

Rural Health Network Development: Public Policy Issues and State Initiatives

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Abstract Rural health networks are a potential way for rural health care systems to improve access to care, reduce costs, and enhance quality of care. Networks provide a means for rural providers to contract with managed care organizations, develop their own managed care entities, share resources, and structure practice opportunities to support recruitment and retention of rural physicians and other health care professionals. The results of early network development initiatives indicate a need for state officials and others interested in encouraging network development to agree on common rural health network definitions, to identify clearly the goals of network development programs, and to document and analyze program outcomes. Future network development efforts need to be much more comprehensive if they are to have a significant impact on rural health care. This article analyzes public policy issues related to integrated rural health network development, discusses current efforts to encourage network development in rural areas, and suggests actions that states may take if they desire to support rural health network development. These actions include adopting a formal rural health network definition, providing networks with alternatives to certain regulatory requirements, and providing incentives such as matching grants, loans, or technical assistance. Without public sector support for networks, managed care options may continue to be unavailable in many less densely populated rural areas of the country, and locally controlled rural health networks are unlikely to develop as an alternative to the dominant pattern of managed care expansion by large urban entities. Implementation of Medicare reform legislation could

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provide significant incentives for the development of rural health networks, depending on the reimbursement provisions, financial solvency standards, and antitrust exemptions for provider-sponsored networks in the final legislation and federal regulations.

Access to affordable, high-quality health care services remains an important concern for rural citizens, who make up one-fourth of the U.S. population. Rural health networks are a potential way for rural health care systems to improve access to care, reduce costs, and enhance quality of care (Christianson and Moscovice 1993). Many different types of rural health networks exist, ranging from networks of similar providers such as rural hospital networks to integrated networks that provide or coordinate a full range of primary care and acute inpatient services. Health care providers may have multiple network affiliations. Network membership may change over time, and networks may pass through stages of development before becoming fully integrated.

The purposes of this article are to analyze public policy issues related to integrated rural health network development, to discuss current efforts to encourage network development in rural areas, and to suggest actions that states may take if they desire to support rural health network development. We define integrated rural health networks as formal organizational arrangements among more than one type of rural health care provider (e.g., physician groups, hospitals, long-term care providers, and public health agencies). Network members may also include social service providers and health insurers. Networks use the resources of more than one member organization, and perform functions or activities according to an explicit plan of action. These functions and activities may range from sharing services or coordinating services provided by member organizations to direct provision and financing of care. Integrated rural health networks may or may not include a managed care component or have risk-sharing contracts with managed care plans. However, a managed care plan by itself does not meet our definition of a network, and neither does a health care system in which all the participants are owned by a single entity.

To date, research on network outcomes has been limited, and more work is needed to evaluate the impact of health care networks on provider performance and the health status of populations (Moscovice, Christianson, and Wellever 1995). At the same time, the growing level of interest in rural health networks and the pace of network development suggests the need to analyze public policy issues related to rural health network development. Furthermore, concerns about access to care in

rural areas, the protection of health care consumers served by networks, and the potential impact of expansion by large, urban-based health care systems into rural areas argue for public sector involvement in rural health network development.

The Environment for Rural Health Network Development

The failure of comprehensive national health care reform efforts has refocused attention on state health care initiatives. Although several states have slowed the pace of their reform efforts, state-level efforts, along with Medicare reform, present the most likely prospects for public sector reform in the near future (Grogan 1995; Congressional Research Service 1995). At the same time, the continued growth of managed care plans and integrated delivery systems is transforming health care markets in many urban areas. This transformation is occurring much more slowly in rural areas. Insufficient capital and low population density make it difficult for rural managed care plans to develop and to achieve financially viable enrollment levels. Many rural areas continue to face significant health care delivery problems, including shortages of physicians and other health care providers, and rural hospital financial difficulties and closures.

Rural health networks are organizational structures that rural providers may use to contract with managed care organizations, and potentially to develop their own managed care entities. Currently, more densely populated rural counties that are located adjacent to metropolitan areas are more likely to be served by an HMO than thinly populated, nonadjacent counties. Most of the HMOs serving rural areas are urban-based; in 1993, only 3.9 percent of all HMOs in the United States were headquartered in rural areas (Christianson 1995). Without public sector support, managed care options may continue to be unavailable in many less densely populated rural areas of the country, and locally controlled rural health networks are unlikely to develop as an alternative to the dominant pattern of managed care expansion by large urban entities. The health care infrastructure in many rural areas needs to be strengthened to maintain access to care locally, as well as to successfully implement managed care systems. Rural health networks provide a means for rural providers to share resources to accomplish activities that they have had difficulty achieving individually, for example, acquiring capital and technical expertise for information systems development. Networks are also a

means of structuring practice opportunities to support recruitment and retention of rural physicians and other health care professionals. In the absence of public sector support, network development will probably occur in more densely populated rural areas with regional referral centers and large physician group practices, but other rural areas will experience continued erosion of the rural health infrastructure.

To help rural areas develop networks, several states and private foundations have recently implemented programs, either in the context of state health care reform efforts or as separate initiatives (Florida Agency for Health Care Administration 1994; Minnesota Department of Health 1994; New York State Department of Health 1994; West Virginia Department of Health and Human Resources et al. 1994; Moscovice, Christianson, Johnson et al. 1995). The federal government has also funded several initiatives to help support rural health network development, including the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH), Integrated Service Network Development, and Rural Managed Care Center programs (Campion et al. 1993; USDHHS, Agency for Health Care Policy and Research 1994; USDHHS, Bureau of Primary Health Care 1994).

For the most part, these initiatives are just beginning to be implemented and have not yet been extensively documented in the health care literature. The available evaluation results are from the earliest network development efforts, which tended to focus on networks primarily as a strategy for rural hospitals to achieve greater efficiencies and reduce costs, rather than as a means of integrating health care financing and delivery in rural areas.

An evaluation of the Robert Wood Johnson Foundation (RWJF) Hospital-Based Rural Health Care program, which provided grant support to rural hospital networks from 1988 to 1992, found that almost one-half of all the rural hospitals in the country participated in a rural hospital network during 1985–1990, but only a limited number were integrated networks whose members shared decision making, contributed significant resources, and gave up some individual autonomy to reach common goals (Moscovice, Christianson, Johnson, et al. 1995). The evaluation concluded that rural hospitals joined networks primarily to improve cost efficiency, but, on average, hospitals did not appear to realize short-term economic benefit from network membership. Possible explanations for this finding are that networks may require longer periods of time before they undertake the kinds of shared programs that yield direct financial benefits, or that the scale of network activities, relative to hospitals' over-

all operations, may not be large enough to have a significant financial impact (Moscovice, Christianson, Johnson, et al. 1995).

The federal EACH/PCCH program was enacted in 1989, and has provided grant funding to more than fifty networks since 1991. However, federal regulations governing the program did not become effective until June 1993. As of November 1995, nineteen small rural hospitals had converted to PCCHs, and thirteen hospitals were designated as EACHs (Weisgrau 1995). Although the program has helped some rural communities maintain access to basic health care services, it has a number of substantive and technical problems that need to be resolved. It has also suffered from a lack of explicit program goals; as a result, it has been viewed by some as a grant program for struggling rural hospitals, whereas others see it as a way to develop broader networks that expand beyond hospitals (Campion and Dickey 1995).

An evaluation of the rural health network demonstration projects funded by New York State between 1988 and 1992 found that five networks created new service programs and increased the supply of health care services in rural communities. However, the evaluation had difficulty quantifying the level of success achieved because of the very different goals and approaches taken by the fourteen projects (Healthcare Management Services Associates 1994).

These results indicate a need for state officials and others interested in encouraging rural health network development to agree on common rural health network definitions, to identify clearly the goals of network development programs, and to document and analyze program outcomes. They also suggest that future rural health network development efforts may need to be much more comprehensive if they are to have a significant impact on rural health care, that is, networks need to be developed that actively involve other types of health care providers in addition to rural hospitals and that assume financial responsibility for providing a broad range of primary care, specialty, and inpatient services.

Potential Roles for States in Rural Health Network Development

States have several potential roles relating to integrated rural health network development. A state may define networks, remove legal and regulatory barriers to network formation, and provide incentives for network development and operation. States may also stimulate network development through health care purchasing activities involving public

employees, Medicaid managed care initiatives, and the promotion of purchasing alliances. A state's decision to encourage network formation through one or more of these activities will be influenced by its political environment, attitudes toward health care regulation, and the extent of rural health network development. Clearly, states will differ in their perceptions of the purposes of rural health networks and the extent to which they view state policy as a means of helping to achieve those purposes. Some states with limited network development may choose to rely on the market to develop rural networks. Some states may want to gain experience with informal guidelines and demonstration projects before proceeding with legislation or regulation, whereas others may use authorization of networks in statute or rule early in the process to set the direction for state policy development. Whether or not a state chooses to adopt legislation or regulations specifically governing rural health networks, other state health laws and regulations may affect network development and operation.

Defining, Licensing, and Certifying Rural Health Networks

A fundamental public policy issue that states need to address regarding rural health networks is whether to adopt a formal rural health network definition in legislation, regulation, or guidelines and, if so, what form the definition should take, and how it should be implemented. A legal definition provides a framework for future network formation, and may be used as the criterion by which states award incentives for the development and operation of rural health networks (e.g., grant support), and establish state antitrust policy regarding network activities.

States that adopt a formal rural health network definition face several policy issues relating to implementation: whether to license or certify networks as organizational entities; how the process should be coordinated with licensure or certification of individual network members; and whether network licensure or certification requirements should replace any of the regulatory requirements currently imposed on network members. States may also want to consider how the recently developed Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) network accreditation process relates to the state licensure or certification of networks. The JCAHO standards constitute a framework for evaluating network performance that incorporates information about both individual network components and the network as a system of care (JCAHO 1994).

State Rural Health Network Definitions

Most states have not adopted formal rural health network definitions. For the most part, the definitions that have been adopted focus on networks as a means of coordinating or integrating service delivery in rural areas, but do not address financing issues. The seven states that participate in the EACH/RPCH program either use the federal EACH/RPCH network definition, which defines network members as EACH and RPCH hospitals and emergency medical services providers (e.g., North Carolina), or have adopted an expanded EACH/RPCH network definition in state law (e.g., Kansas also allows networks to include supporting hospitals, local health departments, clinics, and other health care providers). New York has a state rural health network grant program in addition to participating in the EACH/RPCH program; Florida has a state grant program as well. Both Florida and New York adopted comprehensive rural health network definitions in state statutes in 1993. Minnesota does not have a specific rural health network definition in state statute, but its health care reform legislation defines community integrated service networks (CISNs) and health care provider cooperatives as service delivery and financing models that are expected to serve mostly rural areas.

New York's law defines two types of rural health networks, an informal type, and a more formal network, a Central Services Facility Rural Health Network (CSFRHN), and establishes requirements for each type of network. CSFRHNs must be incorporated as not-for-profit organizations, licensed under Article 28 of the New York State Public Health Law, and governed by a representative board of directors made up of participating providers and consumers from communities served by the network. At a minimum, they must provide or arrange for the provision of comprehensive primary care, emergency care, and outpatient and inpatient care. They must submit a network operational plan, which is approved by the commissioner of health. Informal networks are required to have cooperative agreements approved by the commissioner.

Florida's rural health network definition includes membership, governance, and organizational requirements; networks must be nonprofit and legally incorporated. The law also defines network core services, including disease prevention, health promotion, comprehensive primary care, emergency medical care, and acute inpatient care, as well as additional services that each network should provide directly or by referral within specified times. Network membership is open to all providers, but providers must agree to provide care to all patients referred to them by other

network members. Rural health networks must be certified by the state to be eligible for grant funds for network operations.

In Minnesota, CISNs are nonprofit health plans that are similar to HMOs but are limited in size to fewer than 50,000 enrollees. CISNs are subject to state licensure laws and regulations governing HMOs, with certain exceptions regarding governing board composition, net worth and solvency requirements, and administrative requirements. Health care provider cooperatives are networks of health care providers, primarily physicians and hospitals. They are owned by their provider shareholders, and market the services of those providers to health plans through capitated or similar risk-sharing contracts. Cooperatives are less regulated than CISNs; they are not, for example, subject to net worth or solvency requirements.

Components of a Rural Health Network

Definition

A rural health network definition may include membership requirements (e.g., “any willing provider” or “essential community provider” provisions), and requirements regarding the corporate structure, governance, minimum services, managed care component, and service area boundaries of a network. In deciding which of these requirements to include in their network definitions, states need to achieve a balance between guiding network formation and being overly prescriptive. A network definition must be flexible enough to allow local development of a variety of network models and to accommodate networks in various stages of development.

Network Membership. A network definition may include an any-willing-provider (AWP) requirement that obligates a network to accept all potential members willing to meet the conditions of membership, or a network may be allowed to select participating providers based on its own criteria. Existing AWP state laws developed to regulate managed care plans may also apply to networks. In rural areas with a small number of health care providers, an AWP requirement may not have much impact because networks will probably include most, if not all, providers in the service area. The exclusion of providers from networks in these areas may have a negative effect on access to care, especially if it causes providers to leave the area. In more populated rural areas, an AWP requirement may limit a network’s ability to choose only the providers it needs to provide health

care services effectively and efficiently. It may also allow some organizations to continue outdated patterns of service provision rather than make the transition to providing services currently needed by an area's population. In these cases, an AWP provision may serve the interests of some rural providers who want to maintain their patient bases rather than those of rural consumers and employers interested in obtaining the most cost-effective health care.

A network definition may include an essential-community-provider (ECP) provision that requires inclusion of certain provider types (e.g., local public health agencies, community health centers, or sole community hospitals). The inclusion of local public health agencies in rural health networks is consistent with the idea of integrating services provided by the public health system, including community-needs assessment and population-based community health services, more closely with the medical care system. Requiring networks to include community and migrant health centers and similar providers can be justified as a means of assuring access for medically underserved populations. In Florida, for example, rural health networks must include providers of public health, comprehensive primary care, emergency medical care, and acute inpatient care as members.

An ECP provision may also require networks to reimburse ECPs differently than other providers (e.g., on a cost basis). Reimbursement of providers who serve medically underserved populations is an important policy issue in light of the failure of national health care reform, the reluctance of states to move forward with universal coverage initiatives, and widespread state implementation of Medicaid managed care. Recent experience with Section 1115 Medicaid waiver requests, however, suggests a lack of state support for differential reimbursement of these providers. A majority of the initial state 1115 waiver requests sought to eliminate cost-based Medicaid reimbursement of federally qualified health centers and rural health clinics (Rosenbaum and Darnell 1994).

To limit ECP designation to organizations that are essential for access, states may want to establish ECP criteria in state law and evaluate designation applications on a case-by-case basis. Minnesota, for example, has established statutory criteria and a process for the Commissioner of Health to designate providers as ECPs that have the ability and commitment to serve underserved persons. The ECP criteria include a demonstrated ability to integrate supportive services with medical care for uninsured persons and high-risk and special-needs populations, and status either as a nonprofit, tax-exempt organization that uses a sliding fee

schedule, or as a local government, public health agency, or American Indian tribal organization. The law requires health plan companies to offer provider contracts to any designated ECPs located in their service areas, and ECPs in turn must agree to serve enrollees of all health plans operating in the area. The ECP designation expires after five years.

A network definition may also address the inclusion of urban hospitals and clinics, health plans, and other insurers as rural health network members. By virtue of their greater resources, large urban entities may dominate the rural health networks in which they participate and discourage the development of community-based networks. However, the participation of these entities in rural health networks potentially may benefit the network if they provide needed resources (e.g., capital and technical assistance). Grantee hospitals in the RWJF rural hospital network grant program were evenly split regarding the impact of a large rural or urban hospital's involvement in their network; half of the hospitals felt that they had benefited from the larger hospital's resources and experience, whereas the other half felt that the larger hospital's involvement had a negative impact (Moscovice, Christianson, Johnson, et al. 1995). National experience with rural HMOs suggests that the development of community-based rural networks, especially those that assume financial risk, may be difficult to achieve without either the involvement of large urban organizations or significant state or federal incentives for local development.

Corporate Structure and Governance Issues. Another definitional issue for states is whether to establish corporate structure and governance requirements for rural health networks, such as nonprofit status, or majority consumer membership on a network's governing board. A state may want to require nonprofit status as a condition of receiving state funds. States that are strongly committed to the establishment of community-based rural health networks will want to encourage network governance structures that emphasize community control. Minnesota's CISN statute, for example, requires that 51 percent of governing board members reside in the CISN service area and 40 percent be consumer members elected by the enrollees. Its health care cooperative statute is less prescriptive; boards reflect ownership of cooperative shares and may be composed entirely of local providers or include other owners of cooperative stock.

Experience with the RWJF rural hospital network program suggests that adoption of governance requirements for rural health networks may

have a positive effect on their stability. Moscovice, Christianson, Johnson, et al. (1995) found that the probability of rural hospital network survival was positively related to the presence of a formalized management structure for the network (as measured by the presence of a governing board of directors and a paid director).

Minimum Services and Managed Care Component. States should consider whether to require networks to provide or arrange, either directly or by referral, a minimum set of health care services within defined travel times or distances. Such requirements may help improve access to care by ensuring that all networks provide basic services. In recognition that some rural areas may not currently have the capacity to provide these services, a minimum services requirement may only be achievable if additional resources are allocated to these areas or links are made to institutions that can provide these resources. Minimum service requirements need to be carefully structured so that networks have local control in establishing and maintaining these linkages and are not locked into exclusive relationships.

Policy makers will also need to consider how a managed care component fits into a rural health network definition. Many networks likely will contract with managed care plans or eventually offer their own managed care plans. Participation in risk-sharing arrangements provides an opportunity for the alignment of incentives among members, and may encourage members to make long-term commitments to the network. However, requiring emerging networks to have a managed care component as a condition of licensure or certification creates an entry barrier that many may not be able to overcome.

Service Area Boundaries. A rural health network's service area boundaries have several implications for service delivery and the financial status of the network. Policy issues include: whether the state should have a role either in determining or approving service area boundaries; if it should allow or encourage multiple networks to serve a single service area; if service area designation should be considered differently in more isolated or frontier areas than in more densely populated rural areas; and how the state will deal with network service areas that cross state lines. State decisions regarding network service areas will depend, in part, on whether the state envisions a competitive or a cooperative model of rural health networks, and whether the state has a long-range goal of statewide coverage of rural areas by networks.

State determination of service areas may help assure access to care if, for example, a network is required to serve more isolated portions of the service area as a condition of receiving approval to serve areas that are easier and more financially advantageous to serve. However, providers may have overlapping service areas, making it difficult to define distinct network service areas. State determination of service areas is likely to be controversial and might discourage rural health network development overall. A preferable alternative for a state to achieve its access goal would be to develop an overall policy on rural health network service areas, and then allow networks to define their own service areas with state oversight to prevent inappropriate exclusion of at-risk populations and to address conflicts over service areas and state border issues.

States that have adopted a formal rural health network definition have found it to be a useful means of articulating state policy and setting a direction for network development in the state. Therefore, states that want to encourage network development should consider adopting a formal rural health network definition and a method of approving networks such as licensure, certification, or a less formal designation. In developing and implementing a regulatory structure for rural health networks, states need to ensure that providers have sufficient incentives for seeking state approval of their network. Network regulatory requirements can be coordinated with existing federal and state regulatory requirements for individual network members, so that they do not place additional compliance burdens on network members. States may also allow approved networks to qualify for exemptions from specific state laws or regulations; Florida and New York, for example, allow approved networks to meet modified certificate-of-need requirements and qualify for antitrust immunity. To allow innovative local models to develop, states may grant approved networks priority for receiving state-funded incentives, but refrain from restricting the operation of undesignated networks unless they raise quality-of-care problems that cannot be resolved through other regulatory means (e.g., facility licensure).

Legal and Regulatory Barriers to Rural Health Network Formation

Existing health laws and regulations may negatively affect network development and operation and serve as barriers to the wider development of integrated rural health networks. These potential barriers include health insurance and HMO laws and regulations. In order to encourage

network development, states may consider providing rural health networks with flexibility in the form of exceptions, modifications, or alternatives to certain regulatory requirements. As they evaluate options for modifying regulatory requirements, states need to ensure that mechanisms remain in place to protect health care consumers, for example, financial standards to reduce the likelihood of network insolvency and arrangements to ensure continued provision of care in the event of network dissolution.

Health Insurance and HMO Laws and Regulations

State regulations governing health insurers and HMOs typically include benefit, financial solvency, underwriting, quality assurance, and consumer protection requirements. The degree to which these requirements apply to rural health networks will depend, in large part, on the extent to which the networks assume direct financial risk for the delivery of services. A risk-bearing network may exhibit many characteristics of an HMO or health insurer and as such will be subject to state laws and regulations governing HMOs and insurance companies.

Most states have had little experience regulating rural managed care plans due to the limited presence of managed care entities in the majority of rural areas (Wellever and Deneen 1994). However, as some integrated rural health networks begin to take on a financing role in addition to their health care delivery role, states will need to determine whether specific health insurance or HMO regulations will be problematic for networks that assume financial risk, and then decide whether and how the states should modify these regulations to address the circumstances of rural health networks. For example, financial requirements established to protect health care consumers from insolvent health plans may prevent small, community-based networks from forming unless the network includes an entity such as a large urban hospital or health plan that is able to underwrite potential losses. State options for modifying these requirements include providing state funding or allowing local governments and large, urban-based entities to provide the funds networks need to meet reserve requirements, phasing in requirements over a period of time, or allowing network providers to pledge the future provision of uncompensated services in lieu of a portion of cash reserves.

Florida's HMO law allows public health agencies to form HMOs and use county financing for the \$1 million reserve required. In Minnesota,

a CISN's net worth requirement may include reinsurance credit, may be phased in over three years, and may be reduced by use of contracts with "accredited capitated providers" (network members who agree to provide services without compensation to enrollees of an insolvent CISN for up to six months), or use of guaranteeing organizations.

Low population densities and concentrations of high-risk individuals in some rural service areas may create unacceptable levels of risk for potential rural health networks with a managed care component. Jones, Cohodes, and Scheil (1994) suggested several actions for federal or state government to help manage the increased risk inherent in a health care system undergoing rapid transition, which might be adapted for risk-bearing rural health networks. These actions include assuming the role of a reinsurer for a transitional period of time by establishing a "risk-sharing fund" to share with health plans the financial risks associated with new coverage arrangements and unpredictable changes in price and volume of health services resulting from health care reform, or a "risk-equalization fund" derived from assessments on each participating plan/network's premium and redistributed among plans/networks according to their favorable or adverse risk selection.

States need to assess the availability and affordability of reinsurance in the private market for rural health networks that assume risk. Where problems are found, state insurance law should be changed, if necessary, to allow development of a reinsurance risk pool for rural health networks. Minnesota, Florida, Connecticut, and North Carolina have private sector Small Employer Reinsurance Association risk pools for carriers in the small-group market that might serve as models for a network reinsurance association. A reinsurance risk pool could be structured so that networks still have incentives to manage care. In the Minnesota risk pool, for example, a health insurance company or HMO pays the first \$5,000 of claims and 90 percent of the amount between \$5,000 and \$55,000, whereas the reinsurance association pays 10 percent of the amount between \$5,000 and \$55,000, and 100 percent over \$55,000. The risk pool is funded by assessments on carriers, based on their premium volume in the small-group market. The 1995 Minnesota legislature recently expanded participation in the association to include CISNs.

States will also need to decide whether and how to address the issue of direct contracting between provider-sponsored rural health networks and employers. Provider-sponsored networks (PSNs), which are also called *provider service networks* or *provider service organizations* (PSOs), are groups of physicians and hospitals that contract directly with employers

and other health care purchasers to provide health care services, bypassing health insurers and HMOs. In a number of rural areas, self-insured employers account for a significant proportion of the health care market. Self-insured employers' health plans are exempt from state regulation under federal ERISA preemption provisions. However, the National Association of Insurance Commissioners (NAIC) recently issued a bulletin warning state insurance commissioners that some PSNs were engaged in risk-sharing arrangements that amounted to selling health insurance without a license. The NAIC advocated the application of state health insurance solvency and consumer-protection laws to these arrangements (Aston 1995). The NAIC is currently developing a health plan licensing model act to help states develop a consistent approach to the regulation of risk-bearing entities, including PSNs (Alpha Center 1995).

It may be difficult to identify in advance all of the health care regulations that may impede network development, so states may want to establish a regulatory waiver process similar to New York's. This process allows a network to apply to the commissioner of health for a waiver by identifying the specific regulation that is problematic, and then providing justification of the need for a waiver and assurances that the quality of health care, patient rights, and informed consent will not be negatively affected by the waiver.

Antitrust Laws

The collaborative activities of rural health network members may be subject to litigation brought by the U.S. Department of Justice (DOJ), the Federal Trade Commission (FTC), or private parties under two federal laws. The Sherman Act prohibits conspiracies, contracts, and combinations in restraint of trade; the Clayton Act prohibits mergers and acquisitions of stock or assets that may substantially lessen competition or tend to create a monopoly. The policy of limiting market concentration through antitrust law is based on the assumption that a lack of competition will result in higher prices or costs than those of a competitive market. The public interest is best served, therefore, by limiting market concentrations and promoting competition. Although some rural areas, especially those adjacent to urban areas, are able to support more than one provider network, many less populated rural areas will not be able to support multiple networks. Rural providers who cooperatively plan and operate rural health networks in these areas may be liable to antitrust

actions. Fear of antitrust liability may also retard the development of collaborative activities in rural areas.

Several states have passed legislation to protect rural providers in collaborative relationships such as networks from antitrust liability. These legislative efforts are based on the doctrine of state action immunity, which exempts certain activities from antitrust liability in the belief that cooperation, in defined circumstances, serves the public interest better than competition. The antitrust exemption for rural providers is based on the assumption that rural health network collaboration reduces costs and improves quality and access to health care through sharing and coordination of services. Some states have immunized hospitals from antitrust liability for hospital-to-hospital collaboration, whereas others (e.g., Florida, Kansas, and New York) have attempted to immunize all participants in rural health networks.

The state action immunity doctrine requires more than a simple legislative declaration of a policy to replace competition with cooperation. It also requires active supervision of the cooperative activities by qualified state officials. Some states, such as Colorado, Minnesota, and North Carolina, have established processes that require providers seeking antitrust immunity to apply to a state agency, commission, or board for an exemption. To be approved for an exemption, the providers must show that cooperation is likely to result in lower cost, greater access, or better quality of health care than would otherwise occur under existing market conditions. They may, for example, describe the extent to which the proposed arrangement will result in cost savings to health care consumers or make specific health care services more financially or geographically accessible to persons who need them. Providers who are approved for exemptions are required to submit periodic reports to assure the state that the projected benefits of collaboration are actually achieved. To date, however, rural providers have been reluctant to apply for immunity, making it difficult to judge the effectiveness of the state processes.

Even in the absence of state action immunity, there are cooperative activities that rural providers can engage in legally. Nevertheless, many rural providers have not pursued these activities because of fear of breaking the law. In 1993 and 1994, the DOJ and the FTC attempted to provide some direction to health care providers contemplating mergers and other joint activities by issuing statements that defined “antitrust safety zones,” or circumstances under which the agencies will not pursue prosecution for anticompetitive acts. Unfortunately, the agencies did not describe a safety zone for multiprovider networks, claiming that they needed more experience in evaluating the costs and benefits of these activities.

Instead, they listed the analytical principles they will use in evaluating the likely effect a particular multiprovider network will have on competition. These principles address the following antitrust issues: financial integration, joint pricing and joint marketing, market definition, competitive effects, exclusivity, exclusion of providers, and efficiencies.

This policy statement does not offer blanket protection from enforcement, but it does provide a framework for the analysis that should be undertaken on a case-by-case basis by emerging networks and their local legal counsel. In addition, the antitrust safety zones only indicate the circumstances under which the federal government will not pursue antitrust prosecutions. Private parties are still at liberty to bring suit. Even a successful defense of an antitrust suit can be extremely expensive and detrimental to a rural health network.

The two federal agencies also set forth their policies on expedited business reviews and advisory opinions, procedures by which providers may obtain information concerning their antitrust enforcement intentions. The DOJ and the FTC suggest that persons considering forming a multiprovider network who are unsure of the legality of their conduct request a business review or advisory opinion. The agencies pledge to respond to requests within 120 days (U.S. DOJ and FTC 1994). In the absence of DOJ and FTC guidelines for networks that clearly define legal and illegal activities, rural providers who are interested in greater cooperation should petition the DOJ or the FTC for a business review or advisory opinion, although they need to be aware that the process will delay network development.

At this time, it is difficult to judge how effective the state action immunity doctrine will be in providing antitrust relief to rural health network participants. Rural providers appear hesitant to apply for exceptions, and the state processes have not been tested in court. Nonetheless, states that have implemented the state action immunity doctrine believe that it has helped reduce fear of network formation. Other states, therefore, may want to consider establishing a state policy that supplants competition with cooperation in rural areas, and a process for actively supervising rural health networks.

State Incentives for Rural Health Network Development and Operation

Rural health networks face start-up costs, as well as ongoing operating costs. It may be difficult for small, community-based networks to obtain capital. Developing rural health networks also need access to technical

expertise, including financial and legal consultation. To help meet these needs, states should consider implementing a variety of incentives for network development, including grant, loan, and technical assistance programs.

In comparison to state implementation of a rural health network definition or removal of legal and regulatory barriers to network development and operation, the provision of state incentives for rural health networks will probably involve greater and more direct public expenditures (e.g., a network grant program will require a specific state budget appropriation). Thus, network incentive proposals are more likely to raise questions about the appropriate role of market forces and government in rural health network development. Clearly, network development is occurring in some rural areas and will occur in other areas without public sector involvement. However, networks are unlikely to develop without assistance in rural areas that have a high level of need and are especially lacking in local resources (e.g., high-poverty, medically underserved areas). In these situations, the provision of carefully targeted network incentives can be justified if the network is likely to improve the delivery of health care services in the underserved area, for example, by enhancing health care provider recruitment and retention or by increasing access to specialty services that were not previously available.

Grant and Loan Programs

States designing a network grant or loan program need to address several policy and programmatic issues such as eligibility, award criteria and amounts, allowable uses of the grant or loan dollars, and match requirements. Required local matches for both grants and loans help to ensure community “ownership” of the project as well as increase the overall funds available. Encouraging rural health networks to involve local businesses and link up with economic development efforts helps to increase the likelihood of network success. A variety of methods may be used to prioritize grant or loan applications for funding, including criteria that take into account the financial resources of network members and communities. In addition, state policy makers need to consider whether funds should be distributed geographically within the state, and to what extent the state should seek to fund different types of networks to serve as models for other rural areas of the state.

State officials designing a grant or loan program need to develop a means of assessing the organizational and management readiness of

applicants. In order to make effective use of available funding, recipients must either have the capacity to implement a network successfully, or the state must be prepared to provide or arrange for the provision of technical assistance to help the grantee or loan recipient develop that capacity. Such assistance is especially critical for providers in high-need rural areas. In the EACH/RPCH program, for example, the small rural hospitals most in need of RPCH status are often financially troubled and operationally unstable, and need assistance with a variety of activities, including strategic planning (Campion and Dickey 1995).

Experience with network grant programs suggests that states should pay special attention to developing networks that will be financially self-sufficient after the grant period. Five of the thirteen networks in the RWJF rural hospital network program, for example, ceased to function one year after their grant funding ended, including two of the four networks that were funded for two years, and three of the nine networks that received four years of support (Moscovice, Christianson, Johnson, et al. 1995). The evaluation of the 1988–1992 New York State rural health network demonstration projects concluded that state funding can facilitate network development that would not otherwise have occurred, but the removal of funding can also lead to the dissolution of network efforts. At least four networks ceased functioning once their grants ended (Healthcare Management Services Associates 1994). Possible ways to encourage self-sufficiency among grantees include requiring increasingly greater local matches over the life of the grant, and helping networks to focus on efforts that have a relatively immediate economic benefit to the network. For example, networks may generate revenues through activities for which network members pay fees, such as physician recruitment or continuing education, or by providing health care services that generate patient fees.

Loans have some advantages over grants for network development. They force a network to focus on financial self-sufficiency early in the process in order to be able to repay the loan. In contrast, the availability of grant dollars may delay difficult decisions on the part of network members (e.g., they may postpone making a financial commitment to the network). Repaid loan funds can be loaned out to other potential networks so that the initial state investment is recycled. However, loans are likely to be more difficult for a state to administer, and they are also less appealing to potential network members. Rural providers in financial difficulty may be especially reluctant to take on the risk of a loan; thus, network development in underserved rural areas may be limited unless local

businesses and community members are willing to cosponsor the loans. Loans have not been widely used for network development. The RWJF rural hospital network grant program made loan funds available to grantees, but the loan funds only became available late in the program, so the loan portion of the program was not formally evaluated, and its full impact will not be evident for several years (Moscovice, Christianson, Johnson, et al. 1995).

States with limited resources need not be discouraged from providing grants or loans. Even small grant awards allow networks to pay expenses that may be difficult to fund otherwise, such as staff salaries and consultant fees for initial networking activities, including joint planning and establishing an organizational and governance structure. Another option for states with limited resources is to encourage potential network members to apply for other state and federal rural health grant programs such as rural health transition, outreach, or primary care grants that can support network development activities.

Technical Assistance

Like grant programs, technical assistance programs present a number of design and implementation issues, such as eligibility criteria and the types of assistance that should be provided. States need to decide whether to provide technical assistance directly to networks, contract with private consultants, or use a combination of approaches. Initially, many states may need to rely on consultants to some extent, but they should build internal capacity over time to provide the types of assistance needed by networks. A technical assistance program should facilitate the sharing of knowledge between existing and potential rural health networks. Workshops and resource manuals can be cost-effective means of disseminating information of interest to many potential rural health networks.

A recent survey of sixteen rural health networks in New York State identified a variety of technical assistance needs. Networks expressed a need for assistance in the areas of conflict resolution, organizational development, developing information systems, conducting community-needs assessments, developing managed care systems, and advice about state regulations (Healthcare Management Services Associates 1995). The New York State rural health network program provides technical assistance on a variety of topics, from community development, system planning, and program development, to setting up network information

and quality-improvement systems. Technical assistance is a key component of other state, federal, and foundation network programs as well. The EACH/RPCH program, for example, provides RPCHs with assistance in conducting community-needs assessments and financial feasibility studies through the federal funds awarded to participating hospitals and state health departments; the RWJF also funds a national technical resource center for the seven EACH/RPCH states.

In addition to their practical value in assisting networks, incentives have value as evidence of the states' commitment to rural health network development. States should provide financial incentives for rural health network development, giving special consideration to high-need rural areas, and encouraging networks to become financially self-sufficient prior to the end of the grant or loan period. States should also provide or arrange technical assistance for grantees, loan recipients, and others interested in rural health network development.

Network Financing

Long-term financing of network operations raises a number of public policy issues beyond the scope of this article that will need to be addressed cooperatively by rural providers, states, the federal government, and third-party payers. In particular, Medicare and Medicaid have potentially significant roles to play in rural health network development, because the two programs pay for a considerable portion of rural health care services, and commercial insurers often follow Medicare's lead in determining coverage, covered providers, and payment mechanisms.

States and the federal government need to implement demonstrations to examine ways that financing systems can be changed to support rural health network operations over time (e.g., through provision of capitation payments or global budgets to networks). Recognition of integrated rural health networks as a distinct provider type is an important first step, allowing networks to bill for the services of members, receive revenue for the services provided, and allocate funds to members according to the needs of the network as a whole. The Health Care Financing Administration (HCFA) recently solicited health plans to participate in a demonstration project, Medicare Choices, designed to evaluate the suitability of health care delivery system options, including PSNs and preferred provider organizations (PPOs), for the Medicare program (USDHHS, HCFA 1995a). Although the focus of the project is on metropolitan areas, HCFA is also interested in health plans that serve rural communities.

Five of the twenty-five plans that were selected for the project operate in rural areas (USDHHS, HCFA 1995b, 1996).

Proposed Medicare reform legislation would allow PSNs to qualify as eligible organizations for Medicare managed care contracts (Congressional Research Service 1995). Passage of this legislation could provide significant incentives for the development of rural health networks by substantially increasing the potential pool of enrollees for which networks could receive direct payment. The actual impact on rural health care delivery will depend on how the final legislation and federal regulations address the following policy issues.

- *Reimbursement.* The willingness of rural providers to develop PSNs that serve Medicare enrollees through managed care contracts will be greatly influenced by capitation payment rates. Provisions to establish a minimum floor on capitation rates in rural areas and reduce the amount of variation in capitation rates between rural and urban areas are likely to encourage rural Medicare PSN development.
- *Financial solvency standards.* Proposed Medicare reform legislation would exempt PSNs from state licensure requirements for HMOs and health insurers. Potential alternative financial solvency requirements being considered for PSNs by Congressional leaders include those in the NAIC Model HMO Act. Another option is the risk-based capital standards that the NAIC is developing as part of its model health plan licensing act; these standards base the level of financial reserves required for a plan on the amount of risk assumed (Alpha Center 1995). The adoption of more flexible financial standards that continue to protect consumers would facilitate rural Medicare PSN development.
- *Antitrust exemptions.* Proposed legislation would allow the conduct of provider networks that are negotiating joint pricing agreements to be judged on a case-by-case basis according to the “rule of reason,” rather than automatically being considered a violation of antitrust law. Provider groups, including the American Medical Association, support this proposal and maintain that it is needed to allow integrated networks to function properly; business groups oppose it (Weissenstein 1995).

Conclusion

The establishment of rural health networks requires fundamental changes in health care delivery and financing. Several states have made consid-

erable progress in defining rural health networks, establishing formal designation processes, and providing incentives for network development. However, much work remains to be done in several policy areas, notably the impact of state health insurance and HMO regulations on risk-bearing networks and network financing issues, including Medicare and Medicaid reimbursement. As policy makers address issues related to rural health network development, they should bear in mind the costs of developing networks, and their limitations as well as their potential. Rural health networks are not a panacea for all of the challenges health professionals and policy makers face in assuring the accessibility and affordability of health care services in rural America. However, networks hold considerable potential for improving the delivery and financing of rural health care. They deserve support from states as a strategy for maintaining local access to care and successfully implementing managed care systems in rural areas.

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