

## Models for Integrating and Managing Acute and Long Term Care Services in Rural Areas

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### Executive Summary

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.

### 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. By bringing the various com-

ponents 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.

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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. 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. 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. 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.

(Bird, D., D. Lambert, A. Coburn, and P. Beeson (1998) "Integrating Primary Care and Mental Health in Rural America: A Policy Review," *Administration and Policy in Mental Health*, 25(3): 287-308.  
Leutz, W. (1999) "Five Laws for Integrating Medical and Social Services: Lessons From the United States and the United Kingdom" *The Milbank Quarterly* 77(1): 77-110.)

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Established in 1992, the Maine Rural Health Research Center (MRHRC) is one of five national rural health services research and policy analysis centers funded by the federal Office of Rural Health Policy. The Center is also one of five rural managed care centers funded by the federal Agency for Health Care Policy and Research (AHCPR). The Center has three areas of special interest in its research agenda: (1) the availability, organization, and financing of rural mental health services, (2) institutional and community-based services for rural elders, and (3) changes in the organization and financing of rural health services.

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