

**HEALTH CARE REFORM:
ISSUES FOR RURAL AREAS**

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EXECUTIVE SUMMARY

Health care reform is likely to raise unique issues for rural communities and providers. We identify and discuss a variety of these issues in this paper, with a particular focus on the potential relationship between health care reform and rural health networks. In order to focus, and impose limits, on our discussion of rural issues, it is necessary to make some preliminary assumptions about the structure of health care reform, as it will emerge from the current ferment. The main assumptions are: a mandated set of benefits; all individuals and employers share the cost of health insurance; everyone, except employees of very large firms and Medicare beneficiaries, obtains coverage through health insurance purchasing cooperatives (HIPCs); HIPCs contract with private health plans, including HMOs, PPOs, and one free-choice-of-provider option, and manage the enrollment process; plans are paid by risk-adjusted capitation; the HIPC pays an amount equal to the lowest cost plan; community-rated premiums are charged enrollees and no medical underwriting by health plans is allowed; states have authority to supervise HIPCs and license health plans; the federal government annually determines a maximum allowable rate of increase in the premiums of the "benchmark" (lowest cost) health plan option and a target for capping overall spending; in areas where managed competition does not result in increases consistent with these goals, HIPCs have discretionary authority to set rates and may set rates in all regions for the fee-for-service plan; and, while Medicaid is eliminated, the elderly continue to receive coverage under Medicare.

The paper is divided into four sections; each section begins with a general discussion of the topic to be addressed and ends with a list of important issues related to that topic. The first section discusses the ways in which rural providers might be organized as networks and the ways in which these networks might relate to HIPCs. The second section discusses alternative reimbursement arrangements for rural providers participating in health plans or contracting with HIPCs. Section three raises issues relating to service delivery and the recruitment and retention of providers in rural networks under the marriage of managed competition and global budgets. Section four discusses potential roles for state government under health care reform.

ORGANIZATION OF RURAL HEALTH NETWORKS

In existing rural health networks, participants usually continue to function independently, but work together to deliver specific services or share resources. While participants consist mostly of rural-based providers, urban providers often participate in rural networks as well. Despite the many examples of rural health networks, networks that provide the full range of acute inpatient and outpatient services to rural communities are relatively rare. Instead, existing rural networks tend to be groups of similar primary care, and sometimes secondary care, providers that form to address common problems or to respond to reimbursement opportunities.

Rural health networks have the potential to play a key role in the development of coordinated systems of care in rural areas under virtually every health care reform scenario. Health plans seeking to serve rural communities will attempt to contract with networks of rural providers in order to provide access to care for their enrollees. Where existing network relationships are not available, health plans will create networks through contractual relationships that aggregate rural providers into risk pools for reimbursement purposes. In rural areas that health plans decline to serve, proactive HIPCs are likely to serve as catalysts for the creation of rural networks. Where this fails, HIPCs will need to, in effect, assemble rural networks to serve as free-choice-of-provider or preferred provider plans for rural areas that would otherwise not be served by health plans.

Some analysts have argued that meaningful managed competition can occur only if providers have exclusive affiliations with health plans. Then, when individuals change their health plans they also must change their providers, presumably creating a strong incentive for providers, under contract to health plans, to compete for patients. Under this scenario, rural provider networks would contract with only one health plan, or form their own health plan and not subcontract with existing health plans. In regions where competition was thought not to be feasible, "franchises" could be granted by HIPCs to rural health networks to serve specific geographic areas in return for capitated payments. Other analysts have argued, however, that rural networks could contract with more than one health plan, and that plans would compete in terms of the coverage they offer, their prices and efficiency, and the extent to which their contractual relationships with local providers were more efficient or offered better quality or service.

Since local health care delivery systems in rural areas exhibit considerable diversity, health care reforms are likely to unfold in different ways across rural communities. The issues that are likely to develop relating to rural health networks are:

- **How quickly will rural providers react in developing rural health networks under the stimulus of health care reform? Will the initiative for network formation come primarily from rural providers or from urban-based health plans and health care organizations?**
- **What providers will be included in rural health networks?**
- **What steps should HIPCs take in areas where rural providers decline to participate in health plans or otherwise coordinate services to improve quality of care and contain costs?**
- **Should rural networks be encouraged to participate in multiple health plans? If so, when does this make sense? Or, should they be awarded "franchises" to serve designated geographic areas?**

REIMBURSEMENT OF RURAL PROVIDERS

It seems very likely that most rural providers will continue to be reimbursed under some form of fee-for-service payment whether they participate in prepaid health plans, PPOs, or a free-choice-of-physician plan. If they participate in prepaid plans, they will be required to assume some degree of financial risk for the delivery of care to rural residents, and there are innumerable variations in the way that payment schedules and risk-sharing arrangements can be structured.

In some cases, it may not be possible for any health plan (prepaid, PPO, or free-choice-of-physician) to serve a given geographic area and maintain premium increases within the amounts targeted by the HIPC. If no private health plan is available in a rural area, the HIPC could form and administer a plan. In this case the HIPC would establish provider reimbursement rates and attempt to control utilization (or contract with a private firm to undertake utilization management activities.) Presumably, as in the free-choice-of-physician plan, the primary mechanism for restricting expenditure growth would be the regulation of fees and charges. In this case, providers could only "quit the plan" by refusing to see plan patients (in which case their incomes would depend solely on revenues from Medicare patients), by moving to another location (an option that would presumably be available to noninstitutional providers), or by retiring (for individual providers) or ceasing operations (for institutional providers).

The reimbursement of rural providers raises several important issues that must be considered in designing health care reform initiatives:

- **How should rural providers be grouped for risk-sharing purposes?**
- **Under different reimbursement approaches, how strong should the financial incentives be for rural primary care providers to control or alter referrals to specialists?**
- **How will fee schedules be established and enforced for rural providers?**
- **Will rural networks have sufficient capital to accept financial risk under prepayment?**

IMPACT ON RURAL MEDICAL PRACTICE

The success of health care reform initiatives will depend in part on whether the delivery system in rural areas can be significantly altered in ways that improve the public's health. Under the proposed health reform initiatives, including global budgeting, it is likely

that rural providers will practice under a variety of utilization management techniques that attempt to control costs. The level of micro-management of individual clinical decisions of rural providers imposed by government or health plans, and the corresponding response of rural providers to these efforts, will be a defining characteristic of health care reform, as viewed by rural providers. The degree to which rural providers accept, or rebel against, the imposition of new utilization management techniques will be related to the way in which they are implemented. If utilization management consists primarily of complex information compiled and interpreted by distant urban-based institutions or government agencies, and then fed back to local rural providers, it will meet with substantial resistance. On the other hand, where a rural-based provider network has organized as a health plan, has developed a mechanism for integrating local provider input into the formation of practice guidelines, and carries out utilization management efforts with a sensitivity to local conditions, rural providers are likely to be much more receptive. Another factor that will influence the receptivity of rural providers to increased management and oversight is the responsibility given to primary care providers in networks. In managed care networks, rural primary care providers may serve as case managers, regulating the flow of referrals and specialty services throughout the network. Although the gatekeeper role can increase the status of the rural primary care provider vis a vis specialists, it still may be an uncomfortable position for many rural solo practitioners, particularly if it requires them to share risk with the health plan.

A second important issue relates to the location and availability of specialist services and technology used by rural communities. During the past decade, rural hospitals have used several strategies (including network participation, mobile technology, and specialty outreach clinics) to improve the availability of specialist services and technology in local communities. However, it is not clear that these efforts will be consistent with the strategies developed by health plans under managed competition, or government agencies under global budgeting.

A third issue relates to how differences in urban/rural practice styles will be resolved under health care reform initiatives. Differences are likely to exist in the practice styles of urban and rural providers who are members of the same network or health plan. How these differences are resolved will encourage, or discourage, the participation and commitment of rural providers to a network or health plan. Rural providers may resist the pressure to alter their practice patterns to conform to health plan guidelines and protocols that are based largely on the practice styles of urban providers.

A fourth issue concerns the opportunities that health reform initiatives may create for the development of new provider linkages with hospitals and other providers. Rural networks can be viewed as opportunities to develop shared business units that protect the common interests of rural providers, hospitals and other providers. Providers could legally own a network, partner with hospitals or other members in network ownership, or function in a traditional provider role with no network ownership responsibilities. In any of these alternatives, network development provides an opportunity for network partners to

assume joint responsibility for the health care provided to the residents of rural communities.

A final issue relating to rural medical practice is the impact of health reform on the willingness of providers to remain in rural areas, and to move there over time. For both recruitment and retention, it is desirable that rural practices are structured to encourage the provision of technical, collegial and referral support and to decrease the perception of isolation, overwork, and marginality among rural providers. Network development can directly address these concerns in some rural areas, but isolated rural areas will continue to be difficult to serve under any health care reform initiative. Many of the providers who practice in frontier areas can be characterized by their extreme independence; they may seek to avoid practicing as part of an organized medical system. Health plans will be faced with the dilemma of balancing their desire to effectively manage their provider networks with the potential impact that might have on the desire of providers to continue to practice in underserved rural areas.

The most significant rural medical practice issues that will be raised by health reform are:

- **How will rural providers react to increased management and oversight of their practice?**
- **How will the location and availability of specialist services and technology be affected by health care reform? Which services and technology will be provided locally in rural areas? How will referrals to specialists be managed?**
- **How will differences in urban/rural practice standards be addressed?**
- **What implications does network development have for relationships between rural providers, hospitals, and other health providers?**
- **How will health care reform affect the recruitment and retention of rural providers?**

ROLES FOR STATE GOVERNMENT

Most analysts agree that implementation of managed competition and global budgeting in many rural areas will be difficult and that states should be provided with as much flexibility as possible to develop solutions appropriate to local circumstances. States have traditionally played a central role in the purchasing of health care for public employees and low-income populations eligible for Medicaid and General Assistance.

Many health reform initiatives would eliminate that role but give states authority to supervise and charter or license HIPCs. In addition to this purely administrative role, states might also serve as HIPCs. Some analysts believe that HIPCs should not be risk-bearing entities but rather function as the broker among such entities. Others suggest that state or local governments may be able to go at risk for the financing and delivery of services provided by networks.

A second important role for states might be to support the development and maintenance of rural provider networks, as building blocks for managed care systems or accountable units for global budgeting. States can create incentives to stimulate the formation of networks through loans and/or grants to support the capital investment necessary for network building, the provision of reinsurance to networks in their early stages of development, the provision of necessary technical assistance to support local network development, and the support of the training of health professionals likely to participate in rural health networks.

While the formation of rural provider networks may facilitate the implementation of health reform initiatives in rural areas, it also raises antitrust questions. It has been suggested that federal and state enforcement of antitrust laws be adjusted, if necessary, to permit the undertaking of HIPC-approved joint endeavors, such as rural network development. The Supreme Court has recognized that states can insulate certain activities by private parties that would otherwise be viewed as illegal under antitrust law. For a state exemption to hold, a state must provide prior approval to an arrangement or activity between the parties involved and supervise the arrangement or activity after it is initiated.

Several analysts have suggested that reform initiatives include standardized and streamlined billing systems. States can play several roles in the development of these systems, including: collecting and analyzing utilization, expenditure, and outcomes data, monitoring quality of care and financial and geographic access to care, disseminating performance and cost information to consumers, and developing and monitoring a consumer grievance and complaint system.

A key issue in many health reform initiatives is how a federally set global budget will be allocated to the states, and the role that states will play in managing its implementation. Assuming that states are given some flexibility with respect to meeting expenditure limits allocated to them, several issues are particularly relevant for rural constituencies, including whether allocation procedures will treat urban and rural providers and consumers equitably; which items will be included in a state budget constrained by expenditure limits (especially public dollars that currently flow to categorical programs, income subsidies to attract providers to underserved areas, and the costs associated with building rural network capacity and infrastructure); and, what mechanisms will be used to contain costs for providers not participating in health plans.

In summary, the rural-related issues relating to state government roles in health reform initiatives are:

- **Should states be at risk for the financing and delivery of health care services, particularly in underserved rural areas?**
- **What are the most effective ways for states to stimulate rural network formation? How can existing capacity building programs be incorporated into a managed care system reimbursed under capitated rates?**
- **How aggressive should states be in enforcing antitrust laws when considering rural network formation? Will state action immunity be a successful strategy or will federal action be necessary to permit joint ventures that improve access and contain costs for rural populations?**
- **What role should the state play in collecting and disseminating health care information to the public? How will the special considerations of rural environments (e.g. low volume, relevant comparison groups, interest in patient referral process) be addressed?**
- **How will a federally-determined global budget be allocated to the states? Would budgets be based solely on historical expenditure levels, which have typically been lower on a per capita basis in rural areas? What role should states play in implementing and enforcing budget limits?**

CONCLUSION

One of the measures of success of the health reform package developed by the Clinton Administration will be how it addresses the unique needs of rural areas, which contain one-quarter of the population of our country. The primary purpose of this paper is to identify and discuss the major issues raised by health reform, as they are likely to be viewed by rural residents and providers. Of particular interest are those issues that relate to the development and operation of rural provider networks, which are likely to be stimulated by health care reform and, in turn, play an important role in implementing reform initiatives.

INTRODUCTION

The gathering momentum for health care reform at the federal and state levels has been accompanied by concerns about how reform initiatives could affect rural areas (National Rural Health Association, 1992). It is generally accepted that rural areas are different from urban areas in their population demographics and the availability and organization of their medical care resources (Cordes, 1989; Moscovice, 1989). Therefore, it seems reasonable to expect that health care reform could raise unique issues for rural communities and providers. We identify and discuss a variety of these issues in this paper, with a particular focus on the potential relationship between health care reform and rural health networks. The intent of the paper is not to develop a list of "barriers to change" (e.g. why this won't work in rural areas), but rather to suggest issues that are likely to arise as reform proposals are fleshed out in concept and in legislation.

In order to focus, and impose limits, on our discussion of rural issues, it is necessary to make some preliminary assumptions about the structure of health care reform, as it will emerge from the current ferment. While some of our assumptions may later turn out to be false, we believe that the issues we identify within the framework of these assumptions will continue to be relevant. In general, we assume that future health care reforms will contain elements of both "managed competition" proposals and "global budgeting" initiatives (see, for instance, Starr and Zelman, 1993; Enthoven, 1992; Enthoven, 1993; and Zelman and Garamendi, 1992). A summary of the main assumptions that provide a context for our discussion follows.

1. A mandated set of benefits is defined at the federal level; long-term care will not be part of this benefit package initially.

2. All individuals and employers share the cost of health insurance, with subsidies provided for the poor.
3. Everyone, except employees of very large firms and Medicare beneficiaries, obtains coverage through health insurance purchasing cooperatives (HIPCs) that serve defined geographical areas.
4. HIPCs contract with private health plans, including HMOs, PPOs, and one free-choice-of-provider option, and manage the enrollment process.
5. The plans are paid by risk-adjusted capitation, although providers within the plans could be paid using a variety of different methods.
6. The HIPC pays an amount equal to the lowest cost plan; a consumer choosing a higher cost plan must pay the difference between this payment and the plan's premium.
7. Community-rated premiums are charged enrollees; no medical underwriting by health plans is allowed.
8. States have authority to supervise HIPCs and license health plans. They also have the ability, with federal approval, to experiment with different administrative approaches in order to adapt to local needs.
9. The federal government employs "benchmark budgeting" by annually determining a maximum allowable rate of increase in the premiums of the "benchmark" (lowest cost) health plan option and a target for capping overall spending.
10. In areas where managed competition does not result in increases consistent with these goals, HIPCs have discretionary authority to set rates; they have this authority in all regions for the fee-for-service plan.
11. Medicaid is eliminated, but the elderly continue to receive coverage under Medicare, at least in the initial stages of health care reform.

Clearly, within the limits of this paper we cannot address all of the topics raised by health reform that are likely to be important for rural providers and communities. However, whether "managed competition" or "global budgeting" or some hybrid eventually becomes the dominant approach to health care reform, we expect that a large percentage of rural

providers will be organized in networks for the purpose of contracting with health plans or with HIPCs to serve rural areas. Therefore, an important objective of the paper is to identify those issues relating primarily to rural provider networks that will merit attention under health care reform.

The paper is divided into four sections; each section begins with a general discussion of the topic to be addressed and ends with a list of important issues related to that topic. The first section discusses the ways in which rural providers might be organized as networks and the ways in which these networks might relate to HIPCs. The second section discusses alternative reimbursement arrangements for rural providers participating in health plans or contracting with HIPCs. Section three raises issues relating to service delivery and the recruitment and retention of providers in rural networks under the marriage of managed competition and global budgets. Section four discusses potential roles for state government under health care reform.

ORGANIZATION OF RURAL HEALTH NETWORKS

What is a Rural Health Network?

Networks of organizations have been defined at a general level as "...organizational arrangements that use resources and/or governance structures from more than one existing organization" (Borys and Jemison, 1989). With respect to rural health care, the New York State Department of Health (1992) defines a rural health network as "...a locally directed or governed organization which provides...a set of defined health related and administrative services needed in the community served by the network." In existing rural health networks, participants usually continue to function independently, but work

together to deliver specific services or share resources. While participants consist mostly of rural-based providers, urban providers often participate in rural networks as well. The New York State definition would also include as a network "a health maintenance organization which serves a rural area and integrates existing area providers of care."

The actual organization and structure of rural health networks varies depending on the goals of participants, the availability of providers, and the characteristics of rural communities. The many different types of existing rural health networks illustrate the range of possibilities. For example, in a recent survey Moscovice, Johnson, Finch, et al (1991) found 127 different organizations in the United States that fit their definition of rural hospital consortia. Christianson, Shadle, Hunter, et al, (1986) reported the presence of 14 rural-based HMOs in 1984, with many other urban-based HMOs serving rural areas through contracts with organizations of rural physicians. As one example, the Rural Wisconsin Hospital Co-operative established an HMO as a collaborative effort of a rural hospital network and a rural-based physician individual practice association (Christianson, Shadle, Hunter, et al, 1986).

The development of rural networks has received support from several foundations over the past decade including the Robert Wood Johnson Foundation, which recently funded a demonstration to provide support to thirteen rural hospital consortia. At the federal government level, the Essential Access Community Hospital Program was initiated in 1991, in part to link smaller to larger rural facilities (Christianson, Moscovice, and Tao, forthcoming). At the state level, Minnesota has introduced the concept of "integrated service networks" in the implementation of its reform legislation (Minnesota Health Care

that they can function as contracting entities in negotiating with health plans. Existing networks might also broaden the composition of their membership in order to offer a full range of health services when contracting with health plans. Once organized in this manner, rural networks could conceivably contract with multiple health plans to serve community residents.

In more remote, sparsely populated rural areas the development of integrated, rural health networks will be more difficult. While networks do exist in some areas such as these, examples of provider networks contracting with prepaid health plans are relatively rare. In part, this reflects the fact that prepaid health plans have not found these areas attractive for a variety of reasons (Christianson, 1989). For instance, some rural providers have a "captive market" in these areas; there is little incentive for them to contract with a health plan to attract new patients or retain existing ones. Health care reform is not likely to alter this situation, so HIPC's may have to provide prepaid plans with strong incentives to serve sparsely populated rural areas. For example, contracts to serve more densely populated areas might be awarded only if health plans also demonstrated their ability to serve less-populated areas as well. This may require that the HIPC regulate prices charged by rural providers so that health plans are not forced to pay abnormally high prices to induce rural providers to contract with them.

If the HIPC does not provide strong incentives to prepaid plans to serve remote, sparsely-populated rural areas, it seems likely that residents of these areas will be offered a choice between a statewide PPO or a free-choice-of-physician plan, with regulated fee schedules for rural providers. The HIPC could sponsor and manage the free-choice plan

itself or, as envisioned under some reform proposals, contract with an insurer for this purpose. In either case, defacto networks of rural providers would likely be created to facilitate negotiation over reimbursement and the carrying out of quality assurance and utilization management activities.

In What Form Will Managed Competition Occur In Rural Areas?

In a recent article, Kronick, Goodman, Wennberg, et al, (1993) argue that meaningful managed competition can only occur when providers have exclusive affiliations with health plans. Then, when individuals change their health plans they also must change their providers, presumably creating a strong incentive for providers, under contract to health plans, to compete for patients. Rural provider networks would contract with only one health plan, or form their own health plan and not subcontract with existing health plans. Under this scenario, as Kronick, Goodman, Wennberg, et al, (1993) note, "In a geographically isolated area with a population base large enough to support only one hospital and one group of physicians, it is difficult to envision how competition would work." As a result, they urge "...care on the part of state governments in setting the rules for structured competition" and suggest a possible role for "...alternative models of reform (based on planning and the promotion of cooperation as the basis for achieving the efficiencies that the population-based perspective of the classic HMO brings to the health care economy)."

Rural health networks would seem well-suited for alternative models of reform that rely on some version of "sole source" contracting in rural areas. One of the motivations for the development of rural health networks in the past, and particularly for the formation

of rural hospital consortia, has been to facilitate cooperation among providers and to take advantage of scale economies in the delivery of services (Christianson, Moscovice, Johnson, et al, 1990). More broadly inclusive rural health networks could serve as accountable organizational units for resource rationalization in rural areas as well as vehicles for contracting with HIPCs. In regions where competition was thought not to be feasible, "franchises" could be granted by HIPCs to rural health networks to serve specific geographic areas in return for capitated payments. After granting the franchise, HIPCs would then play an essentially regulatory role to ensure not only that future premium increases fell within permissible boundaries, but also that the network was carrying out its contractual responsibilities to coordinate and rationalize services within its geographic area of responsibility.

It should be noted that the limitations that Kronick, Goodman, Wennberg, et al, (1993) see for the viability of "managed competition" in rural areas are not universally acknowledged. For instance, in designing its health care initiative the Minnesota Health Care Commission (1993) focused on competition among "integrated service networks" (ISNs) for enrollees, rather than direct competition among providers for patients. It suggested that "ISNs are likely to begin to form in rural areas not currently served by managed care health plans because of the incentives for providers to join or form ISNs in order to avoid the regulatory controls on non-MSN services and to take advantage of the benefits and support services that ISNs will offer providers." Furthermore, the Commission foresees the potential for ISNs to compete actively in rural areas in ways that could benefit consumers. It intends to "...promote and facilitate competition between ISNs

even in rural areas of the state where only one provider system exists. Just as multiple health insurance plans are available now, ISNs will compete in terms of the coverage they offer, their costs and efficiency, and the extent to which their contractual relationships with local providers are more efficient or offer better quality or service."

Under this scenario, rural networks could contract with more than one health plan, but would generally not risk the loss of patients when rural residents switched their health plans. No single health plan would be "accountable" for the coordination of resources in a given geographic area, but the rural network would continue to have a financial incentive to promote an efficient configuration of resources under some capitated reimbursement arrangements (see our discussion of payment arrangements below). Some analysts view competition among health plans, all of which employ the same provider network, as potentially inefficient, because it would impose excessive administrative burdens on participating providers, who would need to comply with the administrative and reimbursement practices of multiple plans. This should be of less concern under managed competition, where there presumably would be a standardized benefit plan, common administrative and data collection procedures for health plans, and control exercised by the HIPC over the number of plans offered in a given region. In rural areas, in particular, it seems unlikely that providers would simultaneously participate in large numbers of plans.

A related concern, however, would seem more relevant. If rural networks serve enrollees from multiple plans, it may be difficult for a single plan to exercise sufficient leverage on network providers to ensure meaningful participation in the plan's cost

containment efforts. Then, the potential benefits from competition among health plans in rural areas, as anticipated by the Minnesota Health Care Commission, might be difficult to realize in practice. Health plans finding they cannot control costs might withdraw from the area, forcing the HIPC to grant exclusive franchises to providers serving specific rural areas and to engage in extensive oversight activities.

Issues Relating to the Organization of Rural Health Networks

Local health care delivery systems in rural areas exhibit considerable diversity. Some rural areas are served by technologically sophisticated acute care facilities and large multispecialty group practices, while others struggle with financially marginal, understaffed hospitals and a shortage of primary care physicians and mid-level health practitioners. Rural areas contiguous to urban centers often have relatively high population densities, especially in comparison to sparsely populated frontier areas in many western states. These differences suggest that health care reforms are likely to unfold in different ways across rural communities. In this section, we summarize some of the issues to this point, with the understanding that these issues will vary in their importance across rural areas.

- **How quickly will rural providers react in developing rural health networks under the stimulus of health care reform? Will the initiative for network formation come primarily from rural providers or from urban-based health plans and health care organizations?**

The number of rural health networks will need to be expanded and existing networks will need to be modified if they are to play significant roles under health care reform. Given the conservative nature of many rural providers, and the constraints on their financial capacity to invest in network development, there may be limited potential for rapid network formation under the leadership of rural providers. If rural providers do not exercise

leadership in network formation, rural networks may be formed instead as the result of "shotgun marriages" of providers who happen to contract with the same urban-based health plan, with network leadership provided by health plan staff.

- **What providers will be included in rural health networks?**

In establishing contractual relationships with rural providers, prepaid health plans typically create separate risk pools for different types of providers (unless the health plan contracts with a multispecialty group practice). For reimbursement purposes, specialists are grouped with specialists, primary care providers with other primary care providers, and hospitals with other hospitals. (The reimbursement received by these groups is often tied together through interlocking financial incentives, as discussed below). Thus, the provider networks that result from this process tend to encourage the horizontal integration of providers. However, advocates of greater coordination, or regionalization, of health services in rural areas usually argue for vertical integration of health care delivery as well. Their conceptualization of rural health networks emphasizes the inclusion of a full range of services provided by physicians, mental health professionals, mid-level practitioners, public health agencies, long-term care providers, and other health professionals. While health care reform is likely to stimulate the formation of networks that aggregate providers of similar types, it may require intervention on the part of HIPCs to accomplish greater vertical integration of providers and coordination of service delivery where comprehensive service networks do not develop spontaneously.

- **What steps should HIPCs take in areas where rural providers decline to participate in health plans or otherwise coordinate services to improve quality of care and contain costs?**

In this case, most reform proposals suggest that these areas be subject to regulatory oversight, including the administration of price controls for providers, coupled with stringent utilization management. If these steps are sufficiently onerous, it is assumed that providers will eventually choose participation in a health plan as the least objectionable alternative. However, providers in remote rural areas may respond by moving their practices to more populous areas, creating access problems for some rural communities. HIPCs will need to balance their efforts to ensure that services are provided within a fixed budget with the need to maintain access to care for rural residents. How will HIPCs manage this "balancing act" in rural areas where providers choose to "opt out" of health reform?

- **Should rural networks be encouraged to participate in multiple health plans? If so, when does this make sense? Or, should they be awarded "franchises" to serve designated geographic areas?**

In both instances the concern is that an integrated, organized rural health network consisting of virtually all providers in a given area will be in a position to exercise monopoly power in negotiations with health plans or HIPCs. The issue is whether countervailing power can be most effectively brought to bear by health plans or HIPCs in these negotiations. The fallback position for the network, if an agreement cannot be reached, is to withdraw from the plan, in the first case, or from the franchise, in the second. Withdrawal from the franchise presumably would trigger direct regulatory oversight of individual rural providers on the part of the HIPC, as described above. Under what conditions should rural networks be encouraged to contract with multiple plans? When will it serve public policy better if they are awarded exclusive contracts to serve specific rural areas?

REIMBURSEMENT OF RURAL PROVIDERS

Reimbursement of Rural Providers Participating in Prepaid Health Plans

It seems very likely that most rural providers will continue to be reimbursed under some form of fee-for-service payment whether they participate in prepaid health plans or their rates are regulated under a global budget approach. It is also probable that they will be required to assume some degree of financial risk for the delivery of care to rural residents, and there are innumerable variations in the way that payment schedules and risk-sharing arrangements can be structured. However, the basic features of these arrangements can be illustrated by describing two of the more common variations currently used by prepaid health plans.

To illustrate the first type of arrangement, we assume that rural providers participate in an urban-based, IPA-model plan. Within a designated rural area, the plan groups primary care providers, specialists, and hospitals into separate risk pools for

reimbursement purposes. Primary care providers are reimbursed according to a fee schedule established by the plan, with 20 percent of each payment withheld and placed in a "withhold" fund. This money is returned to the primary care provider after one year (or some designated time period) if expenditures for primary care do not exceed a prespecified, designated amount. If expenditures are greater than budgeted, only a portion (or none) of the withhold pool dollars are returned. Providers receive distributions from the withhold pool according to the numbers of services they provide.

It is common for distribution of the withhold funds to be tied to experience in the hospital and specialist risk pools as well. If the funds allocated to these risk pools are not sufficient to cover all expenditures, shortfalls are covered through a transfer of funds from the primary care providers' withhold pool. This linkage acknowledges the importance of the "gatekeeper role" that primary care providers play in providing enrollees with access to specialty and acute inpatient services. Usually, a referral from a primary care provider is required for enrollees to see a specialist, and "pre-admission certification" is required for all non-emergency hospital admissions.

Under this scheme, rural providers are at limited financial risk, since the most they can "lose" in a given year is their contribution to the withhold pool. The strength of the incentive they feel to contain costs is related to the number of providers participating in the risk pool. The larger the number of providers, the less likely that any single provider will receive a significant reward for cost-containment activities that improve the financial performance of the health plan. Of course, if projected expenditures for any provider group (or the health plan as a whole) are exceeded in a given year, the health plan is

likely to propose lower payment schedules, more substantial withholds (or more substantial risk sharing through other mechanisms, such as paying primary care physicians on a capitated basis), and/or more aggressive utilization review policies in subsequent years. Ultimately, health plans that cannot "break even" in a particular rural area will terminate their contracts with providers, leaving it to the HIPC to determine provider reimbursement and utilization review policies for that area.

A second type of arrangement would require rural providers to assume a greater degree of direct financial risk for the delivery of services. To illustrate this arrangement, assume that the HIPC contracts with an integrated rural health network to act as the health plan for a designated geographic area (the "franchise" model described above). The network is "owned" and administered by the rural providers and receives a capitated payment for each enrollee to provide all covered medical services. The same options are available to structure provider reimbursement and risk-sharing as are used by prepaid health plans more generally. However, providers participating in the capitated rural network may feel stronger incentives to contain costs, in comparison to participating in an urban-based IPA, for two reasons. First, depending on the size of the network, the number of providers participating in a risk pool could be smaller. (An urban-based IPA conceivably could combine providers in many rural areas in structuring a risk pool.) Second, by virtue of their "ownership" of the network, the participating providers must make up any differences between aggregated capitation payments and expenditures for care at the end of the budget period. Of course, they also have the potential to share in any savings. As is the case with health plans, rural networks could protect themselves

against substantial losses, incurred on an aggregate or a per-patient basis, through the purchase of reinsurance.

Reimbursement of Rural Providers Participating in PPOs or Free-Choice-of-Physician Plans

Providers participating in these plans will be reimbursed based on fee schedules established through negotiation with the plans. Participating providers in PPOs would accept discounts from their usual fees in return for the potential to increase the number of patients they treat. PPO enrollees who elect to obtain care from a provider that does not contract with the PPO must pay part of the cost through copayments or deductibles. Thus the PPO creates financial incentives for patients to seek care from "preferred" providers. PPOs usually employ the same types of utilization controls as prepaid plans, but providers are not at direct financial risk for the performance of the PPO. However, if the PPO's premiums increase more rapidly than the targets established by HIPCs, then rural providers will likely face reductions in fee schedules and more aggressive application of utilization management techniques. Providers that are not responsive to efforts to change their utilization patterns could be dropped from the panel of participating providers.

The free-choice-of-physician plan has the least flexibility in the options it has available to control costs. As in PPOs, providers would be reimbursed using a fee schedule established by the plan. Since all providers can participate in the plan, the managers of the plan (or the government agency charged with enforcing budget limits) cannot drop providers that are not responsive to efforts to control utilization. Therefore,

providers. In addition, there is the question of whether fee schedules can be used in rural areas as instruments to reduce costs, if necessary, without causing providers to leave their rural practices, thereby jeopardizing access to care for rural residents in underserved areas. Finally, it seems likely that establishing the appropriate relationship between fee schedules for the non-elderly and Medicare fee schedules will be particularly important in rural areas. Due to the demographic composition of many rural areas, the preponderance of patients seen by primary care providers are elderly. Where this is the case, non-Medicare fee schedules may be crude and relatively ineffective instruments for influencing provider behavior and providers may be unwilling to accept financial risk. Again, attempts to impose financial risk on providers, or reduce their fees, could result in reduced access to medical care for the non-elderly in some rural communities.

- **Will rural networks have sufficient capital to accept financial risk under prepayment?**

When the federal HMO Act was implemented in 1974, funds were set aside to support the development of prepaid health plans in rural areas. However, because of the restrictions placed on accessing those funds, relatively little money was actually spent on this activity. If rural health networks are seen as desirable to facilitate health reform in rural areas, then government may need to allocate funds for investment in network building (see section IV below). Also, in order to protect fledgling networks that assume risk under capitated contracts, it may be necessary for the government to provide reinsurance to contracting networks in their initial stages of development. Networks that serve sparsely populated areas and consequently have relatively low enrollments could benefit from reinsurance provided by the government even after they become well-established. As one of their functions, HIPC's could aggregate the experience of all rural network enrollees into one risk pool for reinsurance purposes and possibly provide rural networks with reinsurance at subsidized rates. Alternative arrangements involving the pooling of rural network enrollees across HIPC's might also prove attractive.

IMPACT ON RURAL MEDICAL PRACTICE

The success of health care reform initiatives will be diminished unless the delivery system can be significantly altered in ways that improve the public's health (Zelman and Garamendi, 1992). Rural health networks can serve as the building blocks for the

implementation of reform initiatives in rural areas and lead to major structural changes in the rural health system. In fact, the quid pro quo for rural support of health reform initiatives might be development of the capacity and infrastructure necessary to build rural provider networks. How this is accomplished will, in part, determine the impact of health reform on rural medical practice.

Traditional rural primary care physicians have been characterized as overworked, inadequately reimbursed, and with insufficient professional support (National Rural Electric Cooperative Association, 1992). They have approximately 20 to 30 percent more patient visits yet earn 10 to 20 percent less than their urban counterparts (Wyszewianski and Mick, 1991). A recent study of rural physicians in Colorado found that two-thirds were in solo practice and more than one-half were on call at least every other night (Moscovice, Rosenblatt and McCabe, 1993).

These data suggest that many rural physicians might be receptive to organization and delivery system changes that improve the circumstances of their practices. The same might be true for nurse practitioners, physician assistants, and other providers practicing in rural areas. This is particularly relevant if the implementation of health reform initiatives in rural areas is receptive to rural provider input. Enthoven (1993) has described one scenario that may be attractive to some rural providers:

HIPCs might request proposals from established urban comprehensive care organizations to establish and operate a network of primary care outposts, paying doctors and nurse practitioners what is needed to attract them to provide high quality ambulatory care in rural locations, while giving them professional support in the form of telephone consultations, temporary replacements, continuing education, and transportation and referral arrangements.

If one of the results of health reform is to stimulate the widespread development of rural provider networks, rural medical practice is likely to be dramatically transformed from the description of the traditional rural primary care physician offered earlier. The remainder of this section discusses five specific aspects of this possible transformation.

Response to Increased Management and Oversight

At present, most rural providers have very little, if any, experience with managed care arrangements. Under the proposed health reform initiatives, including global budgeting, it is likely that rural providers will practice under a variety of utilization management techniques that attempt to control costs. These techniques include pre-admission certification for inpatient care, pre-authorization review for surgery, physician profiling, practice guidelines, and so on. They could be implemented either by health plans that contract with rural providers or by government attempting to control expenditures within a global budgeting framework.

The level of micro-management of individual clinical decisions of rural providers imposed by government or health plans, and the corresponding response of rural providers to these efforts, will be a defining characteristic of health care reform, as viewed by rural providers. On the one hand, under managed competition health plans and networks may be under strong pressure to closely micro-manage providers to maintain their competitive position (Brown, 1993). And, regional governments may feel the same pressure in order to stay within budget caps. On the other hand, the goal of these techniques has been described as not to remove the decision making power of individual providers, but rather to improve their ability to make better decisions (Hillman, Greer, and

Goldfarb, 1993). The degree to which rural providers accept, or rebel against, the imposition of new utilization management techniques on their practice clearly will be related to the manner in which they are implemented and their perceived value to patients.

If utilization management consists primarily of complex information compiled and interpreted by distant urban-based institutions or government agencies, and then fed back to rural providers, it will meet with substantial resistance. This is particularly true if it is accompanied by requirements that telephone approval for treatment be sought from anonymous utilization review professionals with limited knowledge of the rural practice environment. On the other hand, where a rural-based provider network has organized as a health plan, has developed a mechanism for integrating local provider input into the formation of practice guidelines, and carries out utilization management efforts with a sensitivity to local conditions, rural providers are likely to be much more receptive. That is not to suggest that appropriate vehicles for education of providers, feedback of information, and development of financial and behavioral incentives for providers cannot be developed in top-down networks. However, it may be easier to incorporate local provider input and exhibit sensitivity to local consumer values and beliefs and the constraints of local medical care delivery environments in rural-based networks.

Another factor that will influence the receptivity of rural providers to increased management and oversight is the responsibility given to primary care providers in networks. Historically, the fortunes of rural health have depended very much on the relative supply of primary care providers (Moscovice, 1989). In managed care networks, rural primary care providers may serve as case managers, regulating the flow of referrals

and specialty services throughout the network (Hillman, Greer, and Goldfarb, 1993). Depending on the financial relationships that are established, this role may also place the rural primary care provider (or provider group) in a position of financial risk for the services provided to their patients (as described in section III). Although the gatekeeper role can increase the status of the rural primary care provider vis a vis specialists, it still may be an uncomfortable position for many rural solo practitioners who have minimal experience in risk-bearing roles and view themselves primarily as advocates for their patients.

Location and Availability of Specialist Services and Technology

In their proposed guidelines and requirements for rural health networks, the New York State Department of Health (1992) states that:

Rural health networks hold the promise of stemming an almost inevitable hemorrhage of health care services and resources away from rural areas...

Others have pointed out that the majority of dollars rural residents spend for health care are spent outside their local communities (Amundson and Hughes, 1989). If the majority of health care funds were spent at the local level, the range and quality of services available in rural communities conceivably could be expanded.

An important issue related to the development of health plans and rural provider networks is the location and availability of specialist services and technology used by rural communities. During the past decade, rural hospitals have used several strategies (including consortia participation, mobile technology, and specialty outreach clinics) to improve the availability of specialist services and technology in local communities. These

efforts have improved the public perception of rural hospitals but questions remain concerning their costs and effectiveness. Can they improve the financial performance of rural hospitals and the incomes of rural providers by redirecting patient flows? Are technologies and services being used appropriately? What effect does their provision locally have on patient outcomes and quality of care?

It is not clear how the above efforts will mesh with the strategies developed by health plans under managed competition, or government agencies under global budgeting. At some level, subspecialty services will need to be provided outside the local community and health plans will need to contract for these services with non-local providers. Urban-based plans may encourage referrals of the full range of specialty care to urban specialists and hospitals under contract to the plans, thereby increasing the leakage of funds from rural areas. On the other hand, rural-based plans may attempt to limit referrals to urban-based specialists to assure that more care is provided locally. These plans would likely encourage consultants in many specialties to provide outreach clinics in rural areas.

The comparative short-term budget costs of these alternatives will heavily influence the decisions of health plans and government agencies. However, the decision making process should also take into account costs imposed on rural residents and the quality of care provided under the two scenarios. How this issue is addressed will affect the magnitude of cost savings attributed to reform initiatives, public perception of rural providers, the economic base for health care institutions in rural communities, medical

outcomes for rural residents, and the acceptability of health care reform efforts to rural providers.

Differences in Urban/Rural Practice Styles

One salient issue that needs to be addressed is how differences in urban/rural practice styles will be resolved under health care reform initiatives. Rural providers practice in less resource intensive environments where technology and consultant specialists are less readily available. Therefore, differences are likely to exist in the practice styles of urban and rural providers who are members of the same network or health plan. How these differences are resolved will encourage, or discourage, the participation and commitment of rural providers to a network or health plan.

Under one option, a federal board would be responsible for setting standards to eliminate unnecessary care and to assure the use of the most cost-effective technology (Etheredge, 1992). Its work would be facilitated by national data systems that would track utilization, expenditure, and outcomes information. Thus, the responsibility for technology assessment and the development of practice parameters and guidelines would rest at the federal level (Zelman and Garamendi, 1992).

The question of interest to rural providers is how such national standards would be applied to them. At one level, the medical profession clearly will have the responsibility for setting practice standards and guidelines. In rural areas, reaction to and appropriate use of these standards most likely will relate to whether rural provider input is incorporated into their development, and whether some flexibility in their application is shown. At another level, health plans may focus on quality improvements for enrollees

through a system-wide approach. Rural providers may feel the pressure to alter their practice patterns to conform to health plan guidelines and protocols, which may be based largely on the practice styles of urban providers. Is this a better approach than allowing the possibility of different standards depending on environmental and professional factors? The answer is not clear because the impact of managed care arrangements on quality improvement and outcomes is not yet well understood. It is clear, however, that the pooling of data and the use of large-scale management information systems by health plans will facilitate comparisons of patient outcomes across rural providers to a degree that is not now possible.

Provider Relationships With Hospitals and Other Entities

As described earlier, the majority of existing rural networks consist of similar groups of providers organized to address issues of common interest. It is the rare instance when vertically integrated delivery systems have been developed in rural communities, and providers have very little experience in these types of arrangements. In rural communities that currently have a difficult time maintaining access to services for their residents, dysfunctional relationships often exist between local physicians and hospitals, with no apparent linkages between physicians and other providers.

Health reform initiatives may create opportunities for the development of new physician linkages with hospitals and other providers. Nationally, 64.2 percent of the 2,361 rural counties (i.e. non-SMSA counties) had no HMOs providing services to county residents in 1992 (Wholey, 1993). Rural counties adjacent to SMSAs were more likely to have at least one HMO serving residents of the county than rural counties not adjacent

to SMSAs (56.2% versus 22.9% of counties served by at least one HMO; Wholey, 1993).

In Minnesota, which has a mature managed care environment, almost half of the 71 rural counties were not served by HMOs in 1991 and 86 percent had less than 10 percent of their population enrolled in HMOs (Minnesota Department of Health, 1992a). These data suggest that providers in many rural counties (particularly those further away from metropolitan areas) will have little experience delivering medical care within a managed care system with formal organizational linkages to hospitals and other providers.

Rural networks can be viewed as opportunities to develop shared business units that protect the common interests of rural physicians, hospitals and other providers and help them to take risks together in activities such as the creation of HMO/PPO organizations; development of satellite clinics; joint capital ventures; provider recruitment; purchase of new technology; quality assurance, malpractice, and risk management activities; and service diversification initiatives. Providers could legally own a network, partner with hospitals or other members in network ownership, or function in a traditional provider role with no network ownership responsibilities. In any of the above scenarios, network development provides an opportunity for network partners to assume joint responsibility for the health care provided to the residents of rural communities.

The New York State Department of Health (1992) explicitly recognizes that rural health networks will need to provide a complete range of services and suggests they should include as members (or have formal relationships with) one or more hospitals, office-based physician groups, diagnostic and treatment centers, prenatal care clinics and other public health clinics, community health centers, emergency medical service

providers, certified home health agencies, nursing homes, mental health providers, mental retardation and developmental disabilities providers, providers of alcohol and drug abuse services, local transportation services, and other human service agencies and local governments.

Unfortunately, many of the services offered by the above providers are in limited supply in rural areas. How health plans and rural provider networks work together to assure the availability of a complete range of services will significantly affect the acceptability of health reform initiatives to rural residents and the ability of these initiatives to alter traditional provider practice patterns.

Provider Recruitment and Retention

A final issue relating to rural medical practice is the impact of network development under health reform on the willingness of providers to move to rural areas, and to remain there over time. The central health care issue for many rural communities is not cost, but rather the inadequate supply of physicians and other providers and limited access of rural residents to medical services. Physician recruitment and retention remains a widespread problem throughout rural America. Horner, Samsa, and Ricketts (1992) have found that almost 50 percent of rural primary care physicians in North Carolina left their rural practice setting within three years. Physician turnover is an important factor that could hinder the implementation of new health care initiatives in rural communities, and the development of integrated service networks.

The organizational characteristics of the physician practice can have an important impact on rural physician recruitment and retention (Crandall, Dwyer, and Duncan, 1990).

It is desirable that rural practices are structured to encourage the provision of technical, collegial and referral support and to decrease the perception of isolation, overwork, and marginality among rural physicians. Network development can directly address many of these. For example, physician recruitment, training and continuing education often can be accomplished more effectively on a network-wide basis rather than by individual entities (Grandall, Dwyer, and Duncan, 1990). More than half of the rural hospital networks in the United States reported physician and staff recruitment as one of their major activities (Moscovice, Johnson, Finch, et al, 1991).

Another aspect of the recruitment and retention issue is the ability to attract providers to isolated rural areas. These areas will continue to be difficult to serve under any health care reform initiative and it is not clear what incentives can be created by networks to attract physicians or other health professionals to practice in these areas. Many of the providers who practice in frontier areas can be characterized by their extreme independence; they may seek to avoid practicing as part of an organized medical system. These providers will require technical assistance to understand how to become part of a network or how to contract with a health plan. Health plans will be faced with the dilemma of balancing their desire to alter provider practice patterns with the potential impact that might have on the desire of providers to continue to practice in underserved rural areas. How this balance is addressed will directly affect the isolation of providers and the accessibility of health services in sparsely populated, underserved rural areas.

Issues Relating to the Impact on Rural Medical Practice

— This section has raised a variety of issues related to the potential impact of health reform initiatives on rural medical practice. The most significant of these issues are:

- **How will rural providers react to increased management and oversight of their practice?**

Rural providers generally have little experience participating in managed care systems. If utilization management is to be carried out effectively in rural areas, it will need to be somewhat adaptable to the varying conditions present in rural areas and receptive to input offered by local providers. How will local provider input be incorporated into utilization management approaches?

- **How will the location and availability of specialist services and technology be affected by health care reform? Which services and technology will be provided locally in rural areas? How will referrals to specialists be managed?**

Health care reform must be structured to strike the appropriate balance between providing specialty services and technology in rural communities and requiring that rural residents travel to urban areas for this care. The considerations that enter into defining that balance are complex, relating to the nature of the service, the availability of specialists already in the rural area, the willingness of urban specialists to conduct outreach clinics, the outcomes of care under different approaches, and relative costs, including costs imposed on patients. Which services and technology should be provided locally in rural areas? How will referrals to specialists be managed?

- **How will differences in urban/rural practice standards be addressed?**

Practice standards differ significantly between urban and rural areas, and among rural areas. Attempts, through health care reform, to develop and implement practice standards on a broad scale are likely to meet resistance in rural areas unless these standards are flexible enough to accommodate the unique characteristics of some rural practices. Should there be different standards depending on environmental and professional factors? How will rural provider input be used in the development of standards?

- **What implications does network development have for organizational relationships between rural physicians, hospitals, and other health providers?**

In many rural communities, physicians, hospitals and other health care providers are operated independent of each other, sometimes in adversarial relationships. Health care reform could provide a vehicle for better service delivery integration at the local level. How can reform initiatives best be designed to achieve this objective?

- **Will the recruitment and retention of rural providers be enhanced by health care reform?**

The maintenance of access to medical services will continue to be the primary issue for many rural areas, even in the context of national efforts to control costs through health care reform. Efforts to reduce fees, implement utilization management techniques, and institute practice standards could discourage providers from locating or remaining in rural areas, if they are not sensitive to rural needs. On the other hand, if health reform stimulates the formation of rural health networks that support rural practices, then the ability to recruit and retain providers would be enhanced. What incentives can be created by networks to attract physicians and other health professionals to practice in underserved rural areas?

ROLES FOR STATE GOVERNMENT

The goal of state health policy has been described as assuring access to quality health services at a reasonable cost (Altman and Morgan, 1983). Historically, states have been active in paying for health care services, providing health care services directly, establishing rules governing health care providers and marketplace activities, developing and training health care resources, and protecting the public health and safety (Helms, 1991). In the debate over health care reform, several analysts have proposed various roles for federal and state government (Starr and Zelman, 1993; Kronick, 1993). Most agree, however, that implementation of managed competition and global budgeting in many rural areas will be difficult and that states should be provided with as much flexibility

as possible to develop solutions appropriate to local circumstances. In particular, approaches that cross state boundaries may need to be considered in implementing health care reform in some rural areas. The following discussion highlights five roles for state government in administering health reform initiatives. These roles include purchasing health care, building network capacity and infrastructure, balancing antitrust enforcement and network establishment, informing consumers, and allocating and enforcing budgets.

Purchasing Health Care

States have traditionally played a central role in the purchasing of health care for public employees and low-income populations eligible for Medicaid and General Assistance. Many health reform initiatives would eliminate that role but give states authority to supervise and charter or license HIPCs (Starr and Zelman, 1993; Zelman and Garamendi, 1992). States would support HIPC efforts in contracting with health plans, developing risk adjustments across plans, enrolling eligible groups, collecting premiums and so on (Helms, Gauthier, and Campion, 1992).

In overseeing the activities of HIPCs, states could also ensure that rural concerns were addressed by:

- facilitating the entry of new health plans and networks in rural areas
- requiring HIPCs to assure geographic access to services in rural areas
- awarding exclusive franchises when special incentives are necessary to attract health plans to serve rural areas
- requiring HIPCs to have a rural advisory board
- maintaining a safety net (perhaps a state-run health plan) for vulnerable rural populations (e.g. migrants) that may have special needs

- requiring HIPCs to enroll the poor in the same plans that serve the wealthy and the middle class.

An alternative to this purely administrative role would have states serve as HIPCs.

As Starr and Zelman (1993) have pointed out, HIPCs are very similar to existing state health benefits programs. Several states have taken aggressive positions in trying to contain health care costs for their employees. In Minnesota, state employees comprise the largest employer-based health insurance group in the state serving almost 120,000 employees, dependents and retirees (Dowd, Christianson, Feldman, et al, 1992). The state has employees in all 87 counties of the state, many of which include rural areas not served by managed care plans. In 1989, the state replaced the statewide fee-for-service plan with a preferred provider organization (PPO) resulting in changes in physicians or higher out-of-network costs for state employees in some rural areas. In response to the threat of losing patients, physicians in 11 rural counties joined an HMO plan that had not previously served the county (Dowd, Christianson, Feldman, et al, 1992). In this instance, the state, functioning in essence like a HIPC for the pool of state employees, served as a catalyst for rural managed care development. In California, the public employee health benefits system also includes smaller county and local governments as part of the system. In these states, it may not be difficult to add the small employer insurance market to the existing public employee insurance market. Other states (e.g. Florida, Washington, and West Virginia) are currently examining the feasibility of this approach.

Do states have the capacity and willingness to go at risk for the financing and delivery of health care services, particularly in riskier situations such as serving isolated rural areas? What does it mean to have a state or local government "at risk" for cost

- the protection of existing capacity building programs such as community health centers, rural health clinics, federally qualified health centers, and migrant health centers
- the provision of necessary technical assistance to support local network development
- the creation of financial, education, and licensure incentives that support the training of health professionals likely to participate in rural health networks.

A current example of state activities that provide support for rural network development are the efforts of the Office of Rural Health, New York State Department of Health and the New York State Rural Health Council (New York State Department of Health, 1992). State policymakers identified the lack of recognition of networks in existing reimbursement methods and the uncertainty of support beyond grant periods as barriers to rural network formation. As a result, New York State has established a framework for rural network development based on the publication of proposed network guidelines and requirements and proposed criteria and standards for network delivery models. Under one legislative proposal, network development in New York will be promoted through planning grants (up to \$50,000 per year for up to two years), start-up grants (up to \$500,000 to support infrastructure costs such as transportation, communication, medical records), and administrative grants (\$100,000 to \$200,000 per year for up to three years to provide operational support for network administration). The annual cost of this program is expected to be \$4.7 million with most of the support coming from the reallocation of funds from existing state programs. The state has proposed to enact permanent fiscal incentives to support networks through adjustments to existing payment methods and categorical grant programs.

The New York State proposals highlight how a state that believes there is a pressing need to develop new delivery systems in rural areas can take a proactive role in rural network development. The legislature and the State Department of Health have worked together to promote a Hill Burton-like program that supports the development and funding of rural network capacity and infrastructure.

Balancing Antitrust Enforcement and Network Establishment

While the formation of rural provider networks may facilitate the implementation of health reform initiatives in rural areas, it also raises antitrust questions. The major goal of antitrust law is to preserve and enhance competition by making it illegal to enter into contracts or arrangements in restraint of trade or that create a monopoly. Antitrust laws attempt to assure that private arrangements do not reduce public access to services through price increases or output limitations (Struthers, 1991; Motenko and Busey, 1992).

How then should the formation of rural health networks be viewed vis a vis antitrust considerations? In particular, how should this issue be resolved in underserved rural areas where a competitive market is not likely to be established? It has been suggested that federal and state enforcement of antitrust laws be adjusted as necessary to permit the undertaking of HIPC-approved joint endeavors, such as rural network development (Zelman and Garamendi, 1992). Underlying this suggestion is the possibility that the literal application of existing antitrust laws to the delivery of medical care in rural areas may not yield net benefits for consumers. Rather than promoting access to care and containing costs, it could pose a threat to the availability of health care services in some rural communities (Struthers, 1992).

The Supreme Court has recognized that states can insulate certain activities by private parties that would otherwise be viewed as illegal under antitrust law. The state action exemption applies to arrangements that are (Rural Health Advisory Committee, 1993):

- conducted pursuant to a clear state policy to supplant competition, and
- actively supervised by the state.

For the state action exemption to hold, a state must provide prior approval to an arrangement or activity between the parties involved and supervise the arrangement or activity after it is initiated. In Minnesota, the legislation that underpins current state health care reform has a provision for state action immunity for arrangements that the Commissioner of Health believes may improve cost, quality, or access.

State action immunity could be used to address antitrust issues regarding rural network development in isolated rural areas that are not likely to be attractive to health plans or networks. For these areas, it may be desirable to award exclusive franchises or monopolies that will need to be closely monitored to ensure that they operate in the public's interest. The monitoring or regulating function could be the responsibility of the HIPC, the state, or the federal government (Rural Wisconsin Hospital Cooperative, 1993).

Informing Consumers

For health care reform to be successful, the average person will need to understand the changes being proposed and how these changes will affect him or her personally. As Shofar (1993) has suggested, an early challenge will be to explain the

reform package meaningfully to lay people to avoid the substantial implementation barriers that can arise otherwise. This is not an easy task. Proponents of market-oriented approaches have lamented the lack of good information on the quality of care provided in health plans and the price and quality of care provided by individual health professionals. The problems inherent in constructing acceptable measures of quality of care, be they outcomes-based measures or patient satisfaction measures, have been well documented (Shofar, 1993; Reinhardt, 1993). In addition, where such measures are available, it is not obvious what methods are most effective in disseminating information to the public. Nevertheless, the development and dissemination of such measures are essential to the success of a reform process that envisions consumers comparing and choosing health plans based on cost, quality, and access considerations.

Several analysts have suggested that reform initiatives include standardized and streamlined billing systems that will eventually move toward electronic transmission and result in detailed information becoming available on the location, use, cost, and quality of health care services provided in local and regional markets (Etheredge, 1992; Kronick, 1993). States can play several roles in this effort including (Helms, Gauthier, and Campion, 1992):

- Collecting and analyzing utilization, expenditure, and outcomes data
- Monitoring quality of care and financial and geographic access to care
- Establishing a state data commission with mandatory disclosure requirements
- Disseminating performance and cost information to consumers in an accessible Consumer Reports type format

- Certifying "centers of excellence" for certain procedures
- Developing and monitoring a consumer grievance and complaint system

States will vary substantially in their ability to assume the types of roles described above. Florida has proposed entering into a public/private partnership to collect and disseminate health data through its State Center for Health Statistics (Agency for Health Care Administration, 1992). Minnesota plans to take advantage of its decentralized community health boards (i.e. local public health agencies) to disseminate information at the local level (Minnesota Department of Health, 1992b). Most states will require substantial resources and technical assistance to carry out these roles.

There are several aspects of the state's "informing consumers" role that are idiosyncratic to rural areas. Many providers and health plans offering services to rural populations will have a limited volume of specific types of patients they have treated in a given time frame. In the past, small sample sizes have limited the ability of researchers to evaluate the outcomes of care provided by rural health professionals. Aggregating data to the health plan level may alleviate the problem somewhat, but will not permit individual physician/hospital/health professional comparisons that may be particularly useful in providing input to consumer decisions. Establishing relevant comparison groups is another issue that is particularly important for isolated rural areas that may be served by only one provider or health plan. Typically, in this case, comparison groups are constructed using providers or health plans in other isolated rural areas of the state or in neighboring states. Finally, it will be important to examine what services are not provided in rural areas as well as those services that are provided. Analysis of the patient

referral processes used by rural providers would be helpful in understanding the appropriateness of care provided in rural areas and the short and long-term impact of patient referrals on costs.

In summary, states could play a major role in the collection of information from health plans and providers and the dissemination of this information to consumers. Rather than acting solely as a conduit for the passage of information to the federal government, many states are likely to experiment with developing innovative approaches to disseminating information to their residents. States will need to be sensitive with respect to the relative effectiveness of different approaches in informing residents of rural areas.

Allocating and Enforcing Budgets

The role of a global budgeting approach as part of a health reform package has not been settled. Enthoven (1993) has stated that managed competition is not compatible with a global budget established by the government. Others insist that health care costs cannot be controlled without global budgets and that managed competition could readily support the imposition of global budgets through the use of capitated health plans (Aaron and Schwartz, 1993; Reinhardt, 1993; Starr and Zelman, 1993). For the purposes of this paper, we have assumed that reform initiatives will contain a global budgeting process that is initially triggered at the federal level.

From the state perspective, a key issue is how a federally set global budget will be allocated to the states, and the role that states will play in managing its implementation. Kronick (1993) suggests that if states are accountable for their level of health expenditures, they should have the freedom to experiment with different approaches for

setting and meeting a budget. Others suggest that the federal government may need to set state expenditure targets and create disincentives for exceeding those targets (Zelman and Garamendi, 1992). In either case, there are political and technical tradeoffs involved with using different strategies for implementing a global budgeting approach.

Assuming that states are given some flexibility with respect to meeting expenditure limits allocated to them, several issues are particularly relevant for rural constituencies. The first issue is whether allocation procedures will treat urban and rural providers and consumers equitably. If initial expenditure targets and payment rates are based primarily on historical expenditure and/or payment data, the controversies surrounding the early implementation of the DRG system are likely to be repeated. Rural areas have typically had lower per capita health expenditures than urban areas. As Helms, Gauthier and Campion (1992) suggest, expenditure limits need to account for:

the difficult problem of not unduly penalizing states which have already achieved efficiencies in their delivery systems and states which have not made adequate investments to assure adequate health services for all residents.

A second issue involves clearly defining which items would be included in a state budget constrained by expenditure limits. Items of special interest to rural areas include public dollars that currently flow to categorical programs, income subsidies to attract providers to underserved areas, and the costs associated with building rural network capacity and infrastructure.

A final issue relates to mechanisms for containing costs for providers not participating in health plans. This is particularly relevant for underserved rural areas where competitive markets will be difficult to establish. In these cases, it is anticipated that

exclusive franchises or monopolies may be established and paid on a regulated fee-for-service basis. The response of providers to this type of payment mechanism and controls on technology and specialized services will need to be monitored by states. Potential provider responses include changes in patient volume, quality, or casemix and highlight the broad set of implications and tradeoffs that global budgets or expenditure limits may have on the cost, accessibility and quality of services available in rural areas.

Issues Relating to Roles for State Government

This section has discussed potential roles for state government as health reform initiatives are implemented. Important issues raised in the discussion include:

- **Should states go at risk for the financing and delivery of health care services, particularly in higher risk, underserved rural areas?**

The budgetary problems of many states suggest that it may not be timely for states to take on the additional risks associated with the financing and delivery of health care services. On the other hand, it may be relatively straightforward for some states to add all of the small employers in rural areas or entire rural portions of the state not served by health plans to their existing public employee insurance plan. It remains to be seen whether states can expand their current health care purchasing programs to include other groups. It also may be difficult to attract health plans and providers to serve remote rural areas. As a last resort, it has been suggested in section III that exclusive franchise agreements may have to be awarded as an incentive for plans and providers to meet the needs of isolated rural populations. What role should the state play in granting and overseeing these franchises?

- **What are the most effective ways for states to stimulate rural network formation? How can existing capacity building programs be incorporated into a managed care system reimbursed under capitated rates?**

In many states, there is a minimal infrastructure available to support managed care systems in rural areas. Existing health plans and providers will need support to develop rural provider networks that can serve as the foundation for health reform initiatives in rural areas. What specific types of

- **How will a federally determined global budget be allocated to the states? Would budgets be based solely on historical expenditure levels, which have typically been lower on a per capita basis in rural areas? What role should states play in implementing and enforcing budget limits?**

If a global budgeting approach is implemented, perceived inequities in the existing system could be incorporated into the new system. Any approach that depends solely on historical expenditure or payment data is likely to raise concerns in rural areas. What other kinds of factors need to be considered in allocating budgets to rural providers and areas? Would budgets include public dollars that flow to categorical programs, subsidies to attract providers to underserved areas, and costs associated with capacity building and infrastructure improvements?

CONCLUSION

One of the measures of success of the health reform package developed by the Clinton Administration will be how it addresses the unique needs of the approximately one-fourth of the population that lives in rural areas of our country. This paper should be viewed as a first step in the development of a health reform package that is sensitive to the realities of health care delivery in rural America. The primary purpose of the paper has been to identify and discuss the major issues raised by health reform, as they are likely to be important for rural providers and consumers. Of particular interest are those issues that relate to the development and operation of rural provider networks, which are likely to be stimulated by health care reform and, in turn, play an important role in implementing reform initiatives.

The paper provided a framework for discussion of these issues at a meeting on Health Care Reform in Rural Areas held in Little Rock, Arkansas on March 11-12, 1993 under the sponsorship of the Robert Wood Johnson Foundation and the Arkansas Department of Health. One outcome of that meeting is a list of recommendations on how

health reforms can address issues that are critical to the financing and delivery of health care services in rural America.

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