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Rural Managed Care and Disability: A National Perspective

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RTC RURAL

RURALFACTS

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RURAL MANAGED CARE AND DISABILITY

A NATIONAL PERSPECTIVE

Rural access to health care has historically been a concern in the United States. In the late 1980s and early 1990s, lower rural reimbursements for the same services provided in urban areas contributed to a substantial decline in the number of rural hospitals and health care providers. Rural Americans with and without disabilities experienced the negative consequences of those changes. The rapid introduction of managed care is producing explosive changes in the marginal, aging, rural medical care services sector. Managed care policies directly affect both access to medical services by people with disabilities and the economic infrastructure of small rural communities. The RTC: Rural, in collaboration with the Research and Training Center on Managed Care at the National Rehabilitation Hospital Center for Health and Disability Research, is studying managed care's effect on rural Americans with disabilities. Despite managed care's constantly-shifting landscape and the scarcity of data on disability and managed care, some trends are emerging.

Managed Care is . . . . a group of doctors, hospitals, and other health care providers who agree to provide health care to enrollees in exchange for a fixed amount of money. **Capitation** occurs when the physician or hospital is paid a fixed, per capita amount for each person served, regardless of the actual number of services provided to each person. Managed care plans include:

Primary Care Case Management (PCCM) providers coordinate health care services for plan enrollees at fee-for-service rates. Many states use this model for people with disabilities.

An **HMO** (Health Maintenance Organization) provides a wide range of comprehensive health care services for a specified group at a fixed periodic payment. An HMO can be sponsored by the government, medical schools, hospitals, employers, labor unions, consumer groups, insurance companies, or hospital-medical plans.

An **MCO** (Managed Care Organization) manages, coordinates, and assumes financial risk on a capitated basis for the delivery of specified services to enrolled members in a given geographic area.

In a **PPO** (Preferred Provider Organization), a third-party payer such as a business or school contracts with medical care providers who furnish services at lower than usual fees in return for prompt payment and a certain volume of patients.

POS (Point-of-Service) plans are "open-ended" HMOs or PPOs that permit insured members to choose providers outside the plan, yet they encourage the use of network providers.

Medicaid is state-provided health care assistance for low-income persons. Title XIX of the Social Security Act provides matching federal funds for financing state Medicaid programs. Some states use managed care to provide services for Medicaid enrollees.

Current Status of Rural Managed Care

Percent of Rural People Enrolled in Managed Care

In 1995, almost 75% of HMOs included at least one nonmetropolitan county as part of their service area, although only 14 HMOs (2.45%) were actually headquartered in rural counties. More than 80% of rural counties were in the service area of at least one HMO (compared with approximately 60% the previous year). More than one-fourth of rural counties were included in the service areas of four or more HMOs. Data on commercial HMO enrollment rates in rural areas are difficult to obtain. A quarter of the U.S. population is rural, but rural residents only account for an estimated 9% of national HMO enrollment. The limited information available about managed care products comes from a small number of case studies involving MCOs (Christianson, 1998).

Number of States Covering People with Disabilities under Medicaid Managed Care

In 1996, the General Accounting Office reported that only Arizona, Delaware, Oregon, Tennessee, Utah and Virginia required that some or all of their beneficiaries with disabilities participate in managed care programs. Massachusetts, Ohio, Wisconsin, and the District of Columbia had small-scale voluntary programs solely for individuals with disabilities, none serving more than 3,000 beneficiaries. California, Colorado, Florida, Maryland, Michigan, New Jersey, Pennsylvania, and Massachusetts allowed beneficiaries with disabilities to enroll voluntarily in plans open to other Medicaid beneficiaries, but less than 20 percent of the population with disabilities chose to enroll. Table 1 shows the number of eligible persons with disabilities enrolled and the type of program for each state.

Table 1: Disabled Medicaid Beneficiaries (Source: State enrollment & eligibility reports, 2/96)

State	Total Disabled Eligibles	Total Enrolled	Percentage Enrolled	Year Begun
Mandatory programs				
Arizona	64,456	56,775	88.0[a]	1982
Delaware	12,198	n/a	n/a	1996
Oregon[b]	39,906	28,423	71.20	1995
Tennessee	138,931	138,931	100.00	1994
Utah[c]	17,155	8,158[d]	47.60	1982
Virginia	91,082	13,817[d]	15.20	1995
Voluntary programs targeted only to disabled individuals				
District of Columbia	3,200[e]	8	0.25	1996
Ohio	36,000[e,g]	294	0.82[h]	1995
Wisconsin	22,041[e,i]	2,404	10.90	1994
Voluntary programs for the general Medicaid population				
California	770,067	28,262[j]	3.70	1972
Colorado	45,042	8,842	19.60	1974
Florida	n/a	n/a	n/a	1981

State	Total Disabled Eligibles	Total Enrolled	Percentage Enrolled	Year Begun
Maryland	83,350	10,496	12.60	1975
Michigan	234,517	42,373	18.10	1972
New Jersey	143,793	4,226	2.90	1983
Pennsylvania	247,902	50,443	20.40	1972
Voluntary program targeted to disabled individuals and voluntary program for the general Medicaid				
Massachusetts	164,366	7,935	4.80	1992

N/A: The state does not distinguish in enrollment and/or eligibility reports the categories of SSI& related beneficiaries that include aged & disabled.
[a]Medicaid eligible individuals not enrolled in a prepaid plan are Native Americans living on reservations and electing to receive care from an Indian Health Service facility.
[b]Oregon allows disabled beneficiaries, under certain conditions, to receive services in managed or nonmanaged fee-for-service settings
[c] In 1995, Utah's program became mandatory (urban areas only). Enrollment of urban disabled beneficiaries was phased in & should be completed 7/96.
[d] Enrollment figures include both mandatory and voluntary participants.
[e] Numbers reflect those eligible to participate in the targeted programs.
[f] Enrollment began 2/96. As of 3/96, 180 children were enrolled.
[g] Program limited to 3 counties.
[h] Enrollment began in one county 5/95, another in 6/95, and the remaining county in 9/95. March enrollment (3 counties) totaled 355.
[i] Program limited to one county and enrollment capped at 3,000, making current enrollment 80% of capacity.
[j] Enrollment figures understated — 1 county's data don't distinguish between enrollment in prepaid & primary care case management providers.

Rural and Urban Uninsured

Using 1989 data from the March 1990 Census, Frenzen (1993) examined health insurance coverage of the nonelderly population in U.S. urban and rural areas. Access to coverage was assessed by classifying all persons according to family employment status and income. Fewer rural than urban residents were covered through employment, and more rural residents purchased private coverage.

Urban and Rural Differences

Ricketts et al. (1995) reported that in 1989 rural counties included in HMO service areas were those with the largest populations and those near metropolitan areas. Table 2 shows the percent of eight states' rural and urban populations enrolled in managed care.

The U.S. Agency for Health Care Policy and Research sponsored a 1998 national study showing important differences in the types of managed care programs found in urban versus rural areas. In 1997, slightly over half of all rural counties in the United States were covered by some type of Medicaid managed care, compared with nearly three-fourths of urban counties. Mandatory fully-capitated programs were less common in rural than urban counties (10 percent versus 23 percent), although seven states had statewide mandatory fully-capitated Medicaid programs. Rural counties were also less commonly covered by programs combining types of managed care. The study found that Primary Care Case Management (PCCM), a form of managed care without financial risk to the provider, is more common in rural than urban counties.

Table 2: Average Percent of Population under 65 Years of Age Enrolled in Commercial HMOs

State	*Rural*	*Urban*
Florida	4.9	24.3
Minnesota	5.5	35.8
Missouri	6.3	26.2
North Carolina	4.2	13.6
Pennsylvania	12.0	30.8
South Carolina	4.6	9.7
Wisconsin	17.0	35.7
Wyoming	0.6	0.0
Total	7.8	25.7

Methodological Concerns

From a rural perspective there are emerging methodological concerns in the data being reported about managed care. Because managed care is changing rapidly, quantifying its effects is very difficult. In addition, policies are so varied that the same insurance format or company produces different policies in different geographical and social environments, making it difficult to quantify the effects of a format or company.

Another concern is that a managed care company can claim, and enroll residents in, a rural area without actually having providers in that area. Enrollees must often travel great distances for services. Methodologically, this counts as a covered area but services **aren't** readily available. We must view data on claimed service areas with great caution and include reports on distances/travel times to service providers.

References and Resources

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