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INTRODUCTION AND BACKGROUND

New models of financial, clinical and organizational integration of acute and long-term care services continue to emerge in urban areas. At the same time, the potential for similar integration initiatives in rural areas remains unclear. As described in companion articles (Coburn, forthcoming; Saucier & Fralich, forthcoming), there are very few examples of rural initiatives designed to integrate primary, acute and long-term care services in the United States. This article examines the unique characteristics of rural areas in relationship to acute and long-term care integration and then uses case studies to examine the facilitators and barriers to such integration in rural areas. This paper attempts to fill a gap in the literature by developing a framework for analyzing the development of integrated acute and long-term care systems in rural areas.

FEWER RURAL MODELS

It should be anticipated that rural models of integrated acute and long-term care would be different from urban models. The demographics, organizational dynamics and policy conditions vary. The demographics are different in terms of the rural population being older, poorer, and with lower levels of insurance. (Coward, Duncan & Netzer 1993; Miller, Farmer, & Clarke 1994) Rural provider capacity has been characterized by smaller institutions with fewer residents and less diversity of health professionals. Consequently one would expect different models of integration of acute care and chronic long-term care. A parallel occurs with the slower penetration of managed care organizations in rural areas. A market with few providers and few patients is not very attractive to a managed care company (National Association of Rural Health Clinics 1998).

> [E]ven though it is prudent to expect that managed care will extend into rural markets, it is also reasonable to conclude that the type of managed care that will exist in rural America will look significantly different than the managed care that exists in urban America. In other words, managed care organizations will develop unique types or models and submodels of managed care in order to meet the specific needs and concerns or rural residents. (National Association of Rural Health Clinics 1998, pg 3)

At one level, one might anticipate more rural models of integrated acute/long-term care. Within rural communities there is a greater blurring of institutional boundaries. For example, many rural hospitals have established post-acute and long-term care services including swing-beds, skilled nursing facilities and home health services in response to the shrinking demand for inpatient hospital services and/or as a means of diversifying and thereby improving their financial

position (Schlenker & Shaughnessy 1996; Beaulieu 1992). At the same time, rural hospitals and nursing facilities have adopted vertical integration strategies to meet the needs of their communities that tend to have a greater proportion of older adults with more chronic care needs. Increasingly, inpatient providers in rural communities are acquiring or developing adult day programs, respite and hospice services, and housing options. Most recently, assisted living and related non-medical residential care services have become important areas for diversification (Leitenberg 1997). In more urban areas, these services, and other home- and community-based long-term care alternatives would have developed as freestanding organizations. In the case of assisted living in more affluent urban areas, development has largely been under the auspices of private developers. However, despite these structural advantages, there are fewer rural models (Coburn, forthcoming; Saucier & Fralich, forthcoming). What factors might account for this observation? What factors might be necessary but not sufficient to create such integrated systems? What factors might serve as obstacles to such integration?

Rural Capacity

There are recognized financial and organizational challenges associated with serving a small population that is widely dispersed. Few Medicare or Medicaid managed care plans have made forays into rural areas, in part, due to the greater uncertainty and risk associated with having fewer covered lives available to spread the risk for high cost beneficiaries. In addition to the small population of potential covered lives, rural areas frequently have a small number of providers, often having only a single provider of many services within the area. In the absence of competing providers, managed care organizations have found it difficult to negotiate discounts with rural providers, thus making such plans less financially secure and competitive.

The dynamics of current rural long-term care service capacity are not yet fully understood. When the availability of providers is used as the barometer of capacity, rural communities routinely fall short relative to the long-term care capacity of urban areas. What is unclear, is whether supply factors alone are sufficient measures of capacity. While there is clear evidence that the array of services available to rural residents is not the same as in urban areas, the full picture of service deficits is obscured by the blurred boundaries between providers in rural areas. Consequently, an overlap of services or substitution of services may compensate for some of the deficiency.

There are several interpretations of urban/rural differences in the use of long-term care services. Differential service use rates by long-term care consumers in rural areas are attributed by many to be a consequence of poorer access due to the limited supply of providers.

For others, differential use rates are viewed as a correlate of rural consumers' characteristics, preferences, and demand differences. Others have demonstrated that service use differences may be a reflection of the substitution of services across providers in response to the paucity of resources. For example, rural home health agencies have been described as being smaller and offering less diverse services than their urban counterparts (Kenney & Dubay 1990). This difference in provider characteristics has been offered as an explanation for why rural home health users have higher nurse and aide services use rates, and lower medical social services and therapy use rates (Kenney 1993). More recently, however, Dansky's research (1998) reports that urban/rural differences in supply and individual user characteristics alone, do not fully explain the urban/rural differences in long-term care use patterns. Their interpretation of findings speculates that home health visits are in fact substituting for hospital care and physician office visits in rural areas.

From the literature, rural residents appear to have easier access to nursing facility services. Although nursing homes in rural areas tend to be smaller in size, there are more beds per 1000 thousand older adults in rural areas than in metropolitan areas (Shaughnessy 1994). Thus, greater supply of services may contribute to the higher rates of nursing home use observed in rural areas when compared with urban areas (Dubay 1993). There is also evidence that rural nursing facilities may place greater emphasis on chronic care needs rather than acute care needs, as reflected in the lower number of skilled nursing beds in rural areas (Rhoades, Potter & Krause 1998). This interpretation of chronic versus skilled care emphasis, combined with reports that rural long-term care facilities tend to offer less breadth and depth of health services compared with their urban counterparts (Coward & Cutler 1989; Dwyer, Lee & Coward 1990) may signal several critical differences between urban and rural long-term care capacity. The argument has been made, for example, that in many ways nursing homes have long substituted for assisted living facilities in rural areas (Rowles 1996).This argument suggests that rural provider offerings may be designed to fit rural demand and respond to the preferences of older persons who want to stay within their own community.

Whatever the explanation, the limited provider infrastructure in many rural areas presents special challenges to the development of long-term care services. Rural areas are known to have a widely varying supply of long-term care service options and shortages of physicians which may be a barrier to the development of comprehensive long-term care services (Krout 1998). Limited service supply may represent either a potential disadvantage for the development of integrated acute and long-term care services, or an advantage for encouraging participation and collaboration in long-term care capacity development in rural areas.

Management Expertise

In rural communities there is frequently a lack of experience with managed care and thus a limited understanding in the existing primary, acute and long-term care infrastructure relative to the development and management of mutually beneficial provider networks and negotiated financial incentives for care management across settings and disciplines. These issues are discussed in depth in a companion article on rural long-term care integration financing and payment issues (Saucier & Fralich, forthcoming). Within the existing rural health care infrastructure, hospitals tend to have the strongest management team in terms of both depth and breadth. The dominance of hospitals in rural integration efforts may have a major impact on rural integration since there are major philosophical differences of the care for older persons and the need for medical or social solutions. In turn, rural hospitals may look to larger hospitals and health systems for expertise in terms of bargaining with managed care corporations. Similarly, other types of health care providers in rural areas have little expertise in dealing with prospective payment systems, capitation, and managed care. The existence of leadership at the local level becomes a critical factor in the development of strategies to implement a complicated set of institutional arrangements and responses to financial incentives.

Financial Frailty

The financial frailty of rural institutions has been documented (Seavey, Berry & Bogue 1992; Mick, Morlock, Salkever et al. 1994; Harmata & Bogue 1997). For example, rural hospitals have long had profitability margins that are lower than those of larger and more urban facilities. Lower capital assets prevent rural institutions from large capital investments and the assumption of insurance risk. The financial frailty of rural institutions has been increased by the Balanced Budget Act of 1997 (BBA). As a further complication (discussed elsewhere Coburn, forthcoming; Saucier & Fralich, forthcoming) rural primary, acute and long-term care providers are currently seeking a new balance in response to the changes mandated by the BBA that are now being implemented. For example, Federal standards for the development of Medicare Provider Service Organizations (PSOs) were published in the *Federal Register* in the spring of 1998. Some states have implemented their own standards while others are just beginning. In addition, there are many changes in rural health care reimbursement policy that do not apply to urban areas. The dissolution of Disproportionate Share Hospital payments and the introduction of Critical Access Hospital status options and changes in home health reimbursement have a major impact for rural healthcare (Coburn, forthcoming; Saucier & Fralich, forthcoming). For example, rural hospitals that opt for designation as critical access hospitals face limits on their

in-patient acute-care beds and must accept restrictions on patient length of stay. In addition, they are obligated to participate in network and community health development activities.

While these three factors may help to explain the lower number of rural integration models for acute and long-term care, it is important to examine facilitating factors and barriers to such integration efforts.

CASE STUDIES

This article uses observations from four rural systems observed as part of a national study of rural models for integrating acute and long-term care services (Coburn, Bolda, Seavey et al. 1998). The review of lessons learned from the experience of rural delivery systems in Arizona, Illinois and Vermont is offered from the perspective of three very different models of integration. The original study and rural models from which these lessons are derived are briefly described below. The last section of this paper reviews the implications of these lessons for public policy based upon the differences between urban and rural integrated systems and the barriers and facilitators for such development.

Methodology

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 older adults 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 objective 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). We sought rural areas that were in different stages of development, and that were located in different parts of the country. Telephone interviews were conducted with state policymakers (*e.g*. State Offices of Rural Health, State Units on Aging, and Medicaid agency representatives), and representatives of the sites to learn more about specific program features and each site's stage of development to help assure that the selected sites met our study objectives.

The four sites included in the study were visited between June 1996 and February 1997 with in-person and telephone interviews conducted using semi-structured protocols developed for this project. Interviewees varied by site, but generally included, state or county officials, program administrators, clinical or service managers, and network provider organizations.

Readers are referred to the final Working Paper from the study (Coburn, Bolda, Seavey et al. 1998) for an in-depth analysis of the sites, and to the discussion of these models included in the companion articles prepared for this volume (Coburn, forthcoming; Saucier & Fralich, forthcoming).

Following the summary of the three models, key characteristics of the sites are presented in Table 1. These summaries offer readers a context for interpreting the observations discussed.

Rural Arizona (Cochise and Pinal Counties–Medicaid Only

Cochise Health System (CHS) and Pinal County Long-term Care (PCLTC) in Arizona represent the "Medicaid only" approach to managed acute and long-term care services under county government sponsorship. These county-based managed care programs operate under capitated contracts with Arizona Long-term Care Services (ALTCS), the state's managed Medicaid long-term care program. In Arizona, non-federal matching funds for Medicaid services are the responsibility of County governments.

Both counties manage a network of primary, acute and long-term care providers serving nursing facility certifiable frail elderly and younger physically disabled Medicaid clients. The two counties' acute care networks include both rural and urban hospitals and rehabilitation facilities. Members are served by primary care providers under contract with the county. 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 and 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.

Cochise Health System

The risks of taking on the ALTCS program were carefully studied in both Cochise and Pinal Counties. 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 ALTCS contract was then awarded to Ventana Health Systems, a proprietary managed care organization developed by physicians in Arizona.

Following review of annual data on profitability and reports of Cochise County residents' concerns about access to services, particularly the very limited choice of primary care providers, staff from the county's Department of Fiduciary and Medical Assistance urged the County to

become an ALTCS contractor. The decision to establish the Cochise Health System in 1993 was based on two key issues. County staff were concerned about the limited number of providers in the network serving ALTCS members in Cochise County and the threat to the existing health care infrastructure within the county when the out-of-county ALTCS contractor established its network. Staff and elected officials of the County also noted that the ALTCS contract had been profitable for Ventana Health Systems at the expense of Cochise County.

Pinal County Long-term Care

In Pinal County the County Board of Supervisors and staff were equally concerned about the rural nature of the county and whether the population base was sufficiently large to spread the risk of the program. One person interviewed commented that Pinal County was just rural enough to be annoying. The Board was also worried about the possibility of a woodwork effect (*i.e.* an increase in the number of people seeking home and community-based long-term care services) once the program was in place.

From Pinal County's perspective, one of the major selling points of taking control of the system was the opportunity to improve the economic development base of the county. It was seen as a mechanism to create new jobs in a service-based industry and being consistent with the community value of promoting long-term care alternatives that allow people to maintain their independence. Proponents also saw ALTCS as giving the County control of services that were being paid for by the County. Concern for the future of the county hospital was another factor since the previous ALTCS contractor (from outside the county) had been sending county residents to hospitals outside the county. Ultimately, the County Manager and staff argued that the County would have greater control over the financial future of the county hospital if it became the ALTCS contractor.

Carle Clinic in Rural Illinois–Medicare Only

The Community Nursing Organization (CNO) Demonstration at Carle Clinic represents a "Medicare-only" approach to managed acute and post-acute care. The Carle Clinic Association and the Carle Foundation represent a complex, integrated health system serving the 8 million residents of mostly rural central Illinois. The Carle Clinic is the only rural site for the Health Care Financing Administration (HCFA)-sponsored Community Nursing Organization (CNO) demonstration program. Since 1992, this demonstration has provided community nursing and ambulatory care services on a prepaid, capitated basis, to voluntarily enrolled Medicare beneficiaries. Participation in the CNO is restricted to Medicare beneficiaries who are not enrolled in risk-contract HMOs. Persons with end stage renal disease and recipients of hospice

services are also not permitted to enroll. Beneficiaries are disenrolled from the CNO if they have hospital or nursing facility stays of 60 days or longer, thus the CNO target population has less intense chronic care needs than the population served by the Arizona model.

Under this demonstration, the provision of a specific and limited set of primary care and post-acute care services under capitated financing are being tested. This demonstration is part of Carle's collaborative practice model, using nurses as partners with patients, families, and primary care physicians.

Copley Health Systems in Rural Vermont–Community Integration

Copley Health Systems, Inc. located in Lamoille County in Vermont is an example of a community based system which is attempting to develop an integrated system without benefit of Medicare or Medicaid contracts. It does, however, have state support under legislation encouraging locally developed integrated service models. The vision of Copley Health System is to be the lead agency, but not necessarily the controlling agency in the integration of health care for all residents of Lamoille County and the surrounding communities in the Lamoille River Valley.

The Copley Health System includes a 54 bed acute care local community hospital, a privately endowed foundation created for the benefit of older residents of the county, the county community mental health agency, a 40 unit private-pay assisted living facility, and a 72 unit nursing home with an Alzheimer's unit. The system has affiliation agreements with area physician practices and a large tertiary care hospital in an adjacent urban area. The system's Board is composed of representatives of various units within the system as well as external members recruited for the purpose of building relationships with other area providers. In the absence of either Medicare or Medicaid risk contracts, Copley Health Systems remains an evolving model and is continuing to develop an integrated system in the anticipation of managed care and capitated payments for health care in Vermont.

LESSONS LEARNED: FACILITATORS AND BARRIERS TO INTEGRATION

This section explains the facilitators and barriers to rural acute/long-term care integration by using the cases as described in the previous section. These are not grouped as a dichotomy, for in some instances, the same issues could be both a barrier and a facilitator. Many of these lessons support the principles for rural long-term care as described by Rowles, Beaulieu & Myers (1996).

Capacity

Each rural community has a unique set of capacities and characteristics which at the same time limits and enables it to develop a unique response to its environment. Rowles, Beaulieu & Myers (1996) have described the importance of the local community characteristics and local control. As indicated in the beginning of this article, the size of a rural population is a major disadvantage for a managed care system. If it is assumed that a new payment system will mean the assumption of some level of risk, then small populations make the assumption of health insurance risk difficult. The impact of one very expensive case is intensified with a small number of individuals. Therefore, managed care companies are very careful of entering rural areas. Providers too must also be careful under such arrangements. Managed care frequently uses discounts from traditional fee-for-service schedules. To assure the bottom lines are not affected, the calculation of discounts from fee-for-service rates is based upon an assumption of increasing volume in order to compensate for reduced fees. In rural areas, increasing volume may not be possible or sufficient to compensate for such discounts. In contrast, where there is a large market, a small increase in market share can mean a major increase in total dollars despite a decrease in the rate.

Characteristics of a rural population also place rural providers and insurers at a higher level of risk. Rural populations generally have a higher percentage of the poor, the uninsured and the elderly, market segments which are not attractive for managed care companies. Educational levels also tend to be lower in rural areas. In addition, some rural areas tend to lack major employers that are the natural markets for managed care companies. All of these characteristics make it more difficult for a rural area to be attractive to a managed care entity to develop a plan for rural areas.

Problems of rural capacity will continue to create challenges for the development of models of integrated health care delivery in rural areas. However, the rural market has one aspect that is to its advantage, customer loyalty. The extent to which rural systems can retain consumer loyalty may compensate to some degree for market size. The concept of rural capacity and its relationship to integration is an intriguing one. Mergers and other forms of integration are generally sold as saving money. However, their real impact tends to be increasing access to capital and improving the quality of care. As indicated below, the integration of acute and chronic care can lead to the increase in rural capacity.

Smallness in size is not always a disadvantage. 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, small staff, and

small membership size as distinct advantages. The Directors of PCLTC and CHS were able to maintain an active working knowledge of the problems within their systems, both in terms of provider and member activities. When a primary care physician, a pharmacist, or other provider within the network demonstrates practice patterns outside the norm for their area or when a member refuses services or uses excessive services, that information is quickly known by the entire management team. When such instances recur, they are readily recognizable and the history of efforts to resolve problems is known. This enables experience to serve as a guide for the future program improvement efforts. 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 reported that the small 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 where business could be conducted in a collegial manner.

Limited Competition

Since there are fewer alternative providers within a community, there are natural alliances that can and should develop. The need for community vision and cooperative ventures among the various providers has been recognized as being a critical need for long-term care (Rowles, Beaulieu & Myers 1996). However, the need for cooperation and the limited number of providers also means that a balking potential partner can create major obstacles for community provider cooperation. As noted earlier, the availability of primary care, in-home long-term care, and other services is limited in most rural areas. One challenge created by the limited service capacity in rural areas is the difficulty this can create for network formation. 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 & Mollica 1995). There is need for a broad community vision to overcome institutional interests and/or competition.

In Cochise County the ability of an institution to threaten community coordination of long-term care services was exemplified by an existing nursing facility that had expressed a reluctance to continue as a member of the CHS network. In this instance, the nursing facility was the sole provider for one of the five population centers in Cochise County. The provider wanted to withdraw from the network due to what it perceived as insufficient levels of payment. CHS staff was reasonably certain, however, that the facility would have a change of heart when it realized that a majority of its residents were ALTCS members and that CHS was prepared to

restrict access to the facility by their members. CHS staff 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. However, the conflict was resolved and the county set a precedent of not falling prey to a single provider in a potentially monopolistic environment.

In the Vermont case study, the reluctance of an essential community provider has remained a major obstacle to further integration. This is exemplified by Copley Health System's effort to engage in formal negotiations with the certified home health agency serving the area. The home health agency was invited to participate on the Board of Copley Health Systems for six months to familiarize the agency with the goals of Copley Health System. Discussions have also been held between Copley Health System and the home health agency at both the CEO and Trustee levels. To attempt to demonstrate the benefits of integration Copley and the home health agency jointly hired a discharge planner at the hospital to expedite the coordination of services. However, the success of that project appears to have convinced the CEO of the home health agency that contractual project by project agreements were sufficient to assure coordination of services.

While the home health agency realized they were being courted by Copley Health Systems, they did not feel that belonging to Copley Health Systems would create savings or administrative efficiencies. Once it came to this conclusion there was little leverage that could be applied. In Vermont there can only be one certified home health agency per service area. This policy was enacted to assure services in rural areas. However, this has also meant that the home health agency is protected from competition. Copley could not threaten to start its own home health organization or contract with an outside agency. Since home health care is a critical piece of the long-term care continuum of care, this has stymied the completion of the network. The absence of competitors among service providers can reduce the incentives for providers to join a network and limit the ability of payers and plans to negotiate payment discounts or other arrangements designed to control the use of services and reduce costs. As observed in the Vermont case study, the lack of competition can create an environment with few incentives to integrate. When there is no alternate source of needed services, negotiations can quickly break down over turf issues.

Local Control

One of the major incentives for the development of integrated systems is the perception that integration will facilitate the retention of local health resources and patients. This is a powerful incentive for rural health care providers and employers. Health care providers are

cognizant of the fact that managed care organizations attempt to bundle services and restrict access to non-contracted services as much as possible. A rural health care system can be left out of the delivery system if they lack contracts. Strength comes in numbers and being able to offer the entire continuum of care to a specific geographic area. In addition, rural businesses may wish to retain local control of the provision of health care in order to attract or retain employees, reduce employer costs, or retain local medical capacity for emergency medical care. The relationship between the rural economy and the health care delivery system has been cited many times (Cordes, Doeksen & Shaffer 1994; Christianson & Faulkner 1981).

The importance of local control is central. Since communities differ so much in terms of capacity, epidemiology, and physical characteristics, it is important that the local health care system be designed with these differences in mind. While rural communities have generally held healthy skepticism regarding offers of "assistance" from urban health care providers, local control may actually be dependent upon establishing linkages with large urban facilities. The development of local systems of care management may also be important in keeping patients within the local health care system for as long as medically appropriate.

In Cochise County, CHS' anxiety regarding out-of-county hospital placements was based on experience. The cost of hospital care and limited care management provided to a quadriplegic and ventilator-dependent CHS member served out of county was used as anecdotal evidence for the need for local control. In addition, CHS staff reported difficulty in locating and communicating with hospitals outside the county that were serving CHS members. This was particularly troublesome for members with intensive care needs in large metropolitan hospitals in Tucson. In an effort to reduce the loss of control for its members being served in Tucson hospitals, CHS sought a contract with a single hospital in Tucson to provide all member services. In addition, CHS quality management staff worked with care managers and quality management staff from the ALTCS contractor in Pima County (Tucson), on a cooperative basis, to make site visits or obtain member information from hospitals in that county. In the most complex cases, CHS has dispatched its Medical Director to make visits to members in Tucson hospitals.

In Vermont, the culture of the state is dominated by the ethic of local control. At the state level there is a similar ethic for Vermont based services. For example, when Vermont was dominated by out-of-state managed care companies, the state was a major facilitator for developing a Vermont based HMO. In addition, people at the local level feel strongly about the need to keep services local, generally this refers to the county level. As mentioned previously, the monopoly status of home health agencies is a by-product of that ethic. The efforts of Copley

Health System are seen as a vehicle for protecting local health delivery systems from being decimated by outside forces. However, it has also used an affiliation agreement with the state's largest tertiary care provider in the adjacent urban county to help assure this "independence". Through integration it has attempted to protect the local system as a unit. In addition to transfer agreements between the hospitals, the affiliation agreement includes as one of the basic services to Copley Health Systems the negotiation of managed care contracts. By joining with a larger entity with greater experience in negotiating contracts, Copley Health System is assuring that it will be well represented, will gain potential advantages based on network size or geographic coverage, and will protect the integrity of the local delivery system.

Local 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, are all critical in the development of rural long-term care service capacity. This was very evident in all four case study sites. The management expertise to calculate the amount of a discounted fee-for-service without the possibility of balanced billing or the calculation of a capitated payment requires data systems and financial expertise which may not be available among many small providers in rural areas.

In Pinal and Cochise counties local county leadership played a central role in the decision to participate as contractors in the ALTCS program and to develop the capacity to do so effectively. The importance of developing local management capacity as an ALTCS contractor in both counties was largely driven by the interest in building the local health and social service infrastructure and preventing the export of local dollars and clients to out-of-county providers.

At both PCLTC and CHS there appeared to be consensus among the management team and providers that there was value to the community when management of its health system was local. The development of a local network of primary care providers, pharmacy services and other health services has strengthened the existing infrastructure for the entire population of these counties.

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. This is a challenge likely to faced when any new management structure is developed for rural long-term care services. At least one aspect of the network that has relieved provider anxieties about a publicly managed system, has been the careful development of specifications of provider service

contracts and periodic solicitation of contracts through a competitive bidding process. This process draws on Arizona Health Care Cost Containment System (AHCCCS) policies as well as existing County procurement procedures.

Among providers in Cochise County there was initial skepticism of a county controlled network. During the development of the Cochise County proposal to become the ALTCS program contractor, a protest effort was mounted by providers to oppose the county's proposal. Several providers holding contracts with Ventana (Cochise Health Systems' predecessor) were concerned that the County would be unable to manage timely payment for services and that rates would be lowered under county management. Three years after the introduction of the CHS, however, the County has consistently been perceived as an honest partner in the delivery of integrated acute and long-term care services and has exceeded local provider expectations as an ALTCS contractor.

In Pinal County, the Board of Supervisors was able to limit its risk of failure by hiring staff who had previously worked with the Maricopa County (Phoenix) ALTCS. This expertise, combined with support from the county Board of Supervisors and the state AHCCCS office, enabled PCLTC to develop and implement services within a relatively short time frame.

In contrast to Arizona, Carle's CNO was developed as a demonstration project 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 demonstration project managers had to gain approval and get buy-in for the initiatives. However, strong support from senior management was obtained prior to introduction of the CNO project.

According to Carle physicians and Primary Nurse Providers (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 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 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 has less opportunity to establish a collegial relationship.

Established PNP/physician communication and on-going monitoring of the patient have meant that the patients' needs are identified earlier and services are arranged in a more 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.

In Vermont the role of leadership has been critical. Here there are units which are not required to integrate, yet are motivated to do so in order to protect the local delivery of health care. Copley Health System has developed under the guidance of a nationally recognized hospital administrator (former president of the American Hospital Association). The leadership has to be at one hand visionary and on the other hand very practical in order to overcome turf and philosophical differences. Working with leaders from other local agencies the Copley Health System has created an environment in which the network members share a common vision of the need for local delivery of integrated care. Even in the absence of experience with managed care, rural integration efforts can be fostered. An interesting example is found in the unique relationship that Copley Health System has forged with the area community mental health agency.

Unlike many other states, Vermont is trying to develop Medicaid HMO contracts that do not separate out mental health services. This stance explains one of the early integration efforts by Copley Health System, the development of a memorandum of understanding and subsequent merger agreement with the statutorily defined community mental health agency. This required the approval of the Vermont Attorney General. Although initially opposed to the merger due to the state requirement for an independent citizen's board for all community mental health agencies, the Attorney General agreed to approve the merger. As such, Copley Health System is responsible for running the county's mental health system. Somewhat poetically, this completes a circle started 25 years ago when the hospital donated land to the mental health agency for construction of agency offices and program space adjacent to the hospital.

From the mental health agency's perspective the coming of managed care for mental health prompted the mental health agency to seek a merger with Copley Health Systems. The agency's lack of experience with managed care led it to believe, that it would be in a better bargaining position with the hospital as its partner. Under the philosophy of Copley Health Systems, the hospital may be a stimulus to the integration process, but it need not be the controlling force. Here the leader of the hospital has brought a new model of mental health delivery into the community as a mechanism for the county's health care system to adapt to the changes in the health care environment. From all appearances, the mental health services have improved in the county under this new arrangement.

Medical/Social Paradigm

Professional philosophical differences are evident when comparing and contrasting the more **cure-**oriented philosophy of primary and acute care providers with the more **care-**oriented philosophy of long-term care providers. These differences are increasingly acknowledged and discussed among professionals. Yet conflict in the definition of roles and responsibilities and decisions about control and dominance of service delivery in an integrated system remain largely unresolved. The development of bridges between the cultures of primary, acute and long-term care represent both the positive prospects and challenges to integration of services for older adults in rural areas. As has been pointed out elsewhere (Rowles, Beaulieu & Myers 1996) a rural community should recognize that local agencies are interdependent as well as understand that care for the elderly is non-linear. No single agency can provide all the types of care required by the older adults. This recognition should encourage coordination. In addition, long-term care needs vary with intermittent need for acute care, chronic care, nutrition, financial support, and social support services. In the case studies for this paper, the philosophical differences between the medical and the social model of health care became critical.

Conflicting professional cultures and distrust between medical and long-term care service providers are a potential barrier to integrating the financing and delivery of services. Traditional long-term care providers emphasize the use of social support services to maximize independence and quality of life while medical care providers focus on cures. For many medical care providers, lack of experience with the long-term care sector may create a challenge in developing effective communication and collaboration. It is not uncommon for a provider from one side to view the care provided by the other to be inappropriate, resulting in long standing local anecdotal evidence of poor quality of care by one or the other.

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 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.

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 the 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.

In Arizona, new primary care provider-care manager relationships were formed from scratch through intense effort on the part of ALTCS contractor staff. In Vermont, collaborative challenges have been less of an issue relative to physician involvement yet are very apparent in the challenges faced while seeking to develop relationships with other community service providers.

Within Lamoille County in Vermont there have been a fixed number of actors and many of the players have known each other for years. The community has a reputation for pulling together. However, this also has its downside. Anecdotal stories take on a life of their own. Individual cases prove the point that the hospital has a medical framework or that a social service agency did not refer someone for appropriate medical care. These anecdotes create barriers for years after the incidents. This is most aptly articulated by the providers of the social services in the communities. Interviewees repeatedly reported that unless individual provider organizations remain independent, there will be a tendency to institutionalize and to medicalize responses to the needs of older adults as a consequence of the leadership role played by the hospital.

Since the Copley system is a hospital driven network, there remains a degree of distrust among some community participants. While some have acknowledged the need to unite in anticipation of managed care, especially managed care from outside the state, others still see organizational boundaries as being necessary to protect the various interests in the community. While some may even grudgingly admit that it is inevitable that Copley Health Systems will be successful in creating a community-based network, there is hesitation to join a organization with a medically dominated perspective. Many hospitals are regarded as late converts to the notion of community-based care and to the non-medical side of healthcare. These weaknesses, while not major ones in an era of fee-for-service medical reimbursement, become more critical when putting together a network for community care. The hospital is often the local health institution

which is the biggest and the richest in terms of both money and management skills. Where leadership is derived from the hospital, building a community network where there is no competition requires building trust among the smaller yet key parts of the system. In such instances organizational identity may be a critical consideration for long-term care service capacity development. Each organization wants to retain its own identity, to honor its history and to protect what it perceives as its clients' interests. The difficulty is balancing that with the notion of working as one with each agency accomplishing more of its mission by working together. For this reason, breaking down the barriers of community organizations may be the most challenging part of the process. Those not skilled in building consensus face a difficult task indeed.

Copley Health Systems is in the process of building trust on multiple fronts. One of the major challenges is that the hospital not be perceived as the organization that has to dominate all others. Copley Health Systems has indeed articulated the concept that the hospital is but one of the pieces, and perhaps not the lead agency, in creating an integrated community health care system for Lamoille Valley. One effort to build trust and cooperation between community organizations sponsored by Copley Health Systems has been a series of retreats led by an outside mediator to build cooperation among the various community organizations. This activity has been designed to break down barriers among the leadership of community health care organizations. The task of this group is to define how long-term care services could best be organized in the county. While this series of retreats has been funded with money fronted by Copley Health Systems, obtaining partial external funding and prorating some of the cost of this to each of the participants was seen as a means of developing buy-in to the process.

Policy Stimulation

It is obvious that public policy played a major role in the Arizona and Carle Clinic arrangements. The Arizona cases were driven by the adoption of a statewide plan to substitute for Medicaid. The Carle Clinic CNO project was a Medicare demonstration project. Were it not for these major policy initiatives at the federal and state level, these organizational changes would have been unlikely.

Today, the policy implications of the Balanced Budget Act of 1997 for the integration of acute and long-term care are profound. The BBA allows for the establishment of PSO organizations, which is seen to be particularly important for rural areas. The change in reimbursement policies, *e.g.*, freezing payment levels, implementing new prospective payment systems, and the designation of Critical Access Hospitals (CAH) all are major stimuli to the organizational changes occurring in rural health care delivery. The historic fragmentation of the reimbursement system has facilitated organizational duplication and independence. With many

of the changes occurring at the policy level, changes at the organizational level are sure to follow.

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, Farmer & Clarke 1994). Except for a few states where state Medicaid policy has given rise to innovative managed care programs targeted to physically disabled persons eligible for both the Medicare and Medicaid programs, there are few financial or policy incentives driving insurers and providers to develop new integrated delivery arrangements. The state of Vermont has provided strong signals for the development of locally based integrated systems, but these centripetal forces have thus far not been sufficiently powerful to counter the centrifugal forces of turf protection driving local organizations apart. In contrast to Arizona where there was mandatory participation by specific populations (Medicaid), the Vermont model affects the entire population but on a voluntary basis.

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. Given the core services required of ALTCS contractors (claims processing, member services, quality assurance, case management), and the small number 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 policies and technical support, staffs at both PCLTC and CHS credit the leadership and vision of their Boards of Supervisors with creation of their programs. 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. However, as in the case of Vermont, state encouragement and support may not be sufficient to counter the forces of turf protection and differences in philosophies. It remains up to the local continuum of agencies to make any system work.

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 payers 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.

While this study demonstrates the utility of public policy in initiating such changes, it is also important to recognize that policies also have a way of limiting innovation. Rowles, Beaulieu & Myers (1996) refer to this as client-centered philosophy of care; any public policies should be flexible to respond to the unique characteristics of clients' needs. The cases here exemplify the breadth of policy initiatives. The CNO project at Carle Clinic is a specific program for a specific, less frail population. The Arizona examples are more general but they too focus on a particular population (more impaired persons with a need for long-term care services). The Vermont example is the one that is most applicable to broader health system integration in rural communities and is still in the process of being developed.

Capacity Building

The examples below, though limited, suggest that supply limitations can be overcome in the development of integrated acute and long-term care services. 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.

People 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. Since the implementation of their ALTCS contracts, however, 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.

Prior to development of the Pinal County ALTCS program, the network of long-term care services within the county was quite limited. There was 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. Nursing home facilities and residential long-term care services had been in short supply in Pinal County for a number of years.

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. The limited supply of nursing facility beds in combination with a philosophical commitment to providing alternatives for people who want to remain at home 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. In response to their finding that adult foster care as largely unavailable in the county, ALTCS staff have successfully worked with interested individuals, particularly former child foster care providers, to develop additional adult foster care services in the county.

Cochise County also 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 CHS 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, CHS contracted with the local pharmacy rather than out source 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 (Tucson) ALTCS program in hopes of creating a two-county initiative to support improved nursing home services for younger disabled persons. At the time of the study, a willing nursing home facility had been identified and two younger, physically disabled CHS members were in residence.

In Vermont, there has been the further development of long-term care facilities in the Copley area. The hospital has recently constructed a new 40 unit assisted living facility and is now in the process of replacing a old nursing home facility with a new 72 unit nursing home with an Alzheimer's unit. The old nursing home is to be converted into a facility for the mentally disabled.

CONCLUSIONS AND POLICY IMPLICATIONS

Although the experience with managed care models that integrate primary, acute and long-term care services is limited, especially in rural areas, this is likely to change as states expand their policies and providers respond to the provisions of the BBA. 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 cases presented in this paper suggests a variety of rural policy considerations.

There is no single managed care model that fits all places and circumstances. In fact, the diversity of approaches that are being taken currently is likely to be very helpful in sorting out what works and what does not work. This diversity is particularly important to rural areas, many of which are likely to require programmatic improvisation in order to make managed care work. The inventory of the health care organizations, the culture of the community, the history of cooperation, state policy, the extent of community leadership are all elements which need to be taken into account in addition to the technical difficulties of coordination. It is especially important that states, the federal government, health plans, and others provide flexibility to rural communities and providers in meeting program standards. On the other hand, it is essential that policy makers realize that one-size fits all is not the solution for rural long-term care service capacity building. With this understanding comes a greater need for various models to be considered that allow rural communities to select the approach most suited to their situations as they begin to evolve new long-term care service capacity.

Technical Support

Rural communities and providers will require technical support to adapt and effectively participate in new long-term care service delivery configurations. Technical support may be needed to enable providers and communities in their development of appropriate organizational relationships necessary for creation of new financial management and information systems, and for the development of quality assurance capacity across the various long-term care delivery settings. Previously, Rowles, Beaulieu & Myers (1996) called for an alliance of rural communities and universities to engage in research which would help rural communities learn from others so that they might develop new demonstration programs for long-term care innovations. This paper presents three models, but they do not represent the spectrum of

possible models for the integration of acute and chronic care. More models are needed and information on the impact of these models needs to be disseminated to other rural communities.

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. State policies giving counties the "right of first refusal" in the award of ALTCS contracts and 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.

Professional Collaboration

Collaboration among professionals and provider organizations are critical to the development of integrated acute and long-term care services. Educational efforts targeting physician understanding of long-term care services are needed to bring physicians into the process of coordinating and managing care across the acute and long-term care continuum. To foster further collaboration, changes in state professional licensure laws and rules may be needed. Such changes may need to reflect the challenges to collaboration when communication and supervision occur across broad geographic areas. The development of new types of health care professionals that cross traditional boundaries of professionals has been recognized as being an important element of rural long-term care (Rowles, Beaulieu & Myers 1996).

In addition, support for distance communication and education mechanisms such as telecommunications and support for new technologies are essential. Developing technologies can be expected to play an ever increasingly important role to fostering the types of new relationships required for development of rural long-term care service capacity.

Financing

Financial support, will also be needed to support the development of new management and financing arrangements in rural areas. Specifically, flexibility of financing options including partial capitation, case management fees, and/or other payment arrangements are needed. Equally important will be assuring that rural long-term care systems have sufficient start-up resources and reserves if risk contracting is being contemplated.

One of the ongoing activities for states is the need to develop criteria for PSOs regarding level that they can assume risk. States need to determine at what level PSOs are similar or different than traditional insurance companies and other types of HMOs and service

configurations such as an Independent Practice Association (IPA) or a Preferred Provider Organization (PPO). The fact that the BBA now allows for Medicaid-only managed care companies may give pause to many who remember the number of initial bankruptcies which accompanied the development of "Medicaid only" managed care companies under Arizona's system.

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 delivery systems is especially important. The experience in Arizona demonstrates that managed care initiatives to integrate long-term care can serve the interests of rural communities. Long-term care service development can help preserve and build local health and long-term care infrastructure by identifying and addressing service gaps, encouraging the development of local services and organizations, and by building organizational alliances that strengthen the local service system. Such alliance may in fact be essential to the creation of new long-term care options. For example, adult day programs in rural communities require strong community support and financial backing given the funding limitations for such services in most states.

Contrary to common perceptions, rural communities may be both prepared to respond to these challenges, and anxious to serve as a valuable testing grounds for learning what works and what doesn't in rural long-term care capacity building. This is particularly evident from the Arizona cases where state policy provided rural counties with the "right of first refusal" in the award of the ALTCS contracts. While not applicable in all states, where a strong county infrastructure does exist, rural communities have demonstrated initiative necessary for development of rural models that meet state expectations and help build local long-term care capacity. Conversely, in rural areas with a single source for selected services, as is the case in Vermont, purely voluntary integration models face an uphill climb.

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 in the case of Vermont, state encouragement and support alone does not counter the forces of turf protection and differences in philosophies from making integration work. It remains up to the local continuum of agencies to make any system work. Nonetheless, as states consider long-term care contracting strategies, it will be essential that all state policy be aligned to meet the goals of such contracting. As seen in Vermont, state statutes and regulations originally designed to protect access to critical service in rural areas (home health and mental health) may create conflicting incentives for new development activities. Such incentives must be carefully reviewed and revised (if appropriate) to support capacity building for long-term care in rural communities.

Development of rural long-term care services, while challenging, is clearly possible. As more rural areas find unique solutions to their problems, and share those experiences with one another, it is only imagination that will truly limit rural communities' development of long-term care service capacity.

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Table 1: Key Characteristics of Study Sites Table 1: Key Characteristics of Study Sites

DESCRIPTIVE CHARACTERISTICS	*ARIZONA Cochise Health System*	*ARIZONA Pinal County*	*ILLINOIS Carle Clinic - CNO Demonstration*	*VERMONT Copley Health System*
Organizational Base	*County Govt. based health plan*	*County Govt. based health plan*	*Physician-clinic based health system*	*Hospital developed community health system*
Area Population	*Cochise County 108,225 (1994)*	*Pinal County 132,225 (1994)*	*42 counties - 10 are participating in CNO 2.3 million total*	*Lamoille County 19,735 (1990)*
Population Density	*6,219 square miles 17.5 persons/sq. mile*	*5,344 square miles, 25 persons/sq. mile*	*N/A N/A*	*460 square miles 42.8 per square mile*
Enrollment	*Mandatory enrollment*	*Mandatory enrollment*	*Voluntary enrollment*	*No enrollment*
Target Population	*Nursing facility certifiable older adults and younger physically disabled adults.*	*Nursing facility certifiable older adults and younger physically disabled adults.*	*Medicare beneficiaries excludes persons with End Stage Renal Disease (ESRD) enrollees, hospice recipients & those with hospital or NF stays of 60 days or longer.*	*General population as well as older adults, and persons with physical and mental disabilities*
Members	*420 members (1995)*	*385 members (1995)*	*3,000 members (1995)*	N/A

Table 1: Key Characteristics of Study Sites (continued)Table 1: Key Characteristics of Study Sites (continued)

DESCRIPTIVE CHARACTERISTICS	*ARIZONA Cochise Health System*	*ARIZONA Pinal County*	*ILLINOIS Carle Clinic – CNO Demonstration*	*VERMONT Copley Health System*
Medicare/Medicaid Contracts (Risk)	*Capitated risk-based contract for ALTCS (Medicaid) acute and long-term care services*	*Capitated risk-based contract for ALTCS (Medicaid) acute and long-term care services*	*Capitated risk-based contract for selected Medicare acute and post-acute services*	*No Medicare or Medicaid contracts*
Scope of Network Services	*Hospital, physician, rehab. therapies including mental health services, lab., X-ray, pharmacy, durable medical equipment, nursing facility, home health, personal care, medical supplies, transportation, adult day health, homemaker, emergency response systems, hospice, respite and home delivered meals*	*Hospital, physician, rehab. therapies including mental health services, lab., X-ray, pharmacy, durable medical equipment, nursing facility, home health, personal care, medical supplies, transportation, adult day health, homemaker, emergency response systems, hospice, respite and home delivered meals*	*Home health services, outpatient therapies, including counseling, durable medical equipment, medical supplies and ambulance services*	*Hospital, physicians, mental health providers, outpatient services, nursing facility, assisted living, emergency response systems*
Approach	*County plan contracts with providers*	*County plan contracts with providers*	*Clinic ownership with some local provider contracts*	*System ownership with some affiliation agreements*
State Role	*Defines plan specifications and contracts with county*	*Defines plan specifications and contracts with county*	*None*	*State legislation encourages community-based LTC systems development.*

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