The Changing Landscape of Health Care Financing and Delivery: How Are Rural Communities and Providers Responding?

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THE ORGANIZATION AND FINANCING OF HEALTH CARE have changed dramatically in recent years, but not all communities or providers have been affected equally. In order to benefit from economies of scale, health plans are enrolling large numbers of patients in exchange for reduced fees (discounts negotiated by insurers); providers are accepting capitated payment in exchange for managing the health and financial risks associated with insuring groups (providers working in a managed care system); and purchasers of health care benefits are soliciting contractual arrangements to purchase care for defined populations (state Medicaid programs). The requirement of a sizable population base to achieve these goals has meant that most of this financial transformation has originated in urban (metropolitan) centers before spreading to rural (nonmetropolitan) areas. In 1997, when the field studies that form the basis for this paper were completed, the changes in health finance that prevailed elsewhere had barely advanced into the rural communities we visited. However, communities and providers sensed that 1997 would bring change. That year marked the beginning of

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discussions about changes in Medicare and saw the enactment, in August, of the Balanced Budget Act (BBA). The BBA triggered changes in Medicare that mirrored the earlier chronology of developments in private insurance; by 1998, 85 percent of individuals covered by employment-based health insurance were enrolled in some form of managed care plan (Kuttner 1999). We wrote this paper in order to answer one central question: Are rural communities and providers ready to adapt to changes in health insurance and in the behavior of decision makers, such as Medicare and Medicaid policy makers, insurance companies, other providers, and employers?

Trends in health care insurance and delivery (i.e., new health care systems and networks of health care providers) might unfold differently in rural and urban areas, given the differences in population density and number of providers. We will explore how rural providers and others in rural communities are preparing for anticipated changes in the financing and organization of services. We will examine three sets of activities:

1. the development of new organizational and health service networking
2. new strategies for managing patient care, such as utilization management and information systems
3. new approaches to contracting with health insurers, such as capitated payment arrangements or pre-set fee schedules (often based on the Medicare fee schedule)

Our examination is based on field work and case studies that were conducted in six rural communities during 1997. The rural sites in six states (Oklahoma, Tennessee, South Carolina, Minnesota, New York, and Washington) were selected on the basis of past or concurrent changes in the financing of local health care services. The underlying market conditions in these six sites have created a necessary condition for change (new financing schemes allow funding for new systems of care delivery) but have not always been sufficient to motivate local providers and systems to do so. The results of this project suggest some of the ways that rural providers and communities are preparing for changes in health care finance and organization.

Significance

The federal Balanced Budget Act of 1997 increased the likelihood that the organization and financing of rural health care services would change. The Act discarded the historical method of cost-based, fee-for-service (FFS) payment in favor of prospective payment methodologies for hospital outpatient care, other ambulatory care, skilled nursing care, and home health care. The BBA achieves savings in the Medicare program by sharply reducing payment for hospital inpatient care, limiting in-home health payments, reducing payment to hospitals serving disproportionate shares of Medicaid and nonpaying patients, and cutting payments in other areas (Mueller 1997). In contrast, payments to managed care plans that enroll rural Medicare beneficiaries will, in most instances, increase as a result of the BBA. Monthly premiums for each beneficiary enrolling in counties (35 percent of the national total) that make payments to managed care plans will be based on a minimum amount ("floor"), which is higher than previous premium payments, or will utilize a blended rate that combines county and national calculations. Premium payments in rural counties will be raised so that they are closer to the higher rates existing in urban areas (McBride 1998). In addition, rural providers will have financial incentives (due to reduced payment in traditional Medicare) to develop managed care plans, even when this requires them to venture into unfamiliar activities, such as networking with other providers and developing management and operations plans (Mueller 1998).

Rural providers can view these Medicare payment policy changes and other new insurance and payment arrangements as opportunities, threats, or both. The new payment arrangements offer possibilities for securing adequate payment, even as the mode of care delivery changes (e.g., from episodic treatment to preventive measures and case management). New payment policies may also reward closer integration of services, which may result in rural health care delivery networks. Conversely, payment policies designed to yield greater savings for the payer, such as Medicare policies that limit growth in payment to managed care plans, may stimulate systemic change. In the most extreme cases, constraints in payment may cripple small-volume providers. In the case of Medicare, changes incorporated in the BBA appear to create both opportunities and threats. In that environment, the determining factor will be the responses of local

and regional providers. Their past and present behaviors are the basis for predicting their future actions.

Literature Review/Theoretical Expectations

Early literature describing and analyzing the development of organized delivery systems in rural areas (Bowe 1993; Campion, Helms, and Barrand 1993; Christianson and Moscovice 1993; Rural Health Consultants Incorporated 1994; Duncan, Klepper, Krumerman, et al. 1995; Casey, Wellever and Moscovice 1997) can be summarized in these four conclusions:

1. Only a few rural health networks in the country have a long history of operation.
2. Fewer than ve rural-based health systems have a suf cient history to begin an analysis of their development, operations, and impact.
3. Despite increased interest in building systems by creating rural networks, no concrete results have been reported.
4. The impact of these changes on the types of health care plans purchased by consumers and on utilization and/or cost outcomes is unknown.

In 1995 researchers at the University of Minnesota identi ed 180 rural health networks in the United States. Nearly half were networks of hospitals only, and approximately 70 percent had existed for less than four years (Moscovice, Wellever, Christianson, et al. 1997). Rural networks can help providers overcome natural barriers to participating in managed care plans and other alternative nancing and service delivery arrangements. The barriers include too little capital, an insuf cient population base in service areas of individual providers (e.g., hospitals, group practices), inadequate information systems, and limited experience with managed care. Formal networks can enable rural providers to contract with health plans and perhaps form plans of their own (Casey et al. 1997). A few of the 180 networks identi ed in the 1995 study had developed functions and services that set the stage for new nancing and organization. Approximately 20 percent offered or coordinated health services to provide an insurance product, but only 2.5 percent had established a common payroll and/or accounts payable system for all their members.

Information systems were integrated in 19 percent of the networks comprising hospitals or physicians and in 22 percent of the networks that were two to three years old (Casey 1997).

In order to develop a successful managed care product, rural provider-based health networks will need a single system for enrollment, service, and billing. For example, several rural hospitals in Georgia have formed "Home Town Health," a for-profit company that will develop managed care contracts. By July of 1998, 15 hospitals had contributed \$50,000 each for an equity share in the corporation, and they were working with a provider-sponsored organization (PSO) initiated by the Georgia Baptist Health Care System (Greene 1998).

As yet, only a few rural health networks are integrating the services provided by physicians, hospitals, and others. Because those operational networks are still young, their impact on the delivery of services, the financial condition of rural providers, or the development of community-based health plans is not known. Recent literature indicates that communities with existing networks may respond more effectively to changes in health care finance. Thus, probing the status of network development is an important component of this research.

Little actual enrollment in managed care plans has occurred in rural America. In 1995, despite the existence of at least one HMO in more than 82 percent of rural counties, only a small percentage of individuals had actually enrolled in an HMO: a maximum of 19 percent had signed up for commercial plans in eight states, including Minnesota, a state that was thought to have a high HMO penetration (Moscovice, Casey, and Krein 1998). Only 2.5 percent of all potential rural beneficiaries were enrolled in Medicare managed care plans (McBride 1998). The literature suggests several explanations for this low penetration in rural areas: low payment rates to rural providers; a low rate of managed care enrollment by the nonelderly; a low population density, which makes rural areas less attractive to plans seeking market share; an inadequate information system infrastructure among providers; and a scarcity of retiree health plans that would buy into Medicare HMO coverage (Adamache and Rossiter 1986; Porell and Wallack 1990; Serrato, Brown, and Bergeron 1995; Welch 1996; Scanlon 1997; Lamphere, Neuman, Langwell, et al. 1997). Enrollment in Medicaid managed care plans is also low in rural areas; in 1995 and 1996 only seven states had more than 50 percent of their rural Medicaid beneficiaries enrolled in managed care (Moscovice et al. 1998).

Studies of Changes in Rural Communities

Little has been published on how changes in health care markets have affected rural health delivery. Some case studies are helpful. For example, Hudson (1996) describes the case of Colby, Kansas, where citizens discovered that a major group (the schools) had signed up for a health plan that required them to use providers in Wichita rather than at the local hospital. In response, a community council formed the Prairie Health Network to create a regional health plan that was marketed in nine counties. In this case, fear—of losing the local health infrastructure—became a catalyst for change. In rural Minnesota during the mid-1990s, two communities formed networks that would eventually offer their own health plans in the local areas: A partnership of providers and employers in Owatonna began operating a health plan in January, 1994. In Wilmar local providers and Blue Cross/Blue Shield created a rural community integrated service network in response to a state law favoring such entities (Feldman 1994).

The Center for Studying Health System Change is monitoring a set of urban communities, evaluating the impact of health system changes by tracking several outcome variables: insurance coverage; access to care; service delivery; cost; and quality (Kemper, Blumenthal, Corrigan, et al. 1996). The Center used many of the methodologies that we used for our study to gather information, beginning with case studies that included on-site interviews of key informants from health plans, hospitals, employers, and community leaders. The Center also collected other data through survey research, which extended the scope of its project beyond ours. In sum, both studies contribute to the same body of knowledge about how changes in the health care market, and responses of health care systems, are affecting the organization, delivery, and financing of care in local communities.

Methodology

Any effort to describe the current state of affairs in rural health care delivery and financing can be countered by the claim, "That does not describe my community." Rural areas are distinct from urban areas, and they also differ from one another. We did not set out to characterize all of rural America. Instead, we studied the experiences of purchasers,

providers, and others in six rural communities that appear to be "on the cutting edge" in order to address the three questions we posed at the beginning of this paper. These atypical communities offer valuable insights into a dynamic environment of industrywide change. Although it is not possible to generalize from such a sample, this case study approach has the value of serving as a type of "bellwether" of change in other rural communities. (For a discussion of the value of case study methodology, see Diaon [1998].)

Site Selection

Six communities were selected for this study, based on the following criteria.

1. Extent of Health System Changes. In earlier work, we interviewed a panel of 48 informants from four regions of the country, including directors of state offices of rural health, hospital administrators, insurance executives, advocacy organizations, employers, and community leaders (Rural Health Delivery Expert Panel 1996). From those interviews, as well as the trade literature, we identified communities in which significant changes were either occurring or anticipated as the result of private or public purchasing initiatives (e.g., expansion of Medicaid managed care) or organizational changes among health care providers (e.g., development of provider networks).

2. Nature of the Rural Health System. We characterized communities based on the presence or absence of vertical and/or horizontal integration among providers. Integration is present when there are formal agreements among individual providers to abide by the decisions of the collective entity.

3. Geographic, Market Diversity. We tried to select communities in different regions of the country (the West, Southwest, Midwest, East, and Southeast). We also sought varying market definitions (e.g., markets that were geographically contained within a single community versus broader markets that encompassed several communities).

4. Population Diversity. We looked for communities with different percentages of minority populations and different distributions of personal income.

The following six sites were selected: Comanche County, Oklahoma (and 11 other counties in the market area); Renville County, Minnesota (and nine others); Otsego County, New York (and nine others); Stevens

County, Washington (and two others); Campbell County, Tennessee; and Florence County, South Carolina (and six others). Tables 1 to 4 provide background information for each site: age and ethnic distribution, per capita income, and characteristics of the health care delivery system.

The authors broke into teams of two members and rotated assignments so that each team could spend two days at each of the six sites. A local coordinator helped to schedule interviews with health care providers, employers, insurers, community leaders, and others. Before visiting the sites, the research team developed a structured protocol and a set of questions to guide the interviews and to ensure that the generated data were consistent and comparable. The questions covered the market

TABLE 1
Location of Health Service Areas by County

Oklahoma	Minnesota	New York	Washington	Tennessee	South Carolina
Caddo	Big Stone	Chenago	Ferry	Campbell	Darlington
Comanche ^a	Chippewa	Delaware	Pend Oreille	—	Dillon
Cotton	Kandiyohi	Fulton	Stevens ^a	—	Florence ^a
Custer	Lac Qui Parle	Herkimer	—	—	Horry
Greer	Lincoln	Madison	—	—	Lee
Harmon	Lyon	Montgomery	—	—	Marion
Jackson	Redwood	Oneida	—	—	Marlboro
Jefferson	Renville ^a	Otsego ^a	—	—	—
Kiowa	Swift	Schoharie	—	—	—
Stephens	Yellow Medicine	Sullivan	—	—	—
Tillman	—	—	—	—	—
Washita	—	—	—	—	—

^aIndicates the central location of health service area.

Sources: Bassett Health Care 1995: *Community Service Report*; Bureau of Health Professions, Office of Data Analysis and Management (February) 1997: *Area Resource File*; Cooperstown, N.Y. Chamber of Commerce 1996: *Cooperstown Visitors' Guide*; Department of Economic and Community Development 1996: *Tennessee Community Data, LaFollette*; Minnesota Department of Health, Center for Health Statistics 1994: *Minnesota County Health Profiles* (for each county in the health service area); Northeast Tricounty Health District 1995: *Health Status 1995: Ferry, Pend Oreille, and Stevens Counties*; Oklahoma State Department of Health 1995: *Pluto County Health Profiles, Year III* (for each county in the health service area).

U.S. Bureau of the Census—1990—96 *Estimates of the Population of Counties by Age, Sex, and Race/Hispanic Origin*; (March) 1994, 1995, 1996: *Current Population Surveys*; 1993: *State and County Income and Poverty Estimate*; 1996: *USA Counties* (CD-ROM).

TABLE 2
Population Demographics for Health Service Areas in 1995

Demographics	Oklahoma	Minnesota	New York	Washington	Tennessee	South Carolina
Population (N)	301,952	156,651	750,657	55,497	37,033	495,269
Ethnic distribution						
White	82%	98.5%	98%	89%	99%	58%
Black	10%	0.1%	1%	0.5%	0.4%	33%
Native American	6%	0.3%	0%	10%	0%	0.3%
Other	2%	0.1%	1%	0.5%	0.4%	8.7%
Age distribution						
0-4	7%	6%	7%	7%	8%	6%
5-9	8%	8%	18%	9%	8%	7%
10-14	8%	8%	(5-17) —	10%	(5-11) 10%	7%
15-19	8%	6%	7%	7%	(12-17) 9%	8%
20-44	39%	31%	(18-20) 34%	33%	(18-24) 29%	35%
45-64	18%	21%	19%	21%	(25-44) 22%	19%
65-74	8%	10%	9%	7%	8%	8%
75+	6%	10%	6%	5%	6%	5%

Sources: See footnote to table 1.

TABLE 3
Income Demographics for Health Service Areas

	Oklahoma	Minnesota	New York	Washington	Tennessee	South Carolina
Per capita income, 1995	\$15,050	\$15,500	\$16,300	\$14,800	\$12,285	\$14,233
Poverty rate, 1993	22%	18% ^a	13%	20%	25%	24%
Unemployment rate, 1995	4.7	5.4	8.5	11	10.8	9.0
Major employers	Manufacturing, retail, service	Retail, service, manufacturing	Medicine, manufacturing	Service, government	Manufacturing, retail	Tourism, agriculture, manufacturing
Industrial base	Agriculture	Service, manufacturing agriculture	Tourism, manufacturing	Timber, agriculture, mining	Manufacturing	Service, agriculture

^aThis rate is for children from birth to age 19 in this health service area.

Sources: See footnote to table 1.

TABLE 4
Hospital Utilization for Each Health Service Area in 1995

	Oklahoma	Minnesota	New York	Washington	Tennessee	South Carolina
Number of hospitals	19	17	19	4	2	13
Number of beds	1,366	1,646	3,822	187	219	1,812
Total admissions	38,587	15,899	85,174	2,920	4,992	67,929
Total inpatient days	208,718	301,077	915,674	46,555	59,059	405,908
Total outpatient visits	995,845	125,835	1,907,828	53,041	104,119	453,908
Number of nursing-home beds	3,452	3,029	7,817	255	291	2,673

Sources: See footnote to table 1.

behaviors of insurers and private and public purchasers as well as the impact of those behaviors on rural providers. The providers were queried about their responses to events and were asked to comment on what changes they foresaw. The number of interviews varied across sites, averaging nine in each location, and they included business leaders, county executives, hospital administrators, physicians, insurance industry employees, safety-net providers, and consumer advocates. A "modular" data collection protocol was used for conducting the interviews (Kohn 1997). The introductory comments, general sequence of questions, and concluding questions about the future were standard for all interviews, but not every respondent was asked all the questions. Rather, the amount of time spent on a question depended on its relevance to the respondent's background. (The interview protocols are available from the lead author.)

Findings from Community Studies

Network Development

Health care providers in five of the six sites had formed, or were forming, networks of multiple providers. In this section we will describe both the context in which these new organizational arrangements were developing and the steps taken (or not) to do so for each site.

In *Otsego County, New York*, a large regional hospital, Bassett Hospital, dominates a 10-county region (population base of 750,657). The hospital has worked hard to capture market share in the 10 counties, recognizing that it has competitors from Albany (80 miles away), Utica, Binghamton, and two regional plans. Both Bassett and nearby (25 miles) Fox Hospital have been transforming themselves from largely specialty-driven and controlled hospitals to vertically integrated systems. Bassett has developed primary care centers throughout the 10-county region, which it defines as its primary market area, although its physician pool remains largely one of specialists (60 to 80 percent). Fox is also expanding its primary care capacity, particularly in Oneida County, where it is building a multimillion-dollar primary care facility.

The *Renville, Minnesota*, region is a market area of 10 counties with a population of 156,212. There are 16 hospitals and 18 clinics in the area. The hospitals formed a consortium, Medi-Sota, Inc., which later merged into a new organization that includes physicians as well: the Minnesota Rural Health Cooperative (MRHC). The network became a

cooperative in 1995. Initial physician opposition was overcome through the leadership of a family practice physician in Wilmar, the regional population center. The network's goal is to provide access and choice of health plans for the residents of the area. The network negotiates contracts with insurance plans, but individual members can still contract independently of the network.

In *Oklahoma*, the *Comanche County* region has seen the development of a large and sophisticated network of hospitals, primary care clinics, and physicians. First Health Network West (FHW) was established as a nonprofit trust in November, 1993. The network of offices is in Lawton, Oklahoma, as is the tertiary hospital, which is the legal executor of the trust fund. Eight smaller rural hospitals are located throughout southwest Oklahoma. FHW operates 30 primary care clinics, employs 18 primary care physicians in Lawton and 18 more throughout the 12-county area, and 57 specialists, primarily in Lawton. Although the network of medical care providers now offers managed care products, the original purpose of the network was to facilitate group purchasing and develop telecommunications links.

The three-county *Colville region of eastern Washington*, with a small population base (55,497), is served by what a newly consolidated system centered in the hospital and medical group (Northeast Washington Medical Group [NEWMG]) in Colville. According to participants, health care providers came together in order to preserve the local health system because they saw that solo practices would not be able to survive economically. Consolidation helped by creating economies of scale. The physicians and the hospital have formed a physician-hospital organization (PHO), which has developed managed care contracts with the Washington Basic Health Plan (BHP), which is Washington State's program for the uninsured (called "Healthy Options") and with the state's Medicaid Managed Care Program. They were assisted by Blue Cross of Washington and by the state of Alaska, which signed on as an insurance partner.

The *South Carolina* site provides an interesting contrast to the others because it is in a region with a large minority population, it includes a tourist destination (Myrtle Beach), and it is very much influenced by an urban county (Florence County). Enrollment in managed care plans in the region is limited, although all but one interviewee thought that managed care would be coming soon." A large provider network of physicians and hospitals—the Palmetto Community Health Network—has

been formed in order to prepare for dealing with managed care contracts. This organization merged six local independent provider associations (IPAs) in order to become a single signature contractor for managed care plans in the seven-county region. Nine hospitals and 211 doctors are participating in this network. Only three hospitals in the region are not participating; two of these are owned or leased by Quorum, a national hospital management firm.

We selected the rural site, *Campbell County, Tennessee*, on the border of Kentucky, in order to examine the influence of TennCare, the state's Medicaid managed care program, on local markets. However, even though one of the two hospitals in the county has a high percentage of patients from Tennessee Medicaid (35 percent), the advent of TennCare has had little effect on the health care delivery system. Because TennCare contracts through managed care plans, providers do not share the risk directly. Instead, they are paid according to fee schedules that discount customary charges. This environment offers few incentives to develop an integrated network.

Developing New Strategies for Managing Patient Care

In spite of an environment of minimal managed care penetration (less than 10 percent of total patient business) and even less capitated financing of care, most sites expected larger future changes in Medicaid, Medicare, and commercial contracts. In this context, rural providers might be expected to begin adopting new means of managing patient care and the finances of their practices. The continuum of possibilities ranges from minor adjustments in fee schedules to accommodate new insurance plan demands, to the development of integrated information systems for supporting disease management or other protocols for managing patient care.

What point have these sites reached on the continuum of change? In Tennessee, there was little evidence of any change. Although TennCare changed how Medicaid beneficiaries enrolled through managed care organizations, there were no direct effects on providers, who continued to be paid discounted fees by the MCOs. Since the advent of managed care," providers have had to accept larger discounts in fees. Managed care plans also compete for local clients, and local providers appeal to those clients to sign plans with the most favorable reimbursement. With very few commercial managed care activities underway, or anticipated,

providers in Campbell County, Tennessee, are resisting the constraints imposed by managed care in the Medicaid program. One facility in the county, and its associated physicians, carried its complaints to the public in a campaign to convince Medicaid clients not to enroll in a particular TennCare plan. One hospital, the largest employer in its town, was forced to lay off 25 percent of its employees (about 50 employees). That hospital claimed that Medicaid payments were more than \$300 per patient short of what the hospital required for covering its costs. In contrast, Medicaid reimbursement to another hospital in the region increased. The response to shortfalls in the county was to reduce the number of employees and attempt to manage more efficiently." Providers show little readiness or willingness to adopt managed care tools," such as utilization management and utilization review. Without pressure from private purchasers and MCOs, there is not enough leverage to compel providers in this market to change their practice styles and pricing structures.

The small population base in the county (35,000), which is spread through a steep, wooded terrain with small hamlets, offers little opportunity for entry and exit of providers, and therefore not much threat of competition. The few private employers all use indemnity plans and are not interested in shifting to managed care. In short, despite the expectations raised by TennCare, this area is not on the verge of engaging in competitive behavior.

In South Carolina, the organization of the Palmetto Community Health Network, representing nine hospitals and 211 physicians, appears to be consistent with a desire to move the system in the direction of managed care. The underlying motivation of this network, however, is to keep managed care, as defined by others, out of this region of the state. Physician providers want to protect themselves from managed care practices that they find unduly intrusive (e.g., utilization management that enlists measures of external validation for treatment choices). The single HMO now operating in the state is losing money. Medicare and Medicaid beneficiaries are not yet enrolling in managed care plans. One purpose of the network is to prepare providers for contracting with Medicaid and to help them negotiate contract terms that discount fees but do not affect the practices of physicians in the region.

Renville County, Minnesota, has advanced further along the imaginary continuum through the creation of a local managed care plan for Medicaid beneficiaries. Employers in this area, much like those in Tennessee,

as yet are not pushing for major (if any) changes in health care insurance offerings. Thus, the county continues to build a strong local delivery network that can ward off incursions by urban-based MCOs, but it is not experiencing any immediate pressure from commercial contracts.

The other sites we visited were each taking steps to alter the organization and delivery of care in their regions. In Oklahoma, hospitals and physicians in a 12-county area organized a single network, First Health West, which could contract with managed care organizations. The network is now contemplating developing its own commercial managed care product. When signing a contract with Pacifi Care, the network retained the right and responsibility to build the capacity for analysis of utilization and other management functions. First Health West provides group purchasing, back-up technical and clinical support through one of the hospitals, a developing telemedicine system, and coordination of two managed care products.

In the Colville, Washington, area, medical services were organized by region during the 1970s, the high water mark for health planning. Its long history provided financial stability (and a sound foundation) when the network had to begin contracting with managed care organizations, including the state's Medicaid program. Providers have reacted favorably to a shift to capitated payment, saying that they are better paid and that services are more readily available. Local employers strongly support the delivery system in this region, and they are working with providers to develop needed health services locally. The combined incentives of the Basic Health Plan (BHP), the state plan to expand eligibility for publicly supported health insurance, and preferences of local employers, encouraged providers in this region to move rapidly into the use of managed care for contracting with payers. The local physician-hospital organization (PHO) provides a forum for discussion and a way to coordinate services to be more cost effective.

In Colville, a single physician has provided critical leadership for the provider network since the 1970s. This site illustrates how a leader uses another catalyst to motivate others to participate in change. The additional catalyst for Colville was the Basic Health Plan, which enabled providers to secure additional revenue by developing a local network that could negotiate its own contracts to cover its members.

In Oklahoma, a hospital administrator capitalized on the opportunities for network development afforded by a market catalyst, which emerged when Pacifi Care became interested in establishing a market presence. This presence generated some enrollment in a commercially

sponsored managed care product. However, the state Medicaid program, "Sooner Care," which created an opportunity to contract directly with the state, was the most important catalyst for network development in Oklahoma.

In the case of the Bassett Health System, the principal catalyst was the organization's realization that it needed to establish itself as a provider of primary care services if it was to survive in a market surrounded by large, urban-based health systems. The market in the Northeast, including rural Otsego County, New York, is marked by intense competition among different health systems and MCOs. Managed care is already high in the region—ranging from 20 percent in one county to nearly 50 percent in another. At least four different MCOs are competing for enrollment. All are considering offering Medicare risk contracts. Two large employers in the region are sparking competition by offering different HMO choices to their employees. In the 1980s the Bassett Hospital developed a regional network, which was then well positioned to develop its own managed care product. Through a partnership with Community Health Plan of Latham, New York, Bassett developed and marketed a managed care product for self-insured employers that uses typical managed care strategies: utilization management, quality assurance, and case management. The network leadership believes that inpatient hospital days must be reduced by as much as 40 percent in order for the network's health plan to be competitive in that market area. The number of practicing specialists may have to be reduced as well. These cost-cutting goals will require the network to use new approaches to managing medical care.

New Approaches to Contracting with Health Insurers

Rural health care providers can be presented with an array of health plans offering special contracts that include discounted fees or other arrangements in exchange for assurances of patient enrollment in their practices. One reason for rural providers to coalesce is to increase their bargaining power for these contract negotiations.

The Oklahoma site has been working to capture both public and private contracts. Its decision to form a partnership with Paci Care spurred it to engage in more contracting than any other site in this study. When the partnership developed in 1994, Paci Care was the fastest-growing HMO in Oklahoma; commercial enrollees quickly grew to 4,500. In 1996 a Medicaid managed care contract was added to the mix, again

through Paci Care. Once Oklahoma decided to convert the Medicaid program to managed care, the network-HMO partnership became a bidding platform for the Medicaid business in the 12-county region. During the past few years, the managed care contracting activities of the network have been carried out more to secure a financial base for providers than to compete with other insurers or provider groups. Contracts have been negotiated in order to secure payment for existing patients rather than to compete for new ones. When the partnership with Paci Care dissolved, the local network assumed full responsibility for the contracts. The pace of change has been slowed, however, by successful appeals to the state by other networks to deny the regional hospital its own HMO license.

New York is the most advanced" of the sites we visited, principally because of the activities of the large regional hospital that anchors the Bassett Health system. Large employers in the region are beginning to exert more influence on the market. Most have offered multiple plan options, which include managed care plans. One large employer switched the coverage of its several thousand employees and retirees to CHP/Bassett. That employer (self-insured) has influenced the development of the Bassett Hospital's provider network, which wants to expand quickly from an enrollment of 32,000 to one of 150,000. CHP/Bassett has the largest market share of any plan in the region (over 30,000 covered lives), but it must compete with a physician-owned managed care plan, Mohawk Valley Plan (MVP), and WellCare, a new entrant into the market. Blue Cross and Blue Shield of New York also offers a plan within that market area. Competing providers include Fox Hospital, 25 miles from Bassett. Although Fox has a contract with MVP, its market share has been seriously threatened by the exclusive arrangement between CHP and Bassett.

At the time of the site visit, CHP/Bassett and the other plans were gearing up to offer Medicare risk plans. To the surprise of the others, WellCare had recently announced that it would be offering a zero premium product. CHP/Bassett was wondering whether it could match this offer. Although the pressure to move forward with a Medicare plan has lessened, intense competition in the Northeast among health plans is likely to rekindle the Medicare interest once the federal government has dealt with issues of payment and regulation. In any event, the power of the large tertiary hospital, combined with ongoing competition in the market, was pushing the stakeholders in this site more rapidly

forward on the continuum of change than was the case at any other site.

In Minnesota, stabilization in the urban market (the twin cities of Minneapolis and St. Paul) has prompted large insurance plans to look to rural areas for market share, which has increased the competitive pressure from purchasers. Local employers have not organized into separate purchasing activities. To date, the managed care plans have limited enrollments; one insurer had a contract for only 700 members at the time of the site visit (early 1997), leaving room for others to enter this managed care market. The provider sector is dominated by the MRHC, which controls approximately 98 percent of the commercial market. The power of this network limits the leverage of purchasers and plans over payment rates or other matters. Thus, despite greater interest by purchasers and plans in the Rennville market, providers have effectively created a "one-horse" town in which they hold the economic advantage. At the time of the site visits, the network's domination was not threatened by providers from outside the service area.

Conclusions

Reactions to change varied from defensive, when local actors attempted to deflect what they perceived as the evils of managed care, to welcoming, when changes in health finance and organization were viewed as opportunities to improve local delivery systems. We witnessed local providers developing their own "bunker" strategies to ward off the worst effects of financial discounting and medical management that managed care organizations wished to impose. Tennessee and South Carolina illustrate this strategy.

What explains the differences in provider and community responses to changes in the market? Three factors are important:

1. Local leadership desires change.
2. The resources to support change are available.
3. The community (or region) has the capacity to support new systems.

In each of the four sites where local objectives were furthered by market change, a local catalyst led the effort. In the two cases identified as resisting conversion to new financing systems (e.g., managed care), local

leaders were directing the resistance. In South Carolina, network leaders, caught between the competing visions of local physicians and some hospital administrators, were leaning toward the physicians' views. This meant they were willing (reluctantly) to consider managed care contracts, but only on terms that maximized the independence of local providers. In Tennessee, providers' resistance to change was more widespread; there were no clear advocates for changing current practices.

In each case, when aspirations to play in the managed care marketplace became operational plans, major sources of support were available. In New York and Oklahoma, regional health systems were anchored by large regional hospitals that could support changing systems. In Washington, consolidation of local physicians into a single clinic, which then affiliated with the one hospital in the region, led to the pooling of resources. Minnesota also combined resources, but through a regional cooperative.

Community capacity to support change was important in all the sites that actively moved into managed-care contracting. In each site, the combination of a sufficiently large population base and a cohesive provider network enabled providers to improve the delivery system through managed care methodology. South Carolina, which to date has resisted managed care, could move in this direction in the future. The large urban hospital that is supporting the regional network could supply the resources, and the region's population base is sufficient to support new models of health care organization and finance. The missing ingredient in South Carolina is leadership: there is no common vision among key players that can shape the future of the network (differences exist between some local physicians and the network's organizational leadership).

In the years since 1993 a "market philosophy" has dominated policy discussions about improving health care finance and delivery. In 1999 we are entering a new era in Medicare policy with the advent of Medicare + Choice, which will change the basic structure of how health insurance is secured by the nation's elderly population. These policy shifts have occurred as competition has entered the realms of health care purchasing and provision.

However, we know very little about how change based on market ideas of competition affects the delivery of health care services in rural communities. From reports in the scholarly and trade literature, changes are occurring at a slower pace in rural than in urban areas, and with smaller initial effects (e.g., lower penetration of managed care). The six rural sites that we report on here confirm that the pace and magnitude of

any change in rural areas are not keeping up with what is being reported in urban areas. A major reason for this difference appears to be the lack of pressure from rural private employers, who, unlike their larger, urban counterparts, have not pursued aggressive purchasing strategies for their employees' health benefits.

Despite the relatively slow pace of change in rural markets, we have detected trends, now under way, that warrant future observation. First, rural markets and health networks are developing plans that encompass large geographic areas. This appears to be a necessary condition for adopting new systems of managing care that require large populations and a critical mass of organizational, management, and financial capacity. Second, rural providers are organizing themselves into a variety of models: hospitals are assuming leadership in forming physician-hospital organizations; rural providers and large insurance companies are forming partnerships; and physicians are organizing both IPAs and more complex integrated service networks. Both the dynamics of change in delivery organizations, and its impact on health care delivery, warrant further study. Third, the role of the community in rural health care may be changing. With integrated networks, the affiliation of health care providers may change from a local community to a network of communities. The implications of this shift for locally based rural health care delivery models are unknown.

Implications

How will health care delivery in rural America be affected by the changes wrought by market-based activities in health care? Given the nature of rural health systems, many of which have limited provider and service capacity, it seems clear that rural providers must organize themselves into delivery networks that cut across provider types (hospitals and physicians) and communities. What is not as obvious is the nature of the networks. We visited networks that were anchored by a single large rural institution (Bassett Health System in New York), by an urban institution (in South Carolina), and by rural collaborations of physicians and hospitals (Minnesota and Oklahoma). In each case, the network was formed to preserve and protect a local approach to health care and to maximize returns for the local providers. The only practical way to do this is to form integrated networks. Only then can local providers achieve

the economies of scale necessary to support information systems, referral systems, and other techniques for achieving cost efficiencies. Large regional networks can also aggregate populations to pool risk.

Regional network interests may coincide with what is best for the local community, and in most cases they do. The connection between the local service delivery network and the interests of each small community may conflict when the network competes successfully for reimbursed service but does not provide services to the uninsured. In such situations, local safety-net providers, such as community health centers, may be left with the burden of providing uncompensated care without the prospects for securing paying customers. In one community we visited, the regional network started a primary care clinic, designated as a rural health clinic, two blocks from a community health center. The network was preparing to bid for a Medicaid managed care contract, which would siphon off revenues from the community health center. Access to care for the uninsured could suffer as a result of these network strategies. Even when networks are willing to shoulder the burden of uncompensated care (which networks in Oklahoma, Washington, and Minnesota gave as one reason for forming), negotiations to secure large commercial contracts may reduce their operating margins so they can no longer absorb the cost of providing uncompensated care.

Policy Implications

The current paradigm of market-based competition in health care has little applicability in most rural places. Among the sites we visited, which spanned a wide spectrum of community size, concentration of population, region of the country, and proximity to urban areas, only one area—New York—was experiencing competition among provider networks. The number of options for local health plan development is limited in most rural areas. Each plan would need enough enrollment to generate sufficient risk pools to finance the plan. Two of the sites we visited, Washington and Tennessee, had fewer than 60,000 persons in the service area; only two, New York and South Carolina, exceeded 350,000 persons.

Rural areas have had little actual experience with managed care. Indeed, changes in Medicare and Medicaid policies are likely to introduce managed care strategies in many rural areas, including these six sites. Therefore, payment policies predicated on changes in practice and

management that yield savings must allow rural organizations time to implement those practices. Whereas many urban health care providers may have adopted new practices and behaviors for private insurance contracts that are then transmitted to public contracts, the direction of change is likely to be the inverse in rural areas.

Managed care and market changes have potentially important implications for access to health care services in rural areas. To build and sustain access, public policies are needed that help rural providers to participate in new systems of care and maintain their livelihood under new systems of finance. In the communities we studied, we found three main ingredients for actions that molded change to meet the needs of the community: resources, leadership, and community capacity. Resources are needed for the development of information systems and the transaction costs (such as meeting time, meeting places, and administrative overhead) associated with getting new networks started. In some rural communities, such as the New York and South Carolina sites, there may be a "deep pockets" participant in the rural networking effort capable of absorbing those costs. In other places, such as the Minnesota site, local providers and civic leaders may struggle mightily to meet these early expenses. One public policy response, then, is to make funds available to help with these efforts; the network grant program established in 1996 in the Federal Office of Rural Health Policy is an example of this strategy. Resources include expertise as well as funds, to deal with financial, marketing, business plan development, information management, and legal considerations associated with becoming active in health plans.

The second ingredient for positive change is local leadership. Public policy cannot create leaders where there are none, but policies can be enacted to support the leaders who do emerge. This can be done with leadership training and by facilitating exchange among local leaders in different networks. The third ingredient is community capacity. Both Medicaid and Medicare payment policies can be used to encourage rural areas to think of service areas beyond traditional boundaries. To illustrate, payment to new Medicare + Choice plans is based on the capitation rate devised for each county. Rather than defining rates by counties, policies should be established that allow a health plan to define a rate based on an aggregation of several counties in a service area and on the current, or desired, patterns of residents' health care utilization. In Oklahoma the service site that evolved naturally for that network includes 12 counties, whereas a single county constituted a service site in Tennessee. Where

providers seem reluctant to form networks, payment policies can create incentives for them to do so. Because Medicare is the largest single source of patient revenue for most rural areas, and Medicaid is a major source of funding in many areas, these two public programs create leverage that can be used to convince rural providers of the need to work collaboratively.

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