Medicaid Managed Care in Rural Areas:
A Ten-State Follow-Up Study

How is the implementation of managed care in rural areas working?

by Suzanne Felt-Lisk, Pam Silberman, Sheila Hoag, and Rebecca Slifkin

At least 703,000 Medicaid beneficiaries in rural areas now participate in capitated managed care, and even more participate in primary care case management (PCCM) programs. The Balanced Budget Act (BBA) of 1997 is expected to spur further growth in capitated Medicaid managed care in rural areas, because it permits states with mandatory programs to offer only one capitated plan in rural areas. Very little analytic work has focused on implementing Medicaid managed care in rural areas or on its effects on rural providers and beneficiaries.

To address this gap, we conducted case studies in ten states that had already implemented such programs. We focused our research on three questions: (1) Did states consider differences in rural health infrastructure as they implemented Medicaid managed care, and, if so, which program features facilitated implementation? (2) How do rural providers perceive that they have fared under these programs to date, and does this perception relate to the structure of the programs? (3) What evidence is there of changes in access for Medicaid managed care enrollees in rural areas?

The case studies were performed as the second phase of a study funded by the Agency for Health Care Policy and Research (AHCPR). In the first phase we found that many states are implementing capitated programs first or only in urban areas, although PCCM programs are fairly common. States with rural managed care programs most commonly cited both potential cost savings and hopes of improving access as major reasons for implementing such programs.

Methodology and Limitations

We selected the ten case-study states (Idaho, Indiana, Iowa, Louisiana, Michigan, Missouri, Oregon, Tennessee, Virginia, and Washington) to obtain a diverse mix among those states most experienced with rural Medicaid managed care (Exhibit 1). Between August and November 1997 we conducted telephone interviews of 130 key informants in the ten states. These included more than thirty representatives of state agencies; forty-one rural providers; twenty-four representatives of provider associations; thirteen representatives of managed care organizations (MCOs); eighteen consumer advocates; and several rural health clinic administrators and other rural providers who often serve poor people.

Similar to other case-study research, our findings are based on common themes across respondents in varied states. As a group our respondents are not a scientific or statistically valid sample, and our interviews were based on loosely structured discussion guides, not a structured questionnaire. Thus, our findings

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## EXHIBIT 1
### Key Program Features Related To Medicaid Managed Care In Rural Areas

<table>
<thead>
<tr>
<th>State; number of rural counties</th>
<th>Program type (as of 1997) and percent of rural counties in programs</th>
<th>Mandatory program in rural counties?</th>
<th>Penetration rate among beneficiaries with choice of programs (number participating)</th>
<th>Year implemented</th>
<th>Covered populations</th>
</tr>
</thead>
<tbody>
<tr>
<td>ID; 41</td>
<td>PCCM in 34 rural counties; 78%</td>
<td>No^a</td>
<td>40% (22,715)</td>
<td>1993</td>
<td>All Medicaid eligibles</td>
</tr>
<tr>
<td>IN; 55</td>
<td>PCCM and full capitation statewide; 100%^b</td>
<td>Yes, choice</td>
<td>Cap: 31% (15,095)</td>
<td>1994</td>
<td>AFDC, OBRA-related</td>
</tr>
<tr>
<td>IA; 89^c</td>
<td>PCCM and full capitation in 43 rural counties</td>
<td>Yes, choice</td>
<td>Cap: 39% (8,417) PCCM: 61% (13,006)</td>
<td>1990</td>
<td>AFDC, OBRA-related</td>
</tr>
<tr>
<td></td>
<td>PCCM only in 31 rural counties; 83%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LA; 40</td>
<td>PCCM in 18 rural counties; 45%</td>
<td>Yes</td>
<td>Mandatory (34,242)</td>
<td>1992</td>
<td>AFDC, OBRA-related, SSI</td>
</tr>
<tr>
<td>MI; 58^c</td>
<td>PCCM and full capitation in 22 rural counties</td>
<td>Yes, choice</td>
<td>Cap: 13% (3,335) Partial cap: 11% (4,005) PCCM: 86% (46,024)</td>
<td>1982</td>
<td>AFDC, OBRA-related, SSI^d</td>
</tr>
<tr>
<td></td>
<td>PCCM only in 36 rural counties; 100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MO; 92</td>
<td>Full capitation in 31 rural counties; 34%</td>
<td>Yes</td>
<td>Mandatory (22,156)</td>
<td>1995</td>
<td>AFDC, OBRA-related</td>
</tr>
<tr>
<td>OR; 27^e</td>
<td>Full capitation statewide; 94%^f</td>
<td>Yes</td>
<td>Mandatory (90,244)</td>
<td>1994</td>
<td>All eligibles and expansion</td>
</tr>
<tr>
<td>TN; 68^c</td>
<td>Full capitation statewide; 100%</td>
<td>Yes</td>
<td>Mandatory (453,846)</td>
<td>1994</td>
<td>All eligibles and expansion^f</td>
</tr>
<tr>
<td>VA; 59</td>
<td>PCCM and full capitation in 6 rural counties</td>
<td>Yes, choice</td>
<td>Cap: 2% (107) PCCM: 98% (5,368)</td>
<td>1992</td>
<td>AFDC, OBRA-related, non-institutionalized aged, SSI</td>
</tr>
<tr>
<td></td>
<td>PCCM only in 53 rural counties; 100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WA; 27^f</td>
<td>Full capitation statewide; 96%^g</td>
<td>Yes</td>
<td>Mandatory (97,111)</td>
<td>1993</td>
<td>AFDC, OBRA-related</td>
</tr>
</tbody>
</table>

**SOURCE:** Interviews with state officials and other key informants, August–November 1997.

**NOTES:** PCCM is primary care case management. Cap is full capitation. AFDC is Aid to Families with Dependent Children. OBRA-related is poverty-related women and children eligible for Medicaid because of legislation passed in various Omnibus Budget Reconciliation Acts, beginning in 1984. Penetration rates for mandatory programs were high but were not calculated.

^a Counties decide whether program will be mandatory or voluntary; as of September 1997 thirty-two of thirty-four participating counties chose to make it voluntary.

^b Program is voluntary in three rural counties without participating primary care providers and voluntary for some subpopulations (for example, pregnant women) in four other counties without enough providers of a certain type participating.

^c The state has a carved-out mental health program.

^d Michigan also allows dual eligibles, medically needy, and special services waiver children to voluntarily enroll or remain in fee-for-service.

^e Oregon has two rural counties that are not in the fully capitated program but have instead PCCM programs. Also, Oregon foster-care children and elderly and disabled persons can be exempted in any county; those exempted enroll in a PCCM program.

^f Qualified and specified low-income Medicare beneficiaries are excluded.

^g Washington has one county that remains in fee-for-service; it also has a PCCM program for tribal populations and, in one county, a PCCM program for Supplemental Security Income (SSI) populations.

^h Washington had begun enrolling SSI recipients in some counties into the managed care program in 1997 but encountered difficulties and switched them back to fee-for-service in 1998.
may not hold true for all states or for all providers or rural areas. Also, we offer insights into critical program effects but do not provide any information on whether the cost and quality of care changed with implementation of managed care.

**Findings**

Overall, our findings suggest that implementing PCCM and capitated programs was feasible, even in remote rural areas, because states took greater time and effort for implementation in rural areas and ensured that program details were workable in these communities. Enough time must be allowed to accomplish certain tasks prior to implementation: building the provider network; building support for the program through interface with local representatives; and (if applicable) designing geographic program boundaries that take into account local service-use patterns.

Building provider networks in rural areas requires more time and effort than it does in urban areas because of rural providers' inexperience with managed care and the greater difficulty in communicating with dispersed, often remote, independent provider offices. Several states (Missouri, Michigan, and Iowa) found that geographic program boundaries should be set up with input from health plans and others familiar with utilization patterns, which also takes more time. These states had to modify or delay program implementation because their initial boundaries would have forced many residents to change providers. Because none of these states intended to disrupt customary service-use patterns, they revised the plans and/or allowed providers who were outside the boundaries “courtesy” participation in the PCCM program.

**Accommodation to rural health infrastructure.** Primary care provider selection, twenty-four-hour coverage requirements, rural/urban payment differentials, defining and protecting rural safety-net providers, and setting sensible travel/distance standards are the types of program details we found particularly important for rural constituencies.

**Primary care provider selection.** Determining who may be an enrollee’s primary care provider and the selection process itself must be sensitive to rural residents’ use of midlevel practitioners. Most states allowed beneficiaries to select from a variety of types of providers in addition to primary care physicians, including rural health clinics (RHCs) and federally qualified health centers (FQHCs). Some enrollees could not identify “their” practitioner if he or she was not listed in the directory both by name and by health center. (Providers who were not initially selected because of this problem were disadvantaged financially, until the mistake could be corrected.)

**Twenty-four-hour coverage.** How twenty-four-hour coverage requirements are implemented and enforced was another important detail for some rural providers. Nearly all of the states with PCCM programs had assisted some rural providers in making arrangements with local hospitals to provide around-the-clock coverage, and implementing twenty-four-hour coverage requirements was more difficult in some rural areas than in urban areas.

**Capitation rates.** In several states with capitated programs (Oregon, Missouri, and Virginia), payments to plans in rural areas are on average lower than those in urban areas, because payment rates are at least in part based on historical fee-for-service (FFS) costs, which are lower in those rural areas. The argument for evening out the rates is partly that lower rates may be “locking in lower access” in rural areas. Several rural providers and a rural-based MCO viewed this price differential policy as unfair. However, one MCO serving both urban and rural areas worried that current rates are not adequately adjusted for case-mix and that higher costs in urban areas may reflect the tendency for sick patients to locate there. Oregon has reconsidered its policy and raised rates for rural areas near a major city after complaints that many beneficiaries are now receiving care from city providers at higher city prices.

**Safety-net provider protection.** Most of the study states offered some protection for safety-net providers. Five states with rural capitated programs (Indiana, Iowa, Missouri,
Virginia, and Washington) had protective payment policies such as cost-based reimbursement for FQHCs, and a sixth state (Michigan) was implementing a protective policy in conjunction with a new, mandatory program. Several states extended the protective payment policy to designated RHCs. The study states also implemented various policies to encourage or require MCOs to contract with rural (and urban) FQHCs, RHCs, and/or public health departments.

How financial supports are targeted is a key policy issue. The BBA, which requires states to make supplemental payments to all FQHCs and RHCs during a five-year transition period, provides at best an imprecise method to support essential rural providers. For example, not all isolated providers essential to their communities are included in the set of RHCs in a state. Conversely, some respondents believed that only some of the RHCs are truly isolated providers and therefore deserve long-term special support.

Travel guidelines. States’ maximum travel/distance standards should reflect the reality of provider availability in rural areas, we learned. Where existing rural primary care providers are quite distant from one another, more flexible standards or more flexible enforcement was used by the case-study states to reflect lesser provider availability. For example, health plans in Oregon’s urban areas must offer a primary care provider within thirty minutes or thirty miles. In rural areas the guideline is sixty minutes or sixty miles or the community standard (whichever is greater). Not all of the study states varied their travel/distance requirements, nor were these requirements consistently viewed as important by the stakeholder groups we spoke with, since MCOs generally sought to contract with all qualified, available primary care providers. In states with travel/distance requirements, some isolated providers used the requirements to negotiate better payment rates; travel/distance requirements essentially force health plans to contract with isolated providers to serve that area.

States’ requirements for maximum allowable travel/distance are commonly applied to primary care providers, but Washington’s experience suggests that these requirements also may be important for other rural providers. Washington added travel/distance requirements for hospitals, obstetricians, pediatricians, and pharmacies, to ensure access and because the state had noted health plans’ “skipping over” local providers in their contracting for those services, potentially endangering local providers’ viability and forcing longer travel distances on rural residents.

### Feasibility of capitated programs

Capitated programs appear feasible in the remote rural areas we studied, contrary to what some policymakers believe. The experiences of Missouri, Oregon, Tennessee, and Washington show that mandatory fully capitated programs can be implemented in a wide variety of rural settings, including sparsely populated areas. Among the seventeen “frontier” counties in Oregon and Washington (fewer than seven residents per square mile), mandatory programs were operational in all but one. In Oregon much of the more sparsely populated area was covered by a single health maintenance organization (HMO), a model that more states may choose to follow, since the BBA now allows this without a waiver. However, even frontier counties can be served by multiple HMOs; for example, at the time of this writing three of the six frontier counties in Washington were each being served by six health plans.

Voluntary capitated program options are also feasible in rural areas and can generate substantial enrollment, given time, if one or more stakeholders are seriously interested in expanding enrollment. Mandatory enrollment in some form of managed care or default assignment to an MCO when a beneficiary does
not sign up for the state’s PCCM program also may be keys to generating enrollment. In Iowa, seven years after the program was first implemented, almost 40 percent of eligible rural Medicaid beneficiaries were enrolled in one of five participating MCOs. Enrollees who failed to choose either the PCCM option or an MCO were assigned to an MCO by default. Also, in Iowa the capitated program had the highest penetration in areas where an HMO with good name recognition has expanded its provider network and marketing. And in the southern counties of Indiana 52 percent of rural Medicaid managed care participants were enrolled in a capitated health plan rather than the PCCM option. This is largely due to expansion of a single, large, rural-based physician organization associated with the capitated managed care program in Indiana, we were told.

In contrast to Iowa and Indiana, voluntary programs in Virginia and Michigan have not resulted in significant enrollment, probably in part because no stakeholder aggressively encouraged program expansion. Inadequate capitation rates may be another factor limiting the geographic extent of these programs; respondents from both states commented on the inadequacy of rates based on historical FFS costs in the rural counties.

Several factors enabled the state programs and MCOs to extend full-risk Medicaid managed care into many rural areas despite little history of commercial managed care: Blue Cross/Blue Shield (BCBS) participation, regional contracting strategies, and formation of new provider-based plans. In Oregon the presence of a large BCBS plan willing to use its indemnity business as leverage to persuade rural providers to organize and participate was key to initiating the program in much of the state’s rural territory. In Missouri and Iowa plans that wished to bid for urban Medicaid managed care business were required also to cover the adjacent rural counties in that region; this package was apparently attractive enough to generate multiple bids by varied types of existing HMOs.

In addition to existing plans that extended their service areas, new full-risk managed care plans were formed by provider consortia that included rural providers. For example, FQHCs in several states (Oregon, Washington, and Michigan) created their own plans to protect their patient base and capture managed care savings, and providers in Missouri formed a plan to improve the health status of residents in a largely rural region with high rates of uninsurance and poor health.

**Effects of Medicaid managed care.** Under Medicaid managed care, rural providers in our case-study states are experiencing increased competition, facing new financial challenges, making changes in services and staffing, and coping with increased administrative burdens. To understand the effects on rural providers, we first review how capitated managed care works at the provider level.

Although the study states with capitated programs pass full financial risk to MCOs, MCOs varied in how they paid providers and why they paid them as they did. Many rural providers were still receiving discounted FFS payment from plans, and several plans reported that they needed to pay FFS to rural providers with no managed care experience, both to persuade them to sign on and to let providers learn managed care gradually before taking on financial risk. Other providers—generally those with more experience with managed care—were accepting financial risk, through primary care capitation and/or partial risk for specialty and hospital care. Some providers were accepting primary care capitation because they needed or wished to participate with particular plans, and those plans did not vary their payment methodology among providers. Other rural providers sought to accept financial risk to accumulate savings from specialty and hospital care, to learn how to manage capitation before more of their business is paid this way and to generate a more predictable cash flow.

Although it was clearly not a prerequisite to participation in managed care, some rural providers were joining or forming networks. We found by far the most network formation in Oregon, where reform of Medicaid man-
Managed care was a major factor motivating the creation of integrated delivery systems and rural-based independent practice associations (IPAs), physician/hospital organizations (PHOs), and health plans.

**Administrative burden and contracting.** Almost all respondents, even those providers participating in PCCM programs, reported increased costs from managed care. 7 Several noted that the increased administrative responsibilities are especially difficult for the solo and small-group practices more typical in rural areas.

Rural primary care providers we interviewed were able to enter into managed care contracts. MCOs usually sought to include most primary care providers in the rural areas in their networks, simply to attract enrollees from those areas. In response, many rural providers negotiated contracts with multiple MCOs to retain their patients in a more competitive environment. These contract negotiations during program implementation were the first for many rural providers, unlike their urban counterparts, who typically had more managed care experience.

Rural public health departments (like urban ones) generally experienced great difficulty obtaining MCO contracts and often did not meet state requirements to be a primary care case manager. Their difficulty stems from the fact that they generally do not provide a full array of primary care services and twenty-four-hour care. Hence, contracts between MCOs and public health departments often were limited to geographic areas with few other providers or to services not otherwise offered in the community.

In one state (Oregon) some RHCs staffed by midlevel practitioners reportedly found themselves without health plan contracts. In this case, rural providers had been organizing into networks for managed care contracting. The networks sometimes did not include the RHCs because of the clinics’ dependence on midlevel providers not viewed as peers by the physician community, we were told. Further, some clinics were unable to negotiate rates that were sufficient to cover their costs.

**Increased competition.** Respondents in almost all of the study states, including those with PCCM programs but excluding those from very isolated rural communities, reported increased competition for Medicaid patients. The increased competition seems to be coming from providers who are just starting to accept Medicaid patients or, more often, increasing their Medicaid clientele. Also, new RHCs are being established in some areas. Most respondents noted competition as a positive development because it gave recipients a choice of providers, even though the increased competition for Medicaid patients added financial stress and, in some areas, threatened providers’ bottom lines.

**Changes in services and staffing.** Many rural providers were changing the array of services offered to maximize revenues, become more efficient, and better meet consumers’ demands. Several providers expanded clinic hours to cut unnecessary use of the emergency room (ER). Although these changes were not unique to rural areas, increasing the availability of primary care services may have a bigger impact in these communities because there are often few alternative resources.

PCCM programs have had little influence on rural hospitals, but capitated programs along with broader changes in health care financing have contributed to changes in many rural hospitals, we were told. Some rural hospitals expanded services offered, such as home health or nursing home services. We also heard examples of rural hospitals’ developing RHCs, ostensibly to obtain cost-based reimbursement and increase the availability of primary care.

Not all of the changes in providers’ services and staffing were positive. Rural safety-net providers in the two states without financial protections (Oregon and Tennessee) were having to cut back on some staff and non-medical services. Health departments in almost all of our case-study states that had been providing well-child services reported a sharp decrease in the provision of this service, and some reported that they had already stopped or were planning to stop providing any clinical health services. 8 There did not appear to be
any rural/urban differential; whether the loss of primary care services from public health departments would have a negative effect on the rural Medicaid or uninsured populations or whether it would increase health departments’ emphasis on health promotion and disease prevention remains an open question.

**Perceived financial effects.** With the exception of public health departments, PCCM programs were reported to have had little impact on the financial viability of rural providers, as such programs essentially continued the FFS payment structure. Although most primary care providers received an additional case management fee, and some likely gained more patients because of shifts away from public health departments and ERs, the rural providers we interviewed believed that the additional fee was offset or more than offset by the increased administrative costs associated with referrals and follow-up on visits to specialists and hospitalizations. Although some hospitals reported lower revenues because of the decline in ER use, none of the hospitals perceived this change as threatening its overall financial well-being.

Capitated programs have changed the financial situation of rural as well as urban providers, but there was no discernible pattern to the changes. Some reported increased revenues under capitation, whereas others reported the opposite. How rural providers fared under capitated managed care seemed to differ depending on a combination of their market power, their proactive response, the protective payment policies of the program they were under, the level of the negotiated payment rates, and the options offered under the state program. Further study is needed to sort out these factors.

Cost-based payment policies are cushioning but not eliminating adverse financial effects for safety-net providers in several states, we were told. Rural providers under these policies reported some negative effects from the capitated programs, in part because providers under programs with end-of-year cost-based settlement processes have to manage during the year with lower cashflows. In both of the states with statewide capitated programs that had eliminated financial protections as part of their Section 1115 waiver programs (Tennessee and Oregon), safety-net providers reported financial difficulties. These difficulties recently led the Oregon legislature to establish a grant program to help to support urban and rural essential-access providers.

**Changes in access.** We found no evidence of increased travel times for rural recipients, except in isolated instances. Most health plans were reported to be very inclusive in structuring their rural primary care networks. Access to primary care may actually have improved in the case-study states: Across all program types, informants commonly said that more primary care providers are now willing to serve rural Medicaid patients and, in fact, are competing for them; inappropriate use of the ER is down; and after-hours coverage has improved. In states with capitated programs, some informants also reported that specialists and hospitals are more available to Medicaid beneficiaries and that some rural safety-net providers have made operational changes to better compete for Medicaid business, which included improving their hours.

Some informants believed that the improvements in access were less pronounced in rural than in urban areas, because rural providers were already serving Medicaid beneficiaries before managed care programs and unnecessary ER use was thought to be less. Data from Tennessee’s hospital association show that statewide ER use declined 6.3 percent between 1993 and 1996, but much less (2.7 percent) in rural areas. This is consistent with earlier studies showing less decline in ER use from PCCM programs in rural areas than from those in urban areas.

States’ automatic assignment practices may have caused longer travel times for some rural residents during transitions to mandatory PCCM programs. Our information suggests that states may minimize this problem by testing auto-assignment algorithms, ensuring that pre-implementation data on pa-
tient location are reasonably accurate, and being prepared to make prompt corrections when patients request changes.

Providers’ resistance to managed care also caused travel distances to increase temporarily during implementation in some cases, and permanently in rare cases. For example, a university hospital at first refused to participate in one state’s program, so that pregnant women in that area at high risk for complicated deliveries had to travel seventy-five miles to the next major hospital. The hospital later reconsidered and joined the program.

Our findings appear to challenge some of the traditional fears and thinking about implementation of Medicaid managed care in rural areas. Capitated programs appear more feasible in remote areas than many would expect, and the case studies show that commercial managed care networks in rural areas are not always a necessary precursor to implementing Medicaid managed care.

Nevertheless, the extra time and effort needed to implement managed care in rural areas clearly raises the costs involved, and some informants suggested that the programs’ benefits may be less in rural areas. Thus, when cost savings is a major goal, states should examine their historical cost and utilization information specific to rural areas to help assess whether implementation in these areas is likely to be “worth it.”

This study was funded by the Agency for Health Care Policy and Research (AHCPR) under Contract no. 290-93-0038, Task Order no. 4, with the University of North Carolina at Chapel Hill (UNC-CH). However, the findings, opinions, and recommendations expressed here are those of the authors and not necessarily those of UNC-CH or the AHCPR. The authors are grateful for the cooperation of those they interviewed and for the help of their advisory panel, including David Hartley, Bob Hurley, Jane Perkins, and Jim Wray. Linda Siegenthaler and Carole Dillard oversaw the project for the AHCPR. The authors also thank Marsha Gold, Judith Wooldridge, Tom Ricketts, and Jim Verdier for their comments on an earlier draft of this paper.

NOTES
3. Slifkin et al., “Medicaid Managed Care.”
4. Although the BBA eliminates federal matching money for supplemental payments after five years, states may elect to continue such payments using state funds.
5. Of those beneficiaries who did not select a PCCM or HMO option within the prescribed time frame, half were assigned to a PCCM program and half to an HMO. In July 1997 the state began to enroll 100 percent of these beneficiaries into HMOs. Once enrolled in an MCO by default, enrollees continue to have the option to switch back to the state’s PCCM program.
6. The experience of Virginia and Michigan appears fairly typical of voluntary programs that do not mandate enrollment in managed care of some form, our overview of the fifty states’ programs completed prior to these case studies suggests. Slifkin et al., “Medicaid Managed Care.”
7. This was not true in Idaho and Michigan, however, where providers told us that the PCCM program required almost no perceptible change in administrative burden. Providers in these states also reported less perceived benefit from the programs relative to other PCCM programs.
8. Tennessee public health departments were an exception, as they maintained the same role providing primary care services under managed care. This appears to be due to a need for the provider capacity that the public health departments offer in Tennessee more than elsewhere.
9. Some respondents expressed concern about access to specialists for the enrolled Supplemental Security Income (SSI) population or those needing mental health services. Since special populations were not the focus of our study, we did not follow up on these isolated reports.