

**MODELS FOR  
INTEGRATING AND MANAGING ACUTE  
AND LONG TERM CARE SERVICES  
IN RURAL AREAS**

Andrew F. Coburn, Ph.D.

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Maine Rural Health Research Center  
Edmund S. Muskie School of Public Service  
University of Southern Maine  
Portland, Maine 04104-9300  
(207) 780-4430

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## **EXECUTIVE SUMMARY**

### **INTRODUCTION**

Post-acute and long term care services for older persons and persons with serious disabilities are responsible for an ever-larger share of the costs of the Medicare and Medicaid programs. The need to control demand and expenditures has led states and the federal government to seek new managed care strategies, such as capitated financing and coordinated case management, that integrate the financing and delivery of primary care, acute and long term care services. Integration and managed care are viewed as encouraging a substitution of less costly and more appropriate home and community-based services for high cost medical and long term care services which have been heavily funded under fee-for-service financing systems.

From a rural perspective, the development of organizational and delivery systems which better integrate and manage primary, acute and long term care services may help address long-standing problems of limited availability of and access to long term care services. Over the past decade, many rural hospitals have developed or acquired post-acute care services such as home health agencies and/or skilled nursing facilities as a strategy for managing their inpatient use and diversifying their revenue base. And some rural hospitals have ventured into the world of long term care as well, offering assisted living, adult day service programs, respite programs, or sponsoring meal sites for older persons. The growing involvement of rural hospitals in the post-acute and long term care services may provide important opportunities to develop more integrated acute and long term care systems in these communities. Notwithstanding the significant challenges, there are emerging examples of rural networks and managed long term care programs that offer important insights into the opportunities and challenges of using these approaches in rural settings.

This paper discusses the concept of integrated acute (medical) and long term care service networks, some of the model programs that have been demonstrated, the challenges that health care providers, state policymakers, and others have faced in developing these new integrated structures, and the future of integrated approaches in rural areas. The paper updates and expands upon key findings, insights, and conclusions from a recent study of several of these programs (Coburn et al. 1997).

### **WHY INTEGRATE?**

Integration has become a paradigm for health care providers seeking to successfully compete in the rapidly expanding managed care marketplace. The pursuit of integration has been premised on the assumption of both economic and clinical benefits. In theory, integrated models of financing and service delivery produce greater efficiency and cost savings (Shortell and Hull 1996). By bringing the various components of the health system together, it is presumed that integrated systems can achieve economies of scale and cost reductions in both administrative and clinical areas. In addition, better care management systems are expected to produce both cost savings through reductions in inappropriate care and improvements in the quality of care and outcomes (Gilles et al. 1993). For purchasers, including state Medicaid programs, integration of financing (Medicare and Medicaid) and service delivery (primary, acute and long term care) is seen as a way of aligning parts of the health system which, under fee-for service payment arrangements, have tended to be cost-shifted from one payer to

another. For consumers, integration is assumed to produce more convenient, accessible, and clinically effective systems by reducing the degree of service and system fragmentation that characterize much of the medical and long term care financing and delivery systems.

## **THE RURAL ISSUES AND QUESTIONS**

Despite growing interest in integrated models of acute and long term care financing and service delivery, there are still relatively few operational examples of such programs to learn from. Rural models are even harder to find (Coburn et al. 1998). Nevertheless, the experience of selected program models in Arizona, Wisconsin, Illinois and other states, which are profiled in this paper, illustrate some of the critical issues that states and rural communities must consider as they contemplate ways of redesigning the financing and delivery of services to achieve better integration, access and quality. Although many of these issues can be characterized as “barriers” to integrated financing and service delivery approaches in rural areas, there are some which, based on the experience to date, may also represent opportunities.

**Integration costs money:** The development of integrated acute and long term care programs is expensive, requiring an intensive investment of capital and organizational leadership that is often lacking in rural areas (Kane, Illston, and Miller 1992). For example, it has been estimated that PACE programs require between \$1-1.5 million in start-up capital to cover the fixed costs of facility renovations and the initial operating losses that inevitable occur as the program moves to full enrollment (State Workgroup on PACE 1999). The development of the organizational, administrative and clinical systems needed to integrate and manage care, especially in a capitated or risk-based financing system, is well beyond the capacity of the average rural provider or health system.

**Rural providers have limited managed care experience:** Coupled with the problem of the large capital investments needed to develop these programs is the reality that most rural providers have had very limited experience with managed care and therefore are not likely to be inclined or prepared to participate in managed care programs for high risk, vulnerable populations such as the frail elderly.

**Limited services and service delivery mechanisms in rural areas:** To adequately address the complex health care and social support needs of frail, older persons, programs that seek to integrate acute and long term care services in rural areas must deal with the common service limitations in many rural areas. Access to specialty services, such as physical therapists, psychiatrists, and transportation is among the most significant hurdles that must be overcome. The experience to date suggests that rural integrated programs are most likely to be developed through partnerships between rural medical and long term care service providers and larger organizations such as county health systems, hospitals, and/or managed care organizations. The model of urban-based providers reaching out into surrounding rural areas to establish local satellite programs is one that may fit in a number of rural areas. In this way, the rural sites may gain access to a broader range of specialty and other services than could be developed locally.

**Rural means small:** What are the advantages and disadvantages of the small population base of most rural areas? On the one hand, a small population base of most

rural areas makes it difficult if not impossible to consider financing strategies that shift a substantial portion of the financial risk for health care use and costs to rural providers. The small numbers of beneficiaries, together with the unpredictable and volatile nature of health care needs and use in a small population (and especially with a population such as the frail elderly), make such strategies impractical. But there may also be some benefits of small population size that could be an advantage for rural communities and providers. In smaller communities where medical and long term care service providers are likely to know their clients and provider colleagues better, care management across systems may be easier to achieve than in urban settings. Moreover, in smaller communities, health and long term care providers must work together on a regular basis, which may make it possible to achieve cooperation more easily than in more complex organizational environments.

**Aligning the incentives and professional culture:** There are few incentives for communities, medical and long term care providers, or health plans to develop programs that integrate long term care into the continuum of primary and acute care services. The incentives for hospitals under the Medicare PPS and continued cost reimbursement of post-acute care (until the recent BBA changes) propelled hospitals and health systems to add home health care and, in some cases, skilled nursing facility care to their continuum of health services. Few have ventured into the arena of non-medical home care, residential care, and other long term care services, however. The primary reason is that there are few financial or other incentives for doing so. It is hard to overestimate the importance of state long term care policies in shaping the strategies that health plans and providers will take in forming service networks that better integrate the delivery of primary, acute, and long term care services.

**Do organizational and ownership structure matter?** The organizational structure differs significantly among integration initiatives and the experience to date suggests that structure may be important in facilitating the development of both functional and clinical integration, two critical, necessary conditions for effective managed care organizations. In rural areas, however, the problems that distance pose for the integration of clinical and administrative services may be more important than organizational and ownership structure. Physical proximity and, preferably, co-location of providers is highly desirable in encouraging effective communication. Where this is not possible, information systems and communication technologies become important. Long distances among providers make the care management process more challenging.

## **THE FUTURE OF MEDICAL AND LONG TERM CARE INTEGRATION IN RURAL AREAS**

**Is Integration the Gold Standard?** Integration strategies typically involve the creation of new programs or organizational units where resources from multiple systems are pooled. The PACE and S/HMO demonstrations are good examples of such fully integrated models. Do these models conform to the realities of most rural areas? The answer is no in most cases. Yet, this does not necessarily mean that rural communities and health and long term care providers cannot pursue efforts to improve the provision of primary, acute, and long term care services. Integration is not necessarily the gold standard for improving the care of older persons. Other strategies that involve “linkage” or “coordination” approaches may be just as effective and certainly more feasible in most rural areas (Bird et al. 1998; Leutz 1999). Integration is not an end to itself. Rather, it is a means toward the goal of improving the care of older persons by enhancing timely

access to appropriate and high quality health and long term care services. In rural areas, where integration is a noble but difficult goal to achieve, incremental linkage and coordination approaches may be more appropriate and effective.

**Professional Collaboration:** The collaboration of physicians, nurses, social workers, and paraprofessional long term care staff is vital to the development of viable managed care programs that integrate services across the primary, acute, and long term care sectors. The physician's role is critical in this regard. Physician education and other efforts are needed to bring rural physicians into the process of coordinating and managing care across the acute and long- term care continuum. The development of rural geriatric or chronic care team models may be an important strategy. Changes in state professional licensure laws and rules may be needed to enable these teams to function effectively, especially in rural areas where distances and other factors affect supervision and other aspects of the collaborative practice model.

**The Effects of Medicare Policy: Barriers or Opportunities?** It is too early to know how payment policy changes contained in the Balanced Budget Act of 1997 (BBA) and the Balanced Budget Reform Act (1999) will affect the willingness of some rural hospitals and other providers to seek to develop new and innovative integrated primary, acute, and long term care programs. For some providers, the development of programs that link or integrate acute and long term care may be just what is needed to preserve the local rural health infrastructure. The Rural Hospital Flexibility Program (RHFP), in particular, offers states and rural communities an opportunity to go beyond planning for the transition of small, distressed rural hospitals to consider strategies to strengthen the continuum of primary, acute and long term care services

Many rural communities and providers will need considerable technical and financial support to enable them to effectively participate in these new initiatives. The RHFP provides an excellent vehicle for linking communities and providers to that needed support. Technical support may be needed to assist providers and communities to assess their needs and current capacities, develop appropriate organizational relationships or alliances, contracting arrangements, financial management systems, information systems, and quality assurance capacity. The need for technical assistance is especially critical among rural long term care providers, most of whom have even less knowledge of and experience with managed care than providers in the medical and post-acute care sector.

**State Long Term Care Policy: The Defining Moment?** The limited rural experience with managed care models that integrate the financing and delivery of primary, acute and long term care services is likely to change as states expand their long term care reform efforts. It is critical that states and the federal government carefully consider the special circumstances and needs of rural communities, providers, and consumers. In particular, states and the federal government should provide flexibility to rural communities and providers in meeting program standards. Technical and financial support to enable rural communities to effectively participate in these new long term care initiatives will also be needed. Other rural needs include: the development of financing and service delivery arrangements that protect and strengthen the ability of local providers and organizations to participate in these initiatives, and support for the development of rural geriatric or chronic care team and care coordination models that encourage professional collaboration among physicians, nurses, and others working in the medical and long term care systems.

## **INTRODUCTION**

Post-acute and long term care services for older persons and persons with serious disabilities are responsible for an ever-larger share of the costs of the Medicare and Medicaid programs. Driven by growing demand and the need to control expenditures, states and the federal government are searching for new managed care strategies, such as capitated financing and coordinated case management, that better integrate the financing and delivery of primary care, acute and long term care services (Health Care Financing Administration 1995; Booth et al. 1997). Integration and managed care are viewed as encouraging a substitution of less costly and more appropriate home and community-based services for high cost medical and long term care services which have been heavily funded under fee-for-service financing systems. To date, the states, which are the largest payers for long term care services, have been the driving force behind the development of these new approaches. Several states, including Arizona, Colorado, Maine, Massachusetts, Minnesota, New York, and Wisconsin and, are experimenting with new managed care models for the elderly and younger adults with disabilities who are dually eligible for Medicare and Medicaid.

For rural communities, the development of delivery systems which better integrate and manage primary, acute and long term care services may help address long-standing problems of limited access to long term care services. The problems of long term care are especially challenging in many rural communities where the delivery system has relied more heavily on nursing home care, and has been characterized by more limited service options, particularly in the areas of rehabilitation, residential care, and home care (Coburn and Bolda 1999; Krout 1998). In response to the incentives of the Medicare PPS and other market forces, many rural hospitals have developed or acquired post-acute care services such as home health agencies and/or skilled nursing facilities as a strategy for managing their inpatient use and diversifying their revenue base. And some rural hospitals have ventured into the world of long term care as well, offering assisted living, adult day service programs, respite programs, or sponsoring meal sites for older persons. On the one hand, there may be important opportunities to pursue integrated acute and long term care system development in these communities where hospitals and communities have expanded the continuum of services beyond post-acute care to include long term care. Yet, there are also many challenges. While rural hospitals may provide some of the capital, leadership and system infrastructure needed to develop these systems, they may not be the most appropriate provider base

for the development of a long term care service network. Nor can hospitals be expected to offer themselves up as targets for the financial savings which policymakers hope to reap from managed care. Moreover, rural consumers and providers have little experience with managed care and providers and are often not prepared to take on such managed care functions as capitated financing and case management, especially across service settings. Acute and primary care providers in many rural areas have only begun to develop the integrated service networks, which have become a central feature of the managed care environment. And most importantly, few providers have extended their network development activities to include long term care services beyond skilled nursing facility care, home health and other post-acute care services covered by Medicare.

Notwithstanding these challenges, there are emerging examples of rural networks and managed long term care programs that offer important insights into the opportunities and challenges of using these approaches in rural settings. This paper discusses the concept of integrated acute (medical) and long term care service networks, some of the model programs that have been demonstrated, the challenges that health care providers, state and federal policymakers, and others have faced in developing these new integrated structures, and the future of integrated approaches in rural areas.

## **THE CONCEPTS OF MANAGED CARE AND SERVICE INTEGRATION FOR OLDER PERSONS**

The expansion of managed care, together with more competitive purchasing behavior on the part of public and private purchasers, has spawned the rapid development of health care networks and other organizational and health service delivery arrangements. This section discusses the concepts behind these new arrangements, their relevance and application to the development of integrated systems and managed care models for acute and long term care services, and the opportunities and challenges of developing managed care approaches in rural areas.

### **Managed Care and Service Networks**

As public and private purchasers have shifted their attention to competitive health care purchasing models, the emergence and growing dominance of managed care has prompted a fundamental change in the nature of primary and acute care integration and network development strategies. The development of managed care models has effectively moved integration efforts beyond organizational strategies designed by

providers to expand access to capital and improve cash flow, to the development of functional and clinical integration strategies for service products designed to compete for buyers on the basis of cost and quality (Burns et al. 1997; Conrad and Shortell 1996) Underlying these current network development activities are the traditional managed care precepts of: (1) a single care management structure which manages care across settings and levels of care need, (2) scrutiny of user demand and utilization of services, with attention to relative costs and benefits of network services, and (3) introduction of management structures and financial incentives to influence providers' attentiveness to the costs and quality of services rendered.

Embedded in the structure of these competitive, managed care models are extensive information systems, encompassing the multiple services of integrated systems and network providers, and increasingly sophisticated management capacity for analyzing individual consumer and physician behavior, resource use and quality. Other key features of integrated systems in the medical care sector include: creation of clinical care guidelines and pathways and quality management protocols, development of new governance and ownership structures, and perhaps most importantly, system-level strategic planning and decision making which encompasses both the financing and delivery of medical services (Conrad and Shortell 1996; Moscovice et al. 1996).

### **Service Networks and Service Integration**

The restructuring of the American health care system is increasingly moving toward the development of organized delivery systems in which the financing and/or delivery of hospital, physician, therapy, lab, and other services are integrated. In its simplest definition, the term "integration" means the bringing together into a more unified structure, previously independent administrative and service functions, services, and/or organizations (Morris and Lescohier 1978; Bird et al. 1998; Leutz 1999). Integration can occur at different levels of both the organization and service system: policy, financing, organization, structure, administrative, and clinical. There are a number of vehicles that promote integration including organizational and service system planning, the development of integrated information systems that support administrative and clinical integration, integrated care planning and management, and staff training (Leutz 1999).

Organizations may engage in a combination of strategies to integrate medical and long term care services. There is no clear continuum or hierarchy that can easily classify approaches to integration. To understand the concept of integration as applied

to primary, acute, and long term care, it is important to distinguish between **what is being integrated** (the target population(s) and scope of services), **how functional and clinical integration occurs** (types of integration), and the **level of financial incentive and strategic management that is being achieved** (degree of integration).

**Population Served and Scope of Services:** Depending upon the policy or management objectives, there may be differences in the target population(s) as well as the types of services that need to be integrated. For example, integration models targeting the well elderly are most likely to encompass the full range of primary and acute care services and limited post-acute care services (short-term skilled nursing, rehabilitation care, skilled nursing facility services, and hospice care). If the frail elderly are the target population, then the scope of services must be broadened to include additional long term care services, both institutional and home or community-based, including personal care, transportation, assisted living, adult day care, and respite services. Which of these long term care services are included in an integrated system will largely depend on:

- purchasers' demands, including federal and state policy objectives and financial incentives;
- the local medical and long term care service infrastructures; and
- existing service capacity relative to demand.

The breadth of integration generally refers to the number of different services provided along a continuum of care and the depth of integration generally refers to the number of different operating units in a system providing a given service (Shortell et al. 1993).

**Types of Integration:** Among the different types of integration, two are most relevant: clinical integration and functional integration (Gillies et al. 1993). Clinical integration is generally defined as the extent to which patient care services are coordinated within and across organizational units. Functional integration refers to the extent to which administrative and other support functions and activities are coordinated within and across organizational units.

Clinical integration is perhaps the most important element of an integrated medical and long term care system. With regard to long term care, clinical integration is especially important as a means for achieving greater access to the full range of long term care services through “downward” substitution of home and community-based services for more expensive nursing home and other institutionally-based care. At the

organizational level, clinical integration may involve horizontal and/or vertical linkages among different types of service providers. There might be use of common patient assessment tools, a common/shared medical record, quality assurance protocols, and/or the sharing of other clinical procedures or standards. Clinical teams and/or the use of care coordinators are also common strategies for achieving clinical integration.

Functional integration involves the sharing or coordination of support services across organizational units. Common financial management, human resource management, marketing, strategic planning, information systems, and quality improvement are often vehicles for functional integration. Functional and clinical integration strategies may be pursued independently of each other.

**Degree of Integration:** There is no commonly accepted continuum or hierarchy defining or measuring degrees of integration. Various forms of integration are emerging which suggest a continuum (Conrad and Shortell 1996). Two are most relevant to this paper. The first is the classic form of vertical integration through common ownership: a hospital purchases a nursing home. The second form involves tight but changeable contractual relationships, as in the case of a managed care organization, a hospital and a long term care facility that have contractual agreements but maintain separate ownership and governance. Such contractual arrangements may be accompanied by formal affiliation agreements laying out areas of cooperation but maintaining separate ownership and governance. Varying degrees of integration may be represented in these different forms—the proof is in the specific arrangement and agreements. In general, however, the degree of integration defined by mutual financial incentives and strategic management is greatest where organizations have common ownership. Affiliations may approximate common ownership depending upon the tightness of the affiliation arrangement. Contractual integration is the loosest of the forms.

## **WHY INTEGRATE?**

Integration has become a paradigm for health care providers seeking to successfully compete in the rapidly expanding managed care marketplace. The pursuit of integration has been premised on the assumption of both economic and clinical benefits. In theory, integrated models of financing and service delivery produce greater efficiency and cost savings (Shortell and Hull 1996). By bringing the various components of the health system together, it is presumed that integrated systems can achieve economies of scale and cost reductions in both administrative and clinical areas.

In addition, better care management systems are expected to produce both cost savings through reductions in inappropriate care and improvements in the quality of care and outcomes (Gilles et al. 1993). For purchasers, including state Medicaid programs, integration of financing (Medicare and Medicaid) and service delivery (primary, acute and long term care) is seen as a way of aligning parts of the health system which, under fee-for-service payment arrangements, have tended to be cost-shifted from one payer to another. For consumers, integration is assumed to produce more convenient, accessible, and clinically effective systems by reducing the degree of service and system fragmentation that characterize much of the medical and long term care financing and delivery systems. Despite the enthusiasm for organizational consolidation and integration in the health system over the past decade, there is interestingly little research to indicate that these benefits have been attained as a result of the restructuring that has occurred.

### **APPLICATION TO THE LONG TERM CARE SECTOR**

Until very recently, trends toward greater system integration and managed care have proceeded along very separate tracks in the medical care and long term care sectors. Networks and systems for care of persons with chronic care needs are in their infancy (Stone and Katz 1996; Fox and Fama 1996). Few integrated networks and systems include in-home and non-medical residential long term care services. This is especially true for consumers whose needs exceed Medicare's limited post-acute care benefits and/or benefit period.

Acute and long term care services vary on multiple dimensions and operate within very different frames of references, (Figure 1) not the least of which is the reality that acute care costs are driven by **intensity of services** while long term care costs are more sensitive to **duration of services** (Vladeck 1994). Fundamental differences between the medical care and long term care systems contribute to the challenges of developing integrated, managed care programs spanning these two sectors. Unlike changes in the medical sector, neither federal policy, private insurers, nor private purchasers have exercised much direct influence on system integration and the development of managed care models within the long term care sector. These realities and challenges are reflected in the two primary sources of financing—the Medicare and Medicaid programs. In the continuum of primary, acute and long term care services, the Medicare program finances primary and acute care services, including home health and skilled nursing facility services. Medicaid is the primary payer for long term care services

including home and community-based services and non-skilled nursing facility services. The coordination and management of services and costs across the Medicare and Medicaid programs has, until recently, been limited to state efforts to coordinate the benefits of these two programs through their third-party liability units. Medicare, the principal payer for primary, acute, and post-acute care for older persons and persons with long term disabilities, does not cover long term care services. Consequently, there are few federal policy incentives for improved cost-efficiencies within the long term care delivery system.

Medicaid, on the other hand, is the primary payer for long term care services. Long term care has been characterized by continuing efforts by state policy makers to define a system of services that can achieve greater coordination

Figure 1

### Differences in Acute Versus Long term Care

| <b>Acute Care</b>                 | <b>Dimensions</b>    | <b>Long term Care</b>                          |
|-----------------------------------|----------------------|--|
| Acute Illness                     | Demand Source        | Chronic Illness                                |
| Diagnosis                         | Critical Source      | Function                                       |
| Hospital->Outpt Dept              | Site                 | Nursing Home->Home                             |
| Sharply Delineated                | Boundaries           | Fuzzy  |
| Cure                              | Desired Outcomes     | Maintenance                                    |
| Professionals                     | Caregivers           | Family Members                                 |
| Physician Directed                | Professional Roles   | Physician is absent—<br>other turf is disputed |
| Interventionist                   | Styles of Care       | Maintenance                                    |
| High                              | Technology           | Low  |
| Dynamic Science                   | Intellectual Basis   | Pre-paradigmatic                               |
| Intensity<br>(duration minimized) | Cost Drivers         | Duration<br>(intensity minimized)              |
| Medicare                          | Primary Public Payer | Medicaid                                       |

Source: Vladeck, 1994

of care and cost control through more appropriate targeting of high-cost institutional and home care. The initiation of care management programs that provide client assessment, care management, quality assurance, and utilization review has been a common element of states' long term care policy strategies (Weiner and Stevenson 1998).

Private long term care insurance covers a very small proportion of older people and an even smaller percentage of current long term care consumers (Alecxi and Lutzky 1995). Private purchasers of long term care services have, as yet, not demonstrated much influence on the development of managed care plans integrating acute and long term care services. While private payors have been instrumental in creating private demand for integrated long term care products such as those provided through continuing care retirement communities (CCRCs) and newly emerging housing and service options (i.e. "assisted living,"), it is unlikely that federal Medicare coverage of acute and sub-acute care services will promote independent development of integrated acute and long term care managed care products for private purchase.

In the last five years, states have begun to search for new financing and service models for controlling Medicaid-financed long term care costs through the application of managed care principles and systems (Booth et al. 1997). Central to these efforts has been a growing recognition that integrating the financing and management of care across primary, acute, and long term care services (and across the Medicare and Medicaid programs) is critical for controlling costs and assuring appropriate care for persons with chronic illness and disability who are the highest cost users of services.

The basic features of these managed care systems include:

- the development of financing arrangements that encompass medical and long term care services and provide incentives for cost control across both services;
- incentives for the creation of service networks capable of providing or accessing the full range of covered services; and
- the development of care management mechanisms necessary for assuring consumer-centered care, care quality and the appropriate mix and use of resources/services.

These features are beginning to be reflected in demonstration programs, which selected states are implementing under federal Medicare and Medicaid waivers (Booth et al. 1997).

## **THE RURAL ISSUES AND QUESTIONS**

Based on prior research on integrated acute and long term care programs and on our understanding of the characteristics of rural communities and service systems, there are a number of important questions regarding the feasibility of developing managed care and service integration strategies for primary, acute and long term care in rural areas. The following are among the key questions and issues addressed in this paper.

### **How does the level of local experience with managed care affect rural capacity to develop and manage integrated acute and long term care strategies?**

Many of the important demonstrations of integrated acute and long term care systems, including the Social Health Maintenance Organization (S/HMO) demonstration and Arizona managed long term care program, have grown out of market environments in states where managed care has become a central feature of the health care marketplace. Many rural areas lack such a foundation of managed care experience and infrastructure. Between 1984 and 1998, enrollment in managed care plans grew from 5% of those with health insurance to 85% (GAO 1997; Kuttner 1999). Most of this growth has been concentrated in urban areas. Although more than 80% of all rural counties are in the service area of a Health Maintenance Organization (HMO), rural enrollment in managed care is very low. Recent estimates from 8 states show rural enrollment rates ranging from less than one percent in Wyoming to 17% in Wisconsin (University of Minnesota 1997; Christianson 1998). Current enrollment in Medicare managed care plans is equally low among rural beneficiaries--less than 5% compared with nearly 20% enrollment among urban seniors (McBride et al. 1998). The limited experience of providers and consumers with managed care in most rural areas may be a constraining factor in the development of integrated and managed care programs for the elderly.

### ***To what extent, have integrated, managed care programs serving the rural elderly and younger disabled adults used risk-based contracting and with what experience and results?***

The most obvious challenge to the integration of managed acute and long term care is population size. Given the volatility of health risks in smaller populations, some have questioned the capacity of rural providers to assume financial risk in the general

managed care market; assuming financial risk for populations that are older and sicker is even more problematic.

***What strategies have been used to overcome the problems of shortages of physician and other health personnel, and limited community-based and in-home long term care availability in rural communities? What impact has the development of integrated managed care programs had on service supply?***

Managed care penetration tends to be highest in markets where excess provider and service capacity provides health plans the ability negotiate with providers on the basis of price and other considerations. Contrast this with most rural areas where the limited health and long term care service infrastructure in many rural areas presents fundamental challenges to the development of integrated acute and long term care services. In addition to the well-known shortages of physicians, rural areas are known to have widely varying supply of long term care service options (both residential and home-based care) vital to the development of an integrated acute and long term care service system (Krout 1998).

***How does the smaller size and greater interdependence among rural health service providers affect the degree of interdisciplinary cooperation and support between those in the medical and long term care sectors?***

While limited service supply may represent a potential disadvantage for the development of integrated acute and long term care services, smaller size may be a distinct advantage in facilitating participation and cooperation (collaboration) among managed care organizations and the governmental, provider and consumer sectors in rural areas. Does the experience of the rural initiatives suggest that this is the case?

## **INTEGRATION AND MANAGED LONG TERM CARE MODELS: MAKING THEM WORK IN RURAL AREAS**

### **Selected Models**

Despite growing interest in integrated models of acute and long term care financing and service delivery, there are still relatively few operational examples of such programs to learn from. Rural models are even harder to find (Coburn et al. 1998). The purpose of this section therefore is not to present a comprehensive inventory of programs and models but rather, to highlight from a selected few of them, the rural experience and issues.

**Arizona Long term Care Services Program (ALTCS):** In 1982, the Arizona Health Care Cost Containment System (AHCCCS), a statewide, mandatory Medicaid managed care program, was initiated with the authorization provided by a Section 1115 Medicaid waiver. This program only covered primary and acute care services. In 1989, Arizona expanded this Medicaid managed care program to include long term care services for elderly persons and persons with disabilities who are at risk of institutionalization. Known as the Arizona Long term Care Services Program (ALTCS), this program pays a capitated rate to contractors, who are at risk for a full range of Medicaid- financed acute and long term-care services. For those with dual Medicare and Medicaid eligibility, Medicare is billed separately by providers (Riley and Mollica 1995).<sup>1</sup>

Two of the ALTCS contractors are rural counties – Pinal and Cochise Counties. These two counties represent rare examples of fully integrated, capitated rural health care systems for the frail elderly and younger physically disabled adults. Elsewhere in Arizona, the significant managed care penetration and the experience of the AHCCCS program provided the foundation for the ALTCS initiative. In Pinal nor Cochise counties, however, the involvement of the County Health Department was essential for launching the ALTCS program given the limited managed care experience of most rural providers in these counties.

The Pinal and Cochise county long term care programs represent a “Medicaid only” approach to managed acute and long term care services. Both counties manage a capitated primary, acute and long term care service network serving frail elderly and younger physically disabled Medicaid clients. The counties’ acute care networks include both rural and urban hospitals and rehabilitation facilities. Members are served by contracted primary care providers who work with staff care managers. Long term care services are provided through a contracted network of sub-acute care providers, nursing facilities, home health, home care, and respite care providers.

**The Community Nurse Organization (CNO) Demonstration-Carle Clinic:** The Carle Clinic CNO demonstration represents a “Medicare-only” approach to managed acute and long term care (Schraeder and Britt 1997). The Carle Clinic Association and the Carle Foundation represent a complex, integrated health system based in central Illinois. With a third partner, Health Alliance Medical Plans, Inc., a wholly owned subsidiary of

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<sup>1</sup> The majority of ALTCS participants are dually eligible for Medicare and Medicaid. Most Medicare beneficiaries are in the fee-for-service system, which to a degree, provides a safety valve for providers that are capitated under the Medicaid ALTCS program.

Carle Clinic Association, they form the regional medical center for 8 million residents of mostly rural central Illinois. The Carle Clinic is one of four (and the only rural) sites for the HCFA-sponsored Community Nursing Organization (CNO) demonstration.<sup>2</sup> Initiated in 1992, this demonstration provides community nursing and ambulatory care services on a prepaid, partially capitated basis, to voluntarily enrolled Medicare beneficiaries. This demonstration is testing the provision of a specific, limited set of primary care and post-acute care services under partial capitated financing. For Carle, this initiative is part of their collaborative practice model, using nurses as partners with patients, their families, and primary care physicians.

**Program of All-inclusive Care for the Elderly (PACE):** PACE is a national program originally authorized on a demonstration basis under the Social Security Act. Under the Balanced Budget Act of 1997, the PACE program was shifted from a demonstration limited to 15 sites to a permanent program in which the program will be treated as a provider type under Medicare and as a State plan option in the Medicaid program.

PACE is built upon the model of integrated services developed by On-Lok Senior Health Services in San Francisco. Using a provider-sponsored model, the PACE program offers a full range of primary, acute, and long term care services, including home care, nursing home, and hospital. Key program elements include case management provided by multi-disciplinary teams and day health centers where much of the care management, health status monitoring, and primary health care provision takes place. The PACE program targets persons at least 55 years of age that meet the eligibility standard for nursing home care.

There are currently 20 operational PACE sites with an addition 10-12 sites in the pre-operational planning phase. One of the operational sites, Palmetto SeniorCare is sponsored by the Richland Memorial Hospital based in Columbia South Carolina (population 100,000) and serves rural populations and areas in the counties surrounding Columbia; the other PACE sites are located in larger metropolitan areas.

**Social Health Maintenance Organizations (S/HMO):** In the S/HMO model a single organizational entity is responsible under a capitation arrangement with HCFA for managing a comprehensive package of integrated primary, acute and long term care services for older Medicare beneficiaries (Leutz, Greenlick, Capitman 1994). The original

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<sup>2</sup> Abt Associates is currently completing an evaluation of the CNO demonstrations for HCFA. These demonstrations are scheduled to terminate but the current sites are seeking Congressional support for their continuation.

model targeted both healthy older Medicare beneficiaries and those needing long term care services as a way of spreading the financial risk of the program. The long term care benefit in the S/HMO is limited to those who are eligible for nursing home care or at risk of institutionalization. The long term care benefits are limited to home care and nursing home care and are accessed through a case management function performed by the S/HMO. None of the original or expanded S/HMO sites serve rural populations.

**Wisconsin Partnership Program:** The Partnership Program includes an integrated program targeted to older persons (60 years plus) that is serving rural populations. Delivered through community-based agencies with expertise serving older persons, the Partnership Program includes many elements of PACE such as care management and capitation. However, day center attendance is not required as it is in the PACE model. In addition, the Wisconsin Partnership program varies from the PACE model by allowing independent physicians in an IPA arrangement.

**Colorado Rocky Mountain HMO:** The State of Colorado and the Rocky Mountain HMO in Grand Junction have been planning for several years a demonstration to provide integrated primary, acute, and long term care services to Medicaid and Medicare (dually eligible) beneficiaries in rural, Mesa County. The original program design called for the plan to be paid a capitated rate inclusive of the costs of all primary, acute and long term care services. Like many of the demonstrations that are attempting to integrate the financing to include Medicare payments, there have been major problems working out the Medicare payment arrangements (Saucier and Fralich 1999).

**Other State Initiatives:** There are a growing number of new state initiatives that seek to better integrate and manage the primary, acute, and long term care services financed by the Medicaid and Medicare programs (Booth et al. 1997). In Monroe County New York, for example, the Monroe County Community Coalition for Long term Care, has created “Continuum of Care Networks” which are designed to integrate services, capitate funding from public and private sources and improve access to long term care services (Booth et al. 1997). In Maine, the Medicaid program has developed the “MaineNET” program, which will utilize a primary care case management model to promote greater integration and management of the full range of primary care, acute care, and long term care services. As states continue to search for ways to control their long term care costs, we are likely to see more innovative models emerge that seek to integrate the financing and delivery of services in both urban and rural areas.

## **The Rural Issues: Is the Rural Medical and Long Term Care System Ready for Integration?**

With few exceptions, these and other state initiatives target urban rather than rural populations, at least initially. With only limited examples of rural integrated, managed acute and long term care programs, there has been very little research attention paid to the question of whether and how such programs might be developed in rural areas and the effects they could have on rural beneficiaries and health care systems. In 1996-97, the Maine Rural Health Research Center undertook a study of three rural examples of integrated programs: the Arizona Long term Care Services Program (ALTCS), the CNO demonstration at the Carle Clinic in Illinois, and the Copley Health System in Morrisville Vermont. The case studies of these initiatives, which are described in greater detail elsewhere (Bolda and Seavey 1999), revealed a number of important problems and lessons regarding the application of current integration models in rural areas and implications of integrated structures for the delivery of services in rural areas.

There is a growing literature on rural managed care, which although not specific to acute and long term care integration, is nonetheless relevant to the question of whether managed care will expand into rural areas and, if so, with what impact (Christianson 1998; Krein and Casey 1998). This literature, together with the research to date on integrated acute and long term care systems, suggest that there are a number of critical issues for states and rural communities to consider as they contemplate ways of redesigning the financing and delivery of services to achieve better integration, access and quality. Although many of these issues can be characterized as “barriers” to integrated financing and service delivery approaches in rural areas, there are some which, based on the experience to date, may also represent opportunities.

**Integration costs money:** The development of integrated acute and long term care programs is expensive, requiring an intensive investment of capital and organizational leadership that is often lacking in rural areas (Kane, Illston, and Miller 1992). For example, it has been estimated that PACE programs require between \$1-1.5 million in start-up capital to cover the fixed costs of facility renovations and the initial operating losses that inevitable occur as the program moves to full enrollment (State Workgroup on PACE 1999). The development of the organizational, administrative and clinical systems needed to integrate and manage care, especially in a capitated or risk-based

financing system, is well beyond the capacity of the average rural provider or health system.

Rural hospitals have often been the financial engine for health system development in rural communities. There is a dilemma, however, regarding hospital involvement in the development of integrated primary, acute, and long term care systems. On the one hand, the hospital's financial and administrative clout is needed to support the development of these new systems. Yet, given their predominantly medical orientation, hospitals may not be the most appropriate provider base for the development of an acute-long term care network. Nor can hospitals be expected to take the lead in initiatives that will target them for cost reductions.

In some rural communities, financial pressures on small rural hospitals and other health care providers may restrict access to the financial resources needed to develop the critical administrative and clinical systems that are central to an integration strategy. Many rural hospitals have fared very well in recent years under the Medicare PPS system, and have invested heavily in the development of expanded rural health networks as a strategy for survival in the increasingly competitive world of managed care. For example, 1995 data from the American Hospital Association show that over 65% of all rural hospitals have developed or acquired home health agencies; over a third of rural hospital own both a home health agency and a skilled nursing facility. Notwithstanding the changes made in the Balance Budget Reform Act (1999), the effects of Balanced Budget Act cuts in Medicare payments to hospitals and other providers, may reduce the ability of rural hospitals to invest in strategies and programs for achieving greater integration across the primary, acute, and long term care sectors (Rural Policy Research Institute 1999).

**Rural providers have limited managed care experience:** Coupled with the problem of the large capital investments needed to develop these programs is the reality that most rural providers have had very limited experience with managed care and therefore are not likely to be inclined or prepared to participate in managed care programs for high risk, vulnerable populations such as the frail elderly.

**Limited services and service delivery mechanisms in rural areas:** To adequately address the complex health care and social support needs of frail, older persons, programs that seek to integrate acute and long term care services in rural areas must deal with the common service limitations that exist in many rural areas. Not only is service availability crucial to the ability of plans to offer the full range of services included

in the scope of benefits, but having sufficient providers in an area is important for plans to be able to negotiate fee discounts and/or deal with quality of care problems should they arise. Access to specialty services, such as physical therapists, psychiatrists, and transportation is among the most significant hurdles that must be overcome. In addition, programs must recognize that transportation and other costs are often higher than in rural areas, making capitation and other risk-bearing financing arrangements more complicated. From a plan perspective, achieving cost savings in rural areas is likely to be more difficult because of these higher costs. In general, savings are harder to obtain in rural areas as well because there is less “fat” in rural health systems.

The experience to date suggests that rural integrated programs are most likely to be developed through partnerships between rural medical and long term care service providers and larger organizations such as county health systems, hospitals, and/or managed care organizations. The model of urban-based providers reaching out into surrounding rural areas to establish local satellite programs is one that may fit in a number of rural areas. In this way, the rural sites may gain access to a broader range of specialty and other services than could be developed locally.

**Rural means small:** What are the advantages and disadvantages of the small population base of most rural areas? On the one hand, a small population base of most rural areas makes it difficult if not impossible to consider financing strategies that shift a substantial portion of the financial risk for health care use and costs to rural providers. The small numbers of beneficiaries, together with the unpredictable and volatile nature of health care needs and use in a small population (and especially with a population such as the frail elderly), make such strategies impractical.

But there may also be some benefits of small population size that could be an advantage for rural communities and providers. In smaller communities where medical and long term care service providers are likely to know their clients and provider colleagues better, care management across systems may be easier to achieve than in urban settings. Moreover, in smaller communities, health and long term care providers must work together on a regular basis, which may make it possible to achieve cooperation more easily than in more complex organizational environments.

**Aligning the incentives and professional culture:** Currently, there are few incentives for communities, medical and long term care providers, or health plans to develop programs that integrate long term care into the continuum of primary and acute care services. The incentives for hospitals under the Medicare PPS and continued cost

reimbursement of post-acute care (until the recent BBA changes) propelled hospitals and health systems to add home health care and, in some cases, skilled nursing facility care to their continuum of health services. Few have ventured into the arena of non-medical home care, residential care, and other long term care services, however. The primary reason is that there are few financial or other incentives for doing so.

It is hard to overestimate the importance of state policy in shaping the strategies that health plans and providers will take in forming service networks that better integrate the delivery of primary, acute, and long term care services. In states like Minnesota, Wisconsin, and elsewhere, where the Medicaid and state long term care program(s) have been active in developing new financing and managed care arrangements for chronic care population, there is a far greater likelihood of rural participation and experimentation with different program models.

It seems quite clear that integrated networks that encompass the full range of services are most likely to be stimulated to form when the prospects of managed care contracting are real. The recent volatility in the managed care market and especially in the Medicare managed care program, has led many plans to leave rural markets. This trend, if it continues could have a significant effect on the development of rural integrated network if states are unable to secure MCO partners.

The specific characteristics of these networks, including the scope of services included and the nature of the relationships among them will be determined by the nature of those contracts. Contrary to common perceptions, the experience of Arizona, Wisconsin and other states indicates that some rural communities are not only prepared to respond to these challenges, but also represent valuable testing grounds for learning what works and what doesn't in this very new arena of integrated acute and long term care services.

Differences in professional cultures and distrust between those who provide medical services and long term care services are fundamental problems in integrating the financing and delivery of services across these two sectors. Traditionally, long term care providers are more comfortable with models of care that emphasize the use of social support services to maximize independence and quality of life. Conversely, for many medical providers, inexperience in working with the long term care sector can often be a barrier to effective communication and collaboration.

**Do organizational and ownership structure matter?** The experience to date indicates that organizational structure differs significantly among integration initiatives and that

structure may be important in facilitating the development of both functional and clinical integration, two critical, necessary conditions for effective managed care organizations. At one extreme, there are consolidated ownership structures, such as those represented by the Carle Clinic and other integrated delivery systems that enable providers to pursue system re-design with minimal negotiations with other interested organizations. In the case of the CNO demonstration, this consolidated ownership structure has contributed to their ability to integrate care management and administrative functions central to the demonstration. At the other extreme, the Arizona experience demonstrates that ownership is not a necessary condition for success, as both Pinal and Cochise Counties successfully contracted for services most of which fall outside county-operated health services. This network of services operates, however, within a tightly defined set of state and county regulations and contractual arrangements.

Perhaps more important than organizational and ownership structure are the problems that distance pose for the integration of clinical and administrative services. Physical proximity and, preferably, co-location of providers is highly desirable in encouraging effective communication. Where this is not possible, information systems and communication technologies become important. Long distances among providers make the care management process more challenging. Establishing both formal and informal information and communication systems are critical to effective care management in these circumstances.

## **THE FUTURE OF MEDICAL AND LONG TERM CARE INTEGRATION IN RURAL AREAS**

### **Is Integration the Gold Standard?**

Typically, integration strategies involve the creation of new programs or organizational units where financial, staff, and other resources from multiple systems are pooled. The PACE and S/HMO demonstrations are good examples of such fully integrated models. The expansion of these models in rural settings remains uncertain. States and providers may seek to develop rural PACE or PACE-like programs and/or sites now that the PACE program has been opened to further expansion. But do these models conform to the realities of most rural areas? In most cases, the answer to this question is no. Yet, this does not necessarily mean that rural communities and health and long term care providers cannot pursue efforts to improve the provision of primary, acute, and long term care services.

Integration is not necessarily the gold standard for improving the care of older persons. Other strategies that involve “linkage” or “coordination” approaches may be just as effective and certainly more feasible in most rural areas (Bird et al. 1998; Leutz 1999). Rural providers already engage in a great deal of “linking” behavior that connects rural consumers to medical and long term care services to which they are entitled. To encourage this behavior, rural health care providers must understand the eligibility requirements for long term care services and that they actively screen consumers to assess their needs and eligibility for such services. One strategy for system improvement in rural areas is for rural medical and long term care providers to more systematically develop the knowledge and support systems needed to expand and improve these linkage strategies.

“Coordination” represents a more formal approach to service linkage. A coordination strategy involves the development of explicit structures, systems, and protocols for linking consumers to services and managing their care (Leutz 1999). There can be different components to a coordination strategy, ranging from the coordination of benefits to the development of mechanisms to share clinical information among providers. The Carle Clinic CNO demonstration and Maine’s MaineNET initiative represent examples of programs that rely on a coordination strategy. Although, there is usually a designated organization and staff responsible for managing the coordination process, coordination differs from integration in maintaining the autonomous roles of separate organizations and structures.

In the final analysis, integration is not an end to itself. Rather, it is a means toward the goal of improving the care of older persons by enhancing timely access to appropriate and high quality health and long term care services. In rural areas, where integration is a noble but difficult goal to achieve, incremental linkage and coordination approaches may be more appropriate and effective.

### **Professional Collaboration**

The collaboration of physicians, nurses, social workers, and paraprofessional long term care staff is vital to the development of viable managed care programs that integrate services across the primary, acute, and long term care sectors. The physician’s role is critical in this regard. Most physicians are unaccustomed to dealing with long term care providers and rarely have had experience in coordinating with care managers. Some busy rural physicians are likely to view the involvement of the care manager as an additional layer and burden. In all likelihood, however, the care manager can relieve the

physician and his or her office staff of the need to navigate the complex world of long term care themselves. Physician education and other efforts are needed to bring physicians into the process of coordinating and managing care across the acute and long- term care continuum. The development of rural geriatric or chronic care team models may be an important strategy. Changes in state professional licensure laws and rules may be needed to enable these teams to function effectively, especially in rural areas where distances and other factors affect supervision and other aspects of the collaborative practice model.

### **The Effects of Medicare Policy: Barriers or Opportunities?**

The Balanced Budget Act of 1997 (BBA) contains numerous policy changes with important implications for rural health systems. On the one hand, the BBA made changes in Medicare payment policies for hospital inpatient and outpatient services, home health, and skilled nursing facilities which, if they result in the payment reductions to rural hospitals that some are anticipating, could seriously undermine the financial strength and viability of some rural hospitals. On the other hand, the BBA also contains important provisions aimed at strengthening the rural health infrastructure, namely the Rural Hospital Flexibility (Critical Access Hospital) Program and changes in the methodology for calculating the Average Area Per Capita Cost which is used to pay health plans for Medicare beneficiaries enrolled in risk-based managed care plans (Rural Policy Research Institute 1999). While it is too early to know how rural providers and health systems will be affected by these important changes, the uncertainty and concern that the payment policy changes have created will affect the willingness of some rural hospitals and other affected providers to seek to develop new and innovative integrated primary, acute, and long term care programs. Yet, for some providers, the development of programs that link or integrate acute and long term care may be just what is needed to preserve the local rural health infrastructure.

The Rural Hospital Flexibility Program, in particular, offers the opportunity in some communities served by smaller rural hospitals, to reconfigure their health system to address the broader continuum of long term care needs. The Rural Hospital Flexibility Program creates a new category of hospital – the Critical Access Hospital – that provides a more limited range of services than is normally required of an acute care hospital. Specifically, hospitals meeting the CAH designation criteria will be limited to 15 beds (plus 10 swing beds) and can only provide services to patients for up to an average

length of stay of 96 hours. Under the Rural Hospital Flexibility Program the state and federal designation of CAH hospitals must be done within the context of an approved state rural health development plans in which states have broad authority to assess the needs and problems of rural health systems and provide financial assistance to rural providers and communities to begin addressing those needs. Under the Rural Hospital Flexibility Program, states will up to \$25 million in federal support through 2002 for these planning and technical assistance activities.

The framework of the Rural Hospital Flexibility Program provides states and rural communities with an important opportunity to go beyond planning for the transition of small, distressed rural hospitals to consider strategies to strengthen the continuum of primary, acute and long term care services. In doing so, providers and communities must realize that there is no single managed care model that fits all places and circumstances. In fact, the diversity of approaches that is being taken currently is likely to be very helpful in sorting out what works and what doesn't. This diversity is particularly important to rural areas, many of which are likely to require programmatic improvisation in order to make managed care work. It is especially important that states, the federal government, health plans, and others provide flexibility to rural communities and providers in meeting program standards.

Many rural communities and providers will need considerable technical and financial support to enable them to effectively participate in these new initiatives. The Rural Hospital Flexibility Program provides an excellent vehicle for linking communities and providers to that needed support. Technical support may be needed to assist providers and communities to assess their needs and current capacities, develop appropriate organizational relationships or alliances, contracting arrangements, financial management systems, information systems, and quality assurance capacity. The need for technical assistance is especially critical among rural long term care providers, most of whom have even less knowledge of and experience with managed care than providers in the medical and post-acute care sector.

As the cases in Arizona demonstrate, it is possible for smaller, rural plans to assume risk for inherently risky populations and costly services. The context and managed care history of a particular rural area is critical for determining whether and how far a community and its health system can go in meeting the organizational, financial, and clinical management challenges inherent in integrating the financing and delivery of primary, acute, and long term care services. In most cases, however, there

will be a need for flexible risk sharing and/or financial protection options. Specifically, the development and testing of partial capitation, risk sharing approaches, primary care case management models, and other payment arrangements is needed. Stop-loss and re-insurance protections may also be needed to assure that rural providers are appropriately protected from catastrophic losses and that consumers are shielded from the risks of quality of care problems associated with underservice stemming from inappropriate financial incentives.

The infrastructure of local support services for the elderly is particularly fragile in many rural communities. Developing financing and service delivery arrangements that protect and strengthen the ability of local providers and organizations to participate in these new managed care initiatives is especially important. The experience in Arizona demonstrates that managed care initiatives can serve the interests of rural communities in preserving and building their medical and long term care infrastructure by identifying and addressing service gaps, encouraging the development of local services and organizations, and building organizational alliances that strengthen the local service system.

### **State Long Term Care Policy: The Defining Moment?**

The experience with models that integrate the financing and delivery of primary, acute, and long term care services is limited, especially in rural areas. This is likely to change, however, as states expand their long term care reform programs. The Health Care Financing Administration and the Robert Wood Johnson Foundation are both sponsoring demonstration programs that seek to develop innovative programs to better manage the care for older persons and persons with disabilities who are dually eligible for the Medicare and Medicaid programs. Moreover, a number of states are engaged in significant long term care system reform efforts the key features of which include the expansion of non-institutional care alternatives (e.g. home care, non-medical residential care) for at-risk individuals, the development of financing approaches that support better management of complex medical and social support needs and problems, and better coordination or integration of services across the primary, acute, and long term care systems.

These state initiatives may or may not create incentives and/or a framework for health and long term care system reform that are appropriate to the circumstances and needs of rural communities and health systems. It is critical, therefore, that states and

the federal government carefully consider the special circumstances and needs of rural communities, providers, and consumers as they develop and undertake these initiatives. The experience to date is limited and indicates that there are numerous challenges to overcome in rural areas. Yet, it is clear from states like Arizona, that it is feasible for rural areas to apply new approaches to health and long term care financing that create incentives and mechanisms for coordinating and integrating services across the continuum of medical and long term care services. Furthermore, there is evidence that these initiatives can have beneficial effects in strengthening both the medical and long term care infrastructure in rural areas.

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