorado and Oregon), the payments under the managed care system were higher than previous Medicaid fee-for-service payments. As a consequence, more providers were willing to participate in the Medicaid program, and they had a higher level of satisfaction with their income from the program compared with traditional Medicaid fee-for-service payments.

Medicaid patients served by a Medicaid managed care program are expected to benefit from selecting primary care physicians as their principal caregivers and agents. Medicaid managed care programs also are expected to improve access to medical services by increasing the number of rural physicians who participate in the Medicaid program. From this study's limited survey of Medicaid managed care plans, however, judgment could not be made regarding whether these expectations are being fulfilled in rural areas.

Medicaid managed care programs were implemented across the country primarily to reduce the costs of a rapidly expanding program. Whether these programs will be successful at reducing the rate of increase in program expenditures is not known at this time. Pressure on federal and state budgets and the effects of welfare reform on Medicaid may result in the dedication of comparatively fewer resources to Medicaid in the future. To the extent that funding reductions for Medicaid reduce the amounts available for provider payments, the benefits of Medicaid managed care for rural providers and consumers may diminish, smaller provider payments may cause some providers to leave the Medicaid program, thus affecting access to services by Medicaid recipients.

Medicaid and Medicare payments have been used to expand the health professional capacity of rural underserved areas. Providers such as Rural Health Clinics and Federally Qualified Health Clinics are reimbursed on the basis of reasonable cost for care provided to both Medicare and Medicaid patients. How these providers are treated under Medicaid managed care programs may, in certain areas of the country, determine their future viability. If they receive Medicaid managed care payments that are substantially below those they currently receive from Medicaid, their solvency may be threatened. Unlike other providers, these safety-net providers have little capacity to shift costs to other payers.

There is much that is not known about the effects of MCOs on rural providers and consumers. To date, a modest number of empirical studies on the topic has been conducted. This study's findings suggest a number of areas for future research concerning the effects of MCOs on the rural health care system and on the enrollee access to and satisfaction with health care services financed by MCOs. Principal areas of inquiry include:

- the effects of MCO participation on physician and hospital utilization, costs, revenues, and profitability;
- the effects of MCO participation on the referral behavior of rural physicians;
- the influence of MCO participation on rural physician patterns of practice;
- differences in utilization and referral patterns of MCOs based in rural areas vs. urban-based MCOs that also serve rural areas;
- the influence of MCOs on the quality and outcomes of care provided to rural enrollees; and
- rural MCO enrollees' satisfaction with the health care services they receive, compared with the services provided under traditional indemnity insurance or preferred provider organization arrangements.

The effect of MCOs on rural areas is not a static area of study. Increases in MCO enrollment in rural areas, heightened MCO competition, and new models of organizing and financing rural health care services will require rural health services researchers and health policy-makers to revisit these questions regularly.

References

Serrato, C, Brown, R, & Bergeron, J. (1995). Why do so few HMOs offer Medicare risk plans in rural areas? Health Care Financing Review, 17(1), 85-98.