May 2003

Managed Care and Rural America:

An Annotated Bibliography

Managed care is a form of health care organization that combines health service delivery and health service financing into one system. It has grown in popularity as the costs of medical services have skyrocketed. In urban areas, the development of competing managed care plans has been facilitated by large populations and many eligible providers.

Rural communities, which have neither of these characteristics, are attempting to adapt managed care to meet the needs of their citizens. In some communities, hospitals, clinics, and health professionals are forming networks and jointly negotiating contracts with managed care organizations. However, network formation faces policy obstacles, including the interpretation of state and federal antitrust legislation. In addition, rural areas are affected by government efforts to institute managed care programs for Medicaid and Medicare populations.

This selective bibliography includes a variety of materials that address rural managed care. We have tried to include items that are relevant, recent, available, and helpful to those who are dealing with the issues just outlined. Materials are listed in reverse chronological order (most recent materials first), within category. Citations added for the 2000 edition are marked with two asterisks. Please consult your local public or academic library for journal literature. For non-journal literature, contact information is provided at the end of each annotation. There may be a charge for some items. Related information and technical assistance are available to rural groups from the National Rural Health Resource Center. The Center can be reached at (218) 720-0700, (218) 727-9392 (fax), or at nrhrc@ruralcenter.org (e-mail), http://www.ruralcenter.org/nrhrc. In addition, The Center for Managed Care, Health Resources and Services Administration, has publications of interest, although they may not focus on rural issues. The Center can be reached at (301) 443-1550 or http://www.hrsa.dhhs.gov/hrsa/mngdcare/cmc.htm.
Additional Resources are also available at http://www.nal.usda.gov/ric/ruralres/insurance.htm.

Please note that the following acronyms are used throughout the bibliography: **HMO** - health maintenance organization; **IPA** - independent practice association; **MCO** - managed care organization; **PPO** - preferred provider organization. Citations in this bibliography are arranged under the following headings:

Medicare
Physicians
Legal Issues and Contractual Considerations

General Overviews and Case Studies

1.
"Managed Care in Rural Markets: Availability and Enrollment." Jere A. Wysong, Mary K. Bliss, Jason W. Osborne, Robin P. Graham and Denise A. Pikuzinski. *Journal of Health Care for the Poor and Underserved,* Vol 10(1), February 1999, pp. 72-84.

This article describes the authors' examination of two contradictory hypotheses: that variations in managed care availability and enrollment in rural areas of New York state are due to geographic factors, such as adjacency to urban areas, or to population characteristics, such as market attractiveness, population risk, and health resources availability. The authors say that, in general, findings from the study indicate that population characteristics better explain the differences in managed care availability and, to a lesser degree, enrollment in commercial managed care and Medicaid managed care. The authors recommend that future federal and state policy decisions take into account the underlying socioeconomic and health system characteristics of an area rather than focusing exclusively on geographic factors.

2.**
"Rural Managed Care." Michelle M. Casey. In: *Rural Health in the United States*. Edited by Thomas C. Ricketts, III. New York: Oxford University Press, 1999. pp.113-118.

This book chapter provides a brief historical perspective on managed care in rural areas and presents national data on HMOs, rural service areas, and rural enrollment in commercial HMOs. Implications of changes to the Medicare and Medicaid programs authorized by the recently passed Balanced Budget Act are discussed. The author concludes that rural enrollment in HMOs appears likely to increase because of provisions in the Balanced Budget Act as well as increased competition among urban-based HMOs for members. She also reports that analysis of the impact of managed care on rural populations would be greatly improved by uniform collection of county-level Medicaid HMO data and state-level prepaid health plan and commercial HMO enrollment data. (Available from Oxford University Press, 198 Madison Avenue, New York, NY 10016, (212) 726-6000.)

3.
"Future Rural Managed Care Issues." Anthony Wellever. *The Journal of Rural Health,* Vol 14(3), Summer 1998, pp. 274-277.

This article discusses, and encourages research into, several questions about the future of rural managed care that are raised by the case studies and other articles contained in this journal issue. The questions include: the effect on providers and consumers of an increase in competition among MCOs in rural areas; the consequences for rural providers and consumers of MCO expansion into previously unserved areas; the ability of MCOs to develop new products to meet the needs of rural populations; and the likely effects on rural providers and consumers of Medicaid and Medicare policies intended to increase the use of managed care. The author calls on researchers and policy makers to revisit these questions regularly.

4.
"The Growing Presence of Managed Care in Rural Areas." Jon Christianson. *The Journal of Rural Health*, Vol 14(3), Summer 1998, pp. 166-168.

In this introduction to an entire journal issue devoted to discussions of managed care in rural areas, the author offers a brief history of managed care efforts in rural areas and gives a summary of what is known about the current presence of MCOs in rural areas. He also introduces the other journal articles, which contain a conceptual framework for rural managed care, several case studies, and a discussion of the findings from the case studies.

5.
"Potential Effects of Managed Care Organizations in Rural Communities: A Framework." Jon Christianson. *The Journal of Rural Health,* Vol 14(3), Summer 1998, pp. 169-179.

This article provides a conceptual framework for studying the implications of the presence of MCOs in any given community as well as the possible effects of that presence on rural consumers, employers, providers, and the uninsured. The author also lists several questions that need to be explored for a better understanding of managed care in rural areas. This article is part of a journal issue completely devoted to the topic of rural managed care.

6.
"Research on Managed Care Organizations in Rural Communities." Sarah Krein and Michelle Casey. *he Journal of Rural Health*, Vol 14(3), Summer 1998, pp. 180-199.

This article summarizes and discusses the literature on MCOs in rural areas that has been published since 1989. The discussion is divided into groups of studies characterizing the presence of MCOs, groups of studies examining the variation in the presence of MCOs, and groups of studies on the effects of MCOs on rural providers, consumers and employers. The article concludes by examining how well current research addresses questions raised in the Christianson article in the same journal issue.

7.
Local Public Health Agencies and Managed Care Organizations in Rural Areas:

Opportunities and Challenges. Ira Moscovice. Minneapolis, MN: Rural Health Research Center, 1998. 17 pp.

This report explores the nature of current and potential relationships between local health departments and managed care organizations in rural areas. Semi-structured interviews were held with state health officials, local public health officials, health care providers, and HMO managers in Missouri, Minnesota, New York, and Washington. According to the author, results of the interviews indicate that the growth of Medicaid and Medicare managed care enrollment in rural areas will likely reduce the incomes of local health departments if they do not or cannot contract with MCOs to provide care to enrollees. At the same time, many local health departments find their missions shifting from the provision of care to assessment, assurance and policy development. To the extent that local health departments are able to develop expertise in these core public health functions and are willing to market their expertise to MCOs, they may find a willing purchaser (or, at the least, a new user) of their services, according to the author. (Available from the Minnesota Rural Health Research Center, School of Public Health, University of Minnesota, 420 Delaware Street, S.E., Box 729, Minneapolis, MN 55455-0392, (612) 624-6151.)

8.
Market Reform and Managed Care: Implications for Rural Communities. Steven H. McDowell. Kansas City, MO: National Rural Health Association, April 1997. 21 pp.

This paper discusses the effects of a changing health insurance environment on rural communities. It reviews managed care concepts and discusses the development of systems that ensure local access to quality, affordable care. The paper also examines the transition of Medicare and Medicaid from single payer models to multiple payer models and outlines the pressures this will create on rural delivery systems. The publication is an attempt to open discussion on a few key issues that will affect rural delivery systems and to raise awareness of the changes that are taking place in rural health care delivery. (Available from the Federal Office of Rural Health Policy, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857, (301) 443-0835.)

9.
Rural Managed Care: Patterns and Prospects. University of Minnesota Rural Health Research Center. Minneapolis, MN: Minnesota Rural Health Research Center, April 1997. 80 pp.

New interest in the expansion of managed care in rural areas has been stimulated by several factors, including: 1) increased competition among urban-based HMOs for members; 2) expansion of Medicaid managed care through Section 1115 and 1915b; 3) desire to increase Medicare beneficiary enrollment in HMOs as part of Medicare reform; and 4) state health care reform initiatives that rely on managed care. This chartbook summarizes results of the first comprehensive effort to analyze national data on rural HMO enrollment in commercial plans, Medicaid HMOs and prepaid plans, and Medicare risk-based plans. Each chapter highlights major findings, presents key supporting data,

and offers a succinct analysis of policy implications. Policy makers will need current data on managed care enrollment in rural areas to track rural enrollment trends and to understand how the growth of managed care is affecting the delivery and financing of health care in rural areas. This chartbook provides a useful point of departure for those who seek a better understanding of the interaction between managed care and rural America. (Available from the Minnesota Rural Health Research Center, School of Public Health, University of Minnesota, 420 Delaware Street, S.E., Box 729, Minneapolis, MN 55455-0392, (612) 624-6151.)

10.
Assessing Managed Care Preparedness in Rural Community-Based Practices in North Carolina. Julie E. Alexander and Thomas C. Ricketts. Chapel Hill, NC: North Carolina Rural Health Research Program, December 1996. 34 pp. (Working Paper #47)

This study surveyed rural North Carolina community-based practices to assess the extent of their preparedness for managed care participation. Thirty-five centers were interviewed, half of them community health centers (CHCs) and half of them rural health clinics (RHCs). Data from the study suggest that managed care is moving into rural areas but that the predominant type of managed care is not strict capitation, nor are systems tightly structured. The study also found that CHCs are somewhat more prepared for managed care participation than RHCs, mostly due to their larger size, the greater likelihood that they have a full-time administrator on site, and the standards and requirements that accompany their federal funding. The authors state their belief that the managed care preparedness review developed in this study can be used to give practices information about how managed care will affect them. It also can be used to guide state agencies as they provide technical assistance to providers. (Available from the North Carolina Rural Health Research Program, Cecil G. Sheps Center for Health Research, University of North Carolina, 726 Airport Road, CB-7590, Chapel Hill, NC 27599-5764. (919) 966-5541.)

11.
"Capitation or Decapitation: Keeping Your Head in Changing Times." Thomas S. Bodenheimer and Kevin Grumbach. *JAMA*, Vol. 276(13), October 2, 1996, pp. 1025-1031.

This article offers a clear explanation of the concept of capitation, a method of provider reimbursement used by managed care organizations. Capitation, at its most basic, is a method of payment in which providers are paid a lump sum each month for each enrolled patient. It shifts financial risk (the potential to lose money, earn less money, or spend more time without additional payment) from insurers to providers. The authors of this article explain the many different models of capitation, describe common capitation arrangements for primary care physicians and specialists, and discuss the concepts of stop-loss coverage, risk adjustments, physician-hospital relations and integrated delivery systems under capitation.

12.
Assessing Roles, Responsibilities, and Activities in a Managed Care Environment: A Workbook for Local Health Officials. Agency for Health Care Policy and Research. Rockville, MD: AHCPR, July 1996. 195 pp. (Publication #96-0057)

This document seeks to assist local health department officials in identifying appropriate ways to carry out their core functions in the new, managed care environment. It is designed as a workbook that can be completed as part of broader planning activities. Chapters are structured to help local health departments: 1) catalog current mission statement activities and capabilities; 2) examine the changes taking place at the state and federal levels, including market trends and initiatives affecting low-income persons; 3) assess managed care-related changes taking place at the community level; 4) identify new approaches and opportunities for carrying out core functions, 5) analyze utilization and cost information; 6) explore alternative roles in direct delivery of personal health care services; and 7) consider possible actions to take in choosing new roles. The workbook contains several appendixes, including a glossary of managed care terms and resource information. (Available from the AHCPR Publications Clearinghouse, P.O. Box 8547, Silver Spring, MD 20907, (800) 358-9295.)

13.
Promoting Quality Care for Communities: The Role of Health Departments in an Era of Managed Care. The Joint Council Committee on Quality in Public Health. Washington, DC: National Association of County and City Health Officials, June 1996. 33 pp.

This report encourages state and local health departments to become active in evaluating and enhancing the quality of care provided by MCOs. The authors point out that state and local health departments bring unique perspectives to these efforts by focusing on the impact of service delivery on entire communities. The report outlines, discusses, and gives examples of health departments playing the following roles: 1) leader; 2) monitor and analyst; 3) educator; 4) advisor; 5) advocate; 6) facilitator and convener; and 7) regulator. It also offers guidelines for departments as they assume these roles, and discusses the capacities that will help health departments succeed in fulfilling them. (Available from NACCHO, 440 First Street, NW, Washington, DC 20001, (202) 783-5550.)

14.
"Managed Care: Will the Healthcare Needs of Rural Citizens Be Met?" Susan Foley Pierce and Clark Luihart. *Journal of Nursing Administration*, Vol. 26(4), April 1996, pp. 28-32.

This article proposes new roles for registered nurses in rural managed care environments. The authors examine health provider/patient ratios for the state of North Carolina. They demonstrate that the increase in demand for primary care providers and the continuing lack of physicians in rural areas leave a vacuum. The authors say this vacuum could be filled by the abundant supply of nurses. They suggest the use of telecommunications, reinstitution of a health service corps for a select group of professionals, and the use of

mobile health units and satellite clinics as ways of linking nursing personnel to managed care organizations.

15.
A Provisional Framework for the Economic Analysis of Managed Care Development in Rural Areas. John M. Kuder and John B. Colebaugh. Buffalo, NY: New York Rural Health Research Center, March 1996. 24 pp. (Working Paper #12)

This working paper discusses factors that are likely to influence managed care development in rural areas. The factors include: 1) characteristics of rural environments; 2) characteristics of regional health insurance markets; 3) organization of medical services markets; 4) relationships between providers and managed care plans; and 5) public policies regarding rural health. The complexity of each factor and the complexity of their relationships are discussed. The authors call for further research on the varying effects of these factors on rural managed care development. (Available from the New York Rural Health Research Center, Office of Rural Health, Department of Family Medicine, SUNY-Buffalo, 462 Grider Street, Buffalo, NY 14215, (716) 898-5273.)

16.
Market Characteristics and Managed Care Penetration in Rural Areas. Jere A. Wysong, Mary K. Bliss, Jason W. Osborne, and Gregory Bonk. Buffalo, NY: New York Rural Health Research Center, February 1996. 25 pp. (Working Paper #11)

This working paper examines differences in the presence of managed care plans in urban and rural areas of New York. After analyzing publicly available data on a variety of geographic, population and economic characteristics, the authors conclude that the differences are largely explained by two types of characteristics. These include: 1) population characteristics, such as income levels, employment rates, and risk of illness rates; and 2) health system characteristics, such as the ratio of primary care physicians to population, percent of physicians in solo practice, and ratio of hospital beds to population. (Available from the New York Rural Health Research Center, Office of Rural Health, Department of Family Medicine, SUNY-Buffalo, 462 Grider Street, Buffalo, NY 14215, (716) 898-5273.)

17.
Changes in the Health Care Marketplace: What is the Future for Rural Health Care Delivery? Rural Policy Research Institute. Columbia, MO: RUPRI, January 1996. 41 pp.

This paper provides a national overview of the changes in health care purchasing, financing, and delivery systems taking place in rural areas. The study authors conducted interviews with 48 key informants, held a focus group discussion with eight rural health delivery experts, and reviewed scholarly and popular journal literature. Key findings of their research include the following: 1) there is only limited managed care activity in rural areas; 2) while a few HMOs have been active in rural areas for a long time, very little managed care has been initiated in recent years; 3) efforts by state governments to create Medicaid managed care plans could result in more managed care in rural areas; 4)

in response to pressure to develop managed care products, rural providers commonly focus on developing delivery networks; 5) there is little use of managed care by rural Medicare beneficiaries; and 6) the use of purchasing alliances has just begun. The authors also discuss the implications of these findings for consumers, providers, and policy makers. (Available from the RUPRI Coordinating Office, University of Missouri, 200 Mumford Hall, Columbia, MO 65200, (314) 882-0316, http://www.rupri.org/)

18.
Integrated Pathways for Managing Rural Health Services." Lanis L. Hicks and Kenneth D. Bopp. *Health Care Management Review*, Vol. 21(1), Winter 1996, pp. 65-72.

In this article, the authors argue that rural providers, particularly hospitals, need to develop new roles in the more integrated health care delivery systems that are emerging. According to the authors, these new roles should include coordination of access to appropriate services, whether delivered locally or elsewhere within the integrated systems. The authors discuss many of the activities that constitute the coordination role, including: 1) identifying desired patient goals for major diagnoses; 2) defining key events in the prevention, diagnosis, treatment, rehabilitation, and health maintenance processes associated with these diagnoses; 3) guiding and coordinating the delivery of care for specific case types or diagnoses; 4) facilitating patients' interactions with providers; 5) facilitating quality and cost monitoring; and 6) addressing delivery problems when they occur. Finally, the authors illustrate how these roles could be fulfilled for a patient in need of total hip replacement.

19.
"Managed Care: Can It Work in Rural Texas?" *Texas Journal of Rural Health*, Vol. 14(4), Fourth Quarter 1995, pp. 1-110.

This entire journal issue is devoted to a discussion of managed care. Individual articles address a variety of issues, including: 1) a description of managed care and a discussion of possibilities it presents for rural Texas; 2) ethical implications of this type of health care delivery; 3) a discussion of a model for using ERISA legislation to make rural managed care work (see citation #25); 4) a discussion of strategic planning for managed care; 5) a discussion of the role of hospital trustees' responsibilities in the area of community health status; and 6) a description of an alliance of rural hospitals facing managed care. Four editorials are included, as is a glossary of terms and a demographic overview of rural Texas.

20.
Rural Prescriptions for Managed Care: A Roundtable. Federal Office of Rural Health Policy, Health Resources and Services Administration, Rockville, MD: ORHP, November 9, 1995. 40 pp.

This document is an account of a roundtable discussion of rural managed care that was held in November 1995. Participants included a small group of rural providers, managed care executives operating successfully in rural markets, consultants, industry

representatives, and public policy analysts. The report highlights broad recommendations by participants on what might be required to make managed care feasible in and advantageous to rural areas. The document includes comments by participants about their experiences with managed care. (Available from ORHP, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857, (301) 443-0835.)

21.
Impact of Health Reform on Rural Areas: Lessons From the States. Office of Technology Assessment, U.S. Congress. Washington, DC: OTA, September 1995. 27 pp. (OTA-BP-H-173)

This background paper examines the effects of insurance market reforms and reforms aimed at the health care delivery system in rural areas. It clearly enumerates issues facing rural communities and explains the actions recently taken by various states to address those issues. The paper discusses the following: 1) Medicaid managed care plans in Arizona, Tennessee, and Oregon; 2) Minnesota's efforts to encourage integrated provider networks; 3) efforts to control competition and access in North Carolina, Vermont, and Oregon; and 4) the concerns of state legislators for maintaining local control of health delivery systems. (Available from the National Technical Information Service, Springfield, VA 22161, (703) 487-4650, NTIS Publication #PB96107743.)

22.
"Managed Care and Rural America." James K. Cooper. *Journal of Family Practice*, Vol. 41(2), August 1995, pp. 115-117.

This article summarizes the results of a conference sponsored by the Agency for Health Care Policy and Research. Conference participants agreed on the following: 1) small HMOs are being merged into larger ones; 2) three forces seem to be influencing the growth of rural managed care (the growth of locally-driven HMO development, the development of rural services adjacent to urban areas, and efforts by state governments to control Medicaid costs); 3) managed care offers advantages and disadvantages for rural physicians; 4) legal questions, centering on antitrust issues, need to be resolved; and 5) research is needed on the ultimate effect of managed care on rural communities.

23.
"Regional Progress Toward Managed Care." Krisanne L. Combs. *Virginia Medical Quarterly*, Vol. 122(3), Summer 1995, pp. 158-161.

This article reports the results of a survey of the role of managed care in regional Virginia medical markets. It reviews state government activities in moving Medicaid participants into managed care plans, outlines various stages of maturity for medical markets, and discusses managed care activity in eight regions of the state. The author concludes that managed care will impact each regional market uniquely, and advises physicians to stay abreast of the changes in their medical markets.

24.
Managed Care As a Service Delivery Model in Rural Areas. National Rural Health Association. Kansas City, MO: NRHA, May 1995. 5 pp.

This issue brief outlines the Association's position on managed care in rural areas. It makes several recommendations for building a framework that ensures high quality, affordable, and accessible health care to rural residents. The recommendations include: 1) flexible systems that recognize the uniquedevelopment challenges created by geography and other rural limitations; 2) community representation and involvement in planning and development efforts; 3) federal guidelines to ensure consumer choice; 4) financial incentives to encourage providers to improve the health of the population; 5) educational programs for rural providers on negotiating and working with managed care organizations; 6) protection and strengthening of locally-developed health care networks, including technical assistance; and 7) state and federal antitrust policies that clarify business integration practices and encourage cooperative rural managed care networks. (Available from NRHA, One West Armour Blvd., Suite 203, Kansas City, MO 64111, (816) 756-3140.)

25.
Essential Community (Access) Providers. National Rural Health Association. Kansas City, MO: NRHA, May 1995. 2 pp.

This issue brief outlines the Association's position on state-level proposals establishing essential community providers and recommends the following: 1) designations should be part of a community- driven process that determines which providers (practitioners and/or facilities) are essential; 2) cost studies of the efficiency of managed care plans should include hidden costs to consumers; 3) essential community provider status should be defined without regard to tax status or current funding sources on a state-by-state basis; and 4) regulations should not limit the scope of services offered, should allow affiliation with more than one plan, and should not conflict with existing incentives to locate health professionals in rural personnel shortage areas.(Available from NRHA, One West Armour Blvd., Suite 301, Kansas City, MO 64111, (816) 756-3140.)

26.
The Effects of Market Driven Reform on Rural Health Care Delivery Systems: Addressing the Policy Implications. Rural Policy Research Institute. Columbia, MO: RUPRI, 1995. 15 pp.

This report, requested by the Congressional Rural Health Care Coalition, analyzes the effects of market-driven reform on rural health care delivery systems. Study methodology includes a literature review, focus groups and intensive interviews with 45 leaders in the field. Findings and policy implications are given concerning: 1) the extent of implementation of Medicare and Medicaid managed care; 2) the extent of changes in private and public purchasing strategies and their impact on rural areas; 3) the effect of market changes on the supply of health care personnel; and 4) the extent and direction of changes in the organization and financing of rural health care. (Available from the

RUPRI Coordinating Office, University of Missouri, 200 Mumford Hall, Columbia, MO 65200, (314) 882-0316, http://www.rupri.org/)

27.
Issues and Options Facing Rural Communities Under Managed Care. Rosenberg and Associates. Point Richmond, CA: Rosenberg and Associates, 1995. 31 pp.

This report identifies a number of issues raised by the expansion of managed care to rural California and discusses them from the perspectives of rural health care delivery systems and managed care organizations. The report reviews the concerns of local delivery systems and health plans, as well as the set of issues arising at the intersection of the two, and discusses the implications for rural communities. The report also includes a discussion of the basic elements of managed care systems. (Available from the California Institute for Rural Health Management, 30 Railroad Avenue, Suite 3, Point Richmond, CA 94801, (800) 736-2180.)

28.
Rural Health: An Evolving System of Accessible Services. Tracey M. Orloff and Barbara Tymann. Washington, DC: National Governors' Association, 1995. 293 pp.

In a changing health care environment, states and rural communities are striving to enhance their ability to meet the needs of their residents. This report, based on a 50 state survey, includes an assessment of the increase in managed care systems in rural areas and discusses how these systems fit into the context of state-based health care policy changes. Case studies of Minnesota and West Virginia are highlighted, and profiles of specific rural health activities and initiatives of all fifty states are given. (Available from the National Governors' Association, 444 North Capitol Street, Washington, DC 20001-1512, (202) 624-5300.)

29.
"Making Managed Care Work in Rural Texas: A Model Using ERISA Legislation." Timothy S. Brady. *Texas Journal of Rural Health,* Vol. 14(4), Fourth Quarter 1995, pp. 19-25.

This article discusses how the Employee Retirement and Insurance Security Act (ERISA) can provide a mechanism for businesses to jointly provide managed health care in rural communities. The article explains how ERISA can be applied in ways that help rural communities create their own managed care products that are affordable and consistent with traditional models of rural health care. A hypothetical financial model of the proposed mechanism is given.

30.
Managed Health Care Reform and Rural Areas: Literature Review and Synthesis. Anthony Wellever and Valerie Deneen. Minneapolis, MN: University of Minnesota AHCPR Rural Center, March 1994. 49 pp.

This document thoroughly reviews the research literature published through early 1994 on managed care and rural areas. Much of the literature is summarized, the various forms of managed care are introduced, public and private insurance issues are discussed, and the impact of managed care on access to health care and quality of health care are discussed. The document includes a summary of current knowledge about rural managed care and an extensive bibliography. (Available from the Federal Office of Rural Health Policy, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857, (301) 443-0835.)

31.
Making Managed Health Care Work in Rural America. Federal Office of Rural Health Policy, Health Resources and Services Administration and Office of Managed Care, Health Care Financing Administration. Rockville, MD: ORHP, 1994. 29 pp.

This report summarizes discussions held at a workshop sponsored by ORHP and the HCFA Office of Managed Care. Workshop objectives were to increase awareness of rural managed care, to highlight policy options for increasing its use in Medicare, Medicaid and private insurance plans, and to provide input into the development of national standards for managed care plans. Workshop participants included health officials, policy makers, and representatives of managed care plans. Workshop participants suggested changes in policy to encourage the spread of managed care in rural areas, and to ensure that this will be beneficial to rural citizens. The suggestions include: 1) the elimination of ERISA's pre-emption of state laws regarding self-insured plans, which interferes with efforts to extend coverage to rural areas; 2) clear federal definitions on antitrust regulation of rural networks, which would be preferred to separate action by individual states; 3) waivers and exemptions from the usual reimbursement methods since they limit the ability of managed care plans to cover Medicare recipients in rural areas; and 4) competitive bidding for Medicaid enrollees on a county-by-county basis to stabilize the revenue stream. (Available from ORHP, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857, (301) 443-0835.)

32.
Managed Care Plans in Rural America: How They Work, What They Do. National Rural Electric Cooperative Association. Washington, DC: NRECA, 1991. 53 pp.

This report includes case studies of four managed care plans (three PPOs and a staff model HMO) operating in eleven states. Interviews were held with plan administrators, physicians, hospital administrators, employers, and insurance agents. The issues examined include: 1) planning and building of networks; 2) operations, needs and concerns of employers; 3) costs and quality effects; and 4) design of rural health plans. Conclusions include the finding that managed care works in rural areas and succeeds at holding down costs. However, the effects on quality of care are not well understood. (Available from NRECA, 4301 Wilson Boulevard, Arlington, VA 22203-1860. (703) 907-5500.)

Health Maintenance Organizations and Preferred Provider Organizations

33.**
HMOs Serving Rural Areas: Experience with HMO Accreditation and HEDIS Reporting. Michelle Casey and Jill Klingner. Minneapolis, MN: Minnesota Rural Health Research Center, May 1999. 38 pp. (Working Paper #29)

This study, the third in a series of three (see citations #34 and #35), addresses the reasons HMOs serving rural areas have or have not applied for accreditation from the National Committee for Quality Assurance (NCQA). The authors interviewed representatives of 21 HMOs that had applied to NCAQ, and 10 HMOs that had not applied. Study results indicate that major influences for application are: 1) requests from large employers; 2) competition from other HMOs; 3) Medicare, Medicaid, and state requirements; and 4) internal motivation to improve quality of care. Some HMOs cited the cost of preparing and applying for accreditation and uncertainty about their ability to meet accreditation standards as reasons for not applying. However, most of the unaccredited HMOs reported that they plan to apply in the future, and a majority of accredited HMOs indicated that they plan to reapply. Several HMOs in both groups identified difficulties with quality improvement, preventive health, and medical records standards as they are applied in rural areas. All of the HMOs collect HEDIS measures but the majority have difficulty collecting some of them. Half of the HMOs lack enough eligible enrollees to meet sample size requirements for some HEDIS measures. The study authors call for further research into the impact on quality of care of the lower accreditation rate among HMOs serving rural areas and on the question of whether the accreditation process validly assesses the capacity of HMOs with predominantly urban enrollees to provide quality care to rural enrollees. (Available from the Minnesota Rural Health Research Center, School of Public Health, University of Minnesota, 420 Delaware Street, S.E., Box 729, Minneapolis, MN 55455-0392, (612) 624-6151.)

34.**
State HMO Accreditation and External Quality Review Requirements: Implications for HMOs Serving Rural Areas. Michelle Casey. Minneapolis, MN: Minnesota Rural Health Research Center, January 1999. 31 pp. (Working Paper #27)

This study, the second in a series of three (see citations #33 and #35), explores the relationship between accreditation and HMOs serving rural areas. Analysis of state regulations and interviews with state officials revealed that accreditation requirements are still in the early stages of implementation, but that several states that have significant rural populations have incorporated state HMO accreditation or external quality review requirements into their HMO licensure processes. The author was able to identify nine states that have regulations requiring HMOs to apply for or obtain accreditation or to undergo an external quality review as a condition of licensure. Four states were identified that require HMOs to be accredited in order to serve state employees, and all of them have substantial rural populations. (Available from the Minnesota Rural Health Research

Center, School of Public Health, University of Minnesota, 420 Delaware Street, S.E., Box 729, Minneapolis, MN 55455-0392, (612) 624-6151.)

35.**
The NCQA Accreditation Process: Do HMOs Serving Rural Areas Apply For and Obtain Accreditation? Michelle Casey and Michelle Brasure. Minneapolis, MN: Minnesota Rural Health Research Center, December 1998. 31 pp. (Working Paper #26)

This study, the first in a series of three (see citations #33 and #34), explores the relationship between accreditation and HMOs serving rural areas. The study used a logistic regression model, and found that the relationship between the rural proportion of an HMO's service area population and the likelihood of applying for accreditation is initially positive, increasing from a 39 percent probability of applying for an HMO with no rural service area population, to 48 percent for an HMO with a 20 percent rural service area population. The probability levels off when the rural proportion is between 20 and 30 percent and declines in a relatively linear pattern between 30 and 70 percent rural. The probability declines more rapidly above 70 percent rural, reaching 0.5 percent for an HMO whose service area population is entirely rural. Several variables, including HMO size, affiliation, federal qualification, age, market penetration rate, and state HMO accreditation requirements, are significantly and positively related to the likelihood of applying for NCQA accreditation. (Available from the Minnesota Rural Health Research Center, School of Public Health, University of Minnesota, 420 Delaware Street, S.E., Box 729, Minneapolis, MN 55455-0392, (612) 624-6151.)

36.
"Implications of HMOs for Rural Providers and Consumers." Anthony Wellever. *The Journal of Rural Health,* Vol 14(3), Summer 1998, pp. 268-273.

This article discusses the effects on rural providers, employers and consumers of the six HMOs that are profiled elsewhere in this journal issue. The author concludes that the impact on rural providers has been small so far; the impact on employers has been largely positive; and the impact on consumers has been mixed. This article is part of a journal issue completely devoted to the topic of rural managed care.

37.
"Medical Associates HMO." Anthony Wellever and Jon Christianson. *The Journal of Rural Health*, Vol 14(3), Summer 1998, pp. 224-232

This article describes Medical Associates HMO, a mixed model HMO established and owned by a multispeciality medical group practice in Dubuque, Iowa. Medical Associates HMO has 28,000 members in an area of 50 miles around Dubuque. In October 1996, the authors visited two rural communities in the HMO's service area and found that, in general, rural physicians and hospital administrators viewed their contracts with the HMO favorably. However, they did voice concern about the plan's policy of allowing patient self-referrals to specialists without restrictions. Employees seemed satisfied with the plan's inclusion of their primary care providers, and private employers seemed

satisfied by the plan's lower costs. The major issue facing the HMO, according to the authors, is its ability to compete successfully with larger health care systems. This article is one of six case studies in a journal issue completely devoted to the topic of rural managed care.

38.
"Missouri Advantage." Michelle Casey and Barbara Yawn. *The Journal of Rural Health*, Vol 14(3), Summer 1998, pp. 257-267.

This article describes Missouri Advantage, a mixed model HMO established in 1996 and owned by four hospitals in the plan's service area in central, northern, and southwestern Missouri. Missouri Advantage had approximately 5,800 commercial enrollees in March 1997 when the authors visited two communities in its service area. The authors felt that perceptions of local providers, employers, and enrollees regarding the HMO were largely shaped by the local market area offices. According to the authors, Missouri Advantage will face a challenge with the implementation of its Medicare risk initiative, which will need to differ from its commercial product in services offered, marketing strategies employed, enrollment process devised, and member services offered. The authors say that, as one of only 14 rural-based HMO in the nation, Missouri Advantage may serve as a future role model for provider-owned HMOs based in rural areas if it is able to increase its enrollment and solidify its financial base. This article is one of six case studies in a journal issue completely devoted to the topic of rural managed care.

39.
"NorthMed HMO." Jon Christianson and Sara Krein. *The Journal of Rural Health*, Vol 14(3), Summer 1998, pp. 233-243.

This article describes NorthMed HMO, an independent practice association (IPA)-model HMO established in 1986 by physicians in Traverse City, Michigan. The HMO has about 16,000 members living in thirteen rural northwestern Michigan counties. Site visits to the HMO were conducted in December 1996. The authors found that physicians play a dominant role in the HMO through their physician organization, a major stockholder in the plan. Individual physicians reported that, with low patient enrollment, the HMO has offered limited benefits at a minimal cost. The major hospital system in northern Michigan supports the HMO, and employers perceived it as user friendly because it is locally owned. Employees expressed satisfaction with the plan, and noted that their experience seemed inconsistent with the poor image of HMOs portrayed in the national media. Major challenges facing the HMO will be determining how to manage ambitious expansion plans and deciding how to maintain congruence between the demands and expectations of its provider-owners and the interests of the HMO. This article is one of six case studies in a journal issue completely devoted to the topic of rural managed care.

40.
"Regence HMO Oregon." Michelle Casey and Ira Moscovice. *The Journal of Rural Health*, Vol 14(3), Summer 1998, pp. 244-256.

This article describes Regence HMO Oregon, a non-profit, independent practice association (IPA)-model HMO affiliated with Blue Cross and Blue Shield of Oregon. The plan, which is based in Portland, serves all of the state's metropolitan statistical areas and 24 of its 27 rural counties, as well as three rural and one metropolitan counties in southwest Washington. The HMO has about 486,000 members. In rural areas, the plan has approximately 53,000 commercial enrollees, 55,000 state Medicaid enrollees, and 6,700 Medicare enrollees. Site visits to the HMO were conducted in September 1996. Physicians and hospitals expressed satisfaction with the HMO, but voiced concerns about the plan's reimbursement methodology and the usefulness of the data they receive from Regence. Employers seemed to focus on cost as their primary reason for offering an HMO product, and employees expressed satisfaction with the plan's cost, coverage of preventive care, and large provider network. A major issue for Regence HMO Oregon in the future will be competition from other providers. This article is one of six case studies in a journal issue completely devoted to the topic of rural managed care.

41.
"Rocky Mountain HMO." Anthony Wellever and Ira Moscovice. *The Journal of Rural Health*, Vol 14(3), Summer 1998, pp. 211-223.

This article describes Rocky Mountain HMO, a nonprofit independent practice association (IPA)-model HMO with 96,000 members in a service area that, until recent plans to expand, was comprised of 22 mostly rural counties on the western edge of Colorado. In October 1996, the authors conducted site visits in two rural western Colorado communities and found that Rocky Mountain HMO was generally considered physician-friendly and enjoyed good relationships with employers and employees. The authors found that the HMO may risk the good will it has built in western communities by its state wide expansion plans. But the plan's managers hope to maintain their reputation through a joint venture with the state medical society and by strengthening its network of regional offices. This article is one of six case studies in a journal issue completely devoted to the topic of rural managed care.

42.
"United Health Care of North Carolina." Michelle Casey and Anthony Wellever. *The Journal of Rural Health*, Vol 14(3), Summer 1998, pp. 200-210.

This article describes United HealthCare of North Carolina, a for-profit independent practice association (IPA) model HMO with 160,000 participants throughout the state, seventeen percent of whom reside in rural areas. In November 1996, the authors conducted site visits to four rural communities and found that health providers,employers and employees were generally satisfied with their relationship with United HealthCare. However, the authors identified some anxiety among providers and employers about the changes that may take place as a result of the plan's recent purchase by a national managed care firm. In addition, North Carolina is a rapidly developing managed care market, and the authors foresee increased competition for United HealthCare in its rural markets. This article is one of six case studies in a journal issue completely devoted to the topic of rural managed care.

43.
"Patterns of Health Maintenance Organization Service Areas in Rural Counties." Thomas C. Ricketts, Rebecca T. Slifkin, and Karen D. Johnson-Webb. *Health Care Financing Review*, Vol. 17(1), Fall 1995, pp. 99-113.

Using data from the 1993 GHAA Directory of HMOs, the authors of this article determine that 40 percent of the 544 HMOs outside Hawaii and Alaska serve only metropolitan areas, that older HMOs are more likely to include non-metropolitan counties in their service areas, and that the form of HMO most likely to spread in non-metropolitan areas is IPAs. A substantial number of non-metropolitan counties are served by more than one plan, indicating that competitive pressures can be brought to bear on costs. Non-metropolitan counties with sparse populations or high minority populations are less likely to be included in service areas.

44.
"Rural Managed Care." Betsy L. Barnes, Marlon R. Dauner, and Joel Tate. *AAPPO Journal,* Vol. 2(1), February-March 1992, pp. 29-34.

This article outlines existing challenges to the establishment of rural preferred provider organizations (PPOs), and offers possible solutions. The authors say that rural managed health care can be vital to small communities if it is implemented to suit their unique needs. Rural PPOs need to carefully consider payment policies, take responsibility for the future of the community, and often ask other players, such as insurers, to conduct business in a less traditional manner. These actions often result in long-term financial success for rural PPOs, cost-effective provider networks, and quality services.

45.
"HMOs in Rural Areas: Pros, Cons, and Financial Realities." Jon B. Christianson and Maureen Shadle. In: *Financing Rural Health Care*. Edited by L.A. Straub and N.L. Walzer. New York: Praeger, 1988. pp. 149-173.

This book chapter reviews the HMO presence in rural America and discusses the advantages and disadvantages of different HMO structures on delivery of services. Strategies to increase enrollment and improve the financial position of rural HMOs are described. (Available from the Greenwood Publishing Group, 88 Post Road West, Box 5007, Westport, CT 06881, (800) 225-5800.)

46.
"The Growth of HMOs in Rural Areas." Jon B. Christianson, Jeanne McGee, Maureen Shadle, and James Dahl. *GHAA Journal*, Vol. 7(2), Winter 1986, pp. 35-42.

This article uses data from 1981-1984 to describe the growth of HMOs in rural areas of the U.S. The authors estimate that HMO penetration in rural areas in June 1984 was just under two percent (compared to total U.S. HMO penetration of 9.7 percent), that HMOs serving rural areas at that time were more likely to be networks than staff models, and that they were more likely to be Blue Cross/Blue Shield HMOs. The authors also find

that HMOs serving rural areas were much less likely to be owned or managed by multistate HMO entities, less likely to be federally qualified, and more likely to be non-profit. The authors conclude that the movement of HMOs into rural areas will continue as urban-based HMOs search for new markets.

47.
"The New Environment for Rural HMOs." Jon B. Christianson, Maureen Shadle, Mary M. Hunter, Susan Hartwell, and Jeanne McGee. *Health Affairs*, Vol. 5(1), Spring 1986, pp. 105-121.

This article uses national HMO data to identify HMOs serving rural areas. The authors study seven HMOs in depth and identify four general categories of problems limiting HMO expansion into rural areas. The problems include: 1) financing; 2) opposition by rural providers; 3) attracting large enough numbers of enrollees; and 4) cost containment. The authors of this article believe that HMO availability in rural areas will increase, especially through expansion of urban-based IPAs which are not as capital intensive as staff model HMOs.

Rural Health Networks

48.**
"AHCPR-Funded Rural Managed Care Centers: Report From the Field.." David Hartley and Jodie Jackson. *The Journal of Rural Health,* Vol. 15(1), Winter 1999, pp. 87-93.

This paper summarizes the experiences of rural managed care centers in the first three years of a project designed to promote the development of rural health networks. The project was funded by the Agency for Health Care Policy and Research (AHCPR) to help rural providers in Arizona, Maine, Oklahoma, West Virginia, Nebraska. The paper is intended to complement the Fasciano article in the same journal issue (see citation # 49), and offers specific examples from the centers. The authors say that the development of information systems and efforts to foster leadership in the medical community are areas in which funding can be most effective.

49.**
"Preparing Rural Communities for Managed Care: Lessons Learned." Nancy J. Fasciano, Suzanne Felt-Lisk, Thomas C. Ricketts and Benjamin Popkin. *The Journal of Rural Health*, Vol. 15(1), Winter 1999, pp.78-86.

This paper describes lessons learned from an evaluation of five university-based technical assistance projects. The projects were funded by the Agency for Health Care Policy and Research (AHCPR) to help rural providers in Arizona, Maine, Oklahoma, West Virginia, Nebraska and Iowa develop rural health networks. The authors report that real movement toward system integration requires pressure from larger forces external to the community. They also report that the need for technical assistance varied widely among the studied

communities. In addition, they caution that effort often needs to be focused on helping community members plan strategically for health care delivery.

50.
Provider Sponsored Organizations for Medicare Managed Care: What is Next for Rural Providers? Keith J. Mueller. Omaha, NE: Nebraska Center for Rural Health Research, Summer 1998, 26 pp. (Working Paper #98-1)

This paper presents considerations for rural providers who may be thinking of organizing provider sponsored organizations (PSOs) in rural areas. The author sees the advantages of PSOs as possibly including increased revenues, increased minimum payments for managed care plans, greater opportunity for local control, and potential opportunities to invest in local health care delivery infrastructures. He sees the disadvantages as possibly including the risk of losses through Medicare business, increased administrative requirements, and the risk of an insufficient number of enrollees. The paper recommends that those considering this type of organization: 1) have a network of participating providers; 2) complete a financial analysis of their business plan; 3) develop and implement a marketing plan; 4) develop relationships with participating providers; 5) complete negotiations within and outside of the PSO; 6) develop and implement a medical management plan; and 7) implement an information system that will meet the organization's managerial needs. (Available from the Nebraska Center for Rural Health Research, 984350 Nebraska Medical Center, Omaha, NE 68198-4350, (401) 559-5260. http://www.unmc.edu/psm/rural)

51.
Rural Community Health Plans: A Summary Report and Directory. Robert T. Van Hook. Rockville, MD: Federal Office of Rural Health Policy, March 1997. 43 pp.

This report describes 32 organizations located in 13 states who identify themselves (from a survey of 85 networks) as locally-based, community-oriented rural health networks that have recently or will soon begin selling insurance products. Named Rural Community Health Plans (RCHPs) by the author and investigator, these organizations characterize themselves as largely nonprofit, with a median service area population of 100,000 persons and an expected average enrollment by 1997 of about 14,000. The survey was designed to begin identifying rural networks whose level of service integration represents a departure from the more common response to rural market stresses, which has been to form lateral networks of like providers. The report offers descriptive information about the methods of the survey and information about respondents' corporate structures, board composition, network sponsorship, covered lives, approaches to insurance products, types of benefit packages, target markets, types of technical assistance needed, and problems encountered. The report includes a directory of the 32 networks. (Available from ORHP, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857, (301) 443-0835.)

52.
"Rural Health Network Development: Public Policy Issues and State Initiatives." *Journal of Health Politics, Policy and Law*, Vol 22 (1), February 1997, pp. 23-47.

This article analyzes public policy issues related to rural health network development, discusses current efforts to encourage rural network development, and suggests actions that states could take to support rural health network development. These actions include adopting a formal definition of networks, providing alternatives to certain regulatory requirements, and providing support with matching grants, loans, and technical assistance. The authors state their belief that, without such support, locally controlled rural networks are unlikely to develop. They also point out that Medicare reform legislation could provide significant incentives for network development through changes in reimbursement provisions, financial solvency standards, and antitrust exemptions.

53.
"Rural Hospitals Prepare for Impending Managed Care." Gail Stout. *Journal of Healthcare Resource Management*, Vol. 14(2), March 1996, pp. 8-15.

This article profiles Good Samaritan Health Systems in Kearney, NE and Llano Memorial Hospital in Llano, TX, and discusses the steps they have taken to prepare for managed care contracting. The article describes the work of Good Samaritan (a group of two hospitals, four clinics, and a physician practice group) in forming a physician-hospital organization and its efforts to move from an exclusive acute-care service mission to the delivery of a continuum of care. According to the article, Llano Memorial, a hospital too small (30 beds) to form a physician-hospital organization, has learned to influence local employers to include it in HMO contracts. The hospital's promotional program, aimed at developing new services needed by area residents, is described, as are the efforts of both groups to develop coordinated information systems.

54.
Employer-Based Managed Care Initiatives in Rural Areas: The Experience of the South Dakota State Employees Group. Jon B. Christianson and J. Patrick Hart. Minneapolis, MN: Minnesota Rural Health Research Center, February 1996. 23 pp. (Working Paper #12)

In 1993, after large increases in premium costs during the early 1990s, the governor of South Dakota sought the development of a managed care plan to cover state employees. This report is an analysis, based on documents and interviews, of the experience of developing a statewide managed care option. Instead of being offered three plans with different deductible levels, employees would be offered one managed care and one deductible plan. Seventy-four per cent of state employees in Pierre, the state capital, enrolled when the managed care plan became available, and by the second year it was offered to all state employees. Several issues that may be of interest to other rural communities are identified, including the effects of politics on developing plans for state employees, the difficulties of negotiating with physician groups or hospitals, and difficulties establishing quality criteria. Further areas of research are also suggested. (Available from the Minnesota Rural Health Research Center, School of Public Health, University of Minnesota, 420 Delaware Street S.E., Box 729, Minneapolis, MN 55455-0392, (612) 624-6151.)

55.
"Measuring and Evaluating the Performance of Vertically Integrated Rural Health Networks." Ira Moscovice, Jon B. Christianson, and Anthony Wellever. *The Journal of Rural Health*, Vol. 11(1), Winter 1995, pp. 9-21.

This article develops a conceptual approach to the study of vertically integrated rural health networks. It offers a framework for assessing network performance and cites examples of measurable performance indicators. The authors also raise questions for further research concerning the relationships between the environment, structure, and performance of vertically integrated rural health networks.

56.
"Legislative and Policy Strategies for Supporting Rural Health Network Development: Lessons from the 103rd Congress." Andrew F. Coburn and Keith J. Mueller. *The Journal of Rural Health,* Vol. 11(1), Winter 1995, pp. 22-31.

This article evaluates the rural health policy strategies of the major health reform bills considered by the 103rd Congress. The authors conclude that key policy strategies for supporting rural network development include: 1) reform of insurance and payment policies; 2) expansion of targeted support and technical assistance to rural areas; and 3) policies governing purchasing groups or alliances that will ensure appropriate treatment of rural providers and networks.

57.
"Seeing Green." Allison Cleary. *Hospitals & Health Networks*. Vol. 69(19), October 5, 1995, pp. 73-74, 76.

This article profiles three hospitals that belong to the Rural Wisconsin Health Cooperative. The article says that Prarie du Chien Memorial Hospital has regained financial health through diversity. The hospital offers emergency, acute, intermediate, and respite care, home health and hospice services, a community child care center and many other services. Hospital executives say that the Cooperative has helped them through its successful efforts to lessen the inequities between Medicaid reimbursement to rural vs. urban hospitals and through the communication it fosters among departments at different facilities. According to the article, Columbia Community Hospital and Mile Bluff Medical Center credit their financial turn-arounds to successful efforts to recruit speciality and primary care physicians who could help build community confidence in the hospitals. Membership in the Cooperative, their spokesmen say, has contributed to Columbia's ability to negotiate with managed care firms and has given Mill Bluff's chief executive officer a network of mentors to turn to throughout his 21-year tenure.

58.
"Rural Hospital Networks: Implications for Rural Health Reform." Ira Moscovice, Jon B. Christianson, Judy Johnson, John Kralewski, and Willard Manning. *Health Care Financing Review*, Vol. 17(1), Fall 1995, pp. 53-67.

The authors of this article evaluate the Robert Wood Johnson Foundation's Hospital-Based Rural Health Care Program. In the course of the evaluation, 127 rural hospital networks were surveyed. Lessons learned from this survey may be applicable to different kinds of rural health networks. These lessons include: 1) loosely structured networks that bring together diverse types of organizations tend to be unstable; and 2) rural hospitals seek cost efficiencies through network affiliations but are unlikely to see short-term benefits. Directions for future research are suggested.

59.
"Challenges and Opportunities for Integrated Health Systems in Rural Communities." Libby Sternberg. *Health System Leader*, Vol. 2(7), August-September 1995, pp. 11-19.

This article offers insights into the challenges faced by health care facilities as they integrate into larger networks. The experiences of two rural communities in Michigan and three in Vermont demonstrate that no single integration strategy is suited for all rural areas.

60.
The Integrated Service Network Development Initiative--The First Cohort, Spring, 1995. Bureau of Primary Health Care, Health Resources and Services Administration, U.S. Department of Health and Human Services. Bethesda, MD: BPHC, May 1995. 28 pp.

This report provides a brief synopsis of twenty-nine rural and urban participants in the Bureau's Integrated Service Network Development Initiative. The initiative is intended to support efforts of Section 330 health centers, in partnership with at least one other health care entity or provider, to form horizontally and/or vertically integrated delivery systems of managed care that will ensure access for the medically underserved. (Available from the National Clearinghouse for Primary Care Information, 8201 Greensboro Drive, Suite 600, McLean, VA 22102, (703) 821-8955.)

61.
"Rural Priorities." Terese Hudson. *Hospitals & Health Networks*, Vol. 69(4), February 20, 1995, pp. 40, 42, 44.

This article reports the results of a survey of rural hospital administrators concerning rural networking activities. The study's results show that 85 percent of the respondents feel that their hospital's survival depends on close links to doctors. However, only 30 percent report using an integration model such as a physician/hospital organization or a management services organization. Nearly 47 percent report formal contractual affiliations with another hospital or health system. More than 75 percent of respondents cite increased managed care contracting opportunities as the reason for their affiliation. Nearly half of the respondents reported that their community is well aware of the hospital' financial position.

62.
Public Policy Issues and Rural Health Network Development. Michelle Casey, Anthony

Wellever, and Ira Moscovice. Minneapolis, MN: Minnesota Rural Health Research Center, December 1994. 49 pp. (Working Paper #8)

This working paper analyzes public policy issues that affect integrated rural health networks and makes recommendations for state and federal policy initiatives that will support these networks. Recommendations are made concerning: 1) defining, licensing and certifying rural health networks; 2) regulating and insuring rural health networks; 3) modifying antitrust regulations and supervising network development; 4) providing financial incentives, technical assistance, and demonstration projects for networks; and 5) revising, clarifying, and adjusting Medicaid and Medicare regulations concerning networks. (Available from the Minnesota Rural Health Research Center, School of Public Health, University of Minnesota, 420 Delaware St. S.E., Box 729, Minneapolis, MN 55455-0392, (612) 624-6151.)

63.
"Bassett Healthcare - Lessons From a Rural Regional Network." Carol Rodat. *Health System Leader*, Vol. 1(5), July 1994, pp. 13-19.

This article examines the history of Bassett Healthcare in Cooperstown, New York, a network of community health centers, medical groups and hospitals in a rural area. From its beginning as a physician group affiliated with the Bassett hospital in the 1920s, the development of the network is examined, including a recent partnership with an HMO. Problems are discussed and suggestions given for avoiding them in the future.

64.
"Managed Cooperation: An Approach to Health Care Reform in Rural Areas." Henry S. Berman. *Health System Leader*, Vol. 1(3), May 1994, pp. 26-33.

This article, written by the President of Group Health Northwest (GHNW) of Spokane, Washington, proposes a model of service delivery for rural areas that contains many of the principles of managed competition but which includes a collaborative relationship between rural communities and urban-based integrated systems. The article describes the efforts of GHNW to provide managed care to rural residents in its service area and states the author's belief, based on GHNW's experience, that rural areas need systems that bring additional resources into the community rather than stimulating competition among existing ones.

65.
Positioning for Reform: A Case Study for Rural Health Networking. Kenneth L. Oakley, Andrew Danzo, and Jere A. Wysong. Buffalo, NY: New York Rural Health Research Center, 1994. 19 pp. (Working Paper #7)

This working paper examines a rural health network in southwestern New York, provides insight into the organizational dynamics of rural health networks, and assesses their potential to achieve rural health system integration. The study finds that integration is gradually achieved as networks go through a developmental sequence that includes: 1)

establishment of organizational linkages; 2) empowerment of the network; 3) adoption of a proactive stance; and 4) acceptance of risk. The authors conclude that networks have the potential to integrate rural health providers, but warn that providers, administrators, and policy makers must understand that network formation is a complex and time-consuming process. (Available from the New York Rural Health Research Center, Office of Rural Health, Department of Family Medicine, SUNY-Buffalo, 462 Grider Street, Buffalo, NY 14215, (716) 898-5273.)

66.
Rural Health Networks in Florida. R. Paul Duncan, Brian R. Klepper, Caren J. Gassner, and Sandra L. Kuhn. Gainesville, FL: Florida Rural Health Research Center, 1994. 28 pp.

This paper describes rural health networks as an element within Florida's health care reform initiative. Characteristics of four established networks are summarized and the development process of one network is outlined in detail. The authors conclude that the Florida program has demonstrated that rural providers and advocates view networks as potentially supportive of their interests. They also say that this program illustrates a state's ability to establish and implement a grant program in a relatively short time frame. (Available from the Florida Rural Health Research Center, Institute for Health Policy Research, University of Florida, P.O. Box 100177, Gainesville, FL 32610-0177, (904) 395-8041.)

Medicaid

67.
"Medicaid Managed Care in Rural Areas: A Ten-State Follow-up Study." Suzanne Felt-Lisk, Pam Silberman, Sheila Hoag, Rebecca Slifkin. *Health Affairs*, Vol. 18(2):238-245, March/April 1999.

In this paper, the authors interviewed key informants in ten states to discover common concerns and lessons for implementing Medicaid managed care in rural areas. More than 130 people were interviewed, including representatives of state agencies, rural providers, representatives of provider organizations, representatives of MCOs, and consumer advocates. The ten states, chosen nonrandomly to obtain a diverse mix of programs, geography, and enrollment levels, were: Idaho, Indiana, Iowa, Louisiana, Michigan, Missouri, Oregon, Tennessee, Virginia, and Washington. The results of the study include the following findings: 1) capitated programs as well as primary care case management programs appear feasible in remote as well as more populated rural areas; 2) a variety of managed care programs do offer some benefits for enrolled rural Medicaid populations, although their implementation requires considerable effort and flexibility; 3) rural areas share the same types of benefits and concerns about managed care as urban areas; 4) the financial effects and administrative burden on rural providers from capitated programs raise concerns that will require additional study to fully understand.

68.**
"Medicaid Managed Care in Rural Areas." Rebecca T. Slifkin and Michelle M. Casey. In: *Rural Health in the United States.* Edited by Thomas C. Ricketts, III. New York: Oxford University Press, 1999. pp. 95-100.

This book chapter summarizes Medicaid managed care activity in rural areas. It offers brief information on the evolution of the federal-state partnership in the creation of the Medicaid program, explains the relatively recent introduction of managed care to the program, and concentrates on listing the types of programs in rural areas and describing how they have been implemented. The chapter concludes by predicting that, since recent legislation is expected to promote the growth of Medicaid managed care programs in rural areas, research analysis of the outcomes of these programs is needed. (Available from Oxford University Press, 198 Madison Avenue, New York, NY 10016, (212) 726-6000.)

69.
"Medicaid Managed Care Programs in Rural Areas: A Fifty State Overview." Rebecca T. Slifkin, Sheila D. Hoag, Pam Silberman, Suzanne Felt-Lisk, and Benjamin Popkin. *Health Affairs,* Vol.17(6):217-227, November/December 1998.

This 50-state overview, developed in Spring 1997, describes the extent and types of Medicaid managed care programs operating in rural areas, the challenges of implementing those programs, and the accommodations that were made to include rural areas. The authors interviewed administrators in 50 Medicaid agencies to learn what barriers they have encountered and what strategies they have employed to make Medicaid managed care feasible for and in rural communities. The authors find that rural areas are sometimes excluded from managed care due to lack of available or willing providers or plans, or to an inability to assure choice among providers or plans. They describe states' creative approaches to implementing programs in rural areas, including incentives, phase-ins, and regional strategies. They note, however, that expansion of programs into rural areas remains challenging, with nearly 43 percent of rural counties not yet in managed care programs. (For availability information, contact Rebecca T. Slifkin, North Carolina Rural Health Research Program, Cecil G. Sheps Center for Health Research, University of North Carolina, 726 Airport Road, CB-7590, Chapel Hill, NC 27599-5764. (919) 966-5541.)

70.
Medicaid Mental Health Carve-Outs: Impact and Issues in Rural Areas. David Lambert, David Hartley, Donna Bird, Ruth Ralph and Paul Saucier. Portland, ME: Maine Rural Health Research Center, 1998. 42 pp. (Working Paper #9)

This working paper explores the impact of Medicaid mental health managed care in rural areas of Colorado, Oregon, and Washington and draws on the experiences of other states,including Iowa, Montana and Tennessee. The paper describes models of mental health managed care and discusses how they work in rural areas. Major conclusions of the study include the following findings: 1) how a managed behavioral health

organization (MBHO) interacts with providers is more important than the organizational structure of the relationship; 2) rural mental health providers have assumed limited amounts of risk; 3) the integration of mental health services and general health services has not been achieved; 4) linkages between primary care and mental health have not been weakened; 5) access to mental health care has improved in some of the states studied; 6) children's mental health outpatient services have increased; 7) coordination between mental health and substance abuse has decreased under public sector managed care; and 8) states moving to managed mental health could avoid some problems by studying the experience of other states. (Available from the Maine Rural Health Research Center, Edmund S. Muskie School of Public Service, University of Southern Maine, 96 Falmouth Street, P.O. Box 9300, Portland, ME 04104-9300, (207) 780-4430.)

71.
"Medicaid: States Serve Up a Real Turkey." Harris Meyer. *Hospitals & Health Networks,* Vol. 21(22), November 20, 1997.

This article discusses problems occurring in Medicaid managed care plans. According to the author, low reimbursement rates, growing administrative burdens, and intensifying political pressures have caused many national for-profit HMOs to drop out of the Medicaid managed care market. Some experts predict that Medicaid-only plans, run either by safety-net providers or entrepreneurs, will become the prevailing model. This predicted arrangement raises fears that a separate health care delivery system, poorly run and delivering less than top quality care, will ensue. Currently, Kaiser and other not-for-profit plans are still participating in Medicaid managed care, but they are under intense competitive pressure and are limiting Medicaid enrollment. Advocates warn that states are risking undercutting a safety net structure that has been built over decades.

72.
Introducing Medicaid Managed Care in Rural Communities: Guidelines For Policymakers, Planners and Administrators. New York Rural Health Research Center. Buffalo, NY: NYRHRC, May 1997. 42 pp.

This booklet offers guidance to state policy makers and state and local administrators who are dealing with the expansion of Medicaid managed care programs into rural areas. Noting the fragile nature of many rural services and the difficulty of imposing capitation, it recommends that planners employ flexible models with goals that work toward rural ends-- namely the strengthening of local services. The guide begins with a short discussion of rural health care trends and also includes a brief history of prepaid health care, beginning with its rural origins in the 19th century. The booklet then discusses in some detail the potential strengths and drawbacks of urban models of Medicaid managed care for rural settings. In addition to offering suggestions for design flexibility with various models and enrollment options, the booklet provides many recommendations for careful planning and for involving rural participants in the process. (Available from the Federal Office of Rural Health Policy, 5600 Fishers Lane, Room 9-05, Rockville, MD 20857, (301) 443-0835.)

73.
How to Negotiate and Contract for Services With Medicaid Managed Care Organizations. Jeanne Ireland. Rockville, MD: Maternal and Child Health Bureau, Health Services and Resources Administration, U.S. Department of Health and Human Services, 1997. 78 pp.

This workbook is designed to assist providers of maternal and child health (MCH) services and services to children with special health care needs (CSHCN) in their contract negotiations with MCOs. The workbook may also be helpful to state agencies that are providing technical assistance to local health departments and community based-organizations. The workbook provides background on methods of evaluating managed care environments and discusses each step of the negotiating process. The workbook also contains sample contracts, a glossary of terms, and a list of state Medicaid agencies. (Available from the Maternal and Child Health Bureau, Health Resources and Services Administration, 5600 Fishers Lane, Room 11A-22, Rockville, Maryland 20857, (301) 443-2778.)

74.
"TennCare and Academic Medical Centers: The Lessons From Tennessee." Gregg S. Meyer and David Blumenthal. *JAMA*, Vol. 276(9), September 4, 1996, pp. 672-676.

This article discusses the effects of TennCare, Tennessee's experiment with Medicaid reform, on two of Tennessee's academic medical centers. After reviewing pertinent documents, interviewing representatives of all interested organizations, and conducting site visits, the authors conclude that the centers experienced large revenue shortfalls, found it necessary to close some speciality services, experienced adverse patient selection, lost the necessary patient volume to support faculty clinical research, and found it necessary to reduce the number of training program positions. Longer term consequences to the centers, according to the authors, may include integration of community-based services into academic missions, acceleration of clinical diversification, and operational experience in managed care.

75.
"Medicaid Managed Care: Lessons From Five States." Marsha Gold, Michael Sparer, and Karyen Chu. *Health Affairs*, Vol. 15(3), Fall 1996, pp. 153-166.

This article identifies issues and early lessons from the experiences of California, Minnesota, New York, Oregon, and Tennessee in their implementation of managed care systems for low-income populations. The authors offer succinct summaries of each program's development, administrative issues, delivery and coordination efforts, and effects on the state's health care system. They offer ten suggestions that states need to consider to increase their potential success in restructuring Medicaid with managed care for low-income populations. These include: 1) invest in an effective enrollment process, including well-designed written materials, a toll-free telephone number with the capacity to address a large volume of questions, and some way to provide individual, in-person counseling; 2) emphasize education about the system for both enrollees and providers; 3)

build a well-developed oversight system to minimize problems such as marketing abuses and to monitor performance; 4) build strategies that are sensitive to existing plans and providers in their administrative capacity and ability to absorb risk; 5) allow sufficient time for implementation and system development; 6) invest in administrative structures and assume that these will cost, rather than save, money; 7) pay special attention to policies and systems for the chronically ill; 8) set rates that are sensitive to the population enrolled and to the costs associated with treating them; 9) minimize extensive and rapid eligibility turnover; and 10) set realistic objectives and be aware that an adequately financed safety net is critical to maintaining access for those who remain uninsured.

76.
Adapting Managed Care to Rural Delivery Systems: A Decentralized Approach to Medicaid Reform. Mary K. Bliss, Jere A. Wysong, Mary E. Horwitz, Robert E. Hurley, and Andrew Danzo. Buffalo, NY: New York Rural Health Research Center, February 1996. 14 pp. (Working Paper #9)

This working paper reports results of a case study of six rural western New York counties. Using interviews, focus groups and reports, investigators collected data over a two-year period. The authors describe how counties developed Medicaid managed care plans that reflected local needs, characteristics, and interests. They conclude that this decentralized approach permits adaptations aimed at overcoming rural barriers and protecting rural health care delivery systems. They note, however, that the planning process is time consuming. (Available from the New York Rural Health Research Center, Office of Rural Health, Department of Family Medicine, SUNY-Buffalo, 462 Grider Street, Buffalo, NY 14215, (716) 898-5273.)

77.
Managed Care, Medicaid and the Elderly: Five State Case Studies. Robert L. Mollica, Trish Riley, Rosalie A. Kane, Louise Starr and Kimberly Irvin Snow. Portland, ME: National Academy for State Health Policy, 1996. 143 pp.

This report contains case studies of Medicaid managed care programs enrolling elderly recipients in Minnesota, Arizona, Oregon, Utah and Florida. The studies were undertaken to examine the experience of elders in managed care programs for low income, dually eligible elders. The report's first section discusses the implications of managed care for aging networks (state units on aging, area agencies on aging, and other service providers), and compares the varying approaches to service provision adopted by these five states. Subsequent report sections discuss each state's program in detail. (Available from the University of Minnesota National Long Term Care Resource Center, National Academy for State Health Policy, 50 Monument Square, Suite 502, Portland, ME 04101, (207) 874-6524.)

78.
Managed Care and Its Public Health Implication. Jung H. Cho. Blackwood, NJ: Camden County Division of Health, December 1995. 49 pp.

This report discusses the changing roles of state, local and county public health agencies in a Medicaid managed care environment. The author reviews the movement to managed care, describes various models of reimbursement, and explains the current use of legal waivers. The report recommends appropriate roles for local agencies, including: 1) become involved with the process; 2) participate in contract development and review; 3) assure adequate patient and provider education; 4) recommend to the state Medicaid agency that the enrollment phase be carefully planned; 5) build a sound administrative system; 6) collaborate with other health care entities to overcome differences; 7) invest in prevention and health promotion; 8) encourage plans to place an increasing emphasis on truly managing care; and 9) remember to be "customer-friendly." (Available from Jung H. Cho, Camden County Division of Health, P.O. Box 9, Blackwood, NJ 08012-0009, (609) 374-6037.)

79.
"TennCare Health System Reform for Tennessee." David M. Mirvis, Cyril F. Chang, Christopher J. Hall, Gregory T. Zaar, and William B. Applegate. *JAMA*, Vol. 274(15), October 18, 1995, pp. 1235-1241.

This article describes the reform of the Medicaid health care system in Tennessee, called TennCare. Begun on January 1, 1994, TennCare seeks to expand coverage to state residents unable to otherwise obtain insurance. It also seeks to control costs through global budget limits and by enrolling participants in MCOs. Implementation was hampered by the lack of lead time between the federal waiver and the start-up date, and by limited data on true costs, which providers say has resulted in a capitation rate that is too low. Essential and sole community providers face elimination of payments for unenrolled citizens and uncompensated care. Coverage has been extended to many citizens who previously had not been covered. The future of TennCare is uncertain due to legal challenges and political change in the state.

80.
Arizona Medicaid: Competition Among Managed Care Plans Lowers Program Costs. U.S. General Accounting Office. Washington, DC: GAO, October 1995. 35 pp. (GAO/HEHS-96-2)

This document reports the GAO's evaluation of Arizona's implementation of a statewide Medicaid managed care system. The report says that key conditions for containing Medicaid costs without compromising beneficiaries' access to appropriate medical care include: 1) freedom from certain federal managed care regulations; 2) development and use of market forces; 3) controls to protect beneficiaries from inadequate care; and 4) investment in data collection and analysis capabilities. The report concludes that Arizona's experience demonstrates that a successful program requires substantial preparation and development. States need a transition period to make the shift from third-party payer to health plan overseer. (Available from the GAO Publications Office, PO Box 6015, Gaithersburg, MD 20884-6015, (202) 512-6000.)

81.
Community Health Centers: Challenges in Transitioning to Prepaid Managed Care. U.S. General Accounting Office. Washington, DC: GAO, May 1995. 42 pp. (GAO/HEHS-95-138)

This report summarizes the GAO's examination of ten health centers--at least one rural--to determine the effect on Community Health Centers of their efforts to transition to managed care. The authors conclude that Medicaid prepaid managed care is not necessarily incompatible with the missions of health centers, but warns that centers face substantial risks and challenges as they move into these arrangements. Managed care arrangements require new knowledge, skills, and information systems. Centers lacking this expertise face an uncertain future, and those in vulnerable financial positions are at even greater risk. The report summarizes the assistance offered to centers by the Bureau of Primary Health Care of the Health Resources and Services Administration, U.S. Department of Health and Human Services, and offers brief descriptions of the ten centers reviewed. (Available from the GAO Publications Office, PO Box 6015, Gaithersburg, MD 20884-6015, (202) 512-6000.)

82.
Medicaid Managed Care: A Handbook for Public Health Agencies. National Association of County & City Health Officials. Washington, DC: NACCHO, 1995. 129 pp.

This report provides a general overview of Medicaid managed care arrangements, a summary of federal waivers of Medicaid statutes, a description of the 1115 waiver process, and recommendations by public health agencies that have been involved in Medicaid managed care. The report discusses considerations for contractual agreements between states and MCOs, as well as between local public health agencies and MCOs, and includes advice from the public and private sectors. The report includes eight case studies that outline ways in which public health agencies have participated in Medicaid managed care arrangements. The report does not discuss Medicaid from a rural perspective, but contains information that may be of interest to those concerned with Medicaid's impact on rural areas. (Available from NACCHO, 440 First Street, NW, #500, Washington, DC 20001, (202) 783-5550.)

83.
Medicaid and Managed Care: Lessons From the Literature. Kaiser Commission on The Future of Medicaid. Washington, DC: Kaiser Commission on The Future of Medicaid, 1995. 90 pp.

This report reviews the literature on Medicaid and managed care over the past twenty years. It identifies major features of managed care arrangements and discusses their implications for access to care and cost containment for low-income and vulnerable populations. An overview of Medicaid managed care is given, a listing is offered of general trends drawn from the literature, and an extensive annotated bibliography of studies, reports and journal articles is included. The report does not discuss Medicaid from a rural perspective, but contains information that may be of interest to those

concerned with Medicaid's impact on rural areas. (Available from the Kaiser Commission on the Future of Medicaid, 1450 G Street, N.W., Suite 250, Washington, D.C. 20005. (202) 347-5270.)

84.
Rural Coalitions and Health Care Reform: Medicaid Managed Care in New York. Jere A. Wysong, Mary E. Horwitz, Paul A. James, and Thomas C. Rosenthal. Buffalo, NY: New York Rural Health Research Center, July 1994. 18 pp. (Working Paper #5)

This working paper examines a coalition of rural counties that was organized to facilitate Medicaid managed care planning in western New York. The coalition has provided technical assistance, communicated with state agencies on behalf of the counties, acted as a link to rural providers, and promoted rural health policy development at the state level. The coalition's formation was facilitated by the Office of Rural Health at the State University of New York at Buffalo, and the authors suggest that others seeking to form coalitions will need similar assistance from independent agencies, such as health planning bodies, in their own regions. (Available from the NewYork Rural Health Research Center, Office of Rural Health, Department of Family Medicine, SUNY-Buffalo, 462 Grider Street, Buffalo, NY 14215, (716) 898-5273.)

85.
Health Care Reform for Rural Medicaid: Finding Solutions With Limited Resources. Mary E. Horwitz, Jere A. Wysong, Paul A. James, and Thomas C. Rosenthal. Buffalo, NY: New York Rural Health Research Center, July 1994. 15 pp. (Working Paper #4)

This working paper describes a study of the development of Medicaid managed care programs in six rural counties in western New York. It focuses on three factors that affect the development of the programs, including: 1) availability of primary care physicians; 2) HMO penetration in the counties; and 3) availability of other primary care resources. HMO penetration was found to be substantial in half the counties. Findings indicate that low availability of primary care resources limits the forms that Medicaid managed care programs may take. (Available from the New York Rural Health Research Center, Office of Rural Health, Department of Family Medicine, SUNY-Buffalo, 462 Grider Street, Buffalo, NY 14215, (716) 898-5273.)

86.
The Impact of Medicaid Managed Care on Public Health Systems in Arizona: A Case Study of Public Health and the Arizona Health Care Cost Containment System. Association of State and Territorial Health Officials. Washington, DC: ASTHO, May 1993. 23 pp.

This qualitative study, based on interviews with state and local health officials, examines the impact of the Arizona Health Care Cost Containment System (AHCCCS) on public health systems and outcomes in Arizona. While cost increases have been restrained, state and local officials agree that public health and preventive services have not been adequately addressed by AHCCCS. Cost containment rather than quality of care or health

outcomes is perceived as the primary focus of the plan. However, beneficiaries have indicated a high level of satisfaction with their health care. The authors recommend that state health agencies participate in the design of Medicaid managed care systems to ensure: 1) uniform data collection and reporting by MCOs; 2) delivery of preventive health services to Medicaid managed care beneficiaries; and 3) coordination among local health agencies, health plans, and state health financing agencies. (Available from ASTHO, 415 Second Street NE, Suite 200, Washington, DC 20002, (202) 546-5400.)

87.
Medicaid Managed Care For Underserved Populations: The Rural Perspective. Paul A. James, Jere A. Wysong, Thomas C. Rosenthal, and Mary Crawford. Buffalo, NY: New York Rural Health Research Center, March 1993. 13 pp. (Working Paper #1)

This working paper reviews the history of Medicaid managed care and explores ways in which managed care health policies may be adapted to rural communities. The special challenges of Medicaid managed care in rural areas are discussed and the following principles are emphasized: 1) promote access to primary care; 2) foster participation by local providers; 3) insure responsiveness to community needs; 4) utilize cooperative rather than competitive strategies; and 5) provide technical assistance to rural communities. (Available from the New York Rural Health Research Center, Office of Rural Health, Department of Family Medicine, SUNY, 462 Grider Street, Buffalo, NY14215, (716) 898-5273.)

88.
State Efforts to Maintain a Role for Publicly Funded Providers in a Medicaid Managed Care Environment. Harriette B. Fox and Lori B. Wicks. Washington, DC: Maternal and Child Health Policy Research Center, 1993. 33 pp.

This report focuses on the extent to which states have promoted or required linkages between publicly funded providers and their Medicaid managed care contractors for five types of services. These services include: 1) early interventions services; 2) services for children with special health care needs; 3) maternity support services; 3) children's mental health services; and 5) school-based services. "Linkages" include mandatory subcontracting or authorization for services furnished by publicly funded providers; mandatory coordination or referral agreements between the managed care contractors and other publicly funded providers; and training initiatives to facilitate referrals between the two provider networks. The authors find that states generally have not established policies to ensure a role for publicly funded providers. They also foresee a need for states to do so, and suggest that the experience of the few states that have established such policies could serve as models for others. (Available from the Maternal and Child Health Policy Research Center, 1747 Pennsylvania Avenue, N.W., Suite 1200, Washington, DC 20006, (202) 223-1500.)

Medicare

89.**
Medicare Reforms: The Rural Perspective. Curt Mueller, Sheila Franco, and Gail Wilensky. Bethesda, MD: The Project HOPE Walsh Center for Rural Health Analysis, February 2000. 30 pp.

This working paper analyzes implications of major reforms considered by the National Bipartisan Commission on the Future of Medicare from a rural perspective. Specific reforms analyzed include: 1) the premium support model, under which many of the responsibilities currently assumed by the federal government would be assumed by private sector health plans and insurers; 2) the addition of a drug benefit; 3) changes in the means by which Medicare subsidizes graduate medical education; and 4) an increase in the age at which elderly persons become beneficiaries. Major study findings include: 1) the potential for improvement in choice of providers is limited in many rural areas; 2) some "modernization" of the Medicare program is needed, especially for rural areas; 3) there is significant support for enhancement of Medicare benefits, including coverage for prescription drugs and other preventive services; and 4) program reforms may have significant indirect effects on rural areas, such as affecting physician supply and expenditures on behalf of rural residents. (Available from the Project HOPE Walsh Center for Rural Health Analysis, 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814, (301) 656-7401.)

90.**
Rural Neglect: Medicare HMOs Ignore Rural Communities. Kathleen Haddad and Lorie Slass. Washington, DC: Families USA, September 1999. 19 pp.

This report analyzes the effect on beneficiaries who live in rural communities of Medicare reform proposals that rely on HMOs. The authors used HMO contract information from the Health Care Financing Administration (HCFA) to calculate the percentage of rural beneficiaries who have access to HMOs. They found that three out of four rural Medicare beneficiaries (73 percent) live in a county that is not served by any Medicare HMO. One in four (27 percent) lives in a county that is served by one or more HMOs. And one in ten (10 percent) lives in a county that is served by two or more HMOs. Based on data about current availability of HMOs and managed care organizations' announced intentions to withdraw from certain areas, the authors estimate that only 23 percent of rural beneficiaries will have access to an HMO in the year 2000. (Available from Families USA, 1334 G Street, NW, Washington, DC 20005, (202) 628-3030.)

91.
Rural Beneficiaries With Chronic Conditions: Assessing the Risk to Medicare Managed Care. Kathleen Thiede Call. Minneapolis, MN: Minnesota Rural Health Research Center, May 1998. 19 pp. (Working Paper #23)

In this study, the author examines data from the Medicare Current Beneficiary Survey to determine whether four chronic conditions (diabetes; emphysema, asthma or COPD; arthritis; and rheumatoid arthritis) occur more frequently among rural Medicare

beneficiaries. The study also compares the costs of treating these conditions in rural and urban areas. The author concludes that neither prevalence rates, cost to Medicare of care for beneficiaries, or cost of care relative to capitation rates appear to be barriers to the expansion of Medicare managed care in rural areas.

92.
Serving Rural Medicare Risk Enrollees: HMOs' Decisions, Experiences, and Future Plans. Michelle Casey. Minneapolis, MN: Minnesota Rural Health Research Center, November 1997. 42 pp. (Working Paper #19)

This study identifies factors that influence HMOs' decisions to offer a Medicare risk product in rural areas. It also describes recent experiences of HMOs serving rural Medicare enrollees and assesses the potential impact of changes in the program on the future willingness of HMOs to participate. Study data were collected through phone interviews with 27 HMOs, 15 of which currently serve rural Medicare enrollees. Factors that influence the offering of a Medicare product include: 1) adjusted average per capita costs (AAPCC) rates; 2) experience with commercial HMO products in the rural area; 3) having established provider networks in the area; 4) the presence of significant senior populations; 5) employer demand for retiree coverage; 6) competition from other HMOs; 7) corporate mission; and 8) HCFA's requirement that Medicare risk contractors have a contiguous service area. Most of the HMOs indicate that changes in the AAPCC rates could positively influence their willingness to serve rural Medicare beneficiaries. (Available from the Minnesota Rural Health Research Center, School of Public Health, University of Minnesota, 420 Delaware Street, S.E., Box 729, Minneapolis, MN 55455-0392, (612) 624-6151.)

93.
"The Rural Impact of Medicare Capitation Rate Reform: An Analysis of the Balanced Budget Act of 1997." RUPRI Rural Health Panel. *RUPRI Rural Policy Brief*, Vol. 1(2), August 1997, pp. 1-8.

This policy brief provides a summary of some of the legislative changes contained in the Act and outlines key findings regarding the effects of these changes on projected future capitation rates, which are used to determine monthly, per member payments to health plans participating in risk contracts. Principal findings contained in the brief include the following: 1) the specified changes are effective at reducing inequity and geographical variations in capitation rates; 2) the most effective provisions are the blending of rates, the floor on rates, and the provision to "carve out" graduate medical education funding; 3) changes in the rates will be greatest in counties with the lowest and highest 1997 rates, and least for counties with rates nearest the average 1997 rates; 4) a "floor" on the rate is the most important provision of the Act for counties with the lowest 1997 rates; 5) the "hold harmless" provision, which guarantees that a county's rate will not fall below 102 percent of the previous year's rate, protects many counties from low growth in capitation rates; and 6) several provisions help restrain the rate of growth of capitation payments. The policy brief contains several tables and a chart that graphically demonstrate the study's findings. (Available from the RUPRI Coordinating Office, University of

Missouri, 200 Mumford Hall, Columbia, MO 65200, (314) 822-0316, http://www.rupri.org/)

94.
Joint Report to the Congress on Medicare Managed Care. Prospective Payment Assessment Commission and Physician Payment Review Commission. Washington, DC, ProPAC, October 1995. 75 pp.

This report describes the current role of managed care within Medicare and lists potential policy improvements that have been analyzed by the two commissions. It discusses five areas that are central to understanding and improving Medicare managed care. These areas include: 1) beneficiary enrollment; 2) plan participation; 3) payment policy; 4) assurance of quality and access; and 5) data capabilities and needs. The report states that, given the close interrelationships between these areas, policy options affecting any of them should be considered in the context of the impact on the others. (Available from ProPAC, 300 7th Street, SW, Suite 301B, Washington, DC 20024, (202) 401-8986.)

95.
"Why Do So Few HMOs Offer Medicare Risk Plans in Rural Areas?" Carl Serrato, Randall S. Brown, and Jeanette Bergeron. *Health Care Financing Review*, Vol. 17(1), Fall 1995, pp. 85-97.

The authors of this article use 1990 federal data to examine the geographic distribution of Medicare risk plans enrollment. Counties not included in a metropolitan statistical area (MSA) are considered rural. Of 592 HMOs listed in the GHAA directory, only 18 offer services to rural Medicare beneficiaries. Rural enrollment in these plans is limited. Comparisons are made between rural counties with plans and those without. One of the identified factors restricting expansion of Medicare risk plans in rural areas is low reimbursement, based on the formula known as average-adjusted-per-capita-costs (AAPCC).

Physicians

96.
Rural Primary Care Practices and Managed Care Organizations: Relationships and Risk Sharing. Michelle Brasure, Ira Moscovice, and Barbara Yawn. Minneapolis, MN: Minnesota Rural Health Research Center, February 1999. (Working Paper #28)

This paper investigates the contractual arrangements between physicians and MCOs in rural areas to see how differences in organizational arrangements affect the degree of risk borne by the practices. The authors surveyed randomly selected primary care practices in rural counties of nine states that had, in 1996, rural populations of at least 500,000 individuals and which also had statewide HMO penetration rate of at least 20 percent. The results of the study suggest that rural physician practices may benefit by affiliating

with intermediary entities. However, the authors point out that the potential risk reduction, the provision of other services, and the degree of autonomy sacrificed may vary widely between different types of intermediary entities. They call for further investigation to determine the best way to structure affiliations that minimize negative consequences of affiliation. (Available from the Minnesota Rural Health Research Center, School of Public Health, University of Minnesota, 420 Delaware Street, S.E., Box 729, Minneapolis, MN 55455-0392, (612) 624-6151.)

97.
Understanding and Working with Managed Care: A Guide for Rural Providers. National Association of Rural Health Clinics. Washington, DC: NARHC, 1999.

This manual is designed as an introduction to managed care for rural providers as well as a working document that will assist providers in dealing with MCOs. Its chapters are devoted to topics such as an overview of managed care, understanding the local provider market, payment options for managed care, medicare and medicaid managed care, negotiating with managed care, and antitrust concerns. The guide also contains a glossary, a resource list, and several helpful appendixes. (Available from NARHC, 426 C Street,N.E., Washington, D.C. 20002, (202) 543-0348.)

98.**
"Rural Practice and Managed Care: A Success Story." Robert J. Ranney. *Family Practice Management,* Vol. 5(5), May 1998, pp 1-8.

This journal article describes the methods used by family physicians in the small town of Greenville, Texas to manage managed care. The doctors gained rural health clinic certification, formed a medical practice corporation that provided a way for practices to withdraw intact, and created a separate practice management corporation. The article explains how partnership in each corporation is determined and what steps the physicians took to solve problems as they arose. The author reports that the group's bargaining strength has raised the capitation rate from $8.50 to $16 per member per month and the group has grown from six family providers to 32 providers, including family physicians, pediatricians, internists and midlevel practitioners.

99.
Rural Physician Risk-Sharing: Insights and Issues. Ira Moscovice. Minneapolis, MN: Minnesota Rural Health Research Center, 1998. 16 pp.

This report summarizes the findings of a 1997 survey of rural primary care practices in nine states that have relatively high managed care penetration rates and large rural populations. The survey found that, while the magnitude of risk-sharing is still low, the number of practices with active risk contracts (especially capitated contracts) was unexpectedly high. The survey also found it common for rural practices to be owned or affiliated with an intermediary entity, which may absorb some of the risk of managed care contracts. Rural physician practices affiliated with physician-hospital organizations reported lower frequencies of risk-sharing arrangements. The author says that the results

of the survey offer insight into the future of rural managed care and the risk-sharing that rural physicians may face. (Available from the Minnesota Rural Health Research Center, School of Public Health, University of Minnesota, 420 Delaware Street, S.E., Box 729, Minneapolis, MN 55455-0392, (612) 624-6151.)

100.
"Physician-Operated Networks and the New Antitrust Guidelines." Robert Kuttner. *New England Journal of Medicine*, Vol. 336(5), January 30, 1997, pp. 386-391.

This article discusses the regulatory climate surrounding physician-operated networks. It summarizes the changes announced in August 1996 by the Federal Trade Commission and the U.S. Department of Justice in the way they will review proposals for physician networks in the future. The article reviews the development of current policy, discusses the reaction of the American Medical Association to the announced changes, and examines many non-regulatory barriers that remain to the successful functioning of physician networks. The author concludes that "doctors, at last, have a somewhat level playing field on which to pursue the practice of medicine as ordinary commerce. But the doubts remain about whether medicine is, or ought to be, ordinary commerce."

101.
Rural Physicians and HMOs: An Uneasy Partnership. Anthony Wellever, Michelle Casey, Sarah Krein, Barbara Yawn and Ira Moscovice. Minneapolis, MN: Minnesota Rural Health Research Center, December 1996. 35 pp. (Working Paper #17)

This study, conducted through a telephone survey of 100 rural physicians in Minnesota and Oklahoma, examines the physicians' experiences with HMOs and their attitudes toward them. The study found that rural physicians participate in HMO arrangements to preserve market share. In addition, fee-for-service and discounted fee-for-service are the most common payment arrangements. The study found that physician attitudes toward HMOs are primarily negative, although variations exist among subgroups and between the two states. The findings also suggest that rural physicians accept HMOs as an environmental fact of life. They might prefer that managed care did not exist, but they know they must tolerate it. (Available from the Minnesota Rural Health Research Center, School of Public Health, University of Minnesota, 420 Delaware Street, S.E., Box 729, Minneapolis, MN 55455-0392, (612) 624-6151.)

102.
"Managed Care Strategies for Rural Providers." Charles A. Wells, Jr. Healthcare Financial Management, Vol. 50(7), July 1996, pp. 37-39.

This article discusses methods that can be used by rural healthcare providers in evaluating the market demand for their services, thus enhancing their ability to exert leverage when negotiating with managed care entities. The author lists several questions that providers may wish to consider when assessing the power of various components of their local health care market. He also points out many differences in typical urban and

rural markets and demonstrates the importance of quality, access, and cost in relation to provider leverage. Formation of alliances is discussed, as are medical staff relationships.

103.
"The Rural Health Care Enterprise: Keeping Up With the City Slickers." Barry R. Silbaugh. Physician Executive. Vol. 22(5), May 1996, pp. 19-23.

In this article, the author presents practical suggestions to physicians for success in rural health care systems. After outlining major differences between rural and urban health care markets, he lists the following ingredients for success. 1) a mechanism to promote improved health within the local community; 2) expert management resources for medical practices and the merger of practices for effective negotiation and management of limited financial risk; and 3) identification of physician and hospital leaders who are sensitive, sensible, and effective. The author also makes the following suggestions for rural health care financiers and service providers: 1) get practice management expertise for physicians; 2) set up aligned incentives with the hospital with an eye to developing capitation systems; 3) approach MCOs about developing financial relationships to manage risk and provide partial capitalization of community health improvement projects; 4) invest in information systems that track utilization and financial risk pools. The article ends with a reminder that rural health care markets are characterized by challenges unimaginable in urban areas.

104.
Strategies for Managed Care and Integration in Rural Practice. American Academy of Family Physicians. Kansas City, MO: AAFP, 1995. 24 pp.

This document is designed to help rural practitioners understand and adapt to the increasing presence of managed care plans in rural areas. It discusses the growth of managed care, lists the benefits for practitioners and for the managed care systems, describes the necessity for all parties in local health care systems to work together, outlines the benefits and risks of affiliating with urban centers, urges physicians to serve as advocates for their communities, and describes four options for action by practitioners. These options include: 1) develop a local infrastructure; 2) network regionally; 3) join an existing regional network; and 4) establish a community health care plan. The document includes a list of suggested readings and a quiz for continuing education credit. (Available from AAFP, 8880 Ward Parkway, Kansas City, MO 64114, (800) 944-8000.)

105.
"HMO's and Managed Care: Implications for Rural Physician Manpower Planning." Jonathan P. Weiner. Journal of Rural Health, Vol. 7(4 Suppl.), 1991, pp. 373-387.

This article discusses possible effects of the growth of managed care on the supply of physicians in rural areas. The author foresees many changes, including: 1) an increased willingness among physicians to practice in rural areas as the supply of urban physicians increases; 2) an increase in the need for primary care providers as managed care emphasizes nonhospital care; 3) a greater use of capitation payments, possibly

strengthening the financial viability of primary care practices; 4) a possible acceptance by insuring corporations for ensuring adequate access to providers; 5) greater employment opportunities for mid-level providers; 6) an increase in rural provider networks; and 7) greater HMO presence in rural areas near metropolitan areas; and 8) little HMO presence in the most sparsely populated areas.

Mental Health

106.
Best Practices in Rural Medicaid Managed Behavioral Health. David Hartley, editor. Portland, ME: Maine Rural Health Research Center, November 1998.

This series of four research papers is designed to develop practical and useful guidance for states and managed behavioral health firms on approaches and strategies for addressing the special needs and circumstances associated with implementing Medicaid mental health carve-outs in rural areas. The individual papers focus on the following topics: 1) managing and monitoring access; 2) developing infrastructure; 3) credentialing; and 4) consumer issues. Background information is provided in each paper and "best practices," or specific programs, policies or practices that are currently being used to address those problems, are presented. The authors point out that the "best practices" have not existed long enough to have undergone rigorous evaluation. Additionally, the programs are often works in progress. However, information is offered about the in hopes of helping policymakers and managers dealing with the same issues. (Available from the Maine Rural Health Research Center, Edmund S. Muskie School of Public Service, University of Southern Maine, 96 Falmouth Street, P.O. Box 9300, Portland, ME 04104-9300, (207) 780-4430. http://www.muskie.usm.maine.edu)

107.
"Utah's Prepaid Mental Health Plan: The First Year." Jon B. Christianson, Willard Manning, Nicole Lurie, Tamara J. Stoner, Donald Z. Gray, Michael Popkin, and Sally Marriott. *Health Affairs*, Vol. 14(3), Fall 1995, pp. 160-172.

This article analyzes the effect of the Utah Prepaid Mental Health Plan (a local "carve-out" model) on use of mental health services by Medicaid beneficiaries. The article also examines the plan's effect on mental health treatment expenditures. Utilization and expenditure rates per beneficiary per month were analyzed. The results suggest that the plan reduced admissions for inpatient treatment as well as inpatient expenditures. The results also suggest that total mental health expenditures for Medicaid beneficiaries were reduced.

108.
Blueprints for Managed Care: Mental Health Care Concepts and Structure. Western Interstate Commission for Higher Education. Boulder, CO: WICHE, 1995. 79 pp.

In order to clarify the structure and operation of mental health managed care systems, this document presents diagrams of state mental health delivery systems before and after the implementation of managed care. Diagrams are presented for the basic elements of the systems--clients, services, and funds--and these diagrams can be overlain to show their relationships. The document includes case studies of Arizona, Oregon, and Washington. (Available from WICHE, P.O. Drawer P, Boulder, CO 80301, (303) 541-0250.)

109.
"The Case for Managed Cooperation (Not Competition): South Dakota Mental Health Linkage Project." Vinod S. Bhatara, William C. Fuller, and Elwin R. Unruh. *South Dakota Journal of Medicine*, Vol. 47(9), September 1994, pp. 307-311.

This article presents the results of a study of collaboration among rural mental health providers. The authors surveyed all providers in the catchment area of four Community Mental Health Centers in South Dakota as to their job satisfaction and training needs. Based on the survey results, educational workshops were presented, and their effectiveness tested. Statistically significant improvements occurred in both areas, and the authors conclude that the interventions were effective in developing collaboration and in improving coordination of mental health delivery.

110.
"What CMHCs Can Learn From Two States' Efforts to Capitate Medicaid Benefits." Jon B. Christianson and Donald Z. Gray. *Hospital and Community Psychiatry*, Vol. 45(8), August 1994, pp. 777-781.

This article summarizes a study of the efforts of two communities to enter into mental health managed care arrangements. In Minnesota, under a federal waiver, a mainstreaming demonstration model was designed in which the state contracted with HMOs to provide all physical and mental health care for Medicaid beneficiaries. Utah's program was designed so that Community Mental Health Centers (CMHCs) contracted to serve as mental health HMOs for Medicaid beneficiaries. Based on the experiences of these two programs, the article discusses several implications for CMHCs under managed care. These include the need for centers to play a proactive role in the establishment of benefit alternatives and enrollment processes, and the need to implement aggressive policies to manage service utilization.

111.
Where We Stand: A Position Statement on Managed Care in Rural Communities. National Association for Rural Mental Health. Wood River, IL: National Association for Rural Mental Health, 1993. 7 pp.

This paper outlines the Association's position on the necessary components of a national health care reform program to effectively address the mental health needs of rural citizens. The paper discusses the realities and myths surrounding rural mental health care. It calls for a system that is coordinated, community-based, family centered and culturally relevant, and which provides equity in coverage to persons with mental disorders. The

paper also outlines the potential benefits and pitfalls of such a program, listing specific recommendations for its structure and for actions needed by the federal government to improve the delivery of mental health services to rural citizens. (Available from the National Association for Rural Mental Health, P.O. Box 570, Wood River, IL 62095, (618) 251-0589.)

Legal Issues and Contractual Considerations

112.
Rural Health Network Evolution in the New Antitrust Environment. Neil Motenko, Ira Moscovice, and Anthony Wellever. Minneapolis, MN: Minnesota Rural Health Research Center, May 1997. (Working Paper #18)

This working paper reviews antitrust law and enforcement as it has been applied to rural areas. The paper examines possible modifications to antitrust policy to achieve accessible, quality health care. In addition, the effects of current policy on the development of alternative delivery systems such as integrated networks are examined, and options for policy that might better foster such arrangements are discussed. (Available from the Minnesota Rural Health Research Center, School of Public Health, University of Minnesota, 420 Delaware St. S.E., Box 729, Minneapolis, MN 55455-0392, (612) 624-6151.)

113.
Health Care Antitrust Enforcement in Rural America: A Recommended Safety Zone. James W. Teevans and Steven Rosenberg. Rockville, MD: Federal Office of Rural Health Policy, February 1997. 14 pp.

This paper suggests the development of an antitrust policy that would be appropriate for rural America. It describes some of the tension between antitrust policy and the evolving health care marketplace and discusses its effects on health care for rural Americans. It explores the efforts made to date to minimize that tension, defines some of the lessons that have been learned from these efforts, and makes a recommendation for an appropriate Department of Justice/Federal Trade Commission rural health care antitrust policy statement. The National Advisory Committee's February 1997 recommendation to the Secretary of Health and Human Services to develop antitrust safety zone policy for rural networks is included in an addendum. (Available from ORHP , 5600 Fishers Lane, Room 9-05, Rockville, MD 20857, (301) 443-0835.)

114.
Antitrust and State Action Immunity in Rural Washington State. Part I: User's Guide to Antitrust and Rural Health Care Environments. Part II: Antitrust Issues in Rural Washington State. Barry Saver, Susan Casey, Peter House, Denise Lishner, and Gary Hart. Seattle, WA: WAMI Rural Health Research Center, January 1997, 12 pp. (Brochure) 40 pp. (Working Paper #42)

This working paper contains a brief brochure and a more detailed report that discuss antitrust issues and concerns related to health care in rural areas. The brochure was designed for health care providers, hospital board members, and other interested persons in rural areas who have had little or no contact with legal counsel regarding antitrust issues, and who are considering forming networks or applying for antitrust immunity. The report provides information requested by Washington state health officials. In addition to state specific information, however, it contains information of possible interest to those in rural areas outside Washington. The authors conclude that: 1) state action immunity does not appear likely to play a large role in preserving local health care systems in rural areas; 2) applications for immunity from smaller rural areas are unlikely to occur without outside organizational and technical assistance; 3) state action immunity may be useful to the supervision of practice mergers in very small communities and to the stabilization of markets in border areas between states; 4) the report's conclusions could be altered by unanticipated changes in the health care system. (Available from The WAMI Rural Health Research Center, Box 355304, University of Washington, Seattle, WA 98195-5304, (206) 685-0401.)

115.
Navigating Managed Care: A Journal for Rural Hospital Trustees. Washington Health Foundation. Seattle, WA: Washington Health Foundation, 1997, 95 pp.

This document is intended to help trustees understand the changes that are occurring in health care systems, as well as how these changes impact rural communities, and the implications of these changes for rural hospitals. The "journal," as the authors call the document, offers an overview of the American health care delivery system, discusses the impact of managed care in rural areas, and outlines issues that need to be addressed as rural hospitals decide how to position themselves in the changing health care delivery environment. The document concludes with a list of questions and answers, and includes a glossary of terms and a lexicon of acronyms. (Available from the Washington Health Foundation, 300 Elliott Avenue West, Suite 300, Seattle, WA 98119. (206) 285-6355. http://www.whf.org)

116.
Statements of Antitrust Enforcement Policy in Health Care. U.S. Department of Justice and Federal Trade Commission. Washington, DC: FTC, August 28, 1996. 112 pp.

These statements announce revisions to enforcement policies governing health care provider networks. (For background information, see citation #118.) The revisions expand earlier statements in order to make clear that a wider range of physician networks will receive more flexible antitrust treatment The agencies will now expand the examination of activities to see if they have anticompetitive effects that outweigh any procompetitive benefits. The revisions also explain that market conditions in rural areas may justify certain health care arrangements that might raise antitrust concerns in other geographic areas. Finally, the revisions emphasize that networks falling outside the "safety zones" established in previous statements may be lawful. (Available from the Federal Trade Commission, Public Reference Branch, Room 130, 6th Street and

Pennsylvania Avenue, NW, Washington, DC 20580, (202) 326-2222, or from the FTC's Internet Web site at http://www.ftc.gov)

117.
Antitrust and Rural Health. National Rural Health Association. Kansas City, MO: NRHA, May 1996. 11 pp.

This issue brief discusses the status of antitrust regulation, including a brief history of federal antitrust enforcement and a review of the development of "state action immunity" laws, which establish a process by which providers can apply to the state for immunization of various collaborative arrangements. Three Association policies are enumerated: 1) the NRHA believes that the conduct of a health care provider network should be judged on the basis of its reasonableness; 2) the NRHA will aggressively promote the timely development of rural-sensitive network guidelines by federal authorities; and 3) the NRHA will promote the passage and implementation of rural-sensitive state action immunity legislation and regulation within each state. The issue brief also states that the NRHA desires three outcomes. These outcomes include: 1) the resolution of uncertainty regarding rural network development; 2) a set of federal guidelines that facilitates rural providers working collaboratively and having the ability to jointly and fairly negotiate with payers; and 3) the maximum use of state-action immunity in non-competitive markets. (Available from the NRHA, One West Armour Boulevard, Suite 203, Kansas City, MO 64111, (816) 756-3144.)

118.
Rural Healthcare Providers and the Law. An Issue Brief. North Carolina Rural Health Research Program. Chapel Hill, NC: North Carolina Rural Health Research Program, February 1996. 7 pp.

This issue brief reviews legal and regulatory issues surrounding rural health services through the end of 1995. The longest section "How does antitrust law apply to rural providers?" has the greatest application to rural managed care. A brief summary is given of the nine "safety zones" that the Department of Justice and the FederalTrade Commission have designated to provide guidance on antitrust issues. Other sections describe malpractice standards, fraud and abuse rules, and safe harbors involving clinical laboratories, medical equipment, and other services. (Available from the North Carolina Rural Health Research Program, Cecil G. Sheps Center for Health Research, University of North Carolina, 726 Airport Road, CB 7590, Chapel Hill, NC 27599-5764. (919) 966-5541)

119.
Public Oversight of Managed Care Entities: Issues for State Policymakers. The National Governors Association. Washington, DC: The National Governors Association, 1996. 31 pp.

This report outlines government regulation of MCOs and other managed care activities. In addition to public purchasing of managed care, the report examines government

regulation over four relationships, including those between: 1) the enrollee and the plan, which has traditionally been under the purview of states as a part of insurance regulation; 2) the plan and the provider, which arises when plans attempt to limit provider participation in networks or influence provider decision-making; 3) patient/consumers and providers; and 4) public purchasers and their contractors. The report also includes four appendixes, including excerpts from pertinent legislation and a bibliography. (Available from the Alpha Center, 1350 Connecticut Avenue, NW, Suite 1100, Washington, DC 20036, (202) 296-1818.)

120.
"Legal Implications of Integrated Networks." James W. Teevans. *Integrated Community Health Development News*, Vol. 1(2), Winter 1995, pp. 1-2

This newsletter article briefly reviews the antitrust issues facing integrated networks. The author's conclusions include the following: 1) network participants should emphasize the network's procompetitive goals and ensure that the network's formalities are respected; 2) networks must address the question of whether their market shares make them potentially anticompetitive; 3) participants in partially integrated networks must avoid discussions of prices and other confidential information; 4) networks must be sensitive to potential group boycott claims brought by excluded providers or third party payers; 5) payments to participating physicians must be in accordance with the federal anti-kickback statute; 6) networks must be sensitive to outside ownership interests of participating physicians because federal and some state laws prohibit self-referrals; 7) network participants should be aware that the Internal Revenue Service has issued rules that provide guidance on structuring the network in ways to protect members' non-profit status; and 8) participants must be sensitive to potential liability and ensure that members of the network are adequately insured. (Available from Rural Health Consultants, 2400 W. 6th Street, Suite H, Lawrence, KS 66049, (913) 832-8778.)

121.
State Action Immunity: Immunizing Health Care Cooperative Agreements. James W. Teevans. Washington, DC: Alpha Center, December 1995. 55 pp.

This publication offers state officials guidance in implementing antitrust protections for health care networks. It discusses the two-part test that states must meet in order to establish antitrust protections. The test includes: 1) a clearly articulated and affirmatively expressed policy displacing competition with regulation; and 2) a process for actively supervising any permitted private anticompetitive conduct. The publication assesses programs being developed in Kansas, Maine, Minnesota, and Washington, and offers suggestions for structuring state programs in order to meet the legal requirement of the state-action doctrine. (Available from the Alpha Center, 1350 Connecticut Avenue, NW, Suite 1100, Washington, DC 20036, (202) 296-1818.)

122.
"Applying Antitrust Analysis to Integrated Rural Health Systems." James W. Teevans. *Integrated Community Health Development News,* Vol. 1(2), Summer 1995, pp. 1-2.

This newsletter article discusses antitrust issues that affect integrated rural health systems as they form and as they grow. The author reviews the 1988 administrative law case brought by the Federal Trade Commission against Ukiah Valley Medical Center that resulted in the joint Federal Trade Commission/ Department of Justice hospital merger policy statement of September 1993 allowing mergers when one of the hospitals has less than 100 beds. The author also discusses the 1994 Marshfield Clinic case, in which a rural network of physician-owned clinics and the network's HMO were sued by other health providers for price-fixing, group boycotts, and other anticompetitive behaviors. The author stresses that networks must always be aware of their market areas and market shares, not only at the time of the network's formation, but also throughout the system's operation. (Available from Rural Health Consultants, 2400 W. 6th Street, Suite H, Lawrence, KS 66049, (913) 832-8778.)

123.
"Regulation of Accountable Health Plans in Rural Areas." James E. Rohrer. *Journal of Public Health Policy*, Vol. 16(2), 1995, pp. 198-212.

This article discusses ways in which state governments can monitor and regulate vertically-integrated health care delivery systems that serve rural areas. Among the author's recommendations are the following: 1) use only licensed systems for Medicaid enrollees and state employees; 2) offer exemption from antitrust regulation; 3) permit flexible use of non-physician health professionals; 4) strive to assure that primary care providers are locally based; 5) include essential community providers; 6) empower local boards of health to govern the systems; and 7) assist local health agencies in monitoring system performance. The article also discusses the performance of certificate-of-need programs and offers suggestions for structuring the new regulations so that they are pro-active, creative, and effective.

124.
Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust. U.S. Department of Justice and Federal Trade Commission. Washington, DC: FTC, September 27, 1994. 106 pp.

In September 1993, the Federal Trade Commission and Department of Justice issued a Statement of Enforcement Principles in the health care area. After receiving comments on that statement, the two agencies jointly issued this compendium of nine issue statements pertaining to mergers and joint activities in the health care area. The statement on physician network joint ventures is particularly relevant to the development of rural PPOs and IPAs. The compendium describes antitrust safety zones, such as non-exclusive physician networks, that the agencies will not challenge. The statement on analytical principles relating to multi-provider networks provides guidance on antitrust issues, but the agencies lack enough experience with these networks to clearly delineate safety zones. Analytical principles the agencies use to evaluate networks are described. The competitive effect in a geographic market is an especially important consideration in deciding whether to challenge a network. (Available from the Federal Trade

Commission, Public Reference Branch, Room 130, 6th Street and Pennsylvania Ave. NW, Washington, DC 20580, (202) 326-2222.)

125.
Coordinated Managed Care: A Handbook for Rural Providers. Oregon Health Sciences University Office of Rural Health. Portland, OR: Office of Rural Health, 1992. 44 p.

This manual is written to help Oregon rural health providers who are considering contracting with a managed care plan. The manual gives an overview of managed care, helps organizations assess their readiness to participate in managed care, and details the different strengths that managed care plans and rural health care providers bring to the negotiating process. It also describes approaches for limiting overall financial risk, makes recommendations for establishing a working relationship, and describes conditions under which providers may wish to end their managed care contract. While written for Oregon rural health care organizations, this manual would also be helpful to those outside the state. (Available from the Office of Rural Health, Oregon Health Sciences University, 3181 SW Sam Jackson Park Road, ORH4, Portland, OR 97201-3098, (503) 494-4450.)

126.
A Manual For Negotiating With Managed Care Plans. Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration, U.S. Department of Health and Human Services. Rockville, MD: BHCDA, 1991. 65 pp.

This manual offers community and migrant health centers tools to assist them in making informed decisions about contracting with managed care plans. A general introduction to managed care is offered and tips are given for evaluating various plans. Information is given about the negotiating position of health centers, ways to limit risk, and evaluation of capitation rates and contract terms. Advice is offered on building working relationships as well as evaluating continued participation in managed care contracts. (Available from the National Clearinghouse for Primary Care Information, 2070 Chain Bridge Road, Suite 450, Vienna, VA 22182, (703) 821-8955 ext. 248.)

Author and Organizational Index

(Numbers following names refer to citation numbers)

A

B

C

D

F

G

H

I

J

K

L

M

N

O

P

R

S

Author and Organizational Index
(Numbers following names refer to citation numbers)

B

C

E

F

G

H

I

J

L

M

N

P

R

S

T

U

W