

FINANCING AND PAYMENT ISSUES IN RURAL LONG TERM CARE INTEGRATION

Paul Saucier
Julie Fralich

2000

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

FINANCING AND PAYMENT ISSUES IN RURAL LONG TERM CARE INTEGRATION

EXECUTIVE SUMMARY

Purpose

Federal and state policy makers, consumers, health plans, providers, and other stakeholders are interested in the benefits and disadvantages of integrating acute and long term care financing in rural areas. To date, experience with integrated financing is limited and is based largely in urban areas. This paper reviews current research and experience and identifies key policy and program considerations for integrated financing in rural areas.

Why Integrate Financing?

A major concern with fee-for-service reimbursement is that it forces consumers and providers into rigid categories of service, whether or not those services truly meet consumers' needs. This is a particular concern when long term care is needed, because public long term care is funded primarily by Medicaid while public acute care is funded primarily by Medicare. The bifurcation of these two important funding sources results in perverse incentives to shift costs and to maximize reimbursement rather than providing the most appropriate level of care to consumers. The hope of integrated financing is that it will provide the financial incentives and flexibility needed to deliver to consumers the appropriate level of care without regard to funding source.

The Urban Model: Financial Integration through Full Capitation

Integration of acute and long term care financing has been tested primarily in urban areas, and the central design feature has been capitation. Many variations exist, but the general approach has been to create a flexible pool of acute (Medicare) and long term care (Medicaid) dollars at the health plan or provider system level. For each enrolled beneficiary, the State makes a capitated Medicaid payment and the federal Health Care Financing Administration makes a capitated Medicare payment to a single accountable entity. That entity (an HMO, Provider-Sponsored Organization or other qualified risk-bearing organization) must provide all covered services and is at financial risk for costs that exceed the capitation, but is freed from many fee-for-service rules. The entity has a financial incentive to provide or pay for any service that is likely to prevent more expensive needs down the road, such as hospital or institutional long term care. Capitation allows downward substitution of services when appropriate, makes budgets more predictable for payers and allows a greater focus on consumer outcomes by focusing accountability on a single entity responsible for total care.

Full Capitation Often Not Viable in Rural Areas

Full capitation is rare in rural areas. Financial integration through full capitation of acute and long term care payments has not been widely replicated in rural areas. Two PACE sites (Program of All-inclusive Care for the Elderly), based in Columbia, South Carolina and Eau Claire, Wisconsin, are fully capitated for both Medicare and Medicaid. Both sites provide services in rural areas but are based in small cities. The Arizona Long Term Care System (ALTCS) provides capitated Medicaid long term care services

statewide, but Medicare payments remain fee-for-service, protecting ALTCS contractors from acute care risk. The lack of experience in rural areas is not surprising, because capitation works best where there are large numbers of potential members and providers. A large member base allows managed care organizations to spread risk, and a large provider base gives them leverage in negotiating discounted rates.

Capitation may be counter to rural health provider goals: In many rural areas, preservation of existing provider infrastructure is an explicit goal. Depending on the type of provider, capitation can have the opposite effect. Capitation provides a financial incentive to the accountable entity (e.g., HMO, PSO) to use less expensive care. Rural hospitals, for example, should expect to receive fewer referrals from a capitated integrated care entity. Likewise, home health agencies might lose business as integrated entities learn how to substitute home care (provided by personal care assistants) for home health (provided by nurses). Furthermore, the integrated entity will want to negotiate discounts from providers, diminishing revenue per unit of service.

Many rural areas lack managed care infrastructure: Full capitation models require managed care infrastructure that often does not exist in rural areas. A financially healthy organization must be available and willing to bear the financial risk that comes with accepting capitated payments. In urban areas, HMOs, Provider-Sponsored Organizations and other managed care entities have played this role, but they have shied away from Medicare and Medicaid programs in rural areas. The alternative, developing a home-grown organization, is very difficult. With insurance laws in most states requiring such organizations to have reserves of \$500,000 to \$1 million, financially strapped local providers can not step forward, and those that have the resources may not wish to get into the risk management business because the incentives of capitation are generally opposite the familiar incentives of fee-for-service payment.

High hopes for the BBA have not materialized. Changes in reimbursement for Medicare risk organizations were enacted in the Balanced Budget Act of 1997 to make rural areas more attractive to risk-bearing organizations over time, but no significant increase of Medicare managed care has been observed in rural areas to date. It is too early to tell how modifications enacted in the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999 will impact rural infrastructure. The Refinement Act provided additional incentives to Medicare+Choice plans to expand into rural areas, but those incentives may be offset by several provisions that delay or mitigate BBA fee-for-service provisions for providers. To the extent that rural providers feel less immediate financial pressure from BBA, they may be less inclined to negotiate with prospective Medicare+Choice plans or to launch provider-based plans of their own.

Rural Alternatives to Full Capitation

A conclusion of the HCFA-sponsored evaluation of Social HMOs was that integrated financing is necessary but not sufficient to integrate services. Does this suggest that rural areas need not try, given the difficulty of implementing full capitation models? Some policy makers and program designers are experimenting with incremental strategies to determine whether some or all of the benefits of service integration can be achieved with less than full financial integration. Approaches include managed fee-for-service, partial capitation and other risk limitation mechanisms.

Managed fee-for-service refers to models that continue to pay for services on a fee-for-service basis, but manage the services in various ways. For example, the MaineNET Demonstration Program in rural Maine is designed as a Primary Care Case Management (PCCM) program, in which physician practices serve as gatekeepers for services. The physicians partner with the State's designated agency to provide care management when patients need long term care. The State provides utilization reports to participating practices. A logical next step is to select quality indicators discernible from the claims data and reward practices that achieve desired outcomes. While this approach promotes better management of existing services and can include appropriate financial incentives, it does not promote flexibility or substitution of services, since payments are still triggered by providing services that have been predefined as reimbursable.

Partial capitation refers to payment systems in which some services are prepaid through capitation but some remain fee-for-service. In a rural setting, this can be a way of containing risk for a nascent local organization while still allowing some flexibility of services and providing incentives for efficiency. Depending on how the capitated payment is structured, it can also allow an organization to avoid being treated as an HMO or other risk-bearing entity subject to large risk reserve requirements. Key policy questions include what to capitate and how to avoid cost-shifting to the fee-for-service side of the equation. In general, program designers should consider leaving in fee-for-service those services they want to promote (e.g., home care) and capitating services that are overutilized. An example of a partial capitation strategy is the one used with the Wisconsin Partnership Program site in Eau Claire. Medicaid services were partially capitated, and Medicare services remained entirely fee-for-service during a multi-year start-up period. Both (Medicare and Medicaid) became fully capitated after the site had gained considerable experience.

Other risk limitation mechanisms include risk corridors and reinsurance. Risk corridors define the ways in which losses and profits are divided between a plan or program and a payer. For example, in the Program for All-inclusive Care for the Elderly (PACE), risk corridors were used in the first three start-up years of the program to provide the time necessary to develop and refine the service system. If a program's revenues exceeded its expenditures, a risk reserve was created that was used to fund losses or create a risk reserve for future years. If the program's expenditures exceeded its revenues, the losses were shared by the program and the payer. The use or purchase of re-insurance for high cost cases is another method of reducing financial risk. Re-insurance can be structured in a number of different ways. In Arizona, the State buys commercial reinsurance that covers the cost of care for individual cases that exceed certain thresholds. For catastrophic cases associated with certain pre-defined conditions, such as transplants or hemophilia, the reinsurance covers either a certain percentage of the costs or a pre-established amount for the condition. In other states, the Medicaid agency itself offers re-insurance, or plans may be responsible for purchasing their own re-insurance.

Conclusions

Full capitation of acute and long term care payments is an urban financial integration model that is often not applicable in rural areas. Many rural areas do not have adequate infrastructure to support full capitation models, nor are such models necessarily

consistent with the common rural area goal of preserving and strengthening existing providers.

Rural areas may still want to pursue service integration to achieve greater flexibility and less fragmentation of services. A number of incremental payment approaches are more feasible for these areas than full capitation, yet still support some integration of services. These include the creation of fee-for-service incentives, partial capitation and other risk limitation strategies.

Financing Options for Integration in Rural Areas

	Key Features	Risk Management	Pros+ and Cons-
Traditional Fee for Service	Services paid on a per unit basis.	No risk to providers.	+Existing providers can participate directly. -Little opportunity to make services more flexible.
Managed Fee for Service	Payments remain FFS, but management and coordination of services are strengthened. Claims data is actively analyzed and use to change provider practices over time.	Little risk to providers. Incentive payments may be offered to reward certain desired outcomes.	+Existing qualified providers can participate directly. +Allows for targeted financial incentives. -Little opportunity to make services more flexible.
Partial Capitation	Some but not all services are included in the capitation payment. Partial capitation may be from Medicare and/or from Medicaid.	Organization needs capacity to manage/monitor services. Responsibility for risk management, quality oversight, payment can be shared with other entities through ASO arrangements or HMO partners.	Promotes cost consciousness and allows flexibility of benefits. Cost shifting to fee for service system is a problem. Difficult to administer and reconcile payments with payers.
Full Capitation	All inclusive payment rate paid to a single entity that is financially responsible for risk.	Organization must have established network of providers, be able to pay providers, meet quality assurance standards and have systems capacity to monitor service use and reporting requirements. Risk can be shared through re-insurance, risk corridors, or risk	Difficult in rural areas with low population base and low penetration of established managed care providers. May conflict with goals of local area providers and rural market conditions.

		pools.	
--	--	--------	--