Managed Health Care and Rural America

(Adopted 1997 and amended 2004)

After more than a decade of rapid expansion, managed care has become commonplace among the nation's health care delivery systems. While this has resulted in more coordinated patterns of patient care and greater integration among providers, most of the growth of managed care plans has occurred in urban and suburban areas. Although there has been speculation about the impact of managed care in rural areas, the literature provides little information on costs, patterns of care, or access to care in rural areas.

Realistically, generalizations about the present function and future of managed care organizations (MCOs) in rural areas are, at best, difficult to make. Most analysts have split into two camps. One group argues that managed care plans are efficient means of organizing resources and provide lower cost services. Many feel this is especially true in primary care. This reasoning concludes that managed care organizations can build the structure and networks needed to provide rural populations with improved access to an organized set of services.

The other group theorizes that MCOs will find it very difficult to succeed in rural areas. They base this largely on the premise that MCOs require a relatively large member population for financial success. Rural areas, which have low population densities, therefore would not provide the number of patients necessary to support a managed care plan. Some analysts also believe that competition between traditional indemnity insurance carriers and MCOs is not possible in rural areas and that flexibility is necessary if managed care is to have a positive impact in rural communities.

Gaining a Foothold in Rural Markets?

It is difficult to determine rural market penetration by MCOs, and estimates depend on the definition being used. Health Maintenance Organizations (HMOs) have similar structures, require the provider to bear some degree of risk, and are universally considered a form of managed care. Preferred provider organizations (PPOs) vary widely in their structure: "first generation" PPOs offer health care based on discounted fee-for-service; "second generation" PPOs restrict physician participation and often include primary care gatekeeper functions; "third generation" PPOs place the health care provider at risk for the care provided. Point of service plans (POS) function as a hybrid between the HMO and PPO, and therefore are perhaps the most difficult to label. The relatively recent expansion of independent practice associations (IPAs) and the varied plans MCOs offer to different IPAs further cloud the picture.

HMOs, while representing only a portion of managed care, are used as the benchmark for growth in managed care. In 1992, 321 HMOs (60% of all HMO plans) were serving rural counties in all 48 contiguous states.[1] However, service area designation does not measure actual enrollment and available data on HMO penetration

indicate actual enrollment in rural states is rarely more than 4 to 8%. In some rural regions of the country, it tends to be even lower.[2]

Rural America at a Glance

Rural areas are sometimes described as if they were somehow uniquely different from urban areas and as if all rural areas were similar. This is not the case. Rural health care systems face many of the problems of urban areas: uneven access to care, inadequate insurance coverage for certain populations, and lack of capital. Additionally, rural areas vary in character and history. One need only examine the rural frontier areas of the Northwest and Rockies, productive agricultural lands of the Far West and Midwest, poor economies of Appalachia and the South, and rich history of the New England states to realize this. These differences are also reflected in their medical care systems and health care problems.

What all rural areas share, to a greater or lesser degree, are low population density, isolation, a sizable percentage of Medicare- and Medicaid-eligible patients, and, in many cases, difficult access to medical services. Along with the lack of population density, virtually no large or even medium-size employers are present in rural areas. This is in sharp contrast to urban growth zones, where employers' demands for lower health insurance premiums are driving the marketplace. Without large employers and organized medical care systems, rural markets have remained unattractive to the majority of managed care organizations.

The Development of Rural Markets

Although the health insurance market has been difficult to predict in recent years, it is reasonable to assume the market in general will be influenced by managed care. Across rural areas, the nature of health insurance markets is likely to show significant variation. to a large extent, regional insurance market will influence which forms of managed care will occur and at what rate. In addition, federal and state policies on Medicaid managed care may provide entry to large markets, much like a large employer. For some MCOs, this may also provide the necessary structure and patient base for commercial enrollment, thus accelerating penetration into rural markets. However, it should be noted that each state’s medicaid program has some latitude in its coverage criteria and can be somewhat volatile as eligibility requirements may be subject to state budgetary constraints. Coverage categories (e.g., partially disabled individuals) or income determinations (e.g., percentage of the federal poverty level) may change based on available funding and political pressures potentially causing some vulnerable population groups to lose coverage.

Because rural markets have fewer health care providers and fewer managed care plans than ambitious urban markets, different conditions determine the type of plans that will develop and survive. Therefore, the development of managed care plans is likely to be the result of aggressive negotiations between the limited number of providers, managed care plans, local health systems or hospitals, and the payers. Because rural populations have limited access to providers and services, one powerful group is likely to

dictate the outcome of such negotiations. This will most likely be an organized provider group, an integrated health care system, or a managed care plan. Precariously absent from this list are the consumers, who, as in urban areas, may have little or no voice as the market transitions.

The role of the government and public policy may, however, have profound influence on the market. The government will act not only as a payer, but also as an entity that can establish rules in which the bargaining occurs. The rules will need to reflect a comprehensive view of rural health delivery. For example, in areas of poor access, additional services may be necessary to ensure efficient use of the system. While this may increase costs, it may also lead to better patient outcomes. In addition, because the rural marketplace may have little competition, the government may need to act as a "watchdog," ensuring the creation of performance standards and equitable access to care for all population groups.

Influence of Community Organizations

The sense of community, trust, and long-standing relationship between local primary care providers, hospitals, businesses, and patients is the most elusive, and perhaps most important, piece of the rural managed care puzzle. For many rural areas, managed care means forgoing control and responsibility of an integral part of the local community and economy. Assessing community health needs, utilization of local resources, adapting plans to the community, sustaining local relationships, and maintaining a sense of institutional ownership and pride will help preserve local economies and existing health care delivery systems.

Communities with larger local employers are more likely to experience control over change, or at least have extensive local involvement. Creating local hospital boards or other local authorities to specifically address the topic of managed care will accomplish much of this. Although smaller communities may have an easier time mobilizing local involvement, they are also more likely to need technical assistance related to health systems planning and financing. Community assessment, community organization, community education, system design, and negotiations with external parties are all areas in which technical assistance may be helpful.

Stability of Local Markets

As managed care continues to have an impact on the health care marketplace, numerous factors will influence its development in rural America. Each rural region is somewhat unique, and considerable complexity exists in the rural marketplace. Public policy and managed care organizations will have the greatest influence as to how quickly penetration into rural markets progresses. As programs develop, it is important to evaluate the stability of existing rural delivery systems and the potential for adverse effects within a particular community.

For example, the financial incentive to funnel patients to larger urban centers may threaten the survival of rural hospitals. Further, plans may impede access to health care if

they do not include local providers and facilities in their network. The problem could be compounded if local providers leave a particular area, and the managed care plan later ceases operations in the same area. Ultimately, managed care must account for local needs and established patterns of care.

Physician Assistants in Rural Areas

A significant proportion of physician assistants provide health care to rural Americans.[3] In addition to supporting the work of physicians who have chosen a rural practice, many PAs are the sole primary care providers in rural communities. By increasing access to primary care and preventive services, PAs help reduce overall medical costs.

It is in the best interest of rural managed care systems to provide cost-effective local health care services. Sustaining the care provided to rural Americans by PAs not only increases access to primary care, it also promotes continuity of existing care. When patients are satisfied with their current health care providers, they should be allowed, or even encouraged, to continue to utilize them in a managed care system.

Conclusion

The AAPA believes that physician assistants are a key component in any system that serves the health care needs of rural America. Access to primary care services in rural America is possible only with an understanding and sensitivity to the special needs of rural communities and the medical practices and practitioners that serve them. It is with attention to these considerations that the American Academy of Physician Assistants makes the following recommendations:

Physician assistants are qualified to be primary care providers in managed care systems. Including PAs on the list of primary care providers allows patients the option of seeking care from a PA who is an integral part of the physician-PA team.

As managed health care plans in rural areas increase, it is crucial that state and federal officials and other stakeholders ensure access to health care in rural areas. In particular, the needs of vulnerable populations, such as the medically indigent, the handicapped, and the elderly, will need close attention.

As managed care plans are implemented in rural areas, state and federal agencies and other stakeholders need to recognize the importance of exceptions, modifications, and alternatives to certain regulatory and practice requirements. This flexibility can help preserve and expand the availability of needed health care services.

States, communities, and managed care organizations need to actively develop solutions to problems in education, recruitment, and retention of health care providers in rural areas.

References

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