



RURAL MODELS FOR INTEGRATING
AND MANAGING ACUTE AND
LONG-TERM CARE SERVICES



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

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EXECUTIVE SUMMARY

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 integrate the financing and delivery of primary care, acute and long-term care services. For rural communities, 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 access to long term care services.

This paper describes three examples of emerging rural systems that offer insights into the opportunities and challenges of managing and integrating primary, acute, and long term care in rural settings. These examples include: (1) Cochise and Pinal Counties, Arizona, county-based managed care programs which, operating under the state's managed Medicaid long term care program (Arizona Long Term Care Services), manage a capitated primary, acute and long term care service network serving frail elderly and physically disabled Medicaid clients; and (2) The Carle Clinic, one of four (and the only rural) sites for the HCFA-sponsored Community Nursing Organization (CNO) demonstration.

These initiatives illustrate both the diversity of rural managed care and integration models and the variety of challenges that must be faced in developing models that accommodate the realities and circumstances of rural communities and health systems. The case studies examine the importance of population size, the effects of service supply and infrastructure, the role of state and federal policies, and prior experience with managed care in the development and success of these initiatives. These demonstrations suggest that small population bases do not preclude the development of managed care programs for these populations and that various forms of risk-based financing can be used to protect providers and consumers. The introduction of managed care in Arizona has strengthened the rural, previously underserved health and long term care service systems in both Pinal and Cochise counties. Not surprisingly, the level of managed care penetration in the broader health care market and the level of provider and consumer experience with managed care are critical factors in facilitating or inhibiting the development of managed care programs for the elderly and disabled. The characteristics of the community, county, or region, including the effectiveness of local leaders, the sense of community and the degree of support for local organizations and providers, can all be critical factors in the development of these initiatives. Differences in professional cultures and mistrust between those who provide medical services and those who provide long term care are fundamental problems in integrating the financing and managing the delivery of services across these two sectors.

Although experience with managed care 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 as states expand their use of Medicare and Medicaid, Section 1115 waiver demonstrations. Whether these programs work, how much they cost, and whether they deliver high quality care are questions of paramount policy importance. As these initiatives are updated and evaluated, it is critical that states and the federal

government carefully consider the special circumstances and needs of rural communities, providers, and consumers. The experience of these suggest a variety of rural policy considerations, including: the need for states and the federal government to provide flexibility to rural communities and providers in meeting program standards, the need for considerable technical and financial support to enable rural communities to effectively participate in these new managed care initiatives, the development of financing and service delivery arrangements that protect and strengthen the ability of local providers and organizations to participate in these new managed care initiatives, and support for the development of rural geriatric or chronic care team models that encourage professional collaboration among physicians, nurses, and other professionals and paraprofessionals 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, and growing, 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; Saucier et al. 1997). To date, the states have been the driving force behind the development of these new approaches. Several states, including Arizona, Minnesota, New York, Wisconsin, Massachusetts, Maine, and Colorado, have, or are seeking, 1115 waivers to experiment with new managed care models for the elderly and persons with physical disabilities who are dually eligible for Medicare and Medicaid.¹

The problems of long term care are especially great in many rural communities where the long term care 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. 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.

There are, however, many challenges in developing managed care approaches for older and disabled people in rural areas. Rural consumers and providers have little experience with managed care and providers are often not prepared to take on such managed care functions as capitated financing and case management. Providers in many rural areas have only begun to develop the integrated service networks which are essential for managed care; few providers have extended their network development activities to include long term care services beyond skilled nursing 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 describes three such examples. The paper discusses the concept of integrated acute (medical) and long term care service networks, how they have developed in rural communities, the challenges that health care providers, state policymakers, and others have faced in developing these new integrated structures, and the expectations for, or actual impact of, these initiatives in rural areas.² The sites featured in this study vary significantly in their approaches to service integration and managed care, the populations targeted, the degree of integration achieved, and the driving forces that led the sites to develop these initiatives. By selecting and studying sites which were quite different on a number of critical dimensions, we were able to understand better the range of organizational and development options and challenges that exist in rural areas. The three sites are:

Cochise and Pinal Counties, Arizona: The Pinal and Cochise County case studies represent the “Medicaid only” approach to managed acute and long term care services. These county-based managed care programs operate under the state’s managed Medicaid long term care program (Arizona Long Term Care Services). Both counties manage a capitated primary, acute and long term care service network serving frail elderly and physically disabled Medicaid clients. The counties’ acute care networks include both rural and urban hospitals and rehab facilities. Members are served by contracted primary care providers and 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. Although these two counties represent rare examples of fully integrated, capitated rural health care systems for the frail elderly and those with disabilities, they also illustrate the potential opportunities and limitations inherent in a system in which only Medicaid-funded services are fully integrated and managed.

Community Nursing Organization (CNO) Demonstration, Carle Clinic: Carle represents a “Medicare-only” approach to managed acute and long term care. 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 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. Initiated in 1992, this demonstration provides community nursing and ambulatory care services on a prepaid, 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 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.

The sites for this study were selected to illustrate the range of approaches and diversity of challenges faced in developing managed care and integrated service programs for frail older, and younger physically disabled persons in rural areas. To select these sites, we compiled a list of potential sites based on information from other rural network studies, consultation with national provider associations and organizations (e.g. American Hospital Association, National Academy for State Health Policy), and research colleagues across the country. Our goal in this stage was to identify rural sites that reflected different managed care and system integration approaches, that embodied an explicit goal of integrating acute and long term care services (including home-based and residential long term care services), that were in different stages of development, and that were located in different parts of the country.

Through this process, we identified 8 potential rural sites. In order to reduce the number of sites, we conducted telephone interviews with state policymakers (e.g. State Offices of Rural Health, aging units and Medicaid agency representatives), and representatives of the sites to learn more about the specific program features and stage of development of each site. The final sites were then asked to complete a detailed written questionnaire in which they provided information on the business, administrative, clinical, and other characteristics of the sponsoring organization(s) and the managed care or integrated program they had developed.³ This information, together with documents which each of the sites shared with us before our visits, provided the necessary background for our site visits.

Site visits were conducted between June 1996 and February 1997. Each site visit was conducted using site visit protocols developed for this project.⁴ Extensive in-person and telephone interviews were conducted in each site with a minimum site visit of four person days. Interviewees varied by site, but generally included, county officials, program administrators, clinical or service managers, and network provider organizations.

The remainder of this monograph discusses the concepts of managed care and service integration as applied to the medical and long term care sectors (Section One), presents a brief background on each of the three case study sites (Section Two), and discusses the lessons of these cases and their policy and organizational implications relevant to state and federal policy makers, rural communities, and health care providers (Section Three). Despite the limited experience to date with managed care and service integration with older persons, especially in rural areas, the examples profiled here are the proverbial, “wave of the future”. We hope these descriptions provide useful insights into the opportunities and challenges which providers, communities and others face in moving toward this future.

Section One

MANAGED CARE AND SERVICE INTEGRATION FOR OLDER PERSONS

INTRODUCTION

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 service delivery arrangements in the health care system. 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.

BACKGROUND: THE CONCEPTS

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 (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 primary care physicians' 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 hospitals, physician 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. 1997). 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 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 limit 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 services, both institutional and home-based, including personal care, transportation, assisted living, 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. 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, quality assurance protocols, and/or the sharing of other clinical procedures or standards. A common/shared medical record is frequently an indicator of 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 common areas of 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 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 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 existence of alternative organizations and the tightness of the affiliation arrangement. Contractual integration is the loosest of the forms.

APPLICATION TO THE LONG TERM CARE SECTOR

Networks and systems for care of persons with chronic care needs are in their infancy (Stone and Katz 1996). Few integrated networks and systems include in-home and 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).

Figure 1
Differences in Acute Versus Long-Term Care

Acute Care	Dimensions	Long-Term Care
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 – other turf is disputed
Interventionist	Styles of Care	Maintenance
High	Technology	Low
Dynamic Science	Intellectual Basis	Pre-paradigmatic
Intensity (duration minimized)	Cost Drivers	Duration (intensity minimized)
Medicare	Primary Public Payer	Medicaid

Source: 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. These challenges are reflected in the two primary sources of financing—the Medicare and Medicaid programs. The coordination and management of services and costs across the Medicare and Medicaid programs has, until recently, been non-existent. Medicare, the principal payer for primary, acute, and post-acute care for older persons and persons with long term disabilities, provides limited coverage for long term care and, as a result, 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. The long term care system has been characterized by continuing efforts by state policy makers to define a system of services that can achieve greater coordination of care and cost control through more appropriate targeting of high-cost institutional and home care services. 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.

Private long term care insurers, though a growing presence, cover fewer than 5 percent of all older adults, and private long term care insurance pays for care for an even smaller percentage of current long term care consumers. And finally, 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 evidence of private payors is apparent in the development and private support for integrated long term care products such as those provided through continuing care retirement communities (CCRCs) and newly emerging housing and service options, often referred to as “assisted living,” federal Medicare coverage of acute and sub-acute care services likely will preclude independent development of integrated acute and long term care managed care products for private purchase. Hence, unlike changes in the medical sector, neither federal policy, private insurers, or private purchasers have exercised much direct influence on system integration and the development of managed care models within 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. In the last five years, however, 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. 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/or 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 Section 1115 waivers (Saucier et al. 1997).

THE RURAL ISSUES AND QUESTIONS

The characteristics of rural communities and service systems suggest a number of important potential barriers to, and opportunities for, the development of managed care and service integration strategies for primary, acute and long term care. Five key issues and questions are addressed in this paper and the featured case studies:

What drives the development of integrated managed care strategies for acute and long term care services? Are there special factors that are more likely to pertain to rural areas? We know that the forces driving the development of managed acute and long term care models are different from those feeding expansion of managed care and

organized delivery systems. Market forces, including competitive health care purchasing by public and private employers, have not been a factor in the development of integrated acute and long term care initiatives.

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 would seem even more problematic.

How does the breadth and depth of local experience with managed care affect rural capacity to develop and manage integrated acute and long term care

strategies? The limited experience of providers and consumers with managed care in most rural areas may be a limiting factor in the development of integrated and managed care programs for the elderly. To what extent does it affect the technical know-how needed to organize and manage integrated acute and long term care services in a risk-bearing managed care environment?

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? 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?

The limited service infrastructure in many rural areas presents special 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. 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 featured in this paper suggest that this is the case?

What role does organizational and ownership structure play in the development of managed care that integrates acute and long term care services? Based on the experience of integrated systems development for managed care contracting in the medical care sector, we suspect that organizational structure and ownership play a significant role in the development of financial incentive structures and strategic management practices. What can be learned from these case studies regarding the impact of organizational and ownership structures on integrated managed care approaches to serving older and disabled residents of rural communities?

The next section presents a brief description of the three case study sites as background for discussion of these questions. The final section of this paper provides a summary of observations and “lessons learned” from each of the three sites and their approaches to developing integrated managed care programs for the rural elderly. These observations and experiences provide preliminary answers to the questions raised above, as well as other lessons learned that may be helpful to federal, state, and local policy makers as well as providers and purchasers of managed care options spanning the primary, acute and long term care service sectors in rural communities.

Section 2

CASE STUDIES

PINAL AND COCHISE COUNTIES, ARIZONA

The Arizona Long Term Care Services Program

In 1989, the Arizona Health Care Cost Containment System (AHCCCS) began providing long term care services under a capitated, risk-bearing managed care program. This demonstration, the Arizona Long Term Care System (ALTCS), was established under a Medicaid Section 1115 Waiver (Title XIX of the Social Security Act). Under the ALTCS system, there are two population-specific programs: (1) services to the developmentally disabled, and (2) services to the elderly and the physically disabled. The later of these two programs, ALTCS services to the elderly and physically disabled, was the focus of our case studies in Pinal and Cochise Counties.

Counties or private entities serve as program contractors for services to the elderly and the physically disabled. Arizona has a tradition of strong county government and, prior to the introduction of Medicaid funded services, the counties paid for long term care services entirely with county funds. The two largest counties in Arizona are required to participate as ALTCS contractors, while smaller counties have the option of competing to serve as contractors. Where counties have declined, their “right of first refusal” contracts are issued by the state AHCCCS program on a competitive basis.

The mission of ALTCS contractors is to ensure the accessibility, quality, appropriateness and cost effectiveness of medical and medically related services for frail elderly and physically disabled adults. The major responsibilities of these contractors are: processing member enrollments, screening and assessing member needs, providing and monitoring services, maintaining the service network, monitoring quality and utilization of services, processing claims and encounter reports, maintaining financial systems, developing medically related programs and preparing program reports and

financial statements. Eligibility for ALTCS services is determined by regional employees of the Arizona Department of Economic Security and is based on both financial need and determination that the applicant is at risk of nursing home placement.

Among the challenges faced by ALTCS program contractors are the difficulties in determining other health insurance coverage and third party liability for members' services covered by other health insurance or Medicare. This challenge is exacerbated by the growth of Medicare managed care offerings and relatively recent introduction of Medicare risk contracts in the two study counties. In Arizona, over 33% of Medicare beneficiaries in urban areas, and 10.5% of rural beneficiaries, are enrolled in some form of managed care (University of Minnesota Rural Health Research Center 1997). In an effort to encourage integration of payment and services for dually eligible ALTCS members, the state ALTCS program proposed limiting ALTCS members' choice of Medicare HMOs to ensure coordination of ALTCS and Medicare HMO services and payments. In 1996, however, Arizona's request for the necessary waiver of Medicare HMO provider choice requirements was denied by Health Care Financing Administration (HCFA).

ALTCS program contractors are required to provide members with care management support and a comprehensive array of acute, long term, and behavioral health care services. Once a person is determined eligible for the ALTCS program, the ALTCS contractor is responsible for enrolling the member in the program, helping them choose a primary care physician (PCP) from among physicians participating in the ALTCS contractor's network, and providing preliminary information about the program. After enrollment, each person is assigned a case manager who, with the member's PCP, is responsible for establishing individual members' care plans.

ALTCS contractors are responsible for developing and operating quality and utilization management programs. Two state-defined information system requirements- the Client Assessment and Tracking System (CATS) and encounter and claims information-are central to the counties' ability to comply with this requirement. The CATS system incorporates enrollee assessment information, care plans and service

authorization data and is a statewide clinical information system that was developed by the AHCCCS program for ALTCS. Other reporting requirements include monthly submittal of encounter and claims data which are electronically transferred according to state AHCCCS guidelines.

Within the ALTCS program, ALTCS contractors are at full risk for members' care with few exceptions. The level of risk borne by subcontractors, however, varies by local program and type of provider. ALTCS contractors receive a capitated payment per member per month (pmpm) with the risk for excessive liability for hospitalizations on the part of ALTCS program contractors re-insured under a self-insured pool maintained by the state AHCCCS program. "Savings" that result from lower than anticipated costs for member services (e.g. lower than capitation rate) are allocated between the county contractor and state ALTCS program on a 25/75 basis. That is, the ALTCS contractor retains 25% of the savings and 75% of the savings accrue to the state AHCCCS program. Additional detail on the ALTCS program is provided in Appendix A.

PINAL COUNTY LONG TERM CARE

1. Rural Environment

Pinal County, located in southern Arizona, is bordered by two major metropolitan counties and two rural counties. Maricopa County, including the Phoenix metropolitan area, borders the northern and western limits of Pinal, while Pima county, including Tucson, is on the southern border. The northeast and eastern boundaries are defined by rural Gila and Graham Counties. Pinal County has a population of 132,225 (1994) and covers a region of 5,344 square miles of which only 30 are water (population density = 25 persons per square mile). It is a rapidly growing region and experienced a 30 percent population increase from 1982 to 1992 (Arizona Office of Rural Health 1996).

Twelve percent of the people in the county are over 65 and, of these, 16% live in poverty. Overall, almost a quarter of the population (23.6%) lives below the poverty level and almost half (45.8%) live at or below 200% of the poverty level. A number of health planning initiatives and needs assessments have been conducted in Arizona and in Pinal

County and identified certain areas of unmet needs, particularly for seniors, including: access to community support programs, education regarding major risk factors, services to identify and treat depression, and expansion of emergency medical services and community based long term care 1992 (Arizona Office of Rural Health 1996).

2. Pinal County Long Term Care (PCLTC)

Pinal County is governed by an elected 3-member Board of Supervisors who serve staggered four year terms. The PCLTC Director reports to the Assistant County Manager, who in turn reports to the Pinal County Manager and the Board of Supervisors. Pinal County Long Term Care is organized into five major sections including: Community Programs, ALTCS-Case Management, Quality Management and Utilization Review, Contracts and Grievance and Accounting/Information Systems, (Figure 2).

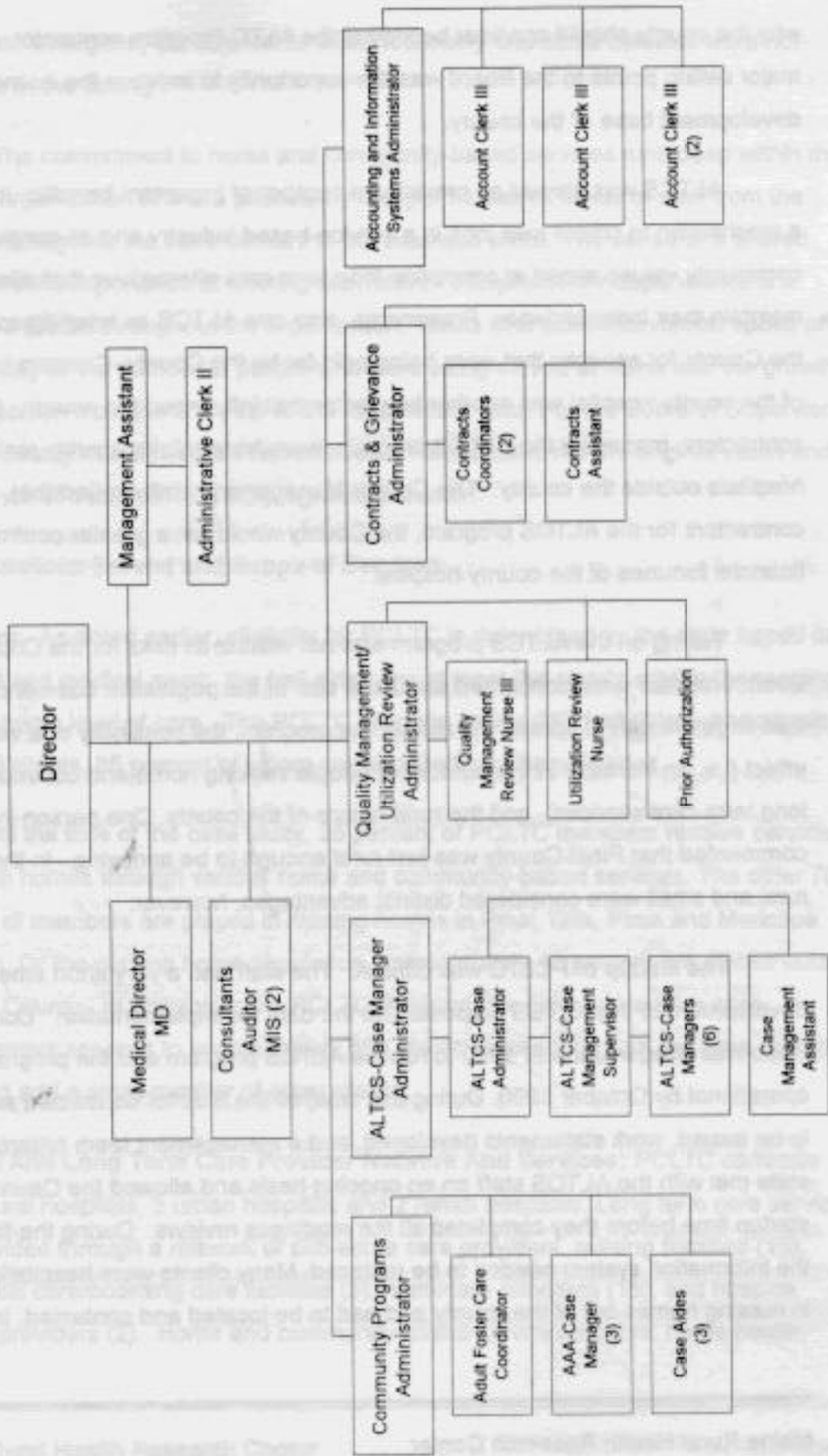
3. Impetus for System Development

Prior to 1990, all long term care services in Pinal County were delivered on a fee-for-service basis and administered directly by the state AHCCCS office in Phoenix. The network of long term care services was poor at that time with only one home health agency in the county, no attendant level care, no adult foster care, a limited supply of nursing home beds, and little, if any, integration of the traditional aging service network with the long term care service system.

In 1990, the Board of Supervisors and the county management began to seriously consider becoming the ALTCS program contractor for Pinal County. The county manager and assistant county manager for health and human services presented a formal proposal to the Board of Supervisors outlining the 10-15 reasons

figure 2

Figure 2
Pinal County Long Term Care



why the county should consider becoming the ALTC Program contractor. One of the major selling points to the Board was the opportunity to improve the economic development base of the county.

ALTCS was viewed as providing a number of important benefits. It was seen as a mechanism to create new jobs in a service-based industry and as consistent with community values aimed at promoting long term care alternatives that allow people to maintain their independence. Proponents also saw ALTCS as bringing control back to the County for services that were being paid for by the County. Concern for the future of the county hospital was another key factor that influenced the county. Outside contractors, managing the ALTCS program, were hospitalizing county residents in hospitals outside the county. The County Manager and staff argued that, as contractors for the ALTCS program, the County would have greater control over the financial fortunes of the county hospital.

Taking on the ALTCS program was not without its risks for the County. The Board and staff were concerned about the size of the population base and whether it was large enough to spread the risk for the program, the possibility of a woodwork effect (i.e. an increase in the number of people seeking home and community-based long term care services), and the rural nature of the county. One person interviewed commented that Pinal County was just rural enough to be annoying. In the end, being rural and small were considered distinct advantages, however.

The startup of PCLTC was difficult. The staff had a very short time between the development of the ALTCS proposal and the date for implementation. Donna Stanley-Robb was hired in June of 1990 to run the ALTCS program and the program was to be operational by October 1990. During this time, all the bids for contracted services had to be issued, work statements developed, and a management team organized. The state met with the ALTCS staff on an ongoing basis and allowed the County some startup time before they completed all the readiness reviews. During the first 6 months, the information system needed to be replaced. Many clients were hospitalized or were in nursing homes out of the county and had to be located and contacted. In some

instances, emergency procurements were necessary and some services were not available in the county.

The commitment to home and community-based services runs deep within the PCLTC organization and is a philosophy that permeates all levels of staff from the county manager to the case workers to the business office. The sense of a shared vision and the importance of offering alternatives that promote independence is a pervasive theme throughout the organization. Those who were interviewed spoke often and proudly of the number of people who were being served at home and the growth in this proportion from the first year to the most recent year. For the Board of Supervisors and the county managers, this represented an actualization of the original vision and importance of being the ALTCS program contractor.

4. Populations Served and Scope of Services

Members: As noted earlier, eligibility for PCLTC is determined by the state based on financial and medical need; the frail elderly must meet the state's criteria for needing nursing home level of care. The PCLTC program serves 385 frail elderly and physically disabled clients, 85 percent of whom are also Medicare beneficiaries.

At the time of the case study, 35 percent of PCLTC members receive services in their own homes through various home and community-based services. The other 70 percent of members are placed in nursing homes in Pinal, Gila, Pima and Maricopa counties. Of the nursing home population, approximately 40 percent are placed outside of Pinal County. In addition to the PCLTC Program, the County provides case management services to approximately 550 clients enrolled through the Area Agency on Aging and a small number of other clients.

Medical And Long Term Care Provider Network And Services: PCLTC contracts with 2 rural hospitals, 3 urban hospitals and 2 rehab hospitals. Long term care services are provided through a network of sub-acute care providers, nursing facilities (15), residential care/boarding care facilities (3), homecare providers (15), and hospice service providers (2). Home and community-based services include: home health, homemaker,

personal care, adult day health and group respite, adult foster care, home delivered meals, environmental modifications, attendant care, transportation, and safety alert services. Other contracted services in the network include pharmacy, therapies (occupational, physical and recreational), durable medical equipment, and mental health services.

Institutional and residential long term care services have been in short supply in Pinal County for a number of years. As a result, PCLTC has had to place many of its members who need nursing facility level of care in facilities in other counties. The limited supply of NF beds, in combination with a philosophical commitment to providing alternatives for people who want to remain at home, has provided an impetus for the development of more home and community-based options. Since the start of PCLTC, the number of home health agencies doing business in the county has increased and the PCLTC staff have actively developed adult foster care alternatives for people in the county.

5. Organization: The director of the PCLTC program has overall responsibility for the day to day operations of the financial, case management, contracting and quality/utilization review functions of the program. The Medical Director also reports to the director of PCLTC and works closely with the Quality Administrator. In addition, the Community Programs Administrator responsible for the adult foster care program also reports to the PCLTC Director. Some components of Area Agency on Aging are contracted to PCLTC and many of the referrals to the program come from the AAA case managers. This coordination between the AAA and PCLTC provides an added level of coordination of services for the consumer.

6. Information Systems: PCLTC has two information systems for management and reporting purposes. The encounter and claims processing system is managed by the PCLTC under contract with an independent information systems firm; and the Client Assessment and Tracking System (CATS, described above) managed by the state. The encounter and claims processing information system manages the authorization of services, the processing of bills and the payment of claims. Reports from this data

system are at the aggregate level and special reports have to be processed through the encounter and claims data system contractor. At the time of the site visit, most PCLTC subcontracting providers did not have on-line billing capacity, so much of the encounter and claims data required a manual claims processing function. While the encounter and claims processing information system was developed to meet the needs of the ALTCS program, it is not able to communicate directly, or generate linked reports, with the CATS client tracking system.

7. Financial Risk (Medicaid and Medicare)

Pinal County receives a single capitation rate for all Medicaid covered services (hospital, physician, home and community services, mental health, nursing facility services etc.) and is at full risk for services provided to its members. Members who are also eligible for Medicare must coordinate their services with their Medicare service providers. An estimated 12% of Pinal County residents over 65 are enrolled in a Medicare HMO; a smaller percentage of PCLTC enrollees are participating in a Medicare HMO. If an ALTCS member is enrolled in a Medicare HMO, they are told to receive their medical and acute care services through their Medicare HMO first. While PCLTC is not a Medicare HMO, it coordinates with providers for Medicare covered services, particularly in instances where PCLTC is responsible for any copayment or deductible amounts.

COCHISE HEALTH SYSTEMS (CHS)

1. Rural Environment

Cochise is a rural county located in the southeastern most corner of Arizona and has a population of approximately 108,225 (1994 estimate), 28% of whom are Hispanic. The poverty rate for elderly residents in Cochise County is 15%, rising to 31% among the Hispanic elderly. The county covers 6,219 square miles and has a population density of 17.5 persons per square mile. The terrain of Cochise County includes high desert, mountains and forest land. Cochise County has five commercial centers: Bisbee, Sierra Vista, Benson, Douglas, and Willcox. Bisbee is the county seat. Sierra Vista is the largest community with a population of 36,855 (1994). Cochise County borders Mexico to

the south, Pima (Tucson area) and Santa Cruz counties to the west, Graham and Greenlee counties to the north, and New Mexico to the east.

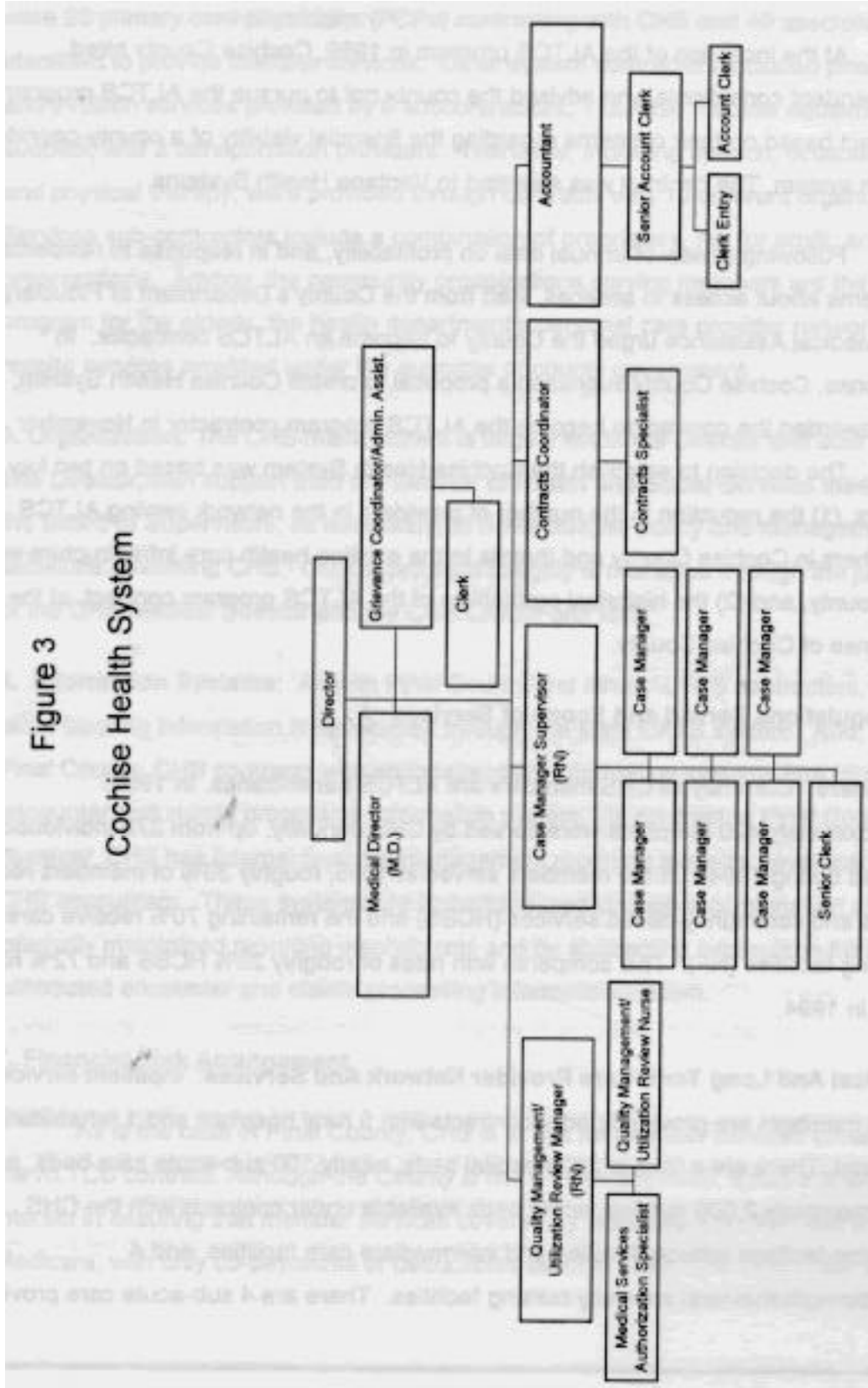
2. The Cochise Health Systems

Cochise County was selected as a study site from among the Arizona Long Term Care System (ALTCS) contractors based on its development history and experience. At its inception in 1989, the ALTCS program contracted with Ventana Health Systems, a subsidiary of Managed Care Solutions for services in Cochise County. Ventana is a proprietary managed care organization developed by physicians in Arizona and was the ALTCS program contractor for Cochise County from 1989-1993.

Since 1993, Cochise Health Systems (CHS) has served as the ALTCS program contractor for the county, operating as a subdivision of the Cochise County Department of Health and Social Services, and overseen by the County Board of Supervisors. The CHS Director reports directly to the County Director of Health and Social Services and is supported by a management team including representatives from the four operational units within CHS: the quality management and utilization review (QMUM) unit; the case management unit; the contracts unit; and the accounting unit. Other administrative and policy support includes the part-time Medical Director and an Administrative Assistant/ Grievance Coordinator (Figure 3).

The QMUM unit manager is supported by two staff nurses responsible for authorizing services and QMUM functions. In addition to the case management supervisor, there are six case managers distributed throughout the county and a single clerk assistant in the outpost office of the program located in Benson. The contracts coordinator has a single contracts specialist support staff person, and within the accounting unit, in addition to the manager, there are three staff who perform the functions of clerical, data entry and accounting support services.

Figure 3
Cochise Health System



3. Impetus for System Development

At the inception of the ALTCS program in 1989, Cochise County hired independent consultants who advised the county not to pursue the ALTCS program contract based on their concerns regarding the financial viability of a county-operated health system. The contract was awarded to Ventana Health Systems.

Following review of annual data on profitability, and in response to residents' concerns about access to services, staff from the County's Department of Fiduciary and Medical Assistance urged the County to become an ALTCS contractor. In response, Cochise County submitted a proposal to create Cochise Health System, and was awarded the contract to become the ALTCS program contractor in November 1993. The decision to establish the Cochise Health System was based on two key issues, (1) the reduction in the number of providers in the network serving ALTCS members in Cochise County and threats to the existing health care infrastructure within the county, and (2) the historical profitability of the ALTCS program contract, at the expense of Cochise County.

4. Populations Served and Scope of Services

Members: Currently all CHS members are ALTCS beneficiaries. In 1995, approximately 420 members were served by CHS annually, up from 378 individuals served during 1994. Of the members served in 1995, roughly 30% of members receive home and community-based services (HCBS) and the remaining 70% receive care in nursing facilities (NF). This compares with rates of roughly 28% HCBS and 72% NF care in 1994.

Medical And Long Term Care Provider Network And Services: Inpatient services for CHS members are provided under contracts with 5 rural hospitals and 1 rehabilitation hospital. There are a total of 232 hospital beds, nearly 100 sub-acute care beds, and approximately 2,000 nursing facility beds available under contracts with the CHS. Nursing facilities include 9 skilled and intermediate care facilities, and 4 wandering/behavioral specialty nursing facilities. There are 4 sub-acute care providers, and 1 residential adult care home within the network. At the time of the site visit, there

were 23 primary care physicians (PCPs) contracting with CHS and 40 specialists identified to provide member services. Other system contractors included pharmacy and infusion services provided by 6 subcontractors, 1 durable medical equipment supplier, and 3 transportation providers. Therapies, including speech, occupational, and physical therapy, were provided through contracts with 10 different organizations. Services subcontractors include a combination of proprietary, not for profit, and public organizations. Among the community organizations serving members are the nutrition program for the elderly, the health department's personal care provider network and respite services provided under the auspices of county government.

5. Organization: The CHS management is largely left to the Director and staff of CHS. The Director, with support from the Director of Health and Social Services meets with the Board of Supervisors, as necessary, to make budget, policy and management decisions governing CHS. Clinical program integrity is managed through the joint effort of the CHS Medical Director and the CHS QMUM unit staff.

6. Information Systems: As with Pinal County and other ALTCS contractors, CHS client tracking information is maintained through the state CATS system. And, like Pinal County, CHS contracts with an independent information systems firm for their encounter and claims processing information system. In contrast to Pinal County, however, CHS has internal financial management reporting systems developed by the CHS accountant. These systems are operationalized through a combination of internally maintained reporting mechanisms and by abstracting information from the contracted encounter and claims processing information system.

7. Financial Risk Arrangement

As is the case in Pinal County, CHS is at risk for member services covered by the ALTCS contract. Although the County is not a Medicare HMO, it has a financial interest in assuring that member services covered by Medicare are billed first to Medicare, with only co-payments or deductibles billed to CHS. The CHS is considering a proposal to become a Medicare competitive medical plan (CMP) to provide Medicare HMO services to

residents of Cochise County. This proposal would develop a separate plan, managed by CHS, that would be open for enrollment to Medicare-eligible residents of the county. The expectation is that this plan would focus enrollment efforts on Cochise County residents who are dually eligible for Medicare and Medicaid, and ALTCS members in particular.

The decision to pursue the CMP option was born from concern about Medicare HMOs entering Cochise County and providing services through a network of providers in Pima County (the Tucson area). Whether such a plan will be accepted by the County Board of Supervisors is unclear. There is support for CHS to pursue a CMP on the part of at least one of the hospitals in the area. Other hospitals in the area are considering introducing their own jointly sponsored plan and thus the course of future managed care development remains unclear.

THE CARLE CLINIC CHAMPAIGN-URBANA, ILLINOIS

1. The Rural Environment

This health care delivery system, commonly referred to as “Carle”, has headquarters in Champaign-Urbana. Outside of the Champaign-Urbana area, Carle’s service area is predominantly rural, made up of many small towns, supported largely by agriculture. Its service area covers 42 counties in east central Illinois and west central Indiana, an area with a population of 2.3 million.

Carle dominates the health care delivery system in its geographic region with its extensive and diverse network of services. It has few competitors and those that exist are much smaller than Carle. There is a Catholic hospital in Champaign-Urbana and a 70-member physician group practice known as the Christie Clinic. The rural community hospitals throughout Carle’s service area are not part of the Carle system, but they are linked through the referrals and services provided by Carle physicians and other Carle providers. Many are working with the Carle Foundation to develop alternative services to hospital care, such as long term care, assisted living, emergency services and ambulatory care so that they can survive in their respective communities.

2. The Carle System

Carle's history began in 1931, when two physicians trained at the Mayo Clinic came to Champaign-Urbana to start a practice. With the philosophy of "bringing services to the patients", they believed that the concept of a multi-specialty group practice like the Mayo Clinic could thrive in rural central Illinois. They teamed up with the local community hospital in Urbana, and from there, Carle Clinic Association and the Carle Foundation were born, with the mission of providing comprehensive health care to the rural communities they served. The Carle Clinic Association and the Carle Foundation, as sister organizations, form a complex integrated health system. With a third partner, Health Alliance Medical Plans, Inc., a wholly owned subsidiary of Carle Clinic Association, they provide regional medical services for the residents of rural central Illinois and western Indiana.

Carle's commitment to a full spectrum of care has provided a natural starting point for the integration of acute, post acute, and other services. The Carle organizations provide primary, specialty, and inpatient care, plus a comprehensive array of ancillary services, from transportation to pharmacies, home health and medical equipment to residential care. Though the system's central location is Champaign-Urbana, it has ensured that services are available throughout its service area, through branch clinics and local community services. Through the work of its Health Systems Research Center, discussed below, Carle has served as a laboratory for a variety of health service demonstrations involving care for the elderly. Most recently, it has administered a Medicare Community Nursing Organization (CNO) demonstration which is the focus of this study (Schraeder and Britt 1997). The CNO is a nurse-managed care approach to delivery of selected Medicare financed acute and post-acute care services delivered under a risk-based contract with the federal Health Care Financing Administration (HCFA).

The Carle Foundation: The Carle Foundation is a not-for-profit holding company which owns and operates Carle Foundation Hospital, a 300 bed tertiary care facility in Urbana. The Foundation also encompasses several other health care entities, including; Carle

Arrow Ambulance; the Carle Arbours, a 240 bed continuing care facility; Carle RxExpress, a network of eight pharmacies; Carle HomeCare; Carle Hospice; Carle Medical Supply; Carle Infusion Services; Carle SurgiCenter; and the Windsor of Savoy, a 137 unit retirement community. The Foundation also owns Health Systems Insurance, Ltd., an offshore medical malpractice company, and the Carle Development Foundation.

Carle Clinic Association: The Carle Clinic Association is a for-profit physician multi-specialty group practice based in Urbana. With nearly 300 physicians practicing in more than 50 medical and surgical specialties and subspecialties, it is one of the largest private group practices in the country. The Carle Clinic Association owns Health Alliance Medical Plans, Inc., a domestic stock insurance company which offers a complete line of insurance products to employers and individuals. Health Alliance is licensed as both a Third Party Administrator and a Preferred Provider Organization by the State of Illinois, and the Health Alliance HMO meets the requirements of a federally-qualified HMO. Its combined membership of insured lives and third party administration services exceeds 140,000 members. Of note, Carle Clinic physicians are restricted from affiliating with competing managed care plans.

Health Systems Research Center: The Health Systems Research Center (the Center), is a department within the Carle Clinic Association. The Center's research and demonstration projects have focused predominantly on the elderly and the integration of primary, acute, and post-acute care services. They have laid the groundwork for Carle's current initiative, the CNO demonstration which links the management of limited set of acute and post-acute care services. The lessons learned from these demonstrations, in turn, have paved the way for Carle's successful bid to become a Medicare Choices Demonstration site which will combine acute and post-acute care services within one managed care system.

Community Nursing Organization (CNO) Demonstration: Carle is one of four sites, and the only rural site, participating in the Medicare CNO demonstration sponsored by the Health Care Financing Administration. This is a multi-year demonstration, begun in 1992, to provide community nursing and ambulatory care services, on a prepaid, capitated

basis, to Medicare beneficiaries who enroll voluntarily. The primary focus of this demonstration is to test the provision of a specified set of services in a nurse-managed delivery system under risk-based capitated financing. The service area for the CNO demonstration includes 10 Illinois counties: Champaign, Coles, DeWitt, Douglas, Edgar, Ford, Iroquois, Piatt, Vermilion, and McClean. CNO enrollees may use any provider or hospital within the service area, regardless of its affiliation with Carle.

As a HCFA demonstration, there are specific evaluation measures for the CNO project for which the Center has primary tracking responsibility. The CNO demonstrations are testing whether (1) CNO participants will use fewer services than non-enrollees, including hospital and physician services, (2) whether non-Medicare covered community services will be used more intensively by enrollees, (3) whether enrollee functional status scores will be higher than those of non-enrollees, and (4) whether health problem ratings will show improvement or resolution.

3. Impetus for System Development

The work of the Health Systems Research Center which has focused on the development of models of managed care for the elderly, has been the principal force behind the development of the CNO and Medicare Choices demonstrations. The history of Carle demonstrates a commitment to being a major player in the health care delivery system on many fronts. According to observers, Carle's Boards and administrators have been very strategic in identifying where its organizations need to be to stay ahead of changes in the health care system to maintain control of the market. The growing elderly market is no exception. Carle has recognized its need to get into the business of Medicare risk contracting in order to be a major provider of health care for the elderly, and is currently working with the Health Care Financing Administration (HCFA) to finalize plans for a Medicare Choice Demonstration.

Beyond the experience and leadership provided by the Research Center, a number of those we spoke with noted that there has also been strong leadership and vision from key individuals in the Carle administration. From the beginning, the Carle

organizations have been physician-driven and directed. They have been willing to push ideas through and to get the buy-in from Carle staff that is critical to the success of any initiative. A senior physician administrator we spoke with noted that “Carle is always moving to where we think we’re going to need to be. We are controlling our destiny”.

Use of nurse care managers for services to older adults, the core of the CNO demonstration was developed through a series of demonstration projects undertaken by Carle. The Community Outreach Program for the Elderly (COPE), funded in 1987 by the Kellogg Foundation, provided nurse case managers for 100 frail elderly, with the goal of providing sufficient community resources so that patients could remain in their homes. The Medicare Alzheimer’s demonstration project, which began in 1988, also used a nurse case management model to provide a comprehensive set of services not usually covered under Medicare (including adult day care, homemakers, and medical equipment), to individuals living at home with Alzheimer’s disease or related memory disorders. Finally, a John A. Hartford Foundation project funded in 1992, introduced use of nurse partners and care assistants in support of physicians as a part of a geriatric collaborative practice model for rural primary care settings. This initiative targeted ambulatory, but at-risk elderly patients and their caregivers, and sought to define, operationally, the concept of “Nurse Partner”.

Carle has sought to integrate certain clinical services through the work of the Research Center. But, it has yet to incorporate the full spectrum of long term care services in its integrated delivery system. To date, the demonstrations have targeted the ambulatory elderly population living in the community and have focused primarily on non-institutional primary, acute and post-acute care. Medicare reimbursement has defined and limited scope of CNO services and the population that can be served.

4. Population Served and Scope of Services

Enrollees: Participation in the Carle CNO project is voluntary for Medicare beneficiaries living in the 10 county service area. Enrollees must maintain their Medicare A and B coverage and must obtain all CNO covered services, except in emergencies, through the CNO. Medicare beneficiaries who have a diagnosis of end-stage renal disease, are receiving hospice care, or are enrolled in a risk-contract HMO are not eligible to enroll in the CNO. If an enrollee moves out of the 10-county service area, or is admitted to a hospital or nursing home for 60 days or longer, he/she is disenrolled from the CNO. Benefits revert to the enrollee's previous Medicare coverage. In contrast with the Arizona Long Term Care Services Program which targets the poor elderly who are frail and at greatest risk for use of high cost, institutional services, the CNO demonstration has enrolled those older Medicare beneficiaries who, although at risk for use of post acute care services, are generally not so frail as to be at risk for nursing home care.

The CNO targeted for enrollment Medicare beneficiaries whose supplemental coverage was through the Health Alliance. For the initial enrollment, they sent letters to this audience, introducing them to the project, and, within 18 months they reached their goal of 3000 participants.

Once beneficiaries are identified for participation, they are scheduled for a face-to-face interview to determine functional status, health perception, and previous use of, and satisfaction with, health services. After the initial interview, they are randomized into either the treatment or control group. Primary Nurse providers (PNPs) then conduct a comprehensive nursing assessment with the enrollees to develop priorities and a plan of care. The PNP meets with the enrollees every six months to reassess their health status and health care needs. Other meetings are scheduled, as needed, to monitor and/or arrange services. Control group participants do not receive CNO benefits but their health status is monitored every 12 months through follow up phone interviews.

Medical And Long Term Care Provider Network And Services: CNO managed services include: home health services (including RN, PT, OT, social work, home health

aide, and homemaker/personal care services); outpatient physical, occupational, and speech therapy; outpatient services of a clinical psychologist or social worker; durable medical equipment, medical supplies, and ambulance services. In addition to services provided through Carle, the CNO contracts with non-affiliated agencies or individuals for the provision of some of these services to the demonstration participants.

5. Organization: The CNO demonstration, as well as the Center's other projects, is managed by staff of the Health Systems Research Center. PNPs are based at the clinics and work with the physicians at those practices. To the extent that coordination with the branch clinics of Carle Clinic Association is required, there is some integration with the Association's operations. However, since the demonstration is administered by the Center and not the Patient Care Department which runs the clinics, the PNPs are quite separate and independent of the clinics' operations. If it is determined that this project can, and should be, integrated into Carle's overall plan for service delivery, then its management may be transferred to the Patient Care Department.

Quality Assurance: The Health Services Research Center conducts quality improvement activities specific to the demonstration. Project staff review patient status through chart reviews and utilization data, looking for any patterns or trends among the patient population. They monitor the case management activities of the PNPs to determine whether the CNO process has been followed appropriately and whether the care plan reflects the indicators and findings of the nursing assessment. Records of nursing time are reviewed to count both indirect time and direct patient time. The quality improvement initiatives of the Carle system are conducted by the Health Alliance and, at this point, do not include the Center's demonstration projects.

Clinical Integration: The CNO concept necessitates coordination and integration between the nurse partners and primary care physicians. As such, the Primary Nurse Provider (PNP), or nurse partner, is the key to the CNO project. This practitioner coordinates the non-physician, non-institutional services provided to Medicare beneficiaries. The PNP is responsible for assessing enrollee's needs, developing care plans in coordination with the enrollee's physician, as well as authorizing, arranging and

monitoring the delivery of services covered under the CNO. This includes those community and non-medical services that can enhance the patient's overall care and well being. The PNP also provides ongoing monitoring and case management, including the management of acute and chronic health conditions, and the support and education of the patient and family through all stages of disease and wellness. According to participants, the CNO has resulted in improved detection of the frail patients and more timely referral to appropriate care specific to their level of functioning.

6. Information Systems

Though Carle has developed a fairly sophisticated information system, only part of that system is being used for the CNO demonstration. Carle patients have a single medical record but this is not used as the nursing record by the CNO. CNO enrollees have a separate medical record for their participation and services received under the demonstration. Only recently has the Carle system been able to flag a CNO patient within the Carle record system. The CNO nurses review the Carle record for medical services provided to the patient and input a brief care plan so that other providers are aware of the patient's participation and status within the CNO initiative.

7. Financial Risk Arrangement

The CNO delivery model is based on a prepaid capitated payment system for CNO-covered services. The CNO is reimbursed on a per-member-per-month rate by HCFA. That rate is established based on age, gender, and number of home health visits in the prior six months. The home health visits are counted from paid claims data. Every six months the individual enrollee's rate cell is re-determined. In addition, HCFA provides an annual cost-of-living rate adjustment.

The CNO is at risk for services covered under the capitation, including home health services; homemaker/personal care services; outpatient physical, occupational, and speech therapy; outpatient services of a clinical psychologist or social worker; durable medical equipment, medical supplies, and ambulance services. At this time, no risk is passed along to providers under contract with the CNO. Payment for these

services is based on the Medicare allowable rate for the service, and, in some cases, discounts have been negotiated.

To date, Carle's demonstrations have been relatively small. They have yet to expand in size or to be transferred, administratively, to the larger organizational culture. Though the expectation has been that successful demonstrations will be incorporated into Carle's standard practice, there is some concern that their modes of care, such as the CNO PNP model, will become diluted outside of the Research Center's sponsorship. Will the Patient Care Department at Carle support the role and activities of nurse partners as another level of nursing within Carle clinics? Will clinic administration accommodate the nurse partners who, throughout the demonstrations, have remained very separate from clinic operations and traditional patient care? The key to answering these questions may lie with the expansion of Medicare managed care in the Carle system.

Section 3

LESSONS LEARNED AND POLICY IMPLICATIONS

These case studies illustrate both the diversity of rural models for integrating and managing acute and long term care services and the challenges that must be faced in accommodating these models to the realities and circumstances of rural communities and health systems. This section summarizes some of the lessons common to the experience of these sites and their implications for federal and state policy.

LESSONS LEARNED

What Drives the Development of Integrated Systems?

What is perhaps most striking about these initiatives is how rare they are. These are among the very few examples of rural programs that are attempting to manage care across the acute and long term care continuum. While this is not surprising given the more general paucity of such programs in urban places, it raises the question of what factors will drive the development of these programs in the future.

From the experience of these three programs, there are at least four factors that appear to be critical in fostering the development of systems that integrate services across the acute and long term care continuum: federal and state policy, financial Incentives, organizational imperatives, and community leadership.

Federal and State Policy: We are likely to see only slow development of managed acute and long term care programs in the future until such time as policy makers or others provide clear signals and incentives. Policy and/or market forces have been the primary drivers behind the expansion of managed care and more competitive health care purchasing and delivery strategies over the past few years (Miller 1996). Yet, except for selected state initiatives in Arizona and Minnesota, where state Medicaid policy has given rise to innovative managed care programs targeted to older and younger physically disabled persons eligible for both the Medicare and Medicaid programs, there are few

financial or policy incentives driving insurers and providers of acute and long term care services to develop new managed care financing and service delivery arrangements.

Arizona, of course, is unique in that, prior to the AHCCCS and ALTCS programs, there was no state Medicaid program and all services were funded at the county level. The county had a history, therefore, of being the financing mechanism for health and social services and certainly a vested interest in bringing the control of those services back to the local level. Given the core services required of ALTCS contractors (claims processing, member services, quality assurance, case management), and the small numbers of people served, the existence of the county-level government and county management infrastructure provided a framework for development of ALTCS programs.

Arizona state policy that placed responsibility for the financing and delivery of acute and long term care services at the local level provided the environment and impetus for the development of the PCLTC and CHS programs. The willingness of the state staff to allow a start-up phase for the program and to help resolve problems as they arose also provided the necessary time and technical support to work through the early implementation phase of the system.

Even with the opportunities afforded by Arizona state policies and technical support, however, staff at both PCLTC and CHS credit the leadership and vision of their Boards of Supervisors with creation of their program. The Boards saw the opportunity to take control of the delivery of services at the local level, to be an active player in the process, and to be responsive to expressed desires of elders and those with disabilities to have more community options available.

Financial Incentives: The importance of financial incentives and, more specifically, the prospect of managed care contracts in fostering the development of integrated networks and managed care systems is clearly evident in both the Arizona sites and Carle experiences. In Arizona, county officials acted on incentives provided in the ALTCS program and sought to create their own managed care program in order to retain any savings locally. There are, however, few places where public payors have moved to managed care for older persons or the disabled. Thus, there are few financial or policy

incentives for providers and insurers of acute and long term care services to develop new financing and service delivery arrangements.

Organizational Imperatives: Increasingly, health care provider organizations are restructuring and consolidating in response to managed care and other market forces. Carle exemplifies rural providers who are positioning themselves and their communities to manage care across the acute and post-acute care continuum within a Medicare managed care framework. The nature and scope of their managed care strategies have been driven largely by incentives provided under the Medicare program; Medicaid, as the primary payer of long term care services, has been virtually invisible in Carle's integrated delivery system initiatives. In the absence of clear financial incentives from the Medicaid program, however, it is highly doubtful that initiatives like Carle will develop managed care programs that integrate the financing and management of in-home and residential long term care services.

As the CNO demonstration's funding period comes to an end, Carle is laying the groundwork for a Medicare Choices demonstration. With a target population of 10,000 enrollees, this initiative will bring the Carle organizations firmly into managed care for the elderly. Health Alliance Medical Plans is the applicant to HCFA for a Medicare Choice Plan, with the Health Systems Research Center doing much of the development work. As of January 1997, HCFA had accepted Carle's rate proposal in their Medicare Choice application, so this initiative is moving forward towards implementation. Health Alliance has proposed a full service HMO with a point-of-service option for the Medicare Choice demonstration. They have incorporated a "Partners in Care" approach, building on the existing collaborative practice model. Nurse partners and physicians will form the primary care teams that work with enrollees to plan and deliver their health care. Unlike the other demonstrations, which only targeted patients in non-institutional settings, "Partners in Care" will continue enrollee management after a nursing home admission.

Community Leadership: The characteristics and qualities of the community, county, or region, including the effectiveness of local leaders, the sense of community and the degree of support for local organizations and providers, can all be critical in the

development of these initiatives. This was most clearly evident in Pinal and Cochise counties where local county leadership played a central role in deciding to participate as contractors in the ALTCS program and developing the capacity to do so effectively. The sense that it was important to the counties and the region to keep the contracts for ALTCS services “local”, as a means for building the local health and social service infrastructure and preventing the potential export of dollars and clients outside the county by out-of-county contractors, was fundamental to the decisions of local leaders.

At both PCLTC and CHS there appeared to be consensus among the management team and providers interviewed that there is value to the community in CHS’ management of its own health system. The development of a local network of primary care providers, pharmacy services and other health services has strengthened the existing infrastructure within the community.

What are the Rural Opportunities and Barriers?

We were particularly interested in understanding how key characteristics of rural areas may affect their ability to successfully develop managed care programs for the elderly and physically disabled. Of particular interest were: the size of the population base and the difficulty of assuming financial risk for small populations; the breadth and depth of local experience with risk-bearing financing approaches and implications for the development of technical capacity for managing integrated acute and long term care services in rural communities; and the adequacy of service availability and the service delivery infrastructure to support the full range of primary, acute and long term care services.

Experience With Managed Care

There is little doubt that the nature of the health care market, together with the managed care experience of local plans and providers, will influence whether and how managed care will develop for chronic care populations. In Arizona, prior to the introduction of ALTCS, many providers in Pinal and Cochise County had little or no experience with managed care, and county government had no experience in managed

care plan management. In contrast, Carle providers were active participants in managed care arrangements and a Carle subsidiary had several years experience offering a commercial managed care product. These vastly different levels of organizational and provider experience with managed care provide a vantage point for better understanding the nature and development of organizational capacity required for the management of integrated acute and long term care services to rural residents. The influence of managed care experience, as well as barriers encountered, successful solutions, opportunities, and apparent advantages afforded rural programs in developing capacity for managing integrated services, are discussed below.

Are risk bearing plans for small rural populations of older and disabled adults viable?

There is no doubt that because of their smaller population base, rural counties, health plans, and providers have a more limited capacity to assume financial risk than larger urban systems. The fact that some of those elderly and/or physically disabled persons targeted for these managed care initiatives are likely to be quite frail and/or sick makes this problem of the small population base even more critical. The experiences of the Arizona ALTCS program generally, and Pinal and Cochise counties specifically, demonstrate that it is possible to successfully use capitated financing approaches in rural areas for these integrated acute and long term care programs (McCall et al. 1993). Likewise, by all accounts, Carle's CNO program has successfully managed care with a special capitation arrangement under the HCFA, Medicare demonstration program. Both of these examples illustrate that, not only is capitation possible, but there are many potential approaches to structuring payments to plans and providers that balance incentives for cost control with the need to assure appropriate protections for plans, providers, and consumers. For example, the payment structures observed at the case study sites included partial capitation options, fee-for-service, and shared savings options as alternatives to full capitation arrangements between the risk-bearing plans (ALTCS contractors and the CNO) and providers.

In Cochise County, where the county-funded share of ALTCS services is approximately \$3.5 million, the Cochise Health Systems (CHS) has twice demonstrated

“annual savings” as a result of members service expenses falling below the ALTCS contract capitation rates and estimated county match requirements. The “annual savings” of from \$150,000 to \$300,000 were separate and beyond the retained earnings required to assure fiscal viability as a risk-bearing health plan.

Physician experience with managed care: While most physicians in Arizona were familiar with the concept of managed care, not all physicians had managed care experience prior to the introduction of the county ALTCS programs. To help remedy this information gap, Cochise Health System (CHS) case management and quality/utilization management staff have participated in educational sessions with primary care physicians (PCPs). These sessions have been designed to help physicians better understand the importance of referrals within the network of CHS subcontractors and the objectives of cost effective care management for members. As a result, CHS's primary care physicians (PCPs) understand CHS's expectations for care coordination and management, and routinely contact the case manager or the QMUM unit, as appropriate, for prior authorization of selected services.

This common understanding has permitted CHS to offer physicians the opportunity to contract under partial-risk agreements, with a capitated rate and participation in a bonus pool maintained by CHS. For physicians opting for capitated contracts, the bonus pool is disbursed at the end of the contract year based on targets set by CHS. Under this agreement, physicians may share savings but bear no risk for financial losses.

Physicians have had mixed reactions to the offer of capitated contracts and CHS is working actively to encourage their participation in this type of arrangement. Based on review of physicians' practice data, CHS identifies physicians who would benefit financially from entering the capitated/bonus pool agreement. Physicians for whom there are apparent financial advantages under the capitated contract arrangement are then provided with this additional information as a means of encouraging physician participation in risk-sharing agreements. Not surprisingly, CHS reports that, among their

PCPs, physicians with the most to gain under a capitated contract have relatively little experience with managed care.

Both PCLTC and CHS have developed a philosophy that the case managers only contact PCPs when absolutely necessary, and working in close coordination with the nursing and office staff of PCPs practices, case managers and the quality/utilization management staff report few difficulties in coordinating and managing member services or the PCP and case management functions.

In contrast to the experience in Arizona, Carle physicians and providers work under a single ownership structure and are not subject to individual plan/provider contract negotiations and risk arrangements. (CNO enrollee services provided by non-Carle providers are paid on a negotiated fee-for-service basis.) This simplification of financial incentives, however, has not obviated the need for physician education and development of communication for CNO enrollee care management. While use of collaborative nurse partnerships have been a part of several earlier demonstration projects within Carle, the CNO primary nurse partners (PNPs) initially encountered some physician reluctance to their involvement with patient care.

The CNO nurse partners and the physicians in the rural areas, however, have found it easier to establish working relationships with each other than have their counterparts in the larger practice settings. Staff report that as a result of working together more closely and establishing a more direct relationship with the CNO enrollees, there are fewer referrals for specialist services on behalf of enrollees. In contrast, in the larger physician practices, such as the Urbana clinic, communications are much more fluid and physicians are more likely to lose contact with the patient due to the involvement of multiple providers and the abundance of specialists. This lack of continuity, in turn, was viewed as jeopardizing the follow-up and case management activities of the PNP.

Long term care provider experience with managed care: Prior to ALTCS, long term care providers (including nursing homes and home and community-based services) in both Pinal and Cochise Counties had no experience with managed care or risk-sharing contracts. At present most HCBS services, including home health services, personal

care and homemaker services in both counties operate under fee for service agreements. Beginning in fiscal year 1996-1997, however, nursing homes that contract with CHS are being offered the option of continuing to contract under the existing fixed fee-for-service agreement or contracting under a blended rate format. The incentive structure for the blended rate contract agreement will permit nursing facilities to maintain savings for member care when members' functional capacity improves compared to their status at the time of admission. (Because the nursing facility blended rate is a new option introduced by CHS for the year after the case study visit, there is insufficient experience on which to base any impressions on the success of this approach.)

Other provider experience with managed care: Risk-bearing contracts with other types of providers have met with mixed success. At the time of the CHS site visit laboratory, x-ray, and durable medical equipment contractors were all operating under full risk contracts. Problems with lab and x-ray services, however, had been identified and consideration was being given to converting these services to fee-for-service contracts.

Pharmacy services in the CHS, operate under a formulary developed by Pinal County and adopted by CHS, also operate under full-risk contracts. CHS has encountered problems with pharmacy services, however, in part due to the complexity of the number of providers serving individual members. To address this problem, CHS established a policy whereby the choice of pharmacy is linked to the selection of a PCP. Under this arrangement, when a member selects a PCP that choice defines what pharmacy within the network will be used. Thus, CHS PCPs are no longer required to interact with multiple pharmacies on behalf of members. Furthermore, by reducing the number of pharmacies per member, physicians are better able to monitor each member's medication regimen.

Can rural integrated acute and long term care project develop or secure the necessary technical capacity to manage services to older and disabled adults under risk-sharing contracts?

While Arizona's county-level government and county management infrastructure provided a framework for development of ALTCS programs, the counties lacked experience with managed care, a fact that did not escape the notice of prospective

providers. An example of this concern was described by a provider in Cochise County. During the development of the Cochise County proposal to become the ALTCS program contractor, an effort was mounted to organize providers to protest the County's proposal for the ALTCS contract. Several providers holding contracts with Ventana (Cochise Health Systems' predecessor) were concerned that the County would be unable to manage timely payment for services rendered, and that payment rates for services would be lowered under county management. In describing this effort to organize opposition to the County decision, the provider admitted to his own concern about the County's capacity to provide managed acute and long term care services. His evaluation of the situation, three years after the introduction of the CHS, however, was that the County had consistently been an honest partner in the delivery of integrated acute and long term care services and had exceeded local provider expectations as an ALTCS contractor.

At least one aspect of the network development activities which has helped relieve provider anxieties about publicly managed services in both Pinal and Cochise counties, has been the careful development of specifications for provider service contracts and periodic reissue of contracts through a competitive bidding process. This process draws on both the state AHCCCS policies and the existing County procurement procedures.

In Pinal County, the Board of Supervisors was able to further limit their risk of failure by hiring staff who had previously worked with the Maricopa County ALTCS. This expertise, combined with support from the state AHCCCS, enabled PCLTC to develop and implement services within a relatively short time frame. PCLTC staff, however, expressed concern that more recently state AHCCCS administration and elected officials staff were becoming increasingly oriented to the private sector. In particular, PCLTC staff were concerned that some of the philosophies that were held by the county, (as a nonprofit enterprise—and in particular their commitment to home and community based services) were being challenged by what they perceive as a bias toward for-profit managed care organizations.

In comparison, Carle's CNO was developed as a demonstration within the broader Carle organization and, therefore, has not encountered the provider skepticism that was problematic in Arizona. As with any new program within a large organization, the Research Center had to gain approval and get buy-in for the initiatives, however, strong support from senior management was established prior to introduction of the CNO project.

Information and quality management: In Cochise County, the QMUM staff and case managers report that with the introduction of the CHS as the ALTCS program contractor, many of the subcontractors, particularly nursing facilities, were suspicious and viewed the QA process of CHS as burdensome. Providers viewed this process as “a policing effort” rather than as a source of technical support. Through considerable effort on the part of the QMUM manager and case managers, most of the nursing homes and other CHS sub-contractors now recognize that the CHS QA process seeks to improve the quality of services to members. CHS, and the QMUM unit in particular, recognize that they need the few providers that are available and see their mission as encouraging the provision of optimal quality services.

According to representatives of both the PCLTC and CHS, the importance of an integrated information system cannot be overstated. The resources necessary to reconcile books, assure timely disbursements and assure successful collections for third party liability (and to be certain that providers bill Medicare rather than ALTCS as the payer of last resort), require an advanced understanding of financial management and careful integration of the contracting, care management, and accounting functions. It is interesting to note that CHS was originally expected to use the Cochise County information system (through the County computer network); this option, however, was deemed inefficient on clarification of the volume, reporting requirements, and processing time standards required under the ALTCS contracts.

For these reasons, both PCLTC and CHS contract with a single independent information systems firm for their encounter and claims management systems. While designed for ALTCS encounter and claims data management, this system nonetheless

has created tremendous frustration on the part of PCLTC and CHS personnel and subcontractors.

Linking member needs, care plan authorizations, service cost, and use data: In Arizona, case managers document each visit, each assessment and each change in the authorized plan of care as it occurs through entry in the state Client Assessment and Tracking System (CATS). At the same time, service authorization data must be entered into the encounter and claims data information system through a separate process. The nature of the rural environment with case managers and service providers often located at considerable distance from each other makes these information and care management needs even more important.

The inability of the CATS and encounter and claims data information systems to communicate, and problems maintaining and reconciling the two data systems is a constant frustration for the clinical and financial staff in both counties. In some instances, the definitions used in the two systems are different, making comparisons and reconciliations difficult, if not impossible. At a minimum, the duplicative data entry process is viewed as inefficient, and a source of potential error in record keeping. PCLTC, CHS and other counties working with the same independent firm providing encounter and claims data processing are supporting a statewide contract to develop a communication bridge between that system and the CATS system. The process of reconciling encounter and claims data with service authorization data, nonetheless was viewed by both PCLTC and CHS as critical for purposes of quality control and utilization management functions, as well as for financial management of the plans.

Beyond the challenges presented by the separate information systems are limitations within the client tracking system (CATS) developed for statewide ALTCS management. An example of the limitations encountered in use of the CATS system is overwriting of members' histories when new data are entered. While the CATS system maintains current information, as information on members needs and caregiving network is updated in the client tracking system (CATS), the history of care needs and services is lost. Experience shared by the CHS management team illustrates the problem created

by this particular limitation. Specifically, CHS staff identified problems with member “doctor shopping.” That is, members who wanted services or medications that their PCP was unwilling to authorize were seeking new PCPs in hopes of securing desired services. As a result, individual PCPs were, at times, unaware of member’s service use.

In response, CHS changed its policies and now permits members to only change PCPs at the beginning of each month and requires that changes of PCP be submitted in writing. In response to such circumstances, CHS has adopted a more careful review of the history of CHS involvement with members, a task that is substantially undermined in the absence of member histories in the CATS system. This experience suggests that capacity to retrieve client histories within the plan may be a very important tool for assuring care managers capacity to meet program goals for care management.

Though Carle has developed a fairly sophisticated information system, only parts of that system are being used for the CNO demonstration. Carle patients have a single medical record but this is not used as the nursing record by the CNO. CNO enrollees have a separate medical record for their participation and services received under the demonstration. The Carle system has only recently been able to even flag a CNO patient within the Carle record system. The CNO nurses input a brief care plan so that other providers are aware of the patient’s participation and status within the CNO initiative. This addition is so recent that there is no experience to date as to whether it is being utilized by either the CNO or Carle providers. At a minimum, Carle’s experience suggests that the challenges of information management for managing acute and long term care services are not idiosyncratic to Arizona’s ALTCS program or the PCLTC or CHS systems.

Are there advantages to being small?

Differences in professional cultures and distrust between those who provide medical services and those who provide 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 which 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.

It is not clear whether these problems are more prevalent in rural communities or whether they are more or less easily overcome in these smaller places than in larger communities. On the one hand, observers in Arizona almost uniformly reported that, since the implementation of ALTCS, collaboration among medical and long term care providers has improved dramatically as a result of their managed care experience. Similarly, in the smaller practices participating in the Carle CNO, the small, rural nature of the operation was credited with fostering stronger collaboration to the benefit of enrollees. This observation suggests that while the Carle CNO has avoided some of the inter-professional problems by limiting its care management program to services that clearly fall within the medical care sector, even within this sector, care management support is not always readily accepted by physicians.

Those interviewed at both sites in Arizona indicated that the smaller number of people served, while increasing the financial risk for the program, made the program more manageable. They viewed their rurality and concomitant small staff and membership size as a distinct advantage. The Directors of PCLTC and CHS are able to maintain an active working knowledge of the problems within their systems, both in terms of provider and member activities. When a PCP, a pharmacist or other provider within the network demonstrates practice patterns outside the norm for their area, or a member refuses services or uses excessive services, that information is known quickly to the entire management team. When such instances recur they are readily recognizable and the history of efforts to resolve problems is known (albeit sometime undocumented due to information system challenges described above). This enables experience to serve as a guide for the future program improvement efforts and the small team size permits solutions to be developed and implemented expeditiously.

According to PCLTC staff interviewed, the small staff size was of particular value during initial development and implementation of the ALTCS program. They report that their smaller size facilitated the development of a management team that could quickly

identify and trouble shoot problems as they arose. In addition, they credit the rural nature of the county, while not without its drawbacks, with providing an environment where key leaders and providers were well known to each other and PCLTC business could be conducted in a collegial manner.

According to Carle physicians and PNPs, ongoing communication is essential, and physical proximity of the two providers is key. When the PNPs are located at the same practice site as the physicians, they are able to maintain a consistent presence and relay information and concerns on an 'as needed' basis. The providers interviewed felt that this physical proximity provides the necessary opportunity for informal communication, and allows a relationship to develop between the doctor and the nurse partner. In instances where the CNO patient does not have a Carle physician, the communication and collaboration become much more difficult because there is no face to face contact between the physician and the PNP. The nurse manager must rely on written and phone communication with the physician and does not have the opportunity to establish a collegial relationship. The rural practice setting, in fact, would appear to benefit the care of the patient in this model. Established PNP/physician communication and on-going monitoring of the patient has meant that the patient's needs are identified earlier and services are arranged in a timely manner. Timely identification of changing patient needs has meant that providers are better equipped to target resources and provide appropriate care. Because the PNP is able to provide the necessary case management for the frail patient, the physician is more willing to work with the CNO and the patient to provide the required physician services.

Why is the integration of hospital services so difficult?

At PCLTC and CHS, case managers are not always aware when members are admitted to hospitals. When members are hospitalized, the case manager may be notified by the hospital, by the nursing facility, or, in the case of persons served at home, by in-home care providers' staff. Within the discharge planning units of hospitals visited in each county, hospital staff report making an effort to identify ALTCS members and notify the ALTCS contractor when members are admitted to their facilities. In both counties, however, hospital staff acknowledge that they are not always aware of patients' status as ALTCS members and that this information is not routinely collected at admission.

Once hospitalized members are identified, however, ALTCS staff report regular (often daily) contact with hospital staff to determine the members' likely length of stay and post-discharge needs. Among the hospitals contracting with the CHS, the QMUM manager reports ease of communication and a clear understanding between hospital nursing staff and the CHS. This working relationship, which is viewed positively by both CHS staff and the contracting hospital we visited, does not seem to hold up for hospitals outside CHS's network of contracting hospitals. This problem was also identified by PCLTC staff.

At CHS, both the QMUM manager and the Medical Director reported difficulty in locating and communicating with hospitals outside the county who are serving CHS members. This was particularly troublesome for members with intensive care needs served in the larger metropolitan hospitals in the Tucson area. In an effort to reduce the loss of control for members being served in Tucson hospitals, CHS has recently developed a contract with a single hospital in Tucson. In addition, CHS QMUM staff also work with care managers and QMUM staff in the ALTCS contract office in Pima County (Tucson), on a cooperative basis, for purposes of making site visits or obtaining member information from hospitals in that county. In the most complex cases, CHS has been able to dispatch its Medical Director to make visits to members in Pima County hospitals.

CHS's anxiety regarding out-of-county hospital placements is based on experience. They cite as an example, the cost of care and limited care management provided to a quadriplegic and ventilator-dependent CHS member who was seen by three physicians within a single specialty on a single day. CHS was then billed for each specialist's services (the member did not have Medicare coverage). Yet, CHS had no information about why such services were necessary. The director of CHS, the QMUM manager, and case manager supervisor agree that it is this type of challenging situation that places CHS at greatest financial risk for losses.

The challenges of determining when an enrollee is admitted to the hospital are also evident from discussion with CNO PNPs. Since hospital services are not part of the managed services in the CNO demonstration, the hospitalization of a CNO patient presents care management (but not financial) challenges for the CNO. If the patient has been admitted by a Carle physician, the PNP relies on that provider to inform the CNO of the patient's status and subsequent care needs. When the patient's provider is not a Carle physician, the CNO nurse, when aware of the hospitalization, attempts to meet with the discharge planning staff to determine the patient's condition. In some instances, the CNO has established a protocol with the hospital so that they are contacted when a CNO patient is hospitalized.

How do limitations in the supply of services affect the development and success of integrated and long term care programs?

As noted earlier, the availability of primary care, in-home long term care, and other services is limited in most rural areas. This could hinder the successful development of managed care programs. 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.

These examples, though limited, suggest that service limitations can be overcome in the development of managed care programs. Managed care programs like Arizona's ALTCS may actually serve to stimulate the development of services and the

preservation of the service infrastructure in rural areas that have had supply problems in the past.

Those we spoke with in Pinal and Cochise Counties noted that the availability of services, especially in-home support services, was a serious problem prior to the development of the ALTCS program, but that since the implementation of the program, there has been a steady expansion in the availability of these services in both counties. Although the expanded public funding for these services under the ALTCS program may explain some of this improvement, there is strong evidence in both counties that the development of the managed care programs also contributed to expanding service availability and access.

In Pinal County, the County has taken a service system planning approach as they developed and implemented their managed care program, to identify and address gaps in services. So, for example, the County identified adult foster care as largely unavailable in the county and has worked to develop such services. Similarly, Cochise County recognized its supply problems as it began to negotiate contracts with providers and responded to the concerns of care managers and consumers. The Cochise Health System has actively sought to develop an expanded primary care physician (PCP) network for members. At the time that CHS accepted responsibility as ALTCS program contractor, members in one of the County's commercial centers were limited in their choice to a single PCP. Since CHS has had the ALTCS contract, there has been a concerted effort to conduct physician education programs and actively recruit physicians in areas with minimal PCP supply. The County also faced a problem in the availability of pharmacy services. Recognizing that it was important to preserve the local availability of those services in one commercial area, the County contracted with the local pharmacy rather than outsource those services to potentially less expensive providers in other counties.

Other development activities have included an effort to identify a single nursing home in Pima County where younger, physically disabled persons' needs could be met. CHS has approached the Pima County ALTCS program in hopes of creating a two-

county initiative to support improved nursing home services for younger disabled persons. Within the scope of this initiative, a willing nursing home facility has been identified and, at present, two younger, physically disabled CHS members are in residence.

Not all network weaknesses, however, have been resolved. Identified weaknesses in the CHS network of services include the lack of inpatient facilities for persons with mental illness, the shortage of group homes for persons with mental illness, the limited number of psychiatrists available within the county, and the limited supply of non-medical residential care services. Under a recent state AHCCCS initiative to provide non-medical residential care services through small adult care homes, CHS has been allotted ten adult care home “slots.” At the time of this study, no CHS members were living in adult care homes. This gap was attributed to the limited supply of such providers and occupancy of available beds by private-pay residents. Unlike PCLTC, CHS has not dedicated staff resources to new adult care home development.

Can sole providers of services in rural areas hold integrated acute and long term care programs hostage?

Another aspect of the limited service capacity in rural areas, are difficulties this can create for network formation. The absence of competitors among service providers can reduce the incentives for providers to join a network. It can also limit the ability of payers and plans to negotiate payment discounts or other arrangements designed to control use of services and reduce costs.

An interesting example of this problem involving nursing facility (NF) services was “in-process” during the site visit. During the competitive bidding process for nursing facility service contracts in 1996, an existing NF contractor expressed reluctance to continue as a member of the CHS network. In this instance, the NF was the sole provider for one of the five commercial areas in Cochise County. CHS was appropriately concerned that a provider wanted to withdraw from the network due to what the provider viewed as insufficient payment for services. CHS staff were reasonably certain, however, that the facility would have a change of heart on the realization that the majority

of their residents were ALTCS members. The CHS staff, in an effort to encourage the facility to participate in the contract bidding process, were preparing to notify the facility of their plan in the event that the NF chose not to continue as a contractor. CHS had decided that members would no longer be offered the option of services at that facility. CHS staff expressed concern for current members residing at that facility and had made a tentative decision to continue to pay for services (under a fee-for-service arrangement) until current residents left the facility, rather than move members to different facilities. Through careful identification of the self interest of that facility and open communication regarding the implications for the facility (if they decided not to participate in the system), CHS appears to have established a strong position from which to manage long term care services and not fall prey to a single provider in a potentially monopolistic environment. The problems of plans being held hostage by single, dominant providers have been identified previously by others and are especially problematic in rural areas (Riley and Mollica 1995).

Do Organizational and Ownership Structure Matter?

The organizational structure differs significantly among these three initiatives. The Carle CNO program operates within the corporate structure of Carle which, through its affiliates owns many, if not most of the facilities and service providers. In contrast, Pinal and Cochise Counties in Arizona operate mixed ownership and contracting models where the county operates some services (e.g. care management), but contracts for acute, primary and long term care services.

While determining the effects of these different organizational approaches and structures on the success of these initiatives is beyond the scope of this study, these cases suggest that structure can be very important in facilitating the development of both functional and clinical integration, two critical, necessary conditions for effective managed care organizations. At one extreme, the consolidated ownership structure of the Carle Clinic has enabled them to mount the CNO demonstration without having to negotiate with many other interested organizations and, this structure has contributed to their ability to integrate care management and administrative functions central to the demonstration.

Yet, even in this structure, participants noted the importance of on-site education and support for providers in the rural practices. At the other extreme, the Arizona cases demonstrate that ownership is not a necessary condition for success, as both Pinal and Cochise Counties have been able to successfully contract 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.

Perhaps more important than organizational and ownership structure are the problems that distance pose for the integration of clinical and administrative services. This was especially evident in Arizona where distances among providers, some of which are out-of-county, makes the care management process quite challenging. Establishing both formal and informal communication systems is critical to effective care management. At Carle it was noted that physical proximity and, preferably, co-location of providers was highly desirable in encouraging effective communication. Where this is not possible, information systems and communication technologies become critically important.

Based on the example and experience of these sites, it is hard to overestimate the importance of state and federal 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. It seem 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 specific characteristics of these networks, including the range of service providers that is included and the nature of the relationships among them, will be determined by the nature of those contracts. One of the important lessons of this study for states and the federal government is that, contrary to common perceptions, 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.

CONCLUSIONS AND POLICY IMPLICATIONS

Although experience with managed care 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 as states expand their use of Section 1115 Medicare and Medicaid managed care demonstrations. Whether these programs work, how much they cost, and whether they deliver high quality care are questions of paramount policy importance. As these initiatives are designed, get underway, and are evaluated, it is critical that states and the federal government carefully consider the special circumstances and needs of rural communities, providers, and consumers. The experience of the three cases presented in this paper suggest a variety of rural policy considerations.

Organizational and Program Models

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.

Technical Support

Many rural communities and providers may need considerable technical and financial support to enable them to effectively participate in these new managed care initiatives. Technical support may be needed to assist providers and communities develop appropriate organizational relationships or alliances, contracting arrangements, financial management systems, information systems, and/or 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.

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 is especially important. 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.

Financing

Flexibility, and technical and financial support, may also be needed to support the development of risk-based financing arrangements in rural areas. As the cases in Arizona demonstrate, it is possible for smaller, rural plans to assume risk for inherently risky populations and costly services. Nevertheless, even these counties have sizable populations relative to many other rural areas where the limited financial capacity of plans and providers suggests the need for risk sharing and/or financial protection options. Specifically, the development and testing of partial capitation, case management fees, and/or 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.

Protecting the Safety-Net

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 health 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.

ENDNOTES

¹ Currently, only the 1115 program in Minnesota is operational. In this demonstration (The Senior Health Options Project), elderly and disabled Medicare beneficiaries in 7 counties in the metro-Minneapolis area, who are also eligible for the Medicaid program, will be enrolled in health plans which will manage both the Medicare (Parts A and B) and Medicaid benefits under a prepaid financing arrangement. For more information of this and other demonstrations, see, P. Saucier et al. 1997.

² The terms “integrated services” and “managed care”, used throughout this paper, though highly related, are not interchangeable. We use the terms “integration” and “integrated services” to refer generally to the types and degrees of linkages between the primary acute and long term care organizations and services. The concept of integration is discussed more specifically in this chapter. The term “managed care” refers generally to the myriad of insurance, financing and care management strategies that may, or may not, encompass the continuum of primary, acute and long term care services.

³ Available from the authors.

⁴ Available from the authors.

REFERENCES

- Arizona Office of Rural Health (1996) "Pinal County Baseline Data Summary," Southwest Border Rural Health Research Center, Tucson, AZ.
- 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), forthcoming.
- Conrad, D. and S. Shortell (1996) "Integrated Health Systems: Promise and Performance," Frontiers of Health Care Management, 13(1): 3-40.
- Fox, P.D. and T. Fama (1996) "Managed Care and Chronic Illness: An Overview," in P.D. Fox and T. Fama, Managed Care and Chronic Illness: Challenges and Opportunities, Gaithersburg MD, Aspen Publishers, pp. 3-7.
- Gilles, R., S. Shortell, D. Anderson, J. Mitchell, and K. Morgan (1993) "Conceptualizing and Measuring Integration: Findings From the Health Systems Integration Study," Hospitals and Health Services Administration, 38(4): 467-489.
- Health Care Financing Administration (1995) "The Role of Medicare and Medicaid in Long Term Care: Opportunities, Challenges, and New Directions," Report of HCFA's Long Term Care Initiative: Final Report.
- Leutz, W., M. Greenlick, and J. Capitman (1994) "Integrating Acute and Long term Care," Health Affairs, 13():59-74.
- McCall, N., J. Korb, L. Paringer, D. Babalan, C Wrightson, J. Wilkin, A. Wade and M. Watkins (1993) Evaluation of Arizona Health Care Cost Containment System Demonstration: Second Outcome Report, San Francisco, CA. Laguna Research Associates.
- Miller, R. (1996) "Competition in the Health System: Good News and Bad News," Health Affairs , 15(2): 107-120.
- Morris, R. and I. Moscovice (1978) "Service Integration: Real Versus Illusory Solutions to Welfare Dilemmas," in R. Sarri and Y. Hansenfeld (eds.) The Management of Human Services, NY: Columbia University Press.
- Moscovice, I., T. Wellever, J. Christianson, M. Casey, B. Yawn, D. Hartley (1996) Rural Health Networks: Concepts, Cases, and Public Policy, Minneapolis, MN,
- Riley, P. and R. Mollica (1995) Managed Care and Long term Care: The Arizona Long term Care System , Portland Maine, National Academy for State Health Policy.

Saucier, P., J. Fralich, T. Riley, R. Mollica, M. Booth (1997) Integration of Acute and Long Term Care for Dually Eligible Beneficiaries Through Managed Care, Portland Maine, Edmund S. Muskie School of Public Service, University of Southern Maine.

Schraeder, C and T. Britt (1997) "The Carle Clinic" Nursing Management, 28:32-34.

Shortell, S., R. Gillies, D. Anderson, K. Erickson, and J. Mitchell (1993) "Creating Organized Delivery Systems: The Barriers and Facilitators," Hospital and Health Services Administration, (4): 447-466.

Stone, R. and R. Katz (1996) "Thoughts on the Future of Integrated Acute and Long term Care in, Annual Review of Gerontology and Geriatrics: Focus on Managed Care and Quality Assurance: Integrating Acute and Chronic Care, 16:217-245.

University of Minnesota Rural Health Research Center (1997) Rural Managed Care: Patterns and Prospects, Minneapolis, MN.

Vladeck, B. (1994) "Overview: The Case for Integration," in Integrating Acute and Long Term Care: Advancing the Health Care Reform Agenda, Washington DC, American Association for Retired Persons, pp. 3-4.

APPENDIX A: DESCRIPTION OF THE ARIZONA LONG TERM CARE SYSTEM

Beginning in 1989, the Arizona Health Care Cost Containment System (AHCCCS) began providing long term care services under a capitated, risk-bearing managed care program. This demonstration, the Arizona Long Term Care System (ALTCS), was established under a Medicaid Section 1115 Waiver (Title XIX of the Social Security Act). Under the ALTCS system, there are two population-specific programs: (1) services to the developmentally disabled, and (2) services to the elderly and the physically disabled. The following summarizes key features of the ALTCS program.

State Requirements for ALTCS Contractors: Contracts issued to county-level program contractors for ALTCS services are embedded in a state system with significant regulatory and program guidance. Specifically, ALTCS contracts identify: the scope of services; care manager to enrollee ratios, the proportion of enrollees that may be served in home and community-based settings (HCBS) relative to the total number of enrollees; uniform information collection and documentation requirements; and quality assurance mechanisms and processes required to be maintained by ALTCS program contractors. In addition, requirements for provider network structure, clinical care standards and medical policies are included in a variety of other governing documents or recommended guidelines.

POPULATIONS SERVED and SCOPE OF SERVICES

Populations Served: Eligibility for ALTCS services is determined by regional employees of the Arizona Department of Economic Security and is based on both financial need and determination that the applicant is at risk of nursing home placement. Following determination of eligibility, the county program contractor for ALTCS is notified that they have a new member to enroll. State guidelines require that assessments of new enrollees be conducted within ten days of notice from AHCCCS and that services be implemented within 30 days. All ALTCS members are reassessed for financial and medical eligibility every 12 to 24 months. If a person's eligibility expires, they are disenrolled from the program. If a person's condition improves, thus making them medically ineligible for the program, a new transition program has been approved by the State of Arizona. This program provides a continuation of coverage for those who continue to need home and community-based services.

Scope of Services: ALTCS program contractors are required to provide members with care management support and a comprehensive array of acute, long term, and behavioral health care services. AHCCCS-defined covered services, and responsibility for authorization of services, are summarized in Figure 4 below. Services not covered by ALTCS contracts include hearing aids, eye exams or glasses for adults (age 21 years or older), routine dental exams, extended services through a psychiatric hospital or TB hospital, miscellaneous personal items or other services that are not considered medically necessary (e.g. cosmetic surgery).

Figure 4
Authorization of Home and Community Based Services^a
Arizona Long Term Care System

SERVICE	PCP ORDERS (Prog. Contractor for Enrolled Members)	AHCCCSA PRIOR AUTHORIZATION (FFS Members Only)	CASE MANAGER SERVICE AUTHORIZATION ONLY
Acute hospital admission (Non-Medicare Admission)	X	X	
Adult Day Health Services			X
Attendant Care			X
Attendant Care (For members also receiving hospital services)		X	
Behavioral Health Services	X		
DME/Medical Supplies	X	X	
Emergency Alert			X
Environmental modifications	See	Policy	1240
Home Delivered Meals			X
Home Health Agency Services	X		
Homemaker Services			X
Hospice Services (HCBS and Institutional)	X		
Medical Acute Care Services	X	X	
Nursing Facility Services	X		
Personal Care			X
Respite Care (In-home)			X
Respite Care (Institutional)	X		
Therapies	X		

a Services require authorization by the case manager, the member's primary care provider (PCP) and/or the AHCCCS Administration.

SERVICE INTEGRATION

Care Coordination: Once a person is determined eligible for the ALTCS program, the ALTCS contractor is responsible for enrolling the member in the program, helping them choose a primary care physician (PCP) from among physicians participating in the ALTCS contractor's network, and providing preliminary information about the program. After enrollment, each person is assigned a case manager who, with the member's PCP, is responsible for establishing individual members' care plans.

Clinical Integration: The PCP and the case manager provide the points of clinical integration within the ALTCS program. Detailed policy guidelines outline the procedures and areas of responsibility for assessment, care planning, prior authorization and service arrangement. When a member is first enrolled, the case manager visits the consumer, conducts an initial assessment and develops a care plan. The case managers work with the consumer to arrange for necessary long term care services, including nursing home care and home and community-based services. In this process, case managers consider the member and family wishes, member safety and home support systems in determining the most appropriate care plan for a member. The PCP is contacted by the case manager regarding the member's medical needs, nursing home placements and transfers, home and community-based service needs, and other specialty care needs. Members are also encouraged to see their PCP when necessary.

All services must be ordered by the person's primary care physician (PCP) or specialty doctor and approved by the prior authorization unit or the case manager. Only the PCP or a physician referred by the PCP can order prescription drugs or medical supplies or equipment.

Following the implementation of a care plan, case managers conduct on-site review and monitoring visits with all enrollees. The periodicity of case management review varies by setting of services. For members who are served through home and community-based services (HCBS), case managers must visit the member at least once every 90 days. For members who are in nursing facilities, case management visits are conducted once every six months; for members who are ventilator-dependent, case managers visit monthly.

Case manager to member ratios are established by the state AHCCCS program and vary by location of care received by the member. At the time of this site visit, one case manager could serve no more than 50 members receiving HCBS services, or 120 members residing in nursing homes. For case managers serving members who lived both in their own homes and in institutions, the maximum number of members managed was 95.

Quality Assurance: ALTCS contractors are responsible for the development and operations of quality and utilization management programs. All ALTCS program contractors are required to have Quality Management and Utilization Review plans that set forth the policies and procedures for implementing, monitoring and analyzing of mandated reviews and reports and the delivery of quality and utilization management services. In both Pinal and Cochise counties, staff responsible for quality and utilization management work cooperatively with their case management and contract units to

develop the necessary data for monitoring the quality and utilization of services provided to members.

The quality and utilization units in both Pinal and Cochise Counties report directly to the Director, and with the Medical Director are responsible for the development of policies and procedures. The Medical Director acts as the physician advisor and is the final authority in the determination of medical necessity in both Pinal and Cochise Counties. The Medical Director is responsible for the development of the policies, procedures and standards by which the medical service components of the plan operate. Primary responsibilities include the direction of the quality management and utilization review program, and training and updating of primary care providers.

Utilization review and management are integral parts of the quality management program in both counties. Utilization management evaluates the cost impact of cost containment activities on the quality of patient care and determines the point at which quality may be compromised. In each county, procedures have been established that outline the areas for prospective review, concurrent review, retrospective review, and focused review activities. Other quality assurance mechanisms proscribed by the state include grievance procedures, and consumer satisfaction surveys managed and conducted by ALTCS contractors.

Functional Integration - Information Systems

Chief among state-defined information system requirements is the Client Assessment and Tracking System (CATS). The CATS system incorporates enrollee assessment information, care plans and service authorization data and is a statewide clinical information system that was developed by the AHCCCS program for ALTCS. All ALTCS contractors are required to input assessment and care plan data into the system. Case managers submit service plans, cost effectiveness studies and placement tracking forms for CATS data entry and subsequent supervisory review following initial and ongoing follow-up field visits with members.

Other reporting requirements include monthly submittal of encounter and claims data which are electronically transferred according to state AHCCCS guidelines. Information systems for the management and reporting of encounter and claims information are the responsibility of individual ALTCS contractors, and thus may vary from county to county. Pinal and Cochise County ALTCS programs contract out their encounter and claims data management functions to an independent information management firm. This firm, which is also used by other ALTCS contractors, offers an ALTCS specific encounter and claims data management system designed to meet state AHCCCS storage and retrieval, and related defined specifications.

FINANCIAL RISK ARRANGEMENTS

LTCS is financed through federal Title XIX (Medicaid) program funds, with non-federal matching funds supplied by county tax revenues. All ALTCS program contractors are risk-bearing.

Risk Sharing: Within the ALTCS program, ALTCS contractors are at full risk for members' care with few exceptions. The level of risk borne by subcontractors, however,

varies by local program and type of provider. ALTCS contractors receive a capitated payment per member per month (pmpm) with the risk for excessive liability for hospitalizations on the part of ALTCS program contractors re-insured under a self-insured pool maintained by the state AHCCCS program. "Savings" that result from lower than anticipated costs for member services (e.g. lower than capitation rate) are allocated between the county contractor and state ALTCS program on a 25/75 basis. That is, the ALTCS contractor retains 25% of the savings and 75% of the savings accrue to the state AHCCCS program.

Factors used to develop each county contractor's pmpm capitation rate include the cost of services as well as administrative and re-insurance expenses. Information to develop capitation rates (negotiated annually) are supplied by data maintained by the AHCCCS program and information submitted by ALTCS program contractors based on their actual experience and annual projections. County program contractors report that data based on contractors' projections are frequently subject to debate between the AHCCCS and ALTCS contractors.

As a Medicaid 1115 waiver demonstration program, the ALTCS program must meet a budget neutrality test. This means that the total cost of ALTCS-funded services cannot exceed expenses that would have been incurred under a non-waivered Medicaid program. One of the mechanisms used to assure budget neutrality by the AHCCCS program is a limitation on the care plan cost for ALTCS members receiving home and community-based services (HCBS). ALTCS members receiving HCBS, on average, must have service care plans which do not exceed 80% of the nursing facility payment rate.

BARRIERS TO SYSTEM DEVELOPMENT: DUALY ELIGIBLE

Among the challenges faced by ALTCS program contractors are the difficulties in determining other health insurance coverage and third party liability for members' services covered by other health insurance or Medicare. This challenge is exacerbated by the growth of Medicare managed care offerings and relatively recent introduction of Medicare risk contracts in the two study counties. In Arizona, over 33% of Medicare beneficiaries in urban areas, and 10.5% of rural beneficiaries, are enrolled in some form of managed care (University of Minnesota Rural Health Research Center 1997). Managed care is a dominant form of health care delivery in Arizona. In 1994, over half of Arizonans (53%) were enrolled in some form of a managed care plan, including 35% of the population who were enrolled in an HMO and 16% in a PPO.

In an effort to encourage integration of payment and services for dually eligible ALTCS members, the state ALTCS program proposed development of mechanisms that would limit ALTCS members' choice of Medicare HMOs to ensure coordination of ALTCS and Medicare HMO services and payments. In 1996, however, Arizona's request for the necessary waiver of Medicare HMO provider choice requirements was denied by Health Care Financing Administration (HCFA), the federal agency which oversees the Medicare and Medicaid programs. Thus, while individual county contractors may establish their own Medicare HMOs, they can only encourage ALTCS members to participate in such plans, thereby enabling coordination of Medicare and Medicaid covered services. At the time of this study, neither of the county program contractors held Medicare risk contracts.



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