

Managed Care and Delivery System Consolidation

Irrespective of public policy changes, the health care system is undergoing a radical transformation. Managed care has become not only common but the dominant form of health care plan in many areas. The crucial characteristics of “managed care,” as the term is used in this paper, are that:

1. providers have a close (sometimes exclusive) contractual relationship with the insurer,
2. the insurer exerts some control over the care that is provided, and
3. patients face financial penalties for using providers not associated with the insurance plan.

Approximately one-fourth of the insured population is enrolled in HMOs the most stringent form of managed care (12). HMO plans not only constrain the providers their enrollees can use without incurring severe financial penalties; they also generally operate on a per-capita payment basis, with a strong incentive to keep costs and service use low. Many additional people are enrolled in “preferred provider organization” (PPO) managed care plans, in which patients’ copayments are lower if they use providers in the plan’s network. According to one estimate, as many as 90 million people were enrolled in either HMOs or PPOs in 1992, an almost 4-fold increase from 1985 (38).

At the same time that consumers have been increasingly turning to managed care plans (often as a result of the insurance their employer or government sponsor has chosen), the health care insurance and delivery systems have been consolidating. HMOs are larger and fewer in number than a few years ago (12). Multihospital systems are proliferating. Most recently, physicians and hospitals, and sometimes other care providers (e.g., nursing homes) are associating to form large “integrated delivery systems” in the interests of efficiency and bargaining power when negotiating with managed care plans and other payers.

universal tax-deductibility --i.e., if necessary, increasing taxes paid on employer-provided insurance benefits in order to pay for an equivalent level of tax deductibility for insurance purchased by individuals.

States' policies and experiences regarding these delivery system changes are very diverse. In many ways, states have actively encouraged changes--especially the expansion of managed care--by encouraging or even requiring many covered populations, like state employees and Medicaid beneficiaries, to enroll in managed care plans. On the other hand, many states also express a wariness with some of the implications of these changes in rural areas, where managed care and multiprovider networks raise some unique issues.

Managed care organizations (such as HMOs) are underrepresented in rural areas. In 1992 there were HMOs present in only 36 percent of 2,361 rural (non-metropolitan) counties (31). Only about half of urban-based HMOs include rural areas in their market areas, and as of 1993 only 10 HMOs were primarily rural plans (22;29). Urban physicians are much more likely to participate in managed care plans than rural physicians (11 ;25).

There are at least four likely reasons for HMOs rural underrepresentation:

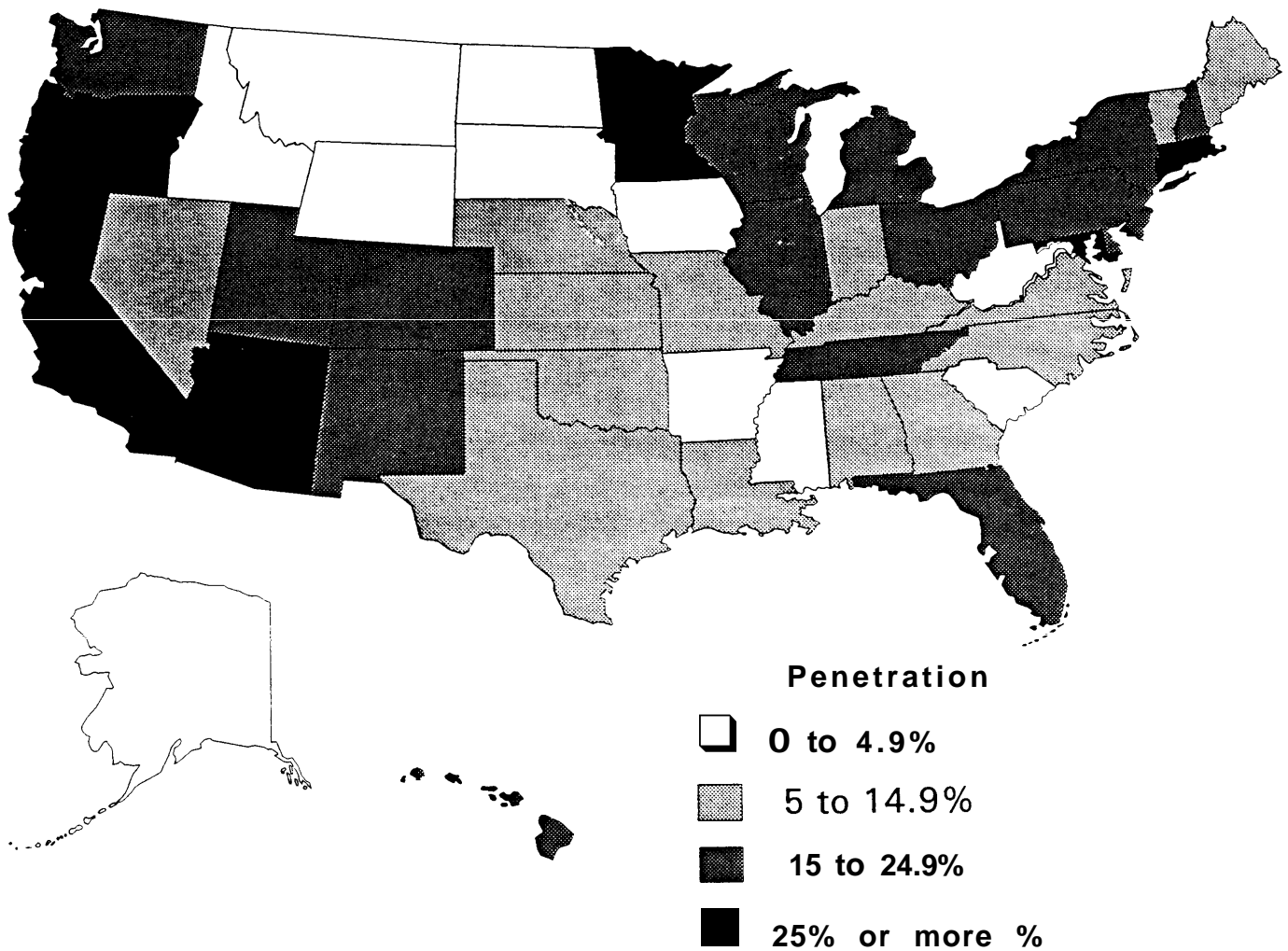
1. Rural providers are often scarce. If a managed care plan cannot convince the few rural hospitals or physicians in a particular area to contract with the plan, the plan cannot serve patients in that area.
2. Many rural providers value autonomy more highly than they do managed care contracts. As one Minnesota health care professional put it: "The reasons people go out to practice in rural areas are somewhat counter to reform. They're out there because they want to get *out* of the bureaucracy" (9).
3. Serving rural residents is often considered less profitable for managed care plans than serving higher-density urban and suburban areas, whose greater number of providers allow plans to take advantage of provider competition for patients.
4. Rural residents often aren't covered by employer-based group insurance, so there is no pre-specified covered group for HMOs to serve in many rural areas.

Thus, managed care penetration in rural areas is generally much less than in urban areas of a given state. But because states themselves differ so dramatically in the extent to which managed care dominates the health market (figure 1), the experiences of rural areas of different states are themselves very diverse.

In states such as Oregon and Minnesota, which have a long history of managed care, for example, managed care has a substantial presence even in many rural areas. In

Figure 1

Percentage of Insured Population in HMOs 1994



SOURCE: Based on data from Group Health Association of America, *Patterns in HMO Enrollment* (Washington, DC: GHAA, June 1995).

contrast, Idaho's rural areas have virtually no managed care; in fact, managed care's share of the overall state market is only 1 % (12). An Idaho policymaker dryly describes the growth of managed care elsewhere in the Northwest as a remarkably effective solution to that state's physician supply problem. A significant number of physicians have reportedly moved their practices to Idaho in an attempt to avoid managed care elsewhere (28).

Issues surrounding managed care delivery systems and rural areas fall into two categories: those that relate to encouraging the current trends toward managed care and delivery system consolidation, and those that relate to controlling managed care's ability to have harmful effects.

ENCOURAGING MANAGED CARE

Many states are interested in promoting managed care systems and rural health networks. They do so for two reasons: in order to control their own health-related state expenditures, and to enable rural residents access to more sustainable, better-coordinated care. To encourage managed care, states are pulling hard on one of the few levers they control directly: payment for services provided to state employees and Medicaid beneficiaries.

Pulling Managed Care into Rural Areas Through Medicaid

When the Medicaid program was established in 1965, it included a "freedom of choice" provision. States receiving Federal Medicaid matching funds were required to permit beneficiaries to receive services from any provider they chose who would serve them. Over time, a number of states have sought and received permission to waive this provision so they could test managed care delivery systems for certain Medicaid beneficiaries, usually in a few selected urban areas. Recently, however, an increasing number of states--13 as of July 1995--have received statewide "Section 1115" Medicaid waivers that, among other things, permit them to vastly increase the number of beneficiaries enrolled in managed care. (In addition, a number of states have more limited waivers that also permit them to enroll many Medicaid beneficiaries in managed care.)

Arizona has the longest experience in using Medicaid to draw managed care into rural areas. Arizona was the first--and for many years the only--state to operate its Medicaid program under a statewide 1115 waiver. Approximately one-third of its Medicaid population lives in rural communities (22). When the state's waiver program began in 1982, it operated through managed care plans in its urban areas but paid many rural providers on a fee-for-service basis (22). Now, however, all rural areas are also served by managed care plans, and all plans receive per capita payments from the state's Medicaid program (23;27).

Of all the states, Tennessee has been the most ambitious in its use of Medicaid as a lever for bringing sweeping changes to its health care delivery system. Until the approval of its statewide Medicaid waiver in 1993, Tennessee had a very low level of managed care. In January 1994, with only a few months' warning, Tennessee greatly expanded its Medicaid program to include tens of thousands of new low-income uninsured persons. At the same time, the state required all Medicaid beneficiaries to enroll in prepaid managed care in order to receive acute care services (30). Although the road to managed care has been very bumpy, with major protests from many provider groups over issues such as coercion and payment levels, it has been undeniably effective in encouraging the expansion of managed care. Tennessee changed its HMO penetration from 5.7 percent to 16.2 percent in the course of a single year (2).

Oregon likewise recently received a statewide Medicaid waiver that enables it to expand Medicaid coverage to many previously uninsured people, and require most beneficiaries to receive their care through prepaid managed care programs. Unlike Tennessee, however, Oregon had an extensive history of managed care in the urban areas of the state at the time it implemented its new program. To encourage providers--and managed care plans--to want to participate in Medicaid, and to stimulate the formation of rural plans, the state did three things:

1. Increased the buying power of the Medicaid program by extending coverage to a large number of low-income people who were previously uninsured (and may previously often have relied on charity care) (32).
2. Recalculated the Medicaid reimbursement rates to make them more representative of actual costs. The rates were per-capita rather than per service, and included some assumptions of lower costs through efficiencies, so these new rates may not

have reflected actual costs (32). The effect, though, was to further encourage participation of both providers and plans in managed care.⁵

3. Designed a continuum of managed care possibilities for providers in rural areas with little experience in managed care. Rural providers were allowed to test the waters of managed care with risk-sharing arrangements in which the physicians would at first receive partial fee-for-service, or be capitated only for some services, but share in any savings from efficiencies and reduced service use. Once the providers had some experience, they could move gradually to a full-risk-bearing per-capita payment system (32).

Supporting Multiprovider Networks

Dragging an entire state delivery system into the era of managed care, as Tennessee's Medicaid program did, or encouraging managed care organizations to expand from urban to rural communities, as Oregon's Medicaid program did, are two ways in which states have encouraged coordination *among rural* and urban health providers. Another mechanism has been to encourage affiliations among providers in rural areas more directly. The public policy goals of this approach are to improve care coordination for patients, and to help rural providers survive in an era of managed care.

Hospitals clearly see multiprovider networks as crucial to their long-term survival, because it improves their ability to negotiate managed care contracts (14;22). Additional perceived benefits to rural hospitals include a chance to hire the medical residents that urban hospitals decline; access to specialized treatments (without ceding all control over patient revenues); and broadening the combined patient base, thus decreasing the financial risk that rural hospitals tend to face (15). Currently, nearly half of rural hospitals have established contracts with other hospitals, most of them in urban areas.

Rural provider networks have most commonly linked "similar types of providers that have joined together to address common problems or to respond to capitated or other payment opportunities" **(22)**. The number of formal networks that integrate across provider types--e.g., linking hospitals, nursing homes, and physicians' offices together--is

⁵Those areas without managed care plans continued to be paid as traditional fee-for-service with primary care case managers; these fees did not increase, except for the primary care managers.

still small (22). Nonetheless, integrating across provider types is an active area in not only urban but rural areas, as providers struggle to position themselves to survive in a managed-care-dominated environment.

In some cases, states have actively encouraged providers to link together, both within and across provider types. Minnesota has been especially active in promoting provider networks (box A).

CONTROLLING RURAL MANAGED CARE

Competition and Access

Although most states are interested in encouraging at least some level of provider networking and managed care in rural areas, rural managed care presents a dilemma. The scarcity of providers and population that characterizes rural health care means that if local providers join a managed care network, what results may be a monopoly (20). Left to itself, the market may not sustain competing plans, leaving consumers with only a single choice (31).

In the most visible example of this dilemma to date, Blue Cross Blue Shield (BC/BS) of Wisconsin sued the physician-led rural health network Marshfield Clinic, long considered a model rural integrated delivery system. BC/BS claimed that Marshfield has required that its affiliated rural physicians contract exclusively with it, and, in doing so, that the network suppressed competition and locked the insurer's HMO plan out of Marshfield-dominated counties, thus violating antitrust law (18). BC/BS prevailed in court, and the Federal District judge ordered the Marshfield network not to prohibit its physicians from affiliating with non-Marshfield HMOs

Even where a second managed care plan exists, requiring enrollees to use a particular plan's providers can exacerbate the long distances rural consumers must often travel for care. One rural health researcher relates an anecdote involving a chicken processor who decided to provide managed care insurance for his workers (24). The processor could not strike an acceptable deal with the managed care plan nearest to the plant and opted to purchase health insurance through another plan, whose closest participating hospital was 70 miles away.

Box A: Integrated Service Networks in Minnesota

In 1993, Minnesota passed landmark health reform legislation that included an important role for newly defined entities called “Integrated Service Networks” (ISNs). Legislation the following year extended this concept to similar but smaller entities, “Community Integrated Service Networks” (CISNs), which were to be particularly appropriate for rural areas.

CISNs are similar in concept to HMOs in that they coordinate service delivery and offer managed care health plans to enrollees for a per-capita fee (6). However, they have a 50,000 enrollee limit and have a unique organization and administration.⁶Specifically, the cost control and delivery systems of CISNs are governed by those who provide the care themselves: hospitals, physicians, other providers, and involved health plans. Over half of a CISN’s governing board members must reside in the immediate service area, to keep community ties strong and keep the service delivery and insurance functions of the plan coordinated at the local level (6).

Three CISNs have been legally operational since January 1995. Minnesota health officials predict that there will be two additional CISNs licensed by the end of 1995, bringing the total to five (5).

Membership in a provider cooperative is another option for rural providers (6). Provider co-ops, as defined by state legislation, are groups of independent providers (rural and urban) who band together to market their services as a group to licensed health plans (e.g., HMOs CISNs). They may be especially attractive for rural providers, since this option permits them to be linked with managed care organizations (thus allowing their patients the security of managed care membership) while still permitting providers the flexibility of continuing fee-for-service care for some patients.

States have begun to grapple with these issues. In North Carolina, for instance, the state’s Health Planning Commission recommended (unsuccessfully) that managed care plans be required to issue coverage to entire geographic regions, not just the most profitable urban areas (3). Similarly, Vermont is currently negotiating for a statewide waiver to enroll most Medicaid beneficiaries in managed care. Under the new program, the state is planning to require that any managed care plan wishing to contract with the state to serve Medicaid patients in a particular region must serve the rural areas of that region, too (37).

⁶In contrast, ISNs are expected to be largely urban entities and are allowed a greater number of enrollees.

In its newly revamped Medicaid program, Oregon requires every rural managed care plan to demonstrate the capacity to serve its enrollees adequately. The state does so by calculating the physician-to-population ratios in each rural county, and requiring each plan to show that it has contracts with a sufficient number of providers in the relevant county to cover its enrollee population (1). As of March 1995, all but 8 of Oregon's rural counties (which contain only 5 % of the population) were served by managed care plans that accepted per capita payment for Medicaid beneficiaries (1).

“Any Willing Provider”

“Any willing provider” laws are an increasingly common form of legislation in the states. These laws require managed care plans to contract with any provider who is willing to meet the plan's contract terms; they prevent plans from limiting the number of providers (e.g., certain specialists) in their network.

These laws may have somewhat different impacts in rural than in urban areas. It is not clear, however, exactly how the impacts will play out.

For example, the relative scarcity of providers in rural areas means that managed care plans that want to move into an area must court those providers, putting the providers in a position to negotiate fairly favorable terms. In Vermont, for example, CIGNA is actively pursuing contracts with several rural health clinics in an area into which it wants to expand (37). In such cases, “any willing provider” laws would have little, if any, positive effect.⁷

Also, many rural providers reportedly have rather skeptical attitudes towards managed care and may not want to participate. Again, in such cases, “any willing provider” laws would be irrelevant.

On the other hand, managed care plans may be equally skeptical about serving rural patients. Where they are unwilling to contract voluntarily with local providers--e. g.,

⁷Managed care organizations argue that “any willing provider” laws can have a negative effect on health care costs, because these laws require the plans to accept any provider meeting the terms of the plan's contract, they prohibit the plans from using their buying power effectively. For example, plans cannot guarantee a certain volume of patients to any one provider in return for a lower negotiated payment rate to that provider, because the total volume of patients per provider is diluted each time another provider contracts with the plan.

because they consider it unprofitable--"any willing provider" laws allow local providers to take the initiative on behalf of their patients and contract with plans. Related laws, such as laws requiring "point-of-service" plans, may allow patients to participate in managed care plans but still choose to go to closer, more convenient nonparticipating local providers (if the patients are willing to pay higher costs).

Maintaining Local Control

State legislators express some concern about the potential effects of large (usually for-profit) delivery systems and managed care organizations when they take over local rural facilities. On the one hand, these moves can infuse needed capital to update rural hospitals (e.g., to invest in telecommunications technologies and information networks), and they can link local facilities to other sources of expertise and tertiary care. On the other hand, large managed care organizations and delivery systems may ignore local community investment issues, and they take control of local facilities out of the hands of local residents.

As one Vermont legislator observed about the proposed purchase of his local rural hospital by a larger multiprovider system: "It's not a question of having a monopoly on services. The hospital always has had a monopoly on serving the local area, but right now it's a monopoly with local people on the board. Once it's purchased by a large distant body, we no longer have any control over what happens to it--we're not even in the information loop" (37).

Other state policymakers are worried that because larger delivery systems must be concerned first with the distant company's bottom line, they may make decisions that ultimately further damage local communities, and critical providers in those communities, instead of supporting them.

Because they restrict the providers that their enrollees may consult and still be covered, managed care plans control where patients go. If a managed care plan should require rural enrollees to use an urban hospital rather than the local one, it would exacerbate the general problem of rural residents bypassing their local hospital and could speed its downfall, without regard to any other non-health benefits of the hospital (e.g., as an employment center, a community core, and an attraction to draw other businesses).

The issue of bypassing local providers has been particularly acute for publicly funded health centers. Community health centers in some states have argued that they are the “safety net” provider for low-income uninsured people, and that if managed care plans control access to Medicaid beneficiaries but do not include the local publicly funded health center, the centers will lose their primary source of service-related payment and be forced to close (box B).

Despite the legitimate concerns of many “critical” local providers, their expectations in the current environment may be unrealistic. Not all may be able to survive, and those that do are likely to need to adapt to managed care and become part of more formal networks and alliances (3).

One final concern is that ambitious managed care plans wishing to expand may move into rural areas and take over or force out all the providers, then pull out and abandon those providers when the local hospital still doesn’t make a profit, or the plan itself loses money or declares bankruptcy. Given the boom-and-bust experiences of many managed care plans in states such as California and Florida over the past two decades, the concern is not easily dismissed and may require policymakers’ close attention over the coming few years.

Box B: Publicly Funded Rural Health Centers in the Managed Care Era

Nearly every state contemplating putting its Medicaid population statewide in managed care has had to consider how to integrate the existing publicly funded primary care clinics (e.g., community health centers and local public health clinics) into the managed care system. These clinics serve a high proportion of Medicaid and low-income uninsured patients, many of them in rural areas, and they often act as last-line safety net providers. Community health centers and public health clinics are subsidized through federal funds. In addition, to protect community health centers financially, federal Medicaid rules require that states reimburse them at cost for any Medicaid services they provide (Public Law 101-239).

Under managed care, however, these clinics have three choices, all of them risky:

1. They can elect not to serve Medicaid patients. If they do not, however, they may not be able to survive financially (since most of the rest of their patients are uninsured and often charity care patients).
2. They can choose to establish managed care plans themselves and contract with states to serve Medicaid patients, accepting per capita payment and the attendant financial risks. This road can be difficult, since most such clinics have little experience managing risk and may lack the financial and personnel resources to establish self-sufficient plans.
3. They can contract with an approved managed care plan to serve that plan's Medicaid enrollees. In this case as well, however, they forego cost-based reimbursement and must accept whatever rates they can negotiate with the plan.

States' experiences have varied. In Vermont, clinics have actually been actively courted by managed care plans wishing to meet the state's requirements for Medicaid participation (37). In Rhode Island, the community health centers successfully joined together to form their own plan (19). In Oregon and Tennessee, on the other hand, clinics have fought bitterly the loss of their right to cost-based reimbursement (4;33).