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RURAL MEDICAID MANAGED CARE: THE CASE OF FOUR STATES

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Although Medicaid managed care (MMC) enrollment grew dramatically during the 1990s, MMC programs in rural areas did not develop as quickly. With the 2002 promulgation of the final Balanced Budget Act managed care regulations, more states may implement rural MMC programs. Further, given the current fiscal climate, states may consider rural MMC programs as a cost containment measure. This study examines the experience of four states—Kentucky, Minnesota, New York and Vermont—in designing and implementing their rural MMC programs. The states enjoyed different levels of success with their initiatives, and encountered a range of obstacles as they moved forward. Among the barriers they faced were securing health plan participation, limited provider competition, provider resistance, and local area opposition. The findings suggest that rural programs can work but that states need to make an honest assessment of what MMC model is feasible in their state, given its unique character and circumstances.

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Introduction

Perhaps the biggest change in Medicaid during the 1990s was the wholesale shift of program beneficiaries into managed care. By 2000, more than 19 million Medicaid beneficiaries (56 percent) were enrolled in some type of managed care, up from 1.5 million (less than 10 percent) in 1990 (Congressional Research Service 1993; USDHHS 2003). Despite this rapid increase, Medicaid managed care (MMC), especially fully capitated programs, did not develop as quickly in rural areas and is still not widely available (Silberman et al. 2002).

Bringing managed care to rural areas is certainly not without its challenges (Silberman et al. 1997; Slifkin et al. 1998; Felt-Lisk et al. 1999, Slifkin and Casey 1999). For instance, the limited supply of providers in many rural communities presents a major challenge to health plans trying to form provider networks. Another problem is the low population density typical of rural areas that can make it difficult for plans to secure large numbers of enrollees. Not only does this make marketing a challenge, it also increases health plans' financial risk.

Despite these challenges, some states have moved their rural Medicaid beneficiaries into managed care. In this paper we look at four states—Kentucky, Minnesota, New York and Vermont—and examine the different approaches they took in implementing rural capitated MMC programs. We also look at the major issues they encountered as they put their programs in place. Experiences of these states may be helpful to other states looking at rural managed care programs. Given the current fiscal climate and the escalating costs of Medicaid, more and more states may be considering or reconsidering implementing a rural MMC program as a cost containment strategy.

The four study states--all of which had received authority to implement mandatory fully capitated managed care programs through Medicaid Section 1115 waivers[1]--have achieved varying degrees of success with their rural MMC endeavors: By far the most successful is Minnesota which as of 2003 operates a MMC program in all but a handful of its rural counties.[2][3] While New York's MMC program operates in several counties, only three rural counties have gone forward with mandatory enrollment as of 2003.[4] After implementing a capitated managed care program for its Medicaid beneficiaries, Vermont eventually abandoned this approach to MMC, and shifted to a primary care case management (PCCM)[5] program. Finally, while Kentucky implemented MMC in the two most urban areas of the state, the program in many rural counties of the state never went forward.

The paper is arranged as follows. First, we provide a brief overview of past state experiences with rural MMC programs under Section 1115 waivers. We then discuss how we collected information for the study. The next section is devoted to an overview of the study states—population and health care market characteristics as well as managed care statistics. Following that, we briefly describe the demonstration program in each state. We next outline some of the programmatic features the states used in designing the rural component of their

[1] The Section 1115 authority allows states to seek waivers from compliance with many of the requirements set out in Medicaid law, including provider payment, delivery of services and program eligibility.

[2] For purposes of this study rural counties are defined as those outside a metropolitan statistical area (MSA). The MSA framework is the rural and urban classification system developed by the U.S. Office of Management and Budget in which rural and urban areas are determined on the basis of population and density of counties. MSAs consist of one or more central and well integrated surrounding counties.

[3] Worth noting, Minnesota also operates MinnesotaCare, a health insurance program for the working poor, in which enrollees across the state are in managed care. The state receives federal matching funds for some MinnesotaCare beneficiaries.

[4] Important to note: In the fall of 2001, New York received an amendment to its 1115 waiver allowing the state to get federal funds for Family Health Plus (FHP), a program which provides coverage to low-income adults. In FHP, all participants must be in managed care; there is no fee-for-service (FFS) program. All New York counties participate in FHP, so Medicaid dollars are going to fund managed care in all counties statewide.

[5] PCCMs are another type of managed care where a primary care provider is paid a monthly management fee to manage the patient's care, but all services are generally paid on a fee-for-service basis and the provider bears no financial risk.

waiver program. We then examine the implementation experience in each state and the adjustments that were made to the original design as implementation proceeded. Finally, we discuss how the experiences of the study states may provide guidance to other states considering extending managed care to rural Medicaid beneficiaries.

Past Experiences with Rural Capitated MMC Programs

Over the past several years, a handful of states have implemented capitated MMC programs in rural areas through the Section 1115 waiver authority. Indeed, in 1996, the bulk of rural Medicaid beneficiaries enrollment was concentrated in Section 1115 states--notably Arizona, Hawaii, Tennessee, and Oregon (Moscovice et al. 1998). In this section we briefly highlight some of the experiences of selected 1115 waiver states (Arizona, Oregon, Hawaii, Oklahoma and Tennessee) in implementing capitated managed care programs in rural areas.

Arizona operates the Arizona Health Care Cost Containment System (AHCCCS), the nation's oldest statewide MMC program. Implemented in 1982, the program has achieved cost savings while generally maintaining beneficiary satisfaction, clinical outcomes, access to care, and quality assurance, for both rural and urban AHCCCS enrollees (Kirkman-Liff 1986; Davis and Potter 1998). In part the success of AHCCCS in rural areas has been credited to the fact that Arizona officials paid close attention to the state's rural areas when developing the program (Silberman et al. 1997; Davis and Potter 1998). Among other things, Arizona officials opted to delay implementation in rural areas until they had sufficient experience with managed care in urban areas which helped to ease the transition. Another important program feature that researchers have noted as contributing to the success of ACHHHS is that the state paid capitation rates that reflected what health care use should be rather than historical use rates (University of Minnesota Institute for Health Services 1995). As will be discussed below, basing capitation

rates on historical use in Minnesota's waiver program proved to be an important issue as the state moved the demonstration into rural areas.

Another important implementation strategy used by Arizona was to contract with managed care organizations (MCOs) separately in each of the state's 15 counties, a decision which resulted in the development of many small- to medium-sized MCOs in rural areas. This was done as way to encourage plans to serve rural areas, something the state initially struggled with. It was also done to ensure that plans had sufficient number of enrollees to be financially viable (University of Minnesota Institute for Health Services 1995). In many rural communities, local physicians and business people successfully developed MCOs that were responsive to the specific needs of the area. In addition, the state relaxed some of its HMO licensure requirements and helped the local MCOs purchase reinsurance.

For more than a decade Arizona was virtually the only state that operated a statewide capitated managed care program for Medicaid beneficiaries living in rural areas. But, beginning in 1993 a second generation of MMC programs was developed owing in large part to the streamlining of the federal waiver process. In the early 1990s several states obtained 1115 waivers—notably Hawaii, Oklahoma, Oregon and Tennessee. All of these demonstrations brought capitated MMC to rural areas with each state adopting a different design and employing varied implementation strategies.

Tennessee and Hawaii developed fully capitated MMC programs and implemented them statewide. The demonstrations included all rural areas and called for enrolling most beneficiaries, AFDC-related as well as SSI beneficiaries, into managed care (Wooldridge et al. 1996).[6] While Tennessee moved to capitated managed care in all parts of the state, it did allow

[6] AFDC stands for Aid to Families with Dependent Children, the precursor to the Temporary Assistance for Needy Families or TANF program. SSI stands for Supplemental Security Income.

both preferred provider organizations to participate in TennCare initially. Oregon also hoped to implement capitated MMC statewide for all Medicaid beneficiaries (Gold et al. 1996). However, in two of its smallest counties the state was never able to execute contracts with managed care plans and these counties continued to operate under a PCCM program which was in place before Oregon implemented its 1115 waiver, the Oregon Health Plan.

Officials in Oklahoma tried a different approach with its waiver program—SoonerCare: Hoping to strengthen the state's rural health infrastructure before introducing full-risk MMC, they developed a unique hybrid program which enrolled urban beneficiaries in HMOs but placed rural beneficiaries in a partially capitated PCCM program (Ku and Wall 1997). Further, in contrast with Hawaii, Oregon and Tennessee, officials in Oklahoma did not initially include the disabled in its SoonerCare effort.

With virtually no previous MMC experience Tennessee's TennCare and Hawaii's QUEST were planned and implemented over a relatively short period of time, in part because state officials wanted to realize savings from managed care as soon as possible (Ku et al. 1998). The two states rapidly enrolled beneficiaries beginning in 1994. By contrast, Oregon's waiver was built on a solid foundation of managed experience in both the public and private sectors. Further, Oregon implemented its waiver program over two year-long phases, with the first phase being TANF-related populations and the second disabled populations. In part, the phased-in approach was due to the lengthy federal review of Oregon's now well known use of a "priority list" to define the benefit package under the waiver (Mittler, Gold and Lyons 1999). In developing and implementing SoonerCare, Oklahoma also engaged in a lengthier planning process and a gradual enrollment process that began in 1996.

Though not always targeted to rural areas, the states used other strategies to develop capitated managed care. For example, on a statewide basis Oregon did not require that each county have a specific provider to patient ratio. Rather, the state mandated that the plan maintain a provider panel with sufficient capacity (Gold et al. 1995). In addition, Oregon adopted a flexible travel time or distance standards for primary care providers: Instead of a pre-determined standard, which is often included in Medicaid managed care contracts, Oregon required that the maximum travel time for MMC beneficiaries be consistent with community standards for at least 90 percent of the plans' members.

The transitions to capitated MMC under the waiver programs were not always smooth, both in rural and urban areas (Ku et al. 1998). Tennessee in particular experienced difficulties in implementing its waiver program. Researchers have attributed these difficulties to a number of factors, including the breadth of TennCare, the fast implementation schedule, the limited managed care infrastructure in place prior to the waiver, and provider resistance. The latter caused problems in forming adequate provider networks which proved especially challenging in rural areas (Gold et al. 1995). Hawaii also encountered similar problems in the early stages of the implementation of QUEST as it too had limited previous Medicaid managed care experience and used a rapid implementation schedule. By comparison, implementation problems were limited in Oklahoma, partially because of their longer planning process (which included key stakeholder input) and phased-in implementation approach. Further, because SoonerCare was implemented a couple years after Hawaii and Tennessee, Oklahoma had the opportunity to learn from other states' experiences (Ku et al. 1998).

Mentioned above, past research has reported that access to care for enrollees in Arizona's waiver program improved or was maintained in both urban and rural areas. Among the more

recent wave of 1115 demonstration states, research findings, on balance, have found relatively few differences between urban and rural MMC enrollees (Brown et al. 2001; Mitchell2003). While few access differences between rural and urban beneficiaries enrolled in managed care have been reported, recent research does suggest that the type of managed care may make a difference (Brown et al. 2001). Specifically, risk-based PCCM models have been reported to provide better service to rural beneficiaries than do fully capitated models.

Study Approach and Methods

Information for the study draws largely from site visits that were conducted as part of a broader evaluation of the 1115 waiver programs in the four study states—Kentucky, Minnesota, New York and Vermont (French et al. 1999; Marstellar et al. 1999; Bartosch et al. 2000; Coughlin et al. 2000; Kendall et al. 2001). As part of the evaluation, researchers visited each state at least two times between 1996 and 2000. In addition to going to the state capitols, several site visits were conducted in selected rural areas. As part of the site visits, a range of key stakeholders were interviewed, including state Medicaid officials, local health officials, staff from health plans, representatives from provider associations, health care providers, and consumer advocates. A special focus of the site visits was to gain some insight into the rural MMC component of the waiver program—for example, whether the state included special design features to accommodate rural areas and what were implementation experiences in rural areas.

Overview of Study States

Area and Population Characteristics

The four study states represent a broad range in their degree of rurality (Table 1).[7] Although 24 of New York's 62 counties are classified as rural, only about 8 percent of New York's population lives outside MSAs. In contrast, all but three of Vermont's 14 counties are rural, comprising 67 percent of Vermont's population. Kentucky is the next most rural with more than half of its population living in non-metropolitan areas in 98 of the state's 120 counties.

Health Care Market Characteristics

Mirroring national trends, the supply of physicians in all of the study states was substantially lower in rural areas as compared to urban areas (Table 1). The disparity was particularly acute in Minnesota where the supply of physicians was less than 1 physician per 1000 persons in rural areas but nearly 2.2 physicians per 1000 persons in urban areas of the state. Reflecting the limited supply of physicians, a sizable share of rural counties (either wholly or partially) in the study states were designated as health professional shortages areas (HPSAs). Particularly noteworthy, 10 out of the 11 rural counties in Vermont and 20 of the 24 in New York were designated as containing a HPSA.

All the study states had some experience with managed care prior to implementation of their waiver program (Table 2). HMO penetration levels (both commercial and public) in all four study states exceeded the national average of 9 percent in 1996. New York had the highest penetration level; statewide, nearly 30 percent of New Yorkers were enrolled in an HMO. Though all of the states had HMO activity in rural areas, most of the penetration was

[7] Rural counties are defined as those outside a metropolitan statistical area (MSA). The MSA framework is the rural and urban classification system developed by the U.S. Office of Management and Budget in which rural and urban areas are determined on the basis of population and density of counties. MSAs consist of one or more central and well integrated surrounding counties.

concentrated in the urban areas. The one exception to this was Vermont where HMO penetration was slightly higher in rural areas than in urban areas (16 versus 13 percent).

Managed care experience in the Medicaid program prior to waiver implementation varied widely across the states. By far, Minnesota, with one of the nation's earliest Medicaid managed care demonstration program, had the most experience and, as of 1996, more than 40 percent of its Medicaid population was enrolled in an HMO. Though not as extensive, New York had also experimented with capitated managed care before their waiver program was implemented and an estimated 22 percent of its Medicaid population was enrolled in an HMO in 1996. In addition, New York operated primary care case management (PCCM) programs in selected counties across the state. Only a very small share (less than 1 percent) of Kentucky's Medicaid population was enrolled in an HMO in 1996. However, Kentucky had operated a statewide mandatory PCCM program for Medicaid enrollees since 1986. Finally, Vermont had virtually no experience with MMC, either capitated or with PCCM, prior to implementing its 1115 waiver program.

Summaries of Study States' Waiver Programs

The four demonstration programs, as designed, were broadly similar in that all featured mandatory enrollment of Medicaid beneficiaries into full-risk managed care plans with goals that included improving beneficiaries' access to care, containing costs, and simplifying administration. Beyond these basic objectives, however, each had unique program features. Before discussing the case study findings, we summarize key characteristics of the states' waiver programs (Table 3).

Kentucky's Partnership Program

Kentucky's Partnership Program 1115 waiver built upon the state's previous experience with managed care through its 1915(b) PCCM waiver program named KENPAC (Kentucky Patient Access), which was initiated in 1986. KENPAC was a statewide program that required beneficiaries in AFDC to join a case management program in which physicians received a monthly fee to coordinate their care.

Under the Partnership waiver—which was approved in October 1995--Kentucky planned to expand its managed care efforts to a fully capitated program. It intended to enroll most of the people eligible for Medicaid into managed care. Included in the waiver population were all AFDC-eligibles, poverty-level women and children as well as SSI and medically needy beneficiaries. Exempted groups included institutionalized individuals, those in other long-term care programs, and other small eligibility categories. Most acute and primary care services were part of the waiver benefit, including inpatient and outpatient hospital physician services, clinic, pharmacy, dental and home health. The one major exception to this was behavioral health services, which were slated to be capitated to behavioral health organizations. Like most managed care programs, long-term care services were largely excluded from the benefit package provided through capitated plans, but continued to be reimbursed by the state on a FFS basis.

For the purposes of the demonstration, Kentucky officials divided the state into eight regions and called on providers (both public and private) in each region to form a partnership to provide services to beneficiaries in their region under a capitation payment from the state. If more than one provider group formed, the state would institute competitive procurement. If local providers were not interested, then the state would allow private plans to bid on the business.

Importantly, unlike most other state MMC initiatives, beneficiaries would have no choice in health plans under Kentucky's waiver program.

The state planned to establish region-specific capitation rates for each of five eligibility categories in negotiation with the partnerships. Each partnership would be responsible for determining how to reimburse individual providers. Since providers were expected to be instrumental in establishing the partnerships, this format gave them a measure of control over their reimbursement within the constraints of the capitation rates.

In November 1997, implementation began in the regions surrounding the cities of Louisville and Lexington and was to be phased in by region as partnerships formed. For a variety of reasons none of the other regions—largely rural areas—ever went forward. After just three years, owing to beneficiary access and cost concerns, the state abandoned the waiver program in all areas except Louisville. Beneficiaries in Lexington were transitioned back into the PCCM program.

Minnesota's Prepaid Medical Assistance Program

Minnesota began its Medicaid managed care efforts in 1985 when it served as one of the original sites for the Section 1115 Medicaid competition demonstration sponsored by the Health Care Financing Administration, now the Centers for Medicare and Medicaid Services or CMS. Under the project, Minnesota developed the Prepaid Medical Assistance Program, commonly referred to as PMAP. For ten years PMAP operated almost exclusively in the Twin Cities metropolitan area. In largely a cost-saving measure, Minnesota in 1995 obtained another 1115 waiver which, among other things, allowed the state to expand PMAP to its remaining 79 counties.[8] This represented the state's first significant effort to extend PMAP to rural areas of Minnesota.[9]

Under PMAP, TANF and poverty-related populations are mandatorily enrolled in capitated managed care plans; the disabled are generally excluded, along with a few other groups such as Qualified Medicare Beneficiaries and Service Limited Medicare Beneficiaries. Services provided under PMAP are broad, covering most acute and primary care services, including dental, drugs and mental health services. Some long-term care services are also in the benefit package including the first 90 days of nursing-home care and home care services covered. Additional long-term services are available on a FFS basis or through the state's waivered services programs. Health plans, all of which are non-profit by state law—are paid a capitated rate 50 percent of which is based on age, sex, eligibility category and county of residence and 50 percent of which is risk-adjusted based on diagnoses.[10]

[8] The 1995 waiver contained several other features including an eligibility expansion to children and pregnant women up to 275 percent of poverty.
[9] Itasca County--a rural county, located in the north central part of the state—had operated under PMAP since the first demonstration that began in 1985.
[10] In 2000, Minnesota began phasing in risk adjustments to its capitation rates.

Minnesota began implementation of its waiver in January 1996 by enrolling Medicaid beneficiaries into managed care plans in eight counties located in the northeastern and central parts of the state. Though the PMAP expansion was delayed significantly, as of late 2002, the wavier program was operating in 70 of Minnesota's 87 counties and in 57 of the state's 69 rural counties.[11]

New York's Partnership Plan

New York's Section 1115 waiver demonstration, the Partnership Plan, was approved in July 1997 and implementation began in several upstate counties in October 1997. Building on an extensive existing network of Medicaid managed care programs—both full risk and PCCM models—the Partnership Plan called for the mandatory enrollment of Medicaid eligibles statewide in capitated managed care plans. Designed to reduce costs and improve access to care, the waiver program envisioned over 2 million Medicaid beneficiaries—including most TANF and poverty-related and SSI populations—enrolling in managed care plans, in both urban and rural areas of the state. Enrollment was to be phased-in based on geography and Medicaid eligibility group, with TANF groups proceeding the SSI population within each area.

Services covered under the Partnership Plan include both primary and acute care services; most long-term care services such as institutional and personal care are excluded from the capitated plans and are reimbursed on a FFS basis. Although initially included in the benefit package, prescription drugs were eventually carved out, but capitation rates were not reduced. In part this was done to protect small, local pharmacies, which were often not included in health plan networks. It was also done to provide a rate increase to plans.

In New York, some mental health and substance abuse (MH/SA) services are carved out of the benefit package for both the SSI and TANF populations. Further MH/SA services are

[11] An additional 14 counties were expected to begin PMAP coverage by the end of 2003.

subject to stop-loss provisions. Once the beneficiary reaches the stop-loss limits, the managed care plan continues to provide MH/SA services and applies for reimbursement through Medicaid FFS. Finally, New York had planned to develop special needs plans or SNPs for persons with serious mental illness and for persons with HIV/AIDS. As of mid-2003, five HIV/AIDS special need plan contracts had been approved for operation in New York and had begun enrolling clients. The MH special need plans, however, were never implemented because their authorizing legislation expired and was not renewed by the New York legislature.

When the Partnership Plan was implemented in 1997, health plan capitation rates were based on competitive bidding. However, New York returned to negotiated rates starting in 1999. The negotiated rate methodology was designed to take into account each plan's experience under MMC as well as adjustments for age, sex, eligibility category and geographic region.

As of January 2003, the Partnership Plan had been implemented in 21 counties (three of which are rural) and in New York City. While New York has made progress in moving beneficiaries to managed care, waiver implementation proceeded much slower than state officials had planned. Further, to date, only TANF-related populations are mandatorily enrolled under the Partnership plan; the SSI population is exempt from mandatory enrollment but may voluntarily enroll or remain in FFS Medicaid. The one exception to this is that SSI beneficiaries in Westchester County are mandatorily enrolled in managed care. Westchester had operated its managed care program under a 1915(b) waiver but was later transitioned into New York's 1115 waiver program.

Vermont's Vermont Health Access Plan

Vermont received approval for its Vermont Health Access Plan (VHAP) in July 1995. In its first ever MMC effort, VHAP mandated managed care enrollment of almost all Medicaid beneficiaries--including SSI beneficiaries--across the state. In keeping with Vermont's longstanding commitment to promoting universal health insurance, the goals of the program included expanded eligibility for the uninsured and provision of a pharmacy benefit for the low-income elderly and disabled not otherwise eligible for Medicaid.

Distinct from the other states, VHAP health plans initially provided a full set of services—primary, acute, and long-term care services, including prescription drugs, hospice services, and mental health and substance abuse services. VHAP also provided a narrow skilled nursing facility benefit consisting of 30 days per episode limit and a limit of 60 days per calendar year. If a beneficiary exceeded these limits, then nursing care services were paid on FFS basis. The state continued to pay for a few services on a FFS basis, including dental care and family planning. As in New York, shortly after VHAP was implemented, the state took over responsibility for pharmaceuticals. This was in response to plans' complaints that drugs costs were well in excess of projections. Vermont used a negotiate rate setting process to develop plan capitation levels. For the process, rate cells based on age, sex and eligibility group were established. A geographic adjustment factor was not included.

After some initial struggles, Vermont began mandatory enrollment of TANF-related populations in May 1997. Because of health plan participation problems (see below), by June 2000--three years after the start of VHAP--all Medicaid beneficiaries had been disenrolled from health plans and transitioned to the state's newly established PCCM program.

Rural Issues Addressed in Program Design

All of the study states set out to extend capitated managed care to as many parts of the their respective states as possible. In designing their programs, the states, to varying degrees, made some programmatic modifications to address the differences between rural and urban areas. These modifications can be seen as falling into five broad areas: exempting specific geographic areas, phasing in implementation, securing plan participation, involving local areas in design, and setting plan capitation rates. Vermont was the one state that designed its waiver program without any particular consideration for rural areas and the same basic plan was to be implemented in all areas of the state.

Exempting Geographic Areas

All of the states had planned to implement capitated Medicaid managed care in all areas of the state. However, from the outset of the demonstration, New York allowed counties to be exempted from participating in the Partnership Program if it was determined that a county had insufficient "managed care capacity." Capacity was determined on the basis of the number of Medicaid enrollees in a county and the level of commercial managed care enrollment in the county. New York believed the presence of commercial managed care plans in a county was a positive indicator of the potential for developing a mandatory program. If a county met one of the criteria, it was granted a three-year exemption from participation in the mandatory program. The exemption criteria were:

- Counties with fewer than 5,000 Medicaid beneficiaries and less than 15 percent HMO penetration.
- Counties with 5,000-10,000 Medicaid beneficiaries and less than 10 percent HMO penetration.
- Counties with 10,000-15,000 Medicaid beneficiaries and less than 5 percent HMO penetration.

The exemption did not preclude the county from operating a voluntary program, including partial capitation models. Indeed, the state encouraged the development of partial capitation models, viewing them as an interim step towards fully capitated managed care.

Phasing-in Implementation

To help ease the transition to managed care, a common strategy used by the states was to implement the waiver program gradually—either by eligibility group, geographic area or both.

Eligibility group phase in. Kentucky, New York and Vermont all had federal approval to mandatorily enroll both the TANF and SSI populations. However, New York was the only state whose waiver design called for phasing in the demonstration by eligibility group, a condition stipulated by CMS.[12] Specifically, as set out in its waiver agreement, the state was required by the federal government to allow at least a one-year delay between when TANF-related populations enrolled and when the SSI population was enrolled within a county. The delay was in part was designed to allow upstate counties, which include New York's rural areas, time to gain experience with mandatory enrollment. The phased inclusion of the disabled was motivated by the state's desire to foster greater plan participation. Since caring for disabled beneficiaries represents greater challenges for health plans, their delayed enrollment was intended to give plans time to develop special care provider networks in rural areas and to solidify enrollment of TANF-related beneficiaries before taking on the risks associated with disabled recipients. In New York City, however, where there was greater existing plan capacity and competition among the plans, the disabled population was able to enroll voluntarily from the start of the program.

By contrast, both Kentucky and Vermont's demonstrations called for shifting the SSI and TANF populations into managed care at the same time. Kentucky was successful in enrolling

[12]Note: Eligibility group phase in was not an issue in Minnesota as its waiver only included the TANF-related populations.

both populations in the two urban regions where the waiver program was implemented. Vermont, however, ended up enrolling its TANF populations first, followed by SSI enrollment in only a limited number of counties. This staggered enrollment in Vermont was at the insistence of the plans. While plans were generally concerned about the adequacy of capitation rates, they were especially concerned about the SSI rates. After about a year, Vermont did shift the SSI population into managed care but in just two counties. However, SSI enrollment was halted after just six months. Plans underestimated how costly the disabled would be to manage, and the state and plans could not come to a contract resolution on the matter. Eventually, SSI enrollees were transitioned to Primary Care Plus, the state's newly implemented PCCM plan.

Geographic phase-in. In general, states planned their implementation schedules around the readiness of counties (or, in the case of Kentucky, regions) for managed care. Since presumed readiness for managed care was in large part determined by prior experience with managed care and since rural counties had had less experience with managed care, the effect was to delay implementation in rural areas. Thus, phasing in the demonstration program by geographic area to allow for plan development generally had the effect of letting rural areas have more time to get ready for managed care.

In Minnesota and New York, where there was prior managed care experience, the states intended to start the move to mandatory managed care in the rural areas believed "most ripe" for managed care. Thus, implementation in Minnesota in the outstate areas—that is, outside the Twin Cities metropolitan area--was planned first for the eight counties located in the northeastern part of the state where Duluth is the major city and where some commercial managed care market existed. Similarly, New York selected upstate counties that had experience

in operating Medicaid managed care programs under previous MMC efforts. Then, New York planned to move other, less experienced counties into the Partnership Plan.

Kentucky similarly made allowances for network development in rural areas. Though Kentucky shifted both its TANF and SSI populations into managed care at the same time, they did phase in implementation by region, starting with the two areas around the urban areas of Louisville and Lexington. State officials believed that providers in these two regions were most ready to develop a regional partnership plan. As mentioned above, Kentucky's waiver program never went beyond these two regions.

Vermont was the only state that had hoped to implement its program statewide all at once. However, owing to health plan issues (see below), the state ended up phasing in the demonstration by geographic area.

Securing health plan participation. At the time these demonstrations were designed, federal Medicaid policy required that beneficiaries under mandatory managed care have a choice of at least two health plans.[13] Given the overall low level of commercial managed care penetration in rural areas, states needed to design a program that would encourage plans to move into rural areas. For most health plans in the study states, rural areas represented un-charted territory.

As mentioned earlier, states gradually implemented programs in rural areas, partly to give health plans time to develop networks. Beyond this concession to the low managed care presence in rural areas, the states designed a variety of "carrots" to encourage plan participation and, in one case, a "stick" to penalize plans that did not participate.

[13] In 1997 Congress passed the Balance Budget Act which, among other things, gave states the authority to contract with a single health plan in rural counties. Prior to this, states had been required to have at least two health plans in rural areas, unless they had a waiver.

Vermont struggled to get plans to participate and implementation of the waiver program was delayed due to a lack of suitable responses to the state's request for bids from insurers. Two proposals were submitted but Vermont was unable to reach a rate agreement with one of the bidders. The capitation rates submitted were much higher than the FFS equivalent. Although a rate agreement was reached with the other plan, a start-up HMO, the plan's Certificate of Need application was later denied due to a lack of any HMO experience as well as an inability to develop an adequate provider network.

As a way to help plans, Vermont offered plans reinsurance for high-cost cases that was paid through a rate reduction. As a further attempt to sustain plan participation, Vermont subsequently decided to carve out prescription drugs[14] and to move the disabled into the PCCM program rather than into full risk managed care.

By contrast, Minnesota on balance did not have a lot of trouble getting plans to participate in its PMAP program. In large part this is because all non-profit health plans--as a condition of HMO licensure in Minnesota--are mandated to provide some community benefit in counties in which they operate. This community benefit has been interpreted as requiring plans to enroll individuals covered by publicly-sponsored health programs. So, if a health plan has commercial enrollees in a county, it must also be willing to participate in PMAP and other public health programs--most prominently MinnesotaCare, the state's subsidized health insurance program.

In New York's Partnership Plan, the state had thought about using a regional approach in its contracting with health plans in rural areas. It was felt that a block of counties rather than a

[14] Another motivating factor to carve drugs out of capitation rates was the state's ability to collect pharmaceutical rebates.

single county would make rural areas more attractive to health plans. In the end, however, New York ended up contracting with plans on a county-by-county basis. In part, this reflects the strong county role in New York Medicaid: Distinct from most states, New York counties contribute about 25 percent of the state share of Medicaid expenditures and thus, historically have had more of a say in program issues. One strategy that New York did use to try to get plans to participate was to offer "capacity" incentive adjustments payments to plans to increase enrollment or expand into new service areas.

Kentucky adopted perhaps the boldest strategy to help secure plan participation. Recall that under the Partnership Program, the state was divided up into eight regions where only one plan would be awarded a contract. Indeed, the single plan approach was central feature of Kentucky's waiver program. Under the plan, the state determined if local health care providers were interested in forming a managed care plan to serve Medicaid beneficiaries. If there was no interest, then private health plans could bid on the business. In designing this regional approach, the state hoped to obtain the support of local providers, advocates, and consumers for the Partnership Program. By letting the resident health community craft the program, it was hoped that the plan would be customized to the local health care infrastructure which would better serve beneficiaries.

Involving local areas. A key issue for some of the states was what role, if any, should local areas play in the waiver program. Local areas, especially rural ones, can sometimes be reluctant to cede control over local matters to non-local authority. Compounding this general hesitancy is that the study states were trying to implement managed care, something that generally has not been favored by health care providers. The states adopted different strategies

in determining the extent of involvement the local area had in the design and implementation of the demonstration program.

Mentioned above, Vermont adopted a "one size fits all" strategy with little local area involvement in the broad design of VHAP.[15] A similar strategy was adopted by Minnesota where, at least initially, there was only very limited local input into the design of PMAP as the state moved into rural areas. As discussed below, the lack of local participation became a major barrier to expansion of Minnesota's demonstration.

With its regional-based plan, Kentucky took a wholly different approach by allowing local area providers broad discretion to designing a waiver program for their residents. Importantly, though, this approach was never tested in rural areas of Kentucky as the Partnership Plan was only implemented in the Louisville and Lexington metropolitan areas.

Although New York sought to implement a similar program statewide, some local control was afforded under the state's demonstration, primarily because of the large financial role that counties play in Medicaid. As mentioned above, New York counties contribute about one-quarter of the state share of Medicaid expenditures. The county share puts a unique spin on the state-local interchange in implementing managed care. Since counties are responsible for some share of Medicaid expenses, many were eager to implement the demonstration because of the expected cost savings for the county. Further, for counties that shifted to managed care, the state offered a financial incentive by lowering the county Medicaid share by 2 percentage points. New York was also eager to have the Partnership Plan operating statewide. However, many counties were exempt from the Partnership Plan because of a lack of choice of providers. Further, as discussed earlier, whether a county participated was left up to local government of that county.

[15] Vermont, however, did seek community input before implementing managed care for special needs groups, including SSI and foster care children.

Another way New York provides some local input to program design is that the counties execute the health plan contracts rather than the state. As part of this--subject to state and federal approval--counties are allowed to include some of their own contractual provisions such as requiring plans to provide optional benefits (e.g., transportation and dental services) or to include certain types of providers.

Setting health plan capitation rates. With the exception of Vermont, all the states adjusted capitation rates to account for geographic variation. Kentucky, for example, developed capitation rates that were specific to each of the eight regions planned under the Partnership Plan. Likewise, New York initially divided the states up into nine geographic regions for rate-setting purposes. Although rural counties wanted rates to more closely represent their areas and did not want to subsidize rates paid to more urban areas in their region, New York still uses the regional rates.

In developing its capitation rates, Minnesota divided the state into three regions—Hennepin County (where Minneapolis is located), other counties located in the Twin Cities metropolitan area, and all other counties. So all counties located outside the Twin Cities were grouped into a single region and received the same geographic rate adjustment. When calculated, non-metro county rates were about 50 percent of metro rates. While non-metro counties overall were upset by the disparity, those with second-tier cities (such as Rochester or Moorehead), were considerably disadvantaged as their Medicaid caseload mix and associated costs approximate those of larger cities. Eventually, the non-metro counties prevailed upon the state legislature and the non-metro rates were legislatively set at 85 percent of metro rates[16]

[16] Since implementing PMAP in rural areas Minnesota started risk adjusting a portion of their rates using Johns Hopkins' ACG Groupers under a phased-in approach. In 2000, 5 percent of the rate was paid on a risk-adjusted basis; in 2001, 30 percent of the rate was paid on a risk-adjusted basis; and in 2002 and 2003, 50 percent of the rate

Challenges in Implementing MMC

States encountered a range of obstacles when implementing managed care in rural areas. While each state is comprised of a unique set of characteristics that affected the manner in which it addressed program implementation, there were several common challenges the states faced. Key ones included limited health plan interest, difficulties in network development, and local opposition to the waiver program.

Limited health plan interest. To varying degrees, all of the states encountered some problems in getting plans to participate. In Vermont, problems with plan participation effectively determined the overall course of its MMC initiative. Several factors contributed to Vermont's health plan troubles. To begin with, there were a very limited number of plans operating in Vermont to draw from, and only one plan with a statewide network. Overlaying this basic market fact, the state's initial solicitation for managed care plans did not lead to any signed contracts because of rate issues. Plans viewed the capitation rates offered by the state as being too low, particularly given the size and geographic distribution of Vermont's population. Plans felt that that the small number of people coupled with the sparse population greatly increased their insurance risks and operation costs (for example, provider network development and marketing costs) in ways that were not adequately accounted for in the rates. Further, Vermont does not have a central metropolitan area that could provide plans with a large membership to balance the small enrollment potential found in rural areas.

Though not nearly as big a problem as in Vermont, Minnesota too had some trouble getting plans to serve rural areas.[17] Plans had several concerns. A major one was the link

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was paid on a risk-adjusted basis. Further phasing in of risk adjustment is pending until an encounter data validation study is complete. With the addition of risk-adjustment, non-metro rates were 91 percent of metro rates in 2003.

[17] Recall that in Minnesota, health plans are required to participate in all public programs in counties where they operate.

between PMAP and MinnesotaCare—a state-funded, publicly-subsidized insurance program for low-income persons. While PMAP historically had been viewed favorably by plans, MinnesotaCare had not. Most prominently, plans had been unhappy with the capitation rates paid under MinnesotaCare. So in some instances, to get plans to go into rural areas—where they would be required to take both PMAP and MinnesotaCare business--the state used access to coveted PMAP business as leverage to secure plans' participation in MinnesotaCare. For example, the state might offer a contract in a sought after PMAP county (such as in the heavily populated Twin Cities area where there was the promise of large membership and more generous capitation rates) in return for participating in a group of rural counties.

The limited market interest on the part of plans had important consequences for Vermont and Minnesota's MMC programs. For example, the lack of plan interest put the state in a difficult bargaining position. This was particularly true in Vermont where the state struggled to keep two plans active in the program. Some felt that because of the lack of managed care competition, the state was not in a position to bargain effectively with plans. For example, carving drugs out of the managed care package and transitioning the SSI population to a PCCM program were cited as accommodations that the state made in an effort to keep the plans in the program. Further, providers claimed that the state's unwillingness to apply regulatory pressure on the plans on a range of issues—for example, timeliness of reimbursement payments, service denial, and education of enrollees about plan rules and benefits—was another example of the state's lack of bargaining power.

In the end, Vermont was not able to sustain plan participation. Larger market forces intervened in Vermont, when one of the two plans decided to leave all markets in the northeastern United States. The state was left with one plan. Ultimately, Vermont failed to reach

a rate agreement with the remaining plan and beneficiaries were transitioned into the state's newly established PCCM program. All in all, mandatory capitated MMC enrollment in Vermont lasted for just over two years.

Similar observations about the lack of balance between the state and plans were made of Minnesota's PMAP program. Because of the relatively few plans operating in Minnesota's overall managed care market and especially in rural areas, the state was sometimes in a difficult bargaining position. One indication of the limited bargaining position held by the state is that while many Minnesota plans lost money in other markets (for example, commercial and MinnesotaCare), the plans made money on the PMAP program.

New York largely avoided the problem of securing plan participation in rural areas by exempting all but three rural counties from the waiver program. One explanation for the limited implementation in rural New York is that the risks posed to the overall success of the program of exempting rural counties was small since rural counties contain less than 10 percent of the state's Medicaid population. By contrast, for example, Minnesota's rural counties hold nearly 40 percent of the state's Medicaid population.

Kentucky had hoped to avoid problems of getting plan participation by assigning responsibility for plan development to local providers. While the waiver program was only implemented in urban areas, the state did begin the partnership development process in rural regions. In south central Kentucky, for example, local providers started to develop a partnership. However, they were motivated less by an interest in managed care than a desire to prevent an outside group coming into their area. The partnership had difficulties early on, primarily because it could not meet capital requirements. Unlike in the two urban regions where

the Partnership waiver took effect, in south central Kentucky there was no university hospital or other well-funded health facility that could put up the necessary funds.

In the Appalachia region of Kentucky, different problems developed. While local providers appeared interested in the initiative, competing groups formed and a lot of back and forth ensued, which caused considerable divisiveness in the region. Eventually the effort got bogged down in formal litigation and it was unclear whether managed care was going to ever go forward. However, no further developments occurred as Kentucky decided to abandon its plans to expand the waiver program beyond the state's two most urban areas.

Limited Provider Competition. Plans too faced problems in bringing managed care to rural areas. Perhaps the most significant problem was developing provider networks. In Vermont, for example, mandatory enrollment was delayed because one of the plans had difficulty establishing an adequate provider network. In fact, in one of the more rural regions of the state, mandatory enrollment never went forward because one of the two plans was not able to contract with a sufficient number of pediatricians. The one major group of pediatricians in this area were employees of one of the VHAP plans and thus could not contract with the other plan.

Lack of provider competition in Vermont's hospital market was also a problem for plans. In Vermont, each community is served by a single hospital. Almost all of the state's 14 acute care hospitals are rural, and most are located 30 miles or more from each other. Thus the distribution of hospitals virtually required both plans to contract with each hospital, placing the hospital in a highly favorable bargaining position, but limiting the plans' ability to negotiate discounted prices. Further exacerbating the health plans' situation, Vermont, with lower than average hospital use rate, had few pre-managed care inefficiencies in hospital care for plans to derive savings.

Minnesota plans also had difficulty developing provider networks, again primarily because of the limited number of providers. Apart from provider scarcity, though, Minnesota was also experiencing fairly widespread consolidation and affiliation among its providers. This consolidation was not limited to second-tier cities but extended into small communities. Large provider groups were buying hospitals and small practices and came to dominate considerable territory in various parts of rural Minnesota. Knowing that plans had no alternative, these consolidated groups were able to command higher payment while assuming less risk, thereby reducing plans' managed care savings.

Provider consolidation also raised the issue of plan dominance: Once a plan was able to secure a contract with the major provider group in a rural area, the plan in effect became the dominant plan. In some cases, the plan negotiated exclusive contracts with the provider group, thus preventing the other competing plan from contracting with the main provider group in the area.

Another network development issue for Minnesota plans was provider credentialing. In many instances, plans had trouble locating providers in rural areas that met their plan credentialing standards, particularly for mental health care. In the end, to meet access requirements, plans had to revise their standards to accommodate less credentialed providers, which raised concerns about quality of care at the plan level. On the other hand, plans were able to bring in new providers from their network, especially specialists, that rural residents previously did not have ready access to.

Related to network development issues is that the arrival of managed care can disrupt an already fragile continuum of care that is typical of rural areas. This can come about through a number of ways. For example, providers were sometimes left out of the Medicaid network

altogether, potentially eliminating a major revenue source. Changes in provider reimbursement levels or referral patterns brought about by managed care can also affect the continuum of care. For example, in Vermont there are only two residential facilities that provide substance abuse to adults and one inpatient facility for adolescents. One of the adult facilities reported facing serious reimbursement problems under managed care and struggled to survive without Medicaid revenue from enrollees in managed care. The adolescent facility had to contend with the issue of significant reduction in the number of referrals from managed care plans.

Local opposition. Another obstacle states faced in implementing rural managed care was local opposition to the waiver program. Indeed, in Minnesota local resistance was the major implementation barrier to expanding PMAP in rural areas. While in some counties previous experience had soured some providers on managed care, overall, the source of counties' reluctance can be traced more to resentment at having the state impose on them a program to which they had had little chance to comment on or to contribute to the design.

Part of the counties' reluctance arose from a general sense that urban prescriptions are seldom the answer to rural problems. But there was, in addition, a strong fear of the damage that managed care could do to the local health care systems. Among other things, the counties wanted the plan contracts to take into account the differences between rural and urban infrastructure such as fewer telephones, longer distances to providers, availability of transportation, and differences in provider credentials. Counties were also concerned about maintaining their local health care system. They wanted to ensure that their current providers (particularly allied providers such as pharmacists and chiropractors) did not get left out of plan networks. Counties feared that the providers—and in turn, the local economy—would suffer

financially if their providers were excluded. Counties also saw the possibility that managed care plans would move some services to "hub" cities or towns outside of the county.

Rural counties appealed to the state legislature, where rural areas wield substantial presence, for help. Eventually the state instituted "enhanced PMAP" under which individual counties were given the opportunity to include county-specific conditions—such as inclusion of certain providers-- into contracts with managed care plans. Counties were also given a say in plan selection and implementation timetable. Beyond these measures, the state offered counties the option of designing their own managed care plan, called County-Based Purchasing or CBP. Under this option, a county could function as a plan and receive capitation payments and be responsible for arranging for the provision of care for Medicaid beneficiaries. As of early 2003, nine counties (as a consortium) have implemented CBP and another group of ten counties continue to pursue the option.

Although to a lesser extent, New York also experienced local resistance to the Partnership Plan. However, unlike Minnesota, the bulk of the resistance was mounted more by local health providers than by counties. Provider resistance, especially among physicians, to managed care is especially strong in the northern counties near the Canadian border. Akin to Minnesota, providers want to keep health care dollars in the county and do not want to see the migration of money to health plans or health care facilities outside their practice area. In at least one case, providers used their political clout to prevail upon county commissioners to reject the managed care initiative.

In addition to provider resistance, state officials noted that rural areas are not accustomed to being involved and follow an ethos that they do not need to be told what to do. Moreover, some rural parts of New York were described as having a fundamental distrust of state programs.

However, New York avoided many of the problems surrounding local opposition by establishing county exemption policies as described above.

Lessons Learned

The experiences of the four study states illustrate some broader policy issues associated with rural MMC. It is clear that states confronted a number of similar challenges in developing their MMC programs for rural areas. Many of these issues echoed those faced by other states that have implemented rural MMC programs in the recent past, including getting health plans to participate, setting sound capitation rates and selecting geographic areas and eligibility groups for implementation. In addition, a few new issues surfaced such as strong local opposition and provider consolidation.

All of the study states started the planned expansion of full risk Medicaid managed care into rural areas around the same time, between 1997 and 1999. New York and Minnesota both had had experience with Medicaid managed care and substantial private managed care penetration, although primarily in urban areas. In New York, that experience led the state to exempt rural counties while in Minnesota, where rural participation is more critical to program success, it led the state to a strategy of accommodation to rural demands. Kentucky began with PCCM experience, and found itself forced to return to PCCM when its forays into full-risk managed care faltered. Vermont found that health plans had little interest in participating in its program and turned to PCCM as an alternative. Of the four areas, only Minnesota succeeded in extending full-risk managed care to its rural areas, although a few counties still are FFS.

Based on these state experiences we identified some key issues that may provide guidance to other states considering rural MMC programs.

- *Ensure area has a sufficient number of covered lives*. Are there enough Medicaid beneficiaries to support a capitated managed care program? New York's strategy was to

set minimum population standards for counties to shift to managed care whereas Minnesota's strategy was to "bundle" Medicaid with other insurance groups. Kentucky's attempted strategy to ensure sufficient number of beneficiaries was to allow only one plan to serve a region that combined several counties.

- *Be aware of the potential need for greater flexibility in requirements for provider networks in rural areas*. Minnesota plans allowed for some relaxing of provider credentialing to build networks while Vermont relaxed standards for travel time in most rural areas. New York, by contrast, exempted counties with too few providers from its managed care program.

- *Be realistic in assessing potential cost-savings in rural areas.* Is there heavy reliance on emergency room or hospital care that could be reduced through greater primary care or care coordination? Is there pent-up demand for care that could lead to initial cost increases? Is the area large enough to support plan competition and provider competition to drive down costs?

- *Allow for local differences and local input*. Distinct from urban areas, health care providers are generally a core part of rural communities. States may need to trade-off some of the gains of managed care against the loss of key providers in local areas.

- *Look to previous state experiences for guidance***.** Some of the challenges that the four states had to contend with have emerged in other states that have implemented rural MMC programs. As states consider rural managed care as an option for their Medicaid programs, examining past state experiences and practices could provide important and very useful information.

Since our study states implemented their waiver programs, the Balanced Budget Act's Medicaid managed care provisions were enacted. With these new provisions, states are allowed to have only one health plan operating in its rural counties. This single-plan feature should help overcome some of the problems the study states encountered. For example, with just one plan in a region, the low population density typical of rural areas may be less of a problem. The single-plan approach also may make it easier for plans to establish provider networks. At the same time, though, it may make it harder for the state to secure expected cost-savings with only limited plan competition. On the whole, the BBA may make it easier to implement MMC in rural areas but harder to obtain or sustain cost savings.

Conclusions

While the states in the study all sought to implement capitated MMC program in rural areas, the states varied in both their strategies and level of success. The findings suggest that rural managed care programs can work but that states have to pay particular attention to its unique character and circumstances. As part of that, they need to make an honest assessment of what managed care model—for example, PCCM versus capitated model, which populations to include or exclude--is feasible and what cost-savings can realistically be achieved in their state.

References

Bartosch, W.J. et al. 2000. "Medicaid Managed Care in Vermont, Site Visit Report 1999." Final report submitted to Centers for Medicare and Medicaid under HCFA Contract 500-94-0040, Evaluation of the Medicaid Health Reform Demonstration, February 2003.

Brown, R. et al. 2001. "Reforming Medicaid: The Experiences of Five Pioneering States with Mandatory Managed Care and Eligibility Expansions." Final report submitted to Centers for Medicare and Medicaid under HCFA Contract 500-94-0047, Evaluation of the Medicaid Health Reform Demonstration, New April.

Coughlin, T.A. et al. 2000. "New York's Partnership Plan: An Early Look at Program Implementation." Final report submitted to Centers for Medicare and Medicaid under HCFA Contract 500-94-0040, Evaluation of the Medicaid Health Reform Demonstration, April 2002.

Congressional Research Service. 1993. Medicaid Source Book: Background Data and Analysis. Washington, DC: U.S. Government Printing Office, p. 1025.

Davis, S. and R.G. Potter. 1998. "Making It Work for the Consumer." In Remaking Medicaid: Managed Care for the Public Good, edited by S.M. Davidson and S.A. Somers. San Francisco, California: Jossey-Bass Inc.

Felt-Lisk, S. et al. 1999. "Medicaid Managed Care in Rural Areas: A Ten-State Follow-Up." *Health Affairs.* Vol. 18, No. 2, pp. 238-245.

French, G.T. et al. 1999. "Medicaid Managed Care in Kentucky, Site Visit Report 1999." Final report submitted to Centers for Medicare and Medicaid under HCFA Contract 500-94-0040, Evaluation of the Medicaid Health Reform Demonstration, February 2003.

Gold, M., Chu K and B. Lyons. 1996. "Managed Care and Low-Income Populations: A Case Study of Managed Care in Oregon." Mathematica Policy Research, Inc.; Washington, DC.

Gold, M, Frazer, H. and C. Schoen. 1995. "Managed Care and Low-Income Populations: A Case Study of Managed Care in Tennessee. Mathematica Policy Research, Inc.; Washington, DC.

Kendall, S.J. et al. 2001. "Minnesota Prepaid Medical Assistance Program, Third Round Site Visit Report." Final report submitted to Centers for Medicare and Medicaid under HCFA Contract 500-94-0040, Evaluation of the Medicaid Health Reform Demonstration, November 2002.

Kirkman-Liff. 1986. "Competition in Health Care and the Rural Poor: An Assessment from Arizona's Competitive Medicaid Experiment." *Journal of Rural Health.* Vol. 2, Number l, pp. 23-38.

Ku, L. and S. Wall. 1997. "The Implementation of Oklahoma's Medicaid Reform Program: SoonerCare." Final report submitted to Centers for Medicare and Medicaid under HCFA Contract 500-94-0047, Evaluation of the Medicaid Health Reform Demonstration, date??.

Ku, L. et al. 1998. "Medicaid Managed Care Programs in Hawaii, Oklahoma, Rhode Island, and Tennessee." In Remaking Medicaid: Managed Care for the Public Good, edited by S.M. Davidson and S.A. Somers. San Francisco, California: Jossey-Bass Inc.

Marstellar, J.A. et al. 1999. "Minnesota Prepaid Medical Assistance Program, Second Round Site Visit Report." Final report submitted to Centers for Medicare and Medicaid under HCFA Contract 500-94-0040, Evaluation of the Medicaid Health Reform Demonstration, September 1999.

Mitchell, J. 2003. Personal communication with the authors about finding from a survey of OHP beneficiaries conducted in the late 1999s. January.

Mittler, J, Gold M. and B. Lyons. 1999. "Managed Care and Low-Income Populations: Four Years' Experience with the Oregon Health Plan." Report for the Kaiser/Commonwealth Low-Income Access Project, Kaiser Family Foundation, Washington DC, May.

Moscovice et al. 1998. "Expanding Rural Managed Care: Enrollment Patterns and Prospects." *Health Affairs*, Vol. 17, No. 1, pp. 172-179.

Silberman, P. et al. 1997. "The Experience and Consequences of Medicaid Managed Care for Rural Populations: Literature Synthesis." Working Paper no.51 North Carolina Rural Health Research Program, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, July.

Silberman, P. et al. 2002. "Tracking Medicaid Managed Care in Rural Communities: A Fifty-State Follow-Up." *Health Affairs*, Vol. 21, No. 4, pp. 255-263.

Slifkin, R.T. et al. 1998. "Medicaid Managed Care Programs in Rural Areas: A Fifty-State Overview." *Health Affairs.* Vol. 17, No. 6, pp. 217-227.

Slifkin, R.T. and M.M. Casey. 1999. "Medicaid Managed Care in Rural Areas." In Rural Health in the United States, edited by RC Ricketts, Oxford University Press Inc. New York, New York.

University of Minnesota Institute for Health Services Research. 1995. "Developing Rural Managed Care Demonstration Projects. Summary Reports for the AHCPR Rural Managed Care Centers." AHCPR Delivery Order No. 3, Contract 282-93-0037. Minneapolis, Minnesota, July.

U.S. Department of Health and Human Services. 2003. Medicaid Managed Care Enrollment Report. Penetration Rates from 1996-2002, National Summary Table. http://cms.hhs.gov/medicaid/managedcare/enrolstats.asp.

Wooldridge, J et al. 1996. Implementing State Health Reform: The First Annual Report of the Evaluation of the Health Reform in Five States, final report for the Health Care Financing Administration, Contract No: 500-94-0047, December.

Table 1. Selected Area Characteristis for the U.S. and for Study States, by Rural and Urban Areas, 1996 [1]

	United States		Kentucky		Minnesota		New York		Vermont	
Characteristic	MSA	Non-MSA	MSA	Non-MSA	MSA	Non-MSA	MSA	Non-MSA	MSA	Non-MSA
Number of counties	835	2246	22	98	18	69	38	24	3	11
Total population	212,679,708	52,604,075	1,873,233	2,010,490	3,247,414	1,410,344	16,691,121	1,493,653	190,548	398,106
Percent of population	80.2	19.8	48.2	51.8	69.7	30.3	91.8	8.2	32.4	67.6
Population density (# people/square mile)	680.8	41.6	299.4	59.5	443.3	27.5	4160.1	72.1	134.0	48.7
Income per capita ($)	22,542	17,825	20,380	15,648	23,403	20,042	24,712	18,630	22,490	20,661
Physicians/1000 people	1.9	0.8	1.5	0.8	2.2	0.8	2.4	1.3	2.6	1.7
HPSA counties (#)	526	1513	10	65	6	33	28	20	1	10

Source: Area Resource File, 2001

1 Rural counties are defined as those outside of a metropolitan statistical area (MSA). The MSA framework is the rural and urban classification system developed by the U.S. Office of Management and Budget in which rural and urban areas are determined on the basis of popualtion and density of counties. MSAs consist of one more more central and well integrated surrounding counties.

Table 2. Managed Care Market Characteristics for the U.S. and for Study States, 1996

Characteristic	United States	Kentucky	Minnesota	New York	Vermont
Total HMO Penetration[1]					
Total	0.09	0.10	0.13	0.29	0.15
MSA	0.23	0.35	0.35	0.37	0.13
Non-MSA	0.04	0.05	0.08	0.16	0.16
Medicaid Managed Care					
Medicaid HMO penetration[2]	0.16	<.01	0.41	0.15	0.00
Other type of Medicaid managed care[3]	n/a	PCCM	--	PCCM	--

[1] Source: Wholey. Average rates across each area. Includes commercial, Medicare, and Medicaid HMO enrollees.

[2] Number of Medicaid HMO enrollees in each state was calculated using InterStudy data on number of Medicaid enrollees by plan. Total number of Medicaid enrollees in each state was accessed at the CMS website, http://www.cms.gov/medicaid/managedcare/mmcss96.asp.

[3] Source: CMS. Accessed at http://www.cms.gov/medicaid/managedcare/mmcss96.asp.

Table 3. Key Characteristics of Study States' Managed Care Waiver Programs

State	Waiver Implementation Date	Planned Population Covered	Planned Exclusion for Primary and Acute Care Services[1]	Type of Managed Care	Waiver Status January 2003
Kentucky	November 1997	TANF-related and SSI	behavioral health	single plan in each of 8 geographic regions; capitates payment	operates in one urban area
Minnesota	January 1996	TANF-related	_____	non-profit plans only; capitates payment	operates in 70 of 87 counties[2]
New York	October 1997	TANF-related and SSI	dental; [3]partial cap on behavioral health and substance abuse[4]	for-profit and non-profit plans; capitates payment	operates in 21 counties, 3 of which are rural and NYC; mandatory enrollment of SSI beneficiaries in one county only[5]
Vermont	January 1996	TANF-related and SSI	_____ [5]	non-profit plans; capitated payment	program terminated June 2000

[1] With the exception of Vermont, benefit packages excluded most long-term care services.
[2] Counties imp lemented include both PMAP counties and counties operating under a county-based purchasing program, a managed care alternative under Minnesota's waiver.
[3] In New York, dental services are available at the discretion of the plan. If dental is not provided though the plan, then it is made available through Medicaid FFS.
[4] In both Vermont and New York, prescription drugs were initially included in the benefit package but were eliminated soon after waiver implementation.
[5] New York has approval to mandate enrollment of SSI beneficiaries in three counties. However, two of the three counties continue to enroll beneficiaries on a voluntary basis as of early 2003.