Key Components for Successful LTSS Integration: Lessons from Five Exemplar Plans

Working Paper 1
Project to Develop the Business Case for LTSS Integration

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LONG-TERM
QUALITY ALLIANCE

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Long-Term Quality Alliance

Long-Term Quality Alliance (LTQA) is a community of organizations aimed at improving outcomes and quality of life for persons and their families who are managing functional limitations due to chronic health conditions. It draws member organizations from the full range of health care and social services delivery systems involved in provision, administration, innovation, policymaking, and advocacy for quality long-term services and supports (LTSS).

Organizations come together in the Alliance to share knowledge and experience needed to advance development and continuous improvement of high-quality systems of integrated, person- and family-centered LTSS. The Alliance serves as a convener of disparate private-sector and governmental organizations, with an eye to identifying and resolving the most significant challenges and advancing the replication of successful models that demonstrate the potential for more widespread adoption of person-centered LTSS integration.

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Executive Summary

The Focus of the Study

A small share of the population with the most complex care needs accounts for a large portion of all health care spending in the U.S. Substantial gains in controlling health care spending can be achieved by better managing care for this population. Especially for those with the most complex care needs, functional limitations and need for social services can impact physical health and health care costs as much as medical interventions. A combination of strategies addressing psycho-social and medical care needs in an integrated manner is needed to lower costs and improve outcomes for high-need, high-cost individuals.

Health care payment and delivery innovation are providing incentives for health plans and other organizations assuming financial risk to target high-value interventions to reduce health care spending. However, many of the organizations that hold financial risk for an enrolled population lack the awareness and tools necessary to design and target fully-integrated interventions to achieve cost and quality outcomes. Widespread experience with integrated approaches and evidence of a return on investment in non-medical services is lacking. Hard evidence of the aggregate financial benefit to health plans, health systems and other program sponsors of providing LTSS in addition to medical and behavioral care is needed to encourage more organizations to invest in integrating LTSS.

Study Justification

This study is a descriptive study that defines the intervention of LTSS integration—what integration is and how it works. This is accomplished with five case studies on "exemplar" programs that integrate LTSS and medical care and with a taxonomy that describes the components of an integrated program. The case studies describe program approaches to and experiences with managing costs and quality outcomes through integration.

The case studies and *Taxonomy* are part of a larger project to measure the impact of LTSS integration on cost and quality outcomes. By clearly defining LTSS integration, this study lays the foundation for quantifying the impact of integration in a follow-on study. This study and the follow-on quantitative study are intended to demonstrate the potential of LTSS integration to improve outcomes and lower overall costs of care for people with substantial functional limitations and complex care needs. The studies should inform business decisions by health plans and other at-risk organizations to fully integrate LTSS, behavioral, and medical care. This research should also inform policy discussions on proposals to expand LTSS financing.

Research Question

The primary hypothesis guiding our long-term research plan is that the presence of "LTSS integration"—that is the integration of medical, behavioral health and LTSS benefits in a single capitated program—when applied to a high-cost, high-risk population, can serve that population with better outcomes at a lower total cost of care than would be the case in the absence of LTSS integration.

The starting point in the measurement of impact is to define and describe the

intervention whose impact we will measure. This study and the related *Taxonomy of LTSS Integration* seek to define LTSS integration in terms of its component parts and the variations of those along a continuum of "integrated-ness." The programs selected for the five case studies are intentionally varied in order to capture the range of activities that occur in an integrated program and provide some understanding of the factors that contribute to variation in those activities in different geographies and with different populations. The study also seeks to understand the aspects of LTSS integration that appear to contribute most to cost and quality outcomes. Each case report in this study provides an in-depth description of the characteristics and operations of programs that are experienced and successful (i.e., "Exemplar Programs") in integrating medical care and LTSS.

Participating Integrated Programs

This analysis compares and contrasts five integrated programs that were selected by the Expert Panel for this study as exemplifying LTSS integration. The programs differ in how they are organized and structured—in part as a result of differences in their funding authorities, state requirements, the types of health plans that operate them, and their own history and culture.

The programs are:

<u>ArchCare (New York)</u>

Archcare is a non-profit, faith-based healthcare system serving vulnerable individuals in the New York City area. ArchCare operates five skilled nursing facilities, a cancer hospital, a home health agency, and three health plans that are profiled in this study. These plans are a PACE program with 487 members established in 2009, a Medicaid MLTSS plan with 2,043 members established

in 2012, and a Medicare I-SNP with 1,567 members established in 2008. All of the members in these plans require some LTSS.

<u>Health Plan of San Mateo (California)</u>

Health Plan of San Mateo (HPSM) is a county-operated health plan that covers nearly all Medicaid beneficiaries in San Mateo County, California. 145,000 individuals are enrolled in the plan, most of whom do not require LTSS. The plan was established in 1987, began covering institutional LTSS in 2010, and added community-based LTSS and an MMP in 2014 as part of California's duals demonstration. The plan has also operated a D-SNP since 2006, and three- quarters of dually eligible members have Medicare coverage with HPSM.

<u>Superior STAR+PLUS (Texas)</u>

Superior STAR+PLUS is a Medicaid managed care plan operated by Superior, a Texas subsidiary of Centene, a national, for-profit, managed care company with a focus on Medicaid and CHIP populations. Superior serves a diverse Medicaid population across the state. The plan participated in this study with their STAR+PLUS product—part of Texas's Medicaid MLTSS program for the elderly and physically disabled. Not all STAR+PLUS beneficiaries require LTSS. Superior launched the plan in 2007, and currently has about 148,000 members enrolled. Superior also operates a D-SNP, which enrolls some of their STAR+PLUS membership, and an MMP as part of the state's duals demonstration.

<u>UnitedHealthcare ALTCS (Arizona)</u>

UnitedHealthcare Community Plan is a Medicaid managed care plan offered by UnitedHealthCare (UHC), a national, for- profit health insurance company with commercial, Medicare, and Medicaid products in many states. UHC serves a diverse Medicaid

population of nearly 500,000 members across Arizona, including in rural areas. This study profiles UHC's Arizona Long-Term Care System (ALTCS) plan—a Medicaid MLTSS plan for the elderly and physically disabled. All members of ALTCS meet the institutional level of need for LTSS. The plan was opened in 1989, and has 9,800 members. About half of the plan's 5,500 dual eligible members are enrolled in a complementary UHC FIDE-SNP for Medicare coverage.

UnitedHealthcare SCO (Massachusetts)

UnitedHealthcare offers a Senior Care Options (SCO) plan in Massachusetts. SCO is a Medicare FIDE-SNP that combines Medicare and Medicaid benefits, including LTSS, for dual eligible individuals age 65 and older. The UHC SCO plan was launched in 2004, and currently has 15,600 members across the state. UHC operates other Medicare Advantage and commercial health insurance plans in the state.

Conclusions from the Case Studies

Program Organization and Structure

A program's success in integrating medical care, behavioral health care, and LTSS and implementing an effective care model is a function of a number of factors, some of which are external to the organization and some of which come with the organization's own history, structure, and culture. Factors that influenced the variation in how the programs integrated LTSS and the challenges they faced included:

State Medicaid Requirements: States strongly influence the emphasis of integrated programs. Every state has its own programmatic approach that dictates many aspects of program operations. Almost every state now provides Medicaid through contracts with private managed care plans although seniors and persons with disabilities

and their long-term services and supports are often carved out of managed care. However, this trend is reversing and today 26 states contract with private managed care plans to provide managed LTSS.[1]

Culture of the Parent Organization: The culture of the parent organization can be a function of its origins and whether it is private or public and non-profit or for profit. Programs in this study reflected a mix of origins and characteristics: public and private, run by county health plans, charitable, faith-based organization, or private for-profit managed care plans. Organizations also varied in their scale and degree of local focus.

Type of Health Plan: All of the programs studied were at risk for medical care and LTSS for an enrolled and capitated population, and were operated by managed health care plans. They differed in whether they were direct providers for all or part of their services or contracted with networks of agencies and service providers.

Population: The population that is covered by the integrated program and the proportion of the total covered population that are recipients of LTSS both influence the care model. Some programs in our study cover only beneficiaries with substantial LTSS need, while other programs in our study provided integrated care to a broader population, such as all dual eligible (Medicare+Medicaid) beneficiaries, only a small portion of whom received LTSS.

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[1] NASUAD (2016) *State Medicaid Integration Tracker*. Available at: http://nasuad.org/sites/nasuad/files/State%20Medicaid%20Integration%20Tracker%2C%20March%207%202016.pdf

Care Model

The care model and it's approach to care management is an essential component of a managed care plan that holds risk for LTSS. It is not only an important tool to integrate care delivery, but also a valuable LTSS-related benefit for members who enroll in plans that cover LTSS. The majority of Medicare beneficiaries with LTSS-level need must either manage their own care or rely on family or hired care managers to do it for them.

The programs we studied employed generally similar care models for members with LTSS needs. Members are assessed upon enrollment to determine their functional capacity and level of need, and, at least for those with a moderate-to-high level of need, a care plan is prepared. A care team, including a care manager, is designated to coordinate care and assist the member in implementing the care plan. The member's care manager takes overall responsibility for the member's care across settings, identifies and engages service providers on behalf of the member, coordinates care and communicates with the member's primary care provider and other service providers, monitors the member's condition and progress in achieving the care plan, and works with the family and caregivers on making adjustments to the plan.

Despite the general similarities, the care models in these programs varied in the extent to which they applied a uniform care model across their entire LTSS population or varied it according to the member's level of need. They also varied in the extent to which they engaged medical providers and shared or pooled information with the medical team. And they varied in size, composition, and frequency of convening of the care team.

Care Management Strategy: The programs we studied were focused on meeting members' needs and enabling members to remain in the appropriate setting for as long as possible. Providing a high level of care management, care coordination, and supports and services in a home-based setting is an expensive proposition. All of the programs were additionally motivated by either the overall financial risk they bore for the cost of care or by specific financial incentives in their payment rates, to manage care to achieve savings. Savings could occur either in LTSS expenditures through efficiencies in LTSS delivery (supporting members needing LTSS in less expensive settings or with less intensive services), or in a reduction in total expenditures for the member through strategic use of LTSS to avoid expensive or intensive medical or institutional settings and services.

It appears likely that LTSS can be cost effective in the context of full capitation when well-targeted and regularly adjusted to meet specific needs. Programs report being able to maintain members in their homes and in the community with less hospitalizations and institutionalizations when LTSS are managed so that they are provided when and where they can have the most benefit.

According to exemplar plans, the key to achieving member outcomes and savings in programs that integrate LTSS involves one or more of the following tactics:

- *Comprehensive Assessment:* Some programs conduct a comprehensive assessment (often with in-home interviews) for all members, while others target it to a subset of high-risk members. A comprehensive assessment enables the program to identify and address factors in the person's circumstances or environment that contribute to the health and functional capacity of the member and that would not be surfaced in a traditional health risk assessment or service needs assessment. It also enables the care

manager to identify opportunities to incorporate family caregivers in the care plan or wrap around resources available in the community and thereby minimize the amount of paid care needed.

- *Risk Stratification and Targeting:* Intensive care management and the provision of LTSS can be costly and produce a limited response if provided generally to a large population. Some of the programs we studied use predictive analytics to identify community-based members most likely to experience a medical event, hospitalization, or institutionalization in the near future and target high intensity care management to a high-risk subset of members. Targeting assures that the volume and intensity of services are appropriate for the level of need, and are not more intensive or longer duration than necessary.

- *Variation in Care Management*: Some of the programs we studied served exclusively a high-risk population and did not vary their care management strategy based on level of need. Programs that served a broader population varied the intensity of care management (e.g., the level of professional certification of the care manager, the frequency of contact with the member, the amount and breadth of care coordination and communication among providers) in relation to the level of the member's needs or perceived risk.

- *Single Point of Accountability:* The integrated approach possible in the programs we studied enables a single care manager to work with an interdisciplinary care team, a single plan of care and an integrated information system and serve as the primary contact and single point of accountability for the member and his or her family. This function has the greatest potential to coordinate care and avoid

duplication and adverse interaction of care or simply loss of attention to the member and the member's care plan.

- *Utilization Management*: The programs we studied are most successful when they minimize hospital admissions and readmissions and nursing facility admissions, and sustain members in their homes and communities. Programs use utilization management in the programs we studied to prevent unnecessary or inappropriate hospitalizations or nursing home placements for members and seek to encourage discharge to a nursing facility or home setting as soon as appropriate. The programs we studied that hold medical risk:

  o <u>Titrate services and supports</u>: to ensure levels of care provided meet the members' current level of need.

  o <u>Manage hospital or nursing home utilization:</u> to ensure adequate care is available in the home, physician orders are appropriate, and members are admitted and retained in a hospital or nursing home only when necessary and only for as long as is necessary.

  o <u>Manage care transitions across settings</u>: to ensure members moved between hospitals, skilled nursing facilities, or other institutions and home are stabilized in the new setting and not at risk for a return to the prior setting.

- *Impact of the Care Model:* Programs we studied believe through care management and their care models they achieve success in lowering costs and improving quality outcomes for populations that have the most complex care needs and are high users of expensive LTSS and medical care.

All of these programs reference anecdotal evidence and some data to support their belief in the success of their models. A comparison of the medical utilization and quality outcomes of members in these programs with similar data for the Medicare fee-for-service population would inform a better understanding of the impact of these integrated care models on overall costs of care and member outcomes.

Provider Alignment with Program Objectives

Medical and LTSS care providers play pivotal roles in an integrated program's capacity to achieve cost and quality objectives. Providers make decisions on and authorize care, monitor care and outcomes, and evaluate and adjust care plans. In order to ensure the best possible cost and quality outcomes for their members, integrated programs must align incentives and work collaboratively with providers.

Most of the integrated LTSS programs involved in our study are operated by managed care health plans that contract for services through networks of independent providers and provider organizations. In most cases, these plans do not have exclusive relationships with the providers, although they may have significant volume in their practices. These models rely on a variety of tools the program controls, including payment incentives and utilization management, to align independent providers with the program's objectives and assure high levels of coordination. A relatively small number of programs have a staff model for care delivery. ArchCare's PACE program is an example of this model, providing much of its member care through staff physicians and other clinicians.

External Factors

A program's success in aligning provider and program incentives and engaging providers effectively in care management and coordination depends on the significance of the program's payment decisions to providers across settings—including physician, hospital, and institutional and community LTSS care. Several factors outside of a program's control can constrain or enhance their ability to do this.

- *Alignment of Medical and LTSS Coverage*: To effectively integrate care, programs need the capacity to align providers across the spectrum of care, not just medical care or LTSS providers. Federal policy that guarantee's an individual's right to choose their Medicare plan limits the ability to align Medicare and Medicaid coverage in a single plan. The programs in this study that did not have alignment for large portions of their dual eligible members struggled to engage providers with whom they did not have a payment relationship.

- *Share of Individual Provider's Patient Panels*: When a significant share of a primary care provider's panel is in the program's medical coverage, providers are more likely to be familiar with the program, respond to care manager outreach, and collaborate clinically with the program and align with the program's goals.

- *Regulation*: State and federal regulation prescribing elements of the relationship between providers and integrated programs can constrain integrated programs' ability to work with a limited group of providers and thus have greater member concentration with and engagement from its providers. Some states are supporting financial alignment and strengthening plan influence by

promoting the use of payment incentives to reward provider performance.

- *Other External Factors:* Other factors such as the limited number of providers in rural areas may constrain the ability to use selection or financial incentives to align providers.

Program Tactics to Align with Providers

Integrated programs use a variety of approaches to achieve alignment of providers with program objectives. These include:

- *Direct Care Provision:* The programs in our study employ care managers to oversee care planning, care management, and care coordination and be accountable for member's care. Care managers typically coordinate a network of contracted providers. In PACE, however, primary care providers are employed by the plan and play an important role in the programs efforts to manage the use of hospital and institutional care.

- *Selective Provider Networks*: Several of the programs in our study selectively contract with providers and have mechanisms that encourage members to choose providers who are more closely aligned with the program's goals. This is more typical of relationships with medical providers. The programs in our study largely bought services from existing LTSS providers, with little evidence of efforts to narrow the network or provide quality-based or other financial incentives.

- *Contractual Requirements:* Health plans can employ significant tools to engage providers through contractual obligations. Contracts can require providers to participate in care team meetings, share member medical records, or achieve certain quality outcomes. In combination with financial incentives and other factors, contracts can help engage and align providers, but proactive communication and in-person contact can be effective in engaging and aligning providers even in the absence of contractual obligations.

- *Financial Incentives:* Programs are increasingly employing or experimenting with provider payment approaches that share risk and incentivize providers to deliver higher-quality, lower-cost care. These are typically layered on a fee-for-service payment mechanism. LTSS providers are typically reimbursed on a fee-for-service basis in the programs we studied, although a few plans were testing shared savings or performance based payment approaches.

- *Proactive and Frequent Communication:* Programs seek to engage providers in care management and integration goals through frequent proactive communication between program staff and providers. Having a clinical champion for integration among the providers can be the key to engaging other providers. For some programs, effective communication is built on long-term relationships and familiarity between program staff and providers. Beyond proactive communication, some programs have found that in-person contact between program staff and providers can improve care and advance integration.

Impact of Financial Alignment and Integration

In theory, financial integration aligns the incentives for plans to invest in a care model that manages the full member experience. By taking financial risk for both the health care and long-term care costs, a plan can realize savings in health care spending from LTSS integration. Holding the financial risk and payment authority for both health care and

LTSS enables the plan to have leverage with medical and social service providers to influence how care is delivered. Plans can get the attention and, hopefully, cooperation of providers, coordinate care across sectors, and create a more seamless experience for beneficiaries.

All of the programs we studied received funding from both Medicare and Medicaid. Their populations that were candidates for integrated care were either eligible for Medicaid only, in which case Medicaid covered the health and LTSS services; or were dually eligible for both Medicare and Medicaid, in which case Medicaid covered the LTSS and Medicare covered health care and prescription drugs.

Components of Financial Integration

We observed three components to integration: financial alignment, flexibility and pooled accountability.

- *Financial Alignment*: Financial alignment occurs when an organization is holding the financial risk for both health care and LTSS for a reasonably large portion of its membership. Financial alignment allows the plan to receive and "pool" resources from both Medicare and Medicaid (and private sources if needed) that cover the full scope of medical, behavioral health, and LTSS.

- *Flexibility in Use of Funds*: Flexibility occurs when the health plan has the ability to use resources from its different funding sources interchangeably for any covered services that are needed, and to use these resources for items and services that are not covered but are considered by the care manager to be necessary to adequately meet the needs of the member.

- *Pooled Accountability*: Accountability is the obligation to report to funding sources on the use of funds. Pooled accountability

refers to the extent to which plans or programs receiving a per capita amount per member are able to pool funds and use them flexibly to meet the needs of members with latitude in how they report the use of funds. The alternative is specific accountability, in which plans or programs are required to disaggregate funding by source and account separately to each funder for use of funds in distinct funder-specific units of service or encounters.

Continuum of Financial Integration

We observed financial integration along a continuum from low to high integration. The degree of financial integration programs were able to achieve was heavily influenced by federal and state requirements associated with different funding authorities.

- *Low Financial Integration:* The integrated programs that started from an MLTSS base and sought to enroll their MLTSS members in their D-SNP or I-SNP experienced the most challenges due to challenges in enrolling a critical mass across SNP and MLTSS products; complete lack of flexibility in the use of funds, and requirements to disaggregate and separately report units of service. These issues complicate program efforts to manage members' care comprehensively.

- *Moderate Financial Integration:* Two Medicare authorities appear to provide better support for integrating federal and state funding: Financially-Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) and the Financial Alignment ("Duals") Demonstration. These authorities aim to improve financial alignment by directing separate Medicare and Medicaid capitation amounts to a single plan and making enrollment in the entire integrated program optional to the beneficiary – thereby ensuring that all enrollees are being served

for all of their Medicare and Medicaid benefits. Yet, limitations appear to remain in the plan's ability to use funds flexibility and in the requirement for separate reporting.

• *Full Financial Integration:* PACE authority allows for the highest level of financial integration – achieved through a separate part of the statute in the Medicare law – that allows complete flexibility in the use of funds for covered and uncovered services in addition to requiring members to be enrolled for both their acute and LTSS as a condition of enrollment. PACE plans are also better financially integrated because they are not required to disaggregate and separately report use of funds by program (i.e. Medicare or Medicaid).

The Effect of Financial Integration

Financial integration is only one factor in achieving integration of medical care, behavioral health care, and LTSS. How critical is full financial integration to the successful operation of the care model, integration of the experience for the beneficiary, and the attainment of intended cost and quality outcomes?

Based on our experience with the programs included in this study, we make the following observations about the relative importance of full financial integration and the incentives that exist within a plan that integrates medical care and LTSS to achieve savings in health care spending:

1) *Financial integration is a necessary but not sufficient tool for achieving optimal care delivery for high cost populations.*

   a. Plan culture may have more influence on how plans approach care management than financial integration.

b. The state historical and regulatory context for a managed care plan's operations heavily influences its approach to care management.

2) *Just taking the risk for LTSS, in the context of a Medicaid managed care plan, appears to provide opportunities to manage the Medicaid LTSS services at a lower cost with the potential for better outcomes.*

3) *A plan or program trying to integrate and manage care across sectors without moderate to full financial integration encounters substantial obstacles to achieving better outcomes and lowering medical costs.*

   a. Plans with MLTSS members who were dual eligible and were not aligned in their D-SNP plan cited difficulties in integrating medical care and LTSS and achieving quality and cost results for these members.

   b. Programs that have multiple funding sources and cannot co- mingle funds face challenges with flexibility in using funds and accountability that interfere in efforts to fully integrate care.

4) *Financial integration creates incentives for plans to manage the totality of care for each member in a way that restrains costs and achieves quality outcomes, although the incentives may be muted by payment methodologies and problems of churn.*

Based on our research to date, it appears that the goals of lower costs and improved quality for beneficiaries with complex care needs enrolled in integrated programs is best served if the funders focus on getting the payment amount right, and let the organizations use

those combined resources as creatively and constructively as possible to obtain the best results at the lowest cost.

Conclusions

The Movement to Integrate LTSS

The way we provide long-term care in the United States has changed dramatically over the last 20 years, but the transformation has really only just begun. Enactment of the Affordable Care Act expanded HCBS options for the states. In addition, many states have sought to manage LTSS spending, improve quality of care, and encourage a more pronounced shift to home and community-based care by contracting with managed care companies to manage Medicaid LTSS. The Center for Medicare and Medicaid Services (CMS) has accelerated the movement toward LTSS integration with a demonstration launched in 2014 to test integrated care and financing models for Medicare and Medicaid dual enrollees.

The movement to integrate medical and LTSS financing and care seeks to achieve several objectives:
- Create a seamless experience for the individual.
- Provide a higher level of support to enable the individual to remain in their home and in the community.
- Support and build on the care that families already provide,
- Avoid unnecessary nursing home and hospital admissions.
- Enable people discharged to stabilize in the home and community.
- Reduce high medical costs associated with high-risk individuals.
- Attain better health and quality of life outcomes.

What Matters Most

We selected progras in five organizations around the country that have experience integrating LTSS and medical care and are held to be successful examples of LTSS integration ("Exemplar Programs"). In observing and comparing these five programs, there are several activities that seem to matter the most in affecting outcomes for members and overall costs of care:

- Anticipating needs and providing enough support in the home and community early enough to reduce the risk of an inappropriate use of ER services, hospitalization, or nursing home admission.

- Arranging for critical supports and services (the social determinants of health: e.g., housing, employment, personal assistance, medication management) that enable medical and behavioral health professionals to earn the trust of the member, address health needs, and elicit the behavioral response from the member needed to make treatment effective.

- Eliminating, through communication, coordination, and a single point of accountability, the conflicts, gaps, and inconsistencies in treatment that arise when multiple professionals perform their work in individual silos, each interacting with an individual member and that interfere with a successful response to treatment.

- Supporting members through transitions of care, particularly in moving from more intensive, higher cost to less-intensive, lower-cost settings for care with the early intervention and planning so that supports and services are in place to stabilize them in that setting and reduce the risk of them moving back.

The Challenges and The Opportunities for LTSS Integration

Our comparative analysis of five of the "Exemplar Plans" led us to draw several conclusions, which we intend as a solid base of understanding for a more empirical study of costs and outcomes of LTSS integration.

1) *Care management is at the heart of what integrated programs do to integrate LTSS and medical care and is key to achieving results.*

2) *Targeting is key to achieving outcomes and savings.*

3) *Integration of medical care and LTSS is difficult to achieve. Statutory and regulatory reforms affecting financing and the siloed nature of the service delivery system are needed to remove barriers that make integration difficult.*

   a. *Statutory and Regulatory Barriers*

   i. Achieving scale with integrated programs requires overcoming the limitations that Medicare and Medicaid place on enrollment. CMS and the states have tried to address the challenges of increasing the scale of LTSS integration in the context of statute requiring choice of plan in the Medicare program.

   ii. Programs that successfully integrate care must overcome the limitations and administrative complexity imposed by the separation of Medicare and Medicaid payments, the distinct requirements of each, and complexity of the administrative

mechanisms and accounting associated with meeting these requirements.

   b. *Service Delivery System Impediments*

   i. The administrative structure of the organization providing the program can affect the ability of the plan to implement an integrated approach and achieve its objectives.

   ii. Financial opportunities in managing LTSS and medical risk are substantial, but factors in the design of rate setting and payment arrangements and risk adjustment need to be addressed to insure the incentives are sufficient to support scaling up workable models of LTSS integration

Conclusion

We found many ways in which programs that take risk for and integrate LTSS and medical care influence the utilization of LTSS and medical services to both manage LTSS spending and to avoid and reduce medical care expenditures for those members at highest-risk for health care spending. It is reasonable to assume there would be substantial health care savings resulting from an intensive approach to a particularly expensive subset of the population.

Our next step is to explore the potential to develop empirical evidence of savings and quality outcomes attributable to integrated LTSS. This study and the *Taxonomy* provide the framework for measuring the impact of integrated LTSS.

Section I: Introduction

Study Justification

Health care spending in the U.S. is highly concentrated in the small share of the population with the most complex care needs. The most expensive five percent of the population drives half of all spending; the most expensive one percent accounts for a quarter of all spending. Forty percent of this high-need, high-cost population is elderly (age 65 and older).[2] Substantial gains in controlling health care spending can be achieved by better managing care for this population.

A growing body of evidence suggests that addressing individuals' functional limitations and need for social services can impact their physical health and health care costs as much as medical interventions. Lowering costs and improving outcomes for high-need, high-cost individuals will require a combination of strategies that address psycho-social and medical care needs in an integrated manner.[3]

A number of recent experiences support the value of integrating medical care and long-term services and supports (LTSS). A case study of two "boutique" models integrating medical and long-term care financing and delivery systems demonstrated improvements in quality and cost-effectiveness on a small-scale but identified significant policy impediments to scaling up.[4] Another study of five model programs demonstrated the potential for substantial cost savings when transitions across the continuum of care are managed through established care coordination interventions.[5] Finally, a quasi-experimental study compared a population of long-term care insurance claimants to a similar population without insurance coverage and found that those using paid LTSS experienced significantly lower medical costs at the end of life.[6]

Health care payment and delivery innovation are providing incentives for health plans and other organizations assuming financial risk to target high-value interventions to reduce health care spending. Success will require addressing the full spectrum of medical and social services in a coordinated fashion—the

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[2] M. Stanton and M. Rutherford (2005) *The High Concentration of U.S. Health Expenditures*, Agency for Healthcare Research and Quality, Research in Action Issue 19. Available at: http://archive.ahrq.gov/research/findings/factsheets/costs/expriach/

[3] H. Komisar and J. Feder (2011) *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services*, Report prepared for The SCAN Foundation. Available at: http://www.thescanfoundation.org/sites/default/files/Georgetown_Trnsfrming_Care.pdf

[4] R. Master and C. Eng (2001) "Integrating Acute and Long-Term Care for High-Cost Populations," *Health Affairs* 20(6):161-172. Available at: http://content.healthaffairs.org/content/20/6/161.long

[5] S. Rodriguez, et al. (2014) *Effective Management of High Risk Populations*, Report prepared for The SCAN Foundation. Available at: http://avalere.com/news/avalere-issues-white-paper-on-the-management-of-high-risk-medicare-populati

[6] S. Holland et al. (2014) "Long-Term Care Benefits May Reduce End-of-Life Medical Care Costs," *Population Health Management* 17(6):332-339. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4273189/

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integration of medical, LTSS, and behavioral health for high-risk populations.

However, many of the organizations that hold financial risk for an enrolled population lack the awareness and tools necessary to design and target fully-integrated interventions to achieve cost and quality outcomes. Widespread experience with integrated approaches and evidence of a return on investment in non-medical services is lacking. Hard evidence of the aggregate financial benefit to health plans, health systems and other program sponsors of providing LTSS in addition to medical and behavioral health is needed to encourage more organizations to invest in integrating LTSS.

This study is a descriptive study that defines the intervention of LTSS integration—what integration is and how it works. This is accomplished with a series of case studies on "exemplar" programs that integrate LTSS and medical care and the development of a taxonomy that describes the components of an integrated program. The case studies describe program approaches to and experiences with managing costs and quality outcomes through integration.

The case studies and *Taxonomy* are part of a larger project to measure the impact of LTSS integration on cost and quality outcomes. By clearly defining LTSS integration, this study lays the foundation for quantifying the impact of integration in a follow-on study.

This study and the follow-on quantitative studies are intended to demonstrate the potential of LTSS integration to improve outcomes and lower overall costs of care for people with substantial functional limitations and complex care needs. The studies should inform business decisions by health plans and other at-risk organizations to fully integrate LTSS, behavioral, and medical care. This research should also inform policy discussions on proposals to expand LTSS financing.

Literature Review

We conducted an extensive literature review to understand prior experience with the integration of medical care, behavioral health and LTSS and to develop research questions that remained unanswered from previous studies and could be addressed in this study. In scanning the literature, we selected studies of programs—existing and past—that integrated LTSS with medical and behavioral or that employed interventions that would be employed in programs integrating LTSS. For these programs, we sought evidence related to their impact on the overall cost of care, on medical costs alone, or on quality outcomes.

Literature on Integrated Programs

We found that there have only been a handful of programs that integrate medical care, behavioral health, and LTSS: the Program of All-Inclusive Care for the Elderly (PACE), Evercare, Social HMOs (SHMOs), and several state-based programs that integrate Medicaid LTSS benefits with medical care.[7] Overall, research on whether these programs improve cost or quality outcomes has been suggestive but inconclusive. Most often, this is due to the lack of an adequate comparison group and the inability to measure key outcomes like quality of life.

Federal Demonstrations of Integrated Programs

Three programs that integrate medical care and LTSS have been evaluated as part of federal demonstration projects. These demonstrations were the PACE program, the Evercare model of care, and SHMOs.

PACE

PACE is the most thoroughly studied of any program that integrates LTSS with medical and behavioral health. Studies of the program, however, have generated mixed evidence on the impact on cost and quality outcomes.[8]

A 1998 evaluation by Abt Associates found that PACE participants had lower rates of nursing home utilization and in-patient hospitalization, higher utilization of primary and preventive care services, and reported better health status and quality of life than comparison group members.[9] A 2009 literature review also found that PACE programs improved members' access to and quality of care.[10] Both studies found that PACE has the greatest impact for the frailest enrollees.

However, a 2014 review commissioned by the Office of the Assistant Secretary of Planning and Evaluation (ASPE) at the Department of Health and Human Services found mixed

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[7] There have been many programs that focus on high-cost individuals, especially those who frequently use hospitals and emergency rooms. However, very few of these programs have incorporated LTSS integration as part of their intervention, and therefore are not included in this literature review.

[8] For a more detailed discussion of the PACE program, refer to Appendix A of this report.

[9] P Chatterji et al. (1998) "Evaluation of the PACE demonstration: The impact of PACE on participant outcomes." Final report to the Health Care Financing Administration. Available at: https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/PACE_Outcomes.pdf

[10] V Hirth et al. (2009). "PACE: Past, present, and future," *Journal of the American Medical Directors Association,* 10(3), 155–160. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/PACE_Article_JAMDA_091.pdf

evidence on the impact of PACE.[11] This review determined that PACE enrollees have fewer inpatient hospitalizations than their fee-for-service counterparts, but have higher rates of nursing home admission. Contrary to previous reports, this study found that PACE increases the total cost of care for participants, as a result of significantly higher Medicaid costs than the fee-for-service comparison group with a lack of offsetting Medicare savings.

Many evaluations of PACE have major methodological shortcomings. Evaluators have been hampered by the difficulty of finding an appropriate comparison group against which to measure outcomes. Most studies also cannot control for differences in unmet need between PACE participants and comparison groups. It is reasonable to suspect that PACE participants have lower rates of hospital admission, institutionalization, and better health outcomes than similar individuals who do not receive the program. However, this hypothesis cannot be conclusively supported without an adequate comparison group.

Evercare

Evercare is a proprietary model of care for nursing home residents that integrates medical care and LTSS. Research has concluded that Evercare decreases hospitalizations, ER visits, and acute episodes in the nursing home, and as a result generates significant savings in medical care.[12] For example, one evaluation found that participants had half the number of hospitalizations compared to a control group, which translated into a savings of about $100,000 annually in hospital costs per Evercare care manager.[13] However, the program is limited to individuals who live in nursing homes. The Evercare model is likely not replicable for a community-dwelling population, because it depends on the efficiencies and economies of scale possible when a care manager serves many individuals in one location.

Social HMOs

The federal government experimented with Social Health Maintenance Organizations (SHMOS)—which combined modest LTSS benefits with a traditional Medicare managed care plan—throughout the 80s and 90s. There were two generations of SHMO demonstration projects—four plans participated in the first generation demonstration, and only one in the second generation demonstration. One of the first generation plans exited the program out before the final evaluation. The first generation demonstration focused primarily on financial integration and innovative rate-setting, and did not prioritize care management and clinical integration across LTSS and medical care.[14] Rate-setting was a

[11] U.S. Department of Health and Human Services ASPE Office of Disability, Aging and Long-Term Care Policy (2014) "Evaluating PACE: A Review of the Literature." Available at: http://aspe.hhs.gov/daltcp/reports/2014/PACELitRev.pdf

[12] Key citations include R. Kane et al. (2003) "The effect of Evercare on hospital use," *J Am Geriatr Soc.* 51(10):1247-1434. Available at: http://www.ncbi.nlm.nih.gov/pubmed/14511163

and R Kane, G Keckhafer, and J Robst (2002) "Evaluation of the Evercare Demonstration Program." Final report to the Health Care Financing Administration. Available at: https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/Downloads/Evercare_Final_Report.pdf

[13] R Kane et al. (2003) "The effect of Evercare on hospital use."

[14] R Kane et al. (1997) "S/HMOs, The Second Generation: Building on the Experience of the First

key issue for the program designers and researchers that worked on SHMOs. Two of the three surviving first generation demonstration plans received significantly higher capitation rates than traditional Medicare HMOs despite serving comparable populations, while the second generation SHMO plan received similar capitation rates relative to traditional Medicare HMOs.

An evaluation of the first generation demonstration that compared SHMO participants to a similar fee-for-service population found that although the plans decreased hospital costs, nursing home costs were higher. The total cost of care was higher in some plans and lower in others.[15] The evaluations of the second generation SHMO found no impact on overall quality or medical utilization, but a subgroup analysis found that hospitalization rates for the highest-risk individuals decreased after enrolling in SHMOs.[16] Although the evaluations for this program had a strong comparison group, other methodological weaknesses limit the ability to draw conclusions on the impact of integration, primarily a small sample size and a limited timeframe for following participants.

S/HMO Demonstrations," *Journal of the American Geriatrics Society* 45:101-107.

[15] R Newcomer et al. (1995) "Case Mix Controlled Service Use and Expenditures in the Social Health Maintenance Organization Demonstration," *Journal of Gerontology: Medical Sciences* 50A(1):111-119.

[16] Key citations include J Wooldridge et al. (2001) "Social Health Maintenance Organizations: Transition into Medicare+Choice," Report submitted to HCFA. Available at: http://www.mathematica-mpr.com/~/media/publications/PDFs/socialhealth.pdf. And T Thompson (2002) "Evaluation Results for the Social/Health Maintenance Organization II Demonstration" Final Evaluation Report. Available at: https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/shmo_report.pdf

State-Based Integrated Programs

State Medicaid agencies operate some of the largest and oldest programs that integrate LTSS and medical care. Most evaluations of these programs have focused on whether the programs generate savings within LTSS, relative to providing these same benefits unmanaged in a fee-for-service program. Researchers have rarely assessed how Medicaid programs integrate across LTSS, medical, and behavioral health, or the impact of integration on total cost of care or medical utilization.

There are several common methodological weaknesses across studies of state-based programs. In many states, integration occurred as part of broad scale implementation of Medicaid Managed LTSS (MLTSS). Programs were not implemented in a controlled, experimental fashion, but were instead often implemented for all Medicaid beneficiaries in a geographic region at the same time, simultaneous with other benefit and programmatic changes. Researchers generally lack robust baseline data on individual costs, outcomes, and needs. This has made it difficult to confidently attribute changes in cost or quality outcomes to the integrated program instead of to other environmental factors. It is also difficult to find an adequate comparison group—in many states, mandatory enrollment in Medicaid MLTSS means that there is no fee-for-service population to compare against, and comparing outcomes across different states raises the possibility of many other confounding differences.

Evaluations have been published on three state-based integrated programs: the ALTCS program in Arizona, the SCO program in

Massachusetts, and the Family Care program in Wisconsin.

Arizona Long-Term Care System (ALTCS)

Arizona established the first Medicaid MLTSS program in 1989. Since then, the state has seen rates of nursing home use decrease from 95 percent to 27 percent of the enrolled population[17]—all of whom are nursing home certifiable. Evaluators have found that the program saves money not only through a shift from institutional care to home and community-based services, but also through decreased hospitalizations.[18] However, these studies are somewhat inconclusive due to the lack of an adequate comparison group—some studies have used the New Mexico fee-for-service Medicaid population as a comparison and others have modeled expected utilization without a comparison group. In neither of these cases can we be certain that the comparison group is truly similar to the population enrolled in ALTCS.

[17] J. Libersky and J. Verdier (2014) *Financial Considerations: Rate Setting for Medicaid (MLTSS) in Integrated Care Programs*. Available at: http://www.mathematica-mpr.com/~/media/publications/PDFs/health/dual_eligibles_ML_TSS_rate_setting.pdf; and, Joint Legislative Budget Committee (2015) *Program Summary: Arizona Long Term Care System*. Available at: http://www.azleg.gov/jlbc/psaxsaltcs.pdf

[18] Key studies of Arizona's MLTSS program include W Weissert et al. (1997) "Cost Savings from HCBS: Arizona's Capitated Medicaid Long-Term Care Program," *J. of Health Politics, Policy and Law*, 22(6):1329-57. N McCall et al. (1992) "Evaluation of Arizona's Health Care Cost Containment System Demonstration: Second Outcome Report." N McCall and J Korb (1997) "Utilization of Services in Arizona's Capitated Medicaid Program for Long-Term Care Beneficiaries," *Health Care Financing Review* 19(2):119-134. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194479/

Massachusetts Senior Care Options

The Senior Care Options (SCO) program was established in 2004 and has also been favorably evaluated. SCO is Massachusetts' managed care program for dual eligible seniors that incorporates LTSS. The program is highly integrated—every member is enrolled for Medicare and Medicaid with the same managed care plan, and receives a comprehensive benefit package. A state evaluation found that the program has succeeded in keeping members in the community and decreasing the utilization of SNFs.[19] The evaluation compared rates of institutionalization between SCO participants and similarly complex individuals who were eligible for SCO but had opted for fee-for-service Medicare.

Wisconsin Family Care

Established in 1998, Family Care is Wisconsin's MLTSS program, and wraps around the standard Medicaid medical benefit for beneficiaries with a nursing home level of need. An independent evaluation of the program in 2005 concluded that Family Care increases access to HCBS and significantly decreases the cost of providing LTSS compared to a group of similar Medicaid beneficiaries who did not enroll in the program.[20] The evaluators also looked at the cost of medical care, and found that Family Care participants had lower outpatient and inpatient hospital costs than the comparison

[19] Jen Associates (2013) "Massachusetts Senior Care Option 2005-2010 Impact on Enrollees: Nursing Home Entry Utilization." Available at: http://www.mass.gov/eohhs/docs/masshealth/sco/sco-evaluation-nf-entry-rate-2004-through-2010-enrollment-cohorts.doc

[20] Wisconsin Department of Health and Family Services (2005) "Family Care Independent Assessment." Available at: https://www.dhs.wisconsin.gov/sites/default/files/legacy/LTCare/pdf/FCIndepAssmt2005.pdf

group, suggesting that LTSS integration does result in medical savings.

Common Interventions of Integrated Programs

A substantial body of literature has been developed on interventions that decrease the cost of care and improve outcomes for individuals with complex health needs, including those who have LTSS needs.

Two such interventions are frequently part of the care models of integrated programs: care management and transitional care programs.

Care management is the assignment of a dedicated care manager—usually a nurse or social worker—to support an individual with complex health needs through tactics like educating them about their disease, coaching them on self-care, monitoring their health, connecting them with medical providers and social supports, and tracking whether they receive recommended care. Care management is not a strictly defined intervention—some programs referred to as "care coordination" or "disease management" interventions are indistinguishable from care management. In general, these programs have demonstrated the ability to decrease high-cost medical utilization like hospitalization, but have not reduced the total cost of care.[21] Care

management interventions have the greatest impact when they include frequent in-person interaction between the care manager and the individual, occasional in-person meetings between the care manager and the individual's providers, a care manager who serves as the communications hub for providers, evidence-based patient education, medication therapy management, and transitional care following hospitalizations.[22] Demonstrations have found that because care management is an expensive intervention, it is only cost-effective when narrowly targeted to populations at high-risk of high-cost medical utilization.[23]

Transitional care programs manage an individual's care as from the time they are discharged from a hospital until they are stabilized in the home. Common elements of these programs include patient education, discharge planning, medication reconciliation, follow-up telephone calls, and home visits.[24] Several variations of this intervention have been validated in randomized controlled trials. The Transitional Care Model developed at the University of Pennsylvania has been shown to decrease the rate of readmissions and overall medical costs of participants.[25] The Coleman

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[21] R Brown and D Mann (2012) "Best Bets for Reducing Medicare Costs for Dual Eligible Beneficiaries: Assessing the Evidence," Kaiser Family Foundation: Medicare Policy Issue Brief. Available at: http://kff.org/health-reform/report/best-bets-for-reducing-medicare-costs-for-duals/ and R Brown et al. (2012) and C Hong et al. (2014) "Caring for High-Need, High-Cost Patients: What Makes for a Successful Care Management Program?" Commonwealth Fund Issue Brief. Available at: http://www.commonwealthfund.org/~/media/files/publications/issue-

brief/2014/aug/1764_hong_caring_for_high_need_high_cost_patients_ccm_ib.pdf
[22] R Brown et al. (2012) "Six Features of Medicare Coordinated Care Demonstration Programs That Cut Hospital Admissions of High-Risk Patient," *Health Affairs* 31(6):1156-1166. Available at: http://content.healthaffairs.org/content/31/6/1156.abstract
[23] Ibid.
[24] L Hansen et al. (2011) "Interventions to Reduce 30-Day Rehospitalization: A Systematic Review," *Annals of Internal Medicine* 155:520-528.
[25] Naylor et al. (1994) "Comprehensive Discharge Planning for the Hospitalized Elderly: A Randomized Clinical Trial," *Annals of Internal Medicine* 120:999-1006, Naylor et al. (1999) "Comprehensive

Care Transitions Intervention has also been found to decrease hospital readmissions and total medical spending in the six months following a hospitalization.[26] Another successful model is Project RED, which decreases both readmissions and emergency department visits.[27] Integrated programs can choose among these different approaches to transitional care, each of which is a proven tool for improving patient outcomes and decreasing medical costs.[28]

These interventions have primarily been studied outside the context of integrated programs. The studies therefore do not tell us

what the results would be of combining these interventions with integration. However, it is reasonable to believe that an integrated program would be more likely to use these interventions because of the financial resources and incentives for doing so. Integrated programs may also be more likely to effectively deploy these tools by targeting them to the individuals most likely to benefit and using more intensive approaches.

Forthcoming Research

We can anticipate more research on LTSS integration in the near future. The Duals Demonstrations currently underway are studying the impact of integration. The early reports from the demonstrations are qualitative and focus on the implementation process and state activity. Quantitative assessments of the impact of the demonstrations will not be available until the evaluations are completed in a few years.

Conclusion

While there is some evidence of the impact on cost and quality of different types of care management and other interventions that is instructive, there is little evidence of the impact of programs that may employ these kinds of interventions in the context of integrated LTSS and medical care. There are only a few working models of LTSS integration, and, while well-studied, the literature on these models has been largely inconclusive. One reason the research has not been definitive is that the studies have methodological shortcomings, primarily the lack of a sufficient comparison group.

One of the models that has been around for a while and could be instructive on the role of LTSS integration in achieving desirable cost and quality outcomes is Medicaid MLTSS –

Discharge Planning and Home Follow-up of Hospitalized Elders," *JAMA* 281(7):613-620, and Naylor et al. (2004) "Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized, Controlled Trial," *Journal of the American Geriatrics Society* 52:675-684.

[26] E Coleman and S Chalmers (2006) "The Care Transitions Intervention: Results of a Randomized Controlled Trial," *Archives of Internal Medicine* 166:1822-1828. Available at: http://caretransitions.org/wp-content/uploads/2015/06/39_The-Care-Transitions-Intervention-Results-of-a-Randomized-Controlled-Trial.pdf and R Gardner et al. (2014) "Is Implementation of the Care Transitions Intervention Associated with Cost Avoidance After Hospital Discharge?" *Journal of General Internal Medicine* 29(6):878–84. Available at: http://caretransitions.org/wp-content/uploads/2015/06/71.-Is-Implementation-of-the-Care-Transitions-Intervention-Associated-with-Cost-Avoidance-after-Hospital-Discharge.pdf

[27] B Jack et al. (2009) "A Re-engineered Hospital Discharge Program to Decrease Rehospitalization: A Randomized Trial," *Annals of Internal Medicine* 150:178-187. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2738592/

[28] M. Naylor et al. (2011) "The Importance of Transitional Care in Achieving Health Reform," *Health Affairs* 30(4):746-754. Available at: http://content.healthaffairs.org/content/30/4/746.full

particularly with reference to the non-dual eligible, Medicaid-only subpopulation. However, the impact of integrated LTSS for this subpopulation on relative cost and quality has not been measured.

One barrier to measuring the impact of LTSS integration has been a lack of clarity on what is actually being measured. LTSS integration has not been defined previously. In order to assess impact, researchers need to know what interventions are incorporated in a program that integrates medical care, behavioral health, and LTSS.

More research is needed to understand the relationship between LTSS integration and health care costs and quality. This report lays the foundation for that research by defining the component activities that make up integrated LTSS and describing the degree of integration involved. The products of this conceptual work are a taxonomy describing the key components of LTSS integration and degrees of integration within those components, case studies of "Exemplar Programs" that show the variations in different models of integrated LTSS, and a more extensive analysis of the most important characteristics of integrated LTSS. The conclusions from this report are limited by its descriptive methodology. Without knowing the costs and outcomes of a population that is not in an integrated program, it is not possible to determine that an integrated program lowers costs or improves outcomes.

Future research will be needed to measure the impact of LTSS integration. Any such research should first create comparison groups within the fee-for-service population that are similar in terms of functional capacity and LTSS needs to populations in integrated programs. The study would then be able to compare the costs and outcomes for populations in integrated programs with those of similar populations not in integrated programs.

Methodology and Limitations

Research Question

The primary hypothesis guiding the long-term research plan is that "LTSS integration"—that is the integration of medical, behavioral health and LTSS benefits in a single capitated program—when applied to a high-cost, high-risk population, can serve that population with better outcomes at a lower total cost of care than would be the case without LTSS integration. The current study develops a basis for defining and measuring LTSS integration in order to address the above hypothesis in a subsequent quantitative study. The long-term objective of this research effort is to answer the quantitative research question.

The principle research questions motivating this study are:

I. What is LTSS integration?
II. What are the activities that occur in an integrated program, how do those activities vary across programs and what factors contribute to that variation?
III. Which aspects of LTSS integration are more or less significant in terms of influencing cost and quality outcomes?

Answering these questions is foundational to future research on LTSS integration. In order to measure the impact of integration, it is first necessary to clearly define integration as an intervention. This study is the first step in a longer-term research initiative.

Study Design

This study uses a case study approach to answer the qualitative research questions described above. Each case study provides an in-depth description of the characteristics and operations of "exemplar" programs that integrate medical care and LTSS.

Taxonomy of LTSS Integration

In addition to the case studies in this report, the research team developed a taxonomy to define and classify the different aspects and features of LTSS integration in the programs studied. This *Taxonomy* specifies the key components of integration and describes varying degrees of integration for each component. It is intended to serve as a standard reference point for the characterization of integrated programs and comparisons between different programs.

In order to develop the *Taxonomy*, the research team reviewed previous definitions and frameworks of LTSS. Key publications include a 2001 article by Robert Master and Catherine Eng,[29] The SCAN Foundation's "Five Pillars of System Transformation"[30] and summary of existing definitions of care coordination,[31] a National Committee for Quality Assurance whitepaper on evaluating the quality of care in integrated programs,[32] a

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[29] R. Master and C. Eng (2001) "Integrating Acute and Long-Term Care for High-Cost Populations," Health Affairs 20(6):161-172. Available at: http://content.healthaffairs.org/content/20/6/161.long

[30] L. Shugarman. (2012) "The SCAN Foundation's Framework for Advancing Integrated, Person-Centered Care," *Health Affairs* 31(12):2821-2825. Available at: http://content.healthaffairs.org/content/31/12/2821.full.html

[31] SCAN Foundation (2013) "Care Coordination in an Integrated, Person-Centered System of Care," Working Paper. Available at: http://www.thescanfoundation.org/sites/default/files/tsf-care_coordination_working_paper-12-4-13.pdf

[32] NCQA (2013) "Integrated Care for People with Medicare and Medicaid: A Roadmap for Quality," White Paper. Available at: http://www.ncqa.org/portals/0/public%20policy/NCQAWhitePaper-

2011 framework by the SNP Alliance for advancing integration of Medicare and Medicaid,[33] and a technical assistance brief from the Center for Health Care Strategies that defined integration from the perspective of the individual being served.[34] This review demonstrated that the field has not coalesced around a single definition of integration, nor is there an agreed upon rubric for distinguishing between programs that are more or less integrated. However, a number of concepts and themes emerge repeatedly: person-centeredness, assessment and care planning, communication and coordination, and financial and administrative integration.

This study makes a contribution to the field by articulating a clearer definition of what constitutes an integrated program, as well as a robust framework for determining the degree of a program's integration along different dimensions.

Expert Panel

The research team convened an expert panel to advise on the development and execution of this study. Members of the panel include researchers, plan administrators, and public policy experts. The panel met with the research team at key points to review and advise on the research design, selection of plans, field research, and analysis of results.

IntegratedCareforPeoplewithMedicareandMedicaid.pdf

[33] SNP Alliance (2011) "A Definitional Framework for Medicare/Medicaid Integration for Dual Beneficiaries," SNP Alliance Recommendation. Received through personal correspondence with expert panel.

[34] A. Lind and S. Gore (2010) "From the Beneficiary Perspective: Core Elements to Guide Integrated Care for Dual Eligibles," CHCS Technical Assistance Brief. Available at: http://www.chcs.org/media/TCDE_Core_Elements_122010.pdf

Program Identification and Selection

The 11 "exemplar" programs for the study were identified and selected through a process that involved the research team, LTQA members and Board members, and the expert panel.

The program identification process started with staff research of health plans and other programs fitting the broad criteria of the study. Programs had to be integrating medical care and LTSS in some fashion for at least part of their enrolled population, but not necessarily taking risk for both or integrating in every component. Additional programs were identified through recommendations from LTQA members and Board members and the expert panel.

Expert Panel Members	
Cindy Adams	Chief Administrative Officer Superior HealthPlan, Centene Corp.
Randall Brown	Director of Health Research Mathematica Policy Research
Ana Fuentevilla, MD	Chief Medical Officer UnitedHealthcare Community and State
Howard Gleckman	Senior Fellow The Urban Institute
Larry Gumina	President & CEO Ohio Presbyterian Retirement Services
Katherine Hayes	Director of Health Policy Bipartisan Policy Center
Jennifer Kowalski	Vice President, Public Policy Institute Anthem, Inc.
Randall Krakauer	(retired) Vice President, National Medical Director, Medicare Strategy Aetna, Inc.
Paul Saucier	Director, Integrated Care Systems Truven Health Analytics

The research team then narrowed the list of potential programs using several criteria. These criteria emphasized diversity in types of programs in order to represent the widest range of experiences in the case studies. The list of programs included some that are fully capitated for both medical and LTSS (including PACE or Duals Demonstrations), some that operate a D-SNP, I-SNP, or FIDE-SNP, and Medicaid MLTSS programs that also have medical risk for the Medicaid-only population.

This list was presented to the expert panel to select programs for the study. The panel selected programs they viewed as "exemplar" in that they are leaders in integration efforts. The panel was also asked to select a diverse range of programs that included both for-profit and non-profit organizations; different state integration environments; different program sizes and geographic locations; different amounts of experience with LTSS integration; programs serving community, institutional, and residential care populations; and programs that served both under-65 and elderly populations. The expert panel identified five programs to study in the fall of 2015 and five to study in the spring of 2016.

Data Collection Process

Information for the case studies was collected and validated through a series of structured communications with participating programs.

Background Information Collection

Study programs completed a survey (either online or with a paper form) that covered general information about the organization. The survey included questions about the different programs the organization operates, covered services, and size and characteristics of the enrolled population.

Initial Phone Interview

The research team conducted a one-hour phone interview with the program leadership for an open-ended discussion of program goals and strategies, approach to LTSS integration,

outcomes of integration, and challenges encountered. This high-level discussion served to familiarize the program with the research project, identify program staff as key study contacts, and sharpen the focus of the on-site interviews.

Site Visit

The research team traveled to participating program offices to conduct three interviews: a 90-minute "person-centered care" interview with senior management and clinical leadership for the program; a 90-minute "financial information" interview with financial management; and a 60-minute interview with a care manager to review the care coordination process. Each interview was conducted using survey instruments designed by the research team and reviewed by the expert panel.

Data Validation

Following each site visit, the research team drafted a preliminary case report. This draft case report was shared with the program for review along with a set of follow-up questions to collect additional information needed to complete the case study. Through conference calls and email communication, the research team worked with participating programs to ensure the accuracy and completeness of the case reports.

Strategy to Minimize Bias

The potential exists in any observational study where the interviewer's own understanding of the context, selection of information, and recall of what is said can influence the presentation of primarily factual information. To minimize interviewer bias, three members of the research team participated in each interview. Interviews were recorded to minimize lapse in recall of factual information. The same individual led all interviewers to minimize inter-rater variation. Additionally, each participating program was provided a

copy of the case report to review and correct any factual errors or misinterpretation.

The expert panel also serves to protect against bias by grounding the study in relevant existing research, validating the research questions, methods, and instruments, and reviewing any analysis and conclusions to ensure that it is supported by the case studies.

Limitations

This study describes LTSS integration from the perspective of organizations that operate integrated programs. In this round of the study, all of the organizations are health plans, although future research could also include provider-sponsored organizations (e.g., Accountable Care Organizations). All of the individuals interviewed for the case reports were employees or contractors of health plans. This perspective may introduce a bias in the results. There are important viewpoints on these programs that were not captured. Of most concern is the absence of the voice of the individual receiving care from the programs. Other stakeholders that might have different perspectives on these programs include providers, state and federal regulators, and consumer advocates.

The case report design of the study entails both advantages and disadvantages. The strengths of the design for this study are that it allows an in-depth exploration and qualitative description of LTSS integration, a complex topic with important nuance. However, the study did not collect quantitative data and lacks a comparison group. All of the programs in the study integrate LTSS and share many characteristics; there is no comparison group of fee-for-service, non-integrated programs. This limits the study's capacity to generate conclusions about how integrated programs differ from non-integrated programs, as well as any conclusions about the relationship between LTSS integration and cost or quality outcomes.

Although the research team strove to include a diverse mix of programs in the study, the small sample size may limit the generalizability of the results. For example, the characteristics of integration we observed in the programs in this study may not hold true for integrated programs in different state policy environments or for programs that serve different populations.

Study Context

This study is primarily an investigation into how programs approach LTSS integration. However, several key contextual trends are influencing and being influenced by integrated programs. The programs in the study are embedded within larger state and federal policy contexts that effect major elements of their operations. One key policy influencing Medicaid LTSS programs is recent federal regulation requiring that care be person-centered. These rules are part of a broader conversation in the field about what it means for care to be person-centered and how this value can be more widely adopted. Finally, although this research looks specifically at LTSS integration, there is an equally essential movement to integrate behavioral and medical care—two systems that have historically been siloed. In this report, when we refer to LTSS integration, we generally mean integration with both medical and behavioral.

These topics came up repeatedly throughout the research process. Each has implications beyond LTSS integration, but they are also important to understanding the history of integrated programs and how they are likely to evolve in the future.

Federal and State Policy and Regulatory Context

Each of the programs in this study operates within a broader regulatory and policy environment that influences program design and operations. Programs are affected not only by current policy and regulation, but also the historical context in which they were established and evolved. In order to understand how each of these organizations approaches integration, one must first understand the federal and state programs in which they participate.

Federal Medicare Programs

Many individuals in this study's programs are dually eligible—that is, they receive their primary medical coverage from Medicare, and receive wraparound LTSS, behavioral, and secondary medical coverage from state Medicaid programs. Individuals often have several choices of how they receive their Medicare benefits, depending on the market where they live and individual characteristics. For individuals who are enrolled in the programs in the study, how they choose to receive their Medicare coverage directly affects the resources available to the integrated programs for their care. Programs have access to and control over the greatest amount of resources to care for dual eligible members when they are enrolled with the same plan for Medicaid and Medicare benefits.

Original Medicare

Most Medicare beneficiaries—69% in 2015[35]—enroll in traditional fee-for-service Medicare, also referred to as "Original Medicare." In Original Medicare, the federal government pays providers directly for every covered service the beneficiary receives. For most dual eligibles, the state Medicaid program covers out-of-pocket Medicare costs like premiums and co-payments. People who enroll in Original Medicare may visit any provider who accepts Medicare, which includes almost all

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[35] G. Jacobson, A. Damico, T. Neuman and M. Gold (2015) *Medicare Advantage 2015 Spotlight: Enrollment Market Update* Available at: http://kff.org/medicare/issue-brief/medicare-advantage-2015-spotlight-enrollment-market-update/

doctors and hospitals in the country. These beneficiaries are not required to choose a primary care doctor and do not need referrals or prior authorizations for specialist or hospital care. Although these individuals have a lot of flexibility, there is no insurance company overseeing and coordinating their care or helping them to make decisions about which providers to visit.

Medicare Advantage and Special Needs Plans

Instead of Original Medicare, about 31% of Medicare beneficiaries choose to receive their benefits from a Medicare Advantage plan.[36] Medicare Advantage plans are sold and operated by private insurance companies. These insurance companies receive a fixed payment every month from the federal government for each individual enrolled in the plan, and in return are responsible for providing all of that person's Medicare benefits. This puts the insurance company at risk—the payment to the plan does not change, even if members have higher or lower medical expenses than expected. Medicare Advantage members are often required to choose a primary care doctor, get referrals from that doctor to see specialists, and get prior authorization from the insurance company for costly medical procedures. Individuals enrolled in MA HMOs typically may only visit providers in the plan's network, which is usually a more limited subset of the providers who accept Original Medicare. Beneficiaries who choose a Point of Service (POS) or Preferred Provider Organization (PPO) MA plan have access to providers outside of the plan's network, but may be subject to higher out-of-pocket costs when visiting those providers.

Special Needs Plans (SNPs) are a specialized subcategory of Medicare Advantage plans created in 2003 to provide targeted care to individuals with specific health needs. SNPs are different from other Medicare Advantage plans because they can restrict enrollment to individuals with certain characteristics. SNPs often have special expertise in caring for the population they enroll and implement processes and systems to manage member care. Three kinds of SNPs show up in this study: (1) Institutional SNPs (I-SNPs), which enroll individuals who require a nursing home level of care; (2) Dual Eligible SNPs (D-SNPs), which enroll dual eligible Medicare beneficiaries; and (3) Fully Integrated Dual Eligible SNPS (FIDE-SNPs), a subcategory of D-SNP created in 2010.[37] D-SNPs are required to have a formal relationship with the state in which they operate to coordinate members' Medicaid benefits, while FIDE-SNPs must have a contract to provide members' Medicaid benefits directly. Nationally, there are about 49,000[38] Medicare beneficiaries enrolled in I-SNPs and 1.6 million enrolled in D-SNPs, including 110,000 enrolled in FIDE-SNPs.[39]

All of the organizations in this study operate SNPs. UHC operates FIDE-SNPs in Arizona and Massachusetts, Health Plan of San Mateo and Superior operate D-SNPs, and ArchCare operates an I-SNP. When a dual

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[36] Ibid.

[37] There is one other type of SNP, Chronic Condition SNPs (CC-SNPs), which enroll individuals with specific diagnoses, for example, dementia or HIV/AIDS. There are about 305,000 Medicare beneficiaries in CC-SNPs nationwide.
[38] Kaiser Family Foundation (2015) *Medicare Advantage: Special Needs Plan (SNP) Enrollment, by SNP Type* Available at: http://kff.org/medicare/state-indicator/snp-enrollment-by-snp-type/
[39] SNP Alliance (July 2015) Comments on CMS Medicaid Managed Care NPRM, Available at: http://op.bna.com.s3.amazonaws.com/hl.nsf/r%3FOpen%3Dmyon-9zbng5

eligible individual enrolls in a SNP with the same plan where they receive Medicaid benefits, they have coverage for medical, behavioral, and LTSS with a single organization, and there is the potential provide more uniform coverage across the spectrum.

Program of All-Inclusive Care for the Elderly (PACE)

The Program of All-Inclusive Care for the Elderly (PACE) is a fully-integrated healthcare and insurance program for elderly individuals who live in the community and require a nursing home level of care. The program provides continuous, intensive care management for a high-risk population. PACE programs are fully-capitated and at risk for the entirety of members' Medicare and Medicaid benefits—including medical, behavioral, and LTSS. Typically, participants attend adult day health centers operated by the PACE program several times a week, where their care is overseen by an onsite interdisciplinary team led by a physician.

Most PACE programs are small, community-based organizations and serve a relatively small population—there are only 35,000 participants nationwide.[40] Despite its small scale, PACE is an important part of the policy landscape of LTSS integration. In many ways, PACE programs are the most integrated programs currently available to dual eligible individuals with LTSS needs. Programs act as both the insurer and provider of care. Programs also have a unique degree of financial integration in the form of a joint capitation payment for all benefits from the federal and state government. This study includes a PACE

program operated by ArchCare in New York.[41]

Medicare-Medicaid Plans

Medicare-Medicaid Plans (MMPs) are a new kind of plan developed for the CMS Financial Alignment Initiative—also called "the Duals Demonstration"—to align Medicare and Medicaid benefits for dual eligible individuals. *The Affordable Care Act* authorized CMS to test new integrated payment and care delivery models, and the Duals Demonstration is an important experiment in LTSS integration. The intent of the demonstration is to provide all Medicare and Medicaid benefits through a single, integrated program. As of June 2015, 355,000 individuals were enrolled in demonstration plans in eleven participating states.[42] Two of the organizations in this study—Health Plan of San Mateo and Superior—are currently participating in their states' demonstrations. A third, ArchCare, withdrew from New York's demonstration in 2015.

State Medicaid Programs

All of the programs participating in this study are operated by managed care organizations contracting with states to provide Medicaid benefits, and almost all of the individuals enrolled in these programs are Medicaid beneficiaries. Researchers who study LTSS integration often focus on the Medicaid population, because very few people have insurance coverage for LTSS outside of Medicaid. Individuals who are not eligible for Medicaid are typically supported

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[40] National Pace Association (June 2015) Letter to Senate Finance Committee, Available at: http://www.npaonline.org/sites/default/files/PDFs/Final%20Response%20to%20SFC%20Chronic%20Care%20soliciation.pdf

[41] Refer to Appendix A for more detailed information on the PACE program.
[42] Kaiser Commission on Medicaid and the Uninsured (2015) *Health Plan Enrollment in the Capitated Financial Alignment Demonstrations for Dual Eligible Beneficiaries* Available at: http://kff.org/medicaid/fact-sheet/health-plan-enrollment-in-the-capitated-financial-alignment-demonstrations-for-dual-eligible-beneficiaries/

by unpaid family members or pay out-of-pocket for LTSS[43]—care that cannot be integrated because it is financed and provide outside of any organized system. If these individuals exhaust their personal financial resources, they may become eligible for Medicaid and have the opportunity to enroll in an integrated program. Medicaid is therefore the primary route by which people access integrated care, and state Medicaid programs have shaped the current landscape of LTSS integration.

Medicaid Managed Care and Managed Long Term Services and Supports (MLTSS)

State Medicaid programs began to move beneficiaries out of fee-for-service care and into managed care arrangements in the 1980s. The shift to managed care initially focused on children, pregnant women, and parents, who represent the large majority of Medicaid enrollees. Over time, Medicaid managed care continued to expand to new geographic areas and covered populations, and today the majority of Medicaid beneficiaries are covered by some kind of managed care arrangement.[44]

Until the late 1990s, very few Medicaid managed care programs included disabled and elderly beneficiaries. Most states kept these high-cost, complex individuals carved out in a fee-for-service Medicaid arrangement. However, by 2004 a number

of states had begun experimenting with expanding Medicaid managed care to include LTSS benefits and populations that received them. These new programs serving disabled and elderly individuals are referred to as Medicaid Managed LTSS (MLTSS). Since 2004, Medicaid MLTSS has grown rapidly, and many new states have established programs. Some of the recent growth is driven by the Duals Demonstrations.[45]

Medicaid MLTSS programs vary considerably by state. Programs may cover different services: in some states the program covers all Medicaid benefits, in others certain categories may be carved out of the program, and in others the program may be limited to LTSS. Programs may cover different populations, with separate programs based on age (e.g., under 21, between 21 and 64, and 65 and older), kind of disability (e.g., intellectual and development disabilities), and/or level of disability (e.g., limited to those who require a nursing home level of care). Programs also vary in enrollment requirements. In some states, enrollment in managed LTSS is mandatory to access Medicaid benefits, while in others beneficiaries have a choice of enrolling in managed care or fee-for-service. Beyond this programmatic variation, states also differ in how many and what kind of contractors participate in the program. Private for-profit, private non-profit, and public / quasi-public organizations all participate in Medicaid MLTSS programs. The predominant contractors are large, national for-profit organizations—including

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[43] For more information on how Americans access and pay for LTSS see E. Reaves and M. Musumeci (2015) *Medicaid and Long-Term Services and Supports: A Primer* Available at: http://kff.org/medicaid/report/medicaid-and-long-term-services-and-supports-a-primer/
[44] For more background information on managed care in Medicaid, please see Kaiser Commission on Medicaid and the Uninsured (2012) *Medicaid Managed Care: Key Data, Trends, and Issues* available at http://kff.org/medicaid/issue-brief/medicaid-and-managed-care-key-data-trends/

[45] For more background information on Medicaid MLTSS, please see P. Saucier et al. (2012) *The Growth of Managed Long-Term Services and Supports (MLTSS) Programs: A 2012 Update* Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/mltssp_white_paper_combined.pdf

UnitedHealthcare, Amerigroup, Centene, and Molina—but the market is distinct in each state.

Finally, each state approaches coordinating Medicaid MLTSS program benefits with Medicare benefits for the dually eligible population slightly differently. Some require contractors to manage both programs simultaneously for enrollees, others require MLTSS contracts to offer a D-SNP or otherwise coordinate with enrollees Medicare provider, and some states have no coordination requirements in place. The Duals Demonstration is leading to an evolution in how participating states approach MLTSS coordination for dual eligibles.

Each of the organizations in this study manages Medicaid LTSS through a capitated payment. Each plan has been shaped by the state environment in which they are situated and their approach to integration is influenced by that environment.[46]

Medicare Choice

One challenge facing programs that seek to integrate dual eligible individuals' Medicare and Medicaid coverage is federal policy that guarantees an individual's right to choose how they receive their Medicare coverage. Some states have adopted policies that increase alignment of medical and LTSS coverage for Medicaid beneficiaries without compromising the individual's right to choose. In Massachusetts, dual eligible individuals can only enroll in the SCO program if they choose to receive both Medicaid and Medicare coverage from the program. Arizona's state Medicaid agency periodically moves dual eligible beneficiaries' Medicaid coverage to the plan where they are enrolled for Medicare Advantage

coverage. Federal programs have also been developed that address this constraint. PACE programs, FIDE-SNPs, and programs in the Duals Demonstration all require that members receive both Medicare and Medicaid coverage from the same program.

Person-Centeredness

Person-centeredness—the practice of orienting care to the person receiving it—is a critical part of high quality, integrated LTSS. Person-centeredness can be woven into every component of care management in order to provide care that is consistent with an individual's goals and preferences and result in outcomes that are important to the individual. This study focuses on how organizations integrate LTSS and medical care. The goals of integration—improving the quality and managing the total cost of care—are closely aligned with person-centeredness. While LTSS integration may result in a more person-centered system of care, major progress on person-centeredness will require a transformation in how the field thinks about care, control, and patient engagement and participation.

CMS is behind some recent efforts to advance person-centered planning. In 2014, CMS released the final Home and Community Based Services regulation,[47] which stresses the rights of individuals to receive services in the most integrated setting and to have full access to the benefits of community living. The regulation requires that service plans be "developed through a person-centered planning process that addresses

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[46] Refer to Appendix B for more details on the state Medicaid MLTSS programs in which the programs we studied operate.

[47] Home and Community-Based Services Rule, 79 Federal Register 2947 (January 16, 2014). Available at: https://federalregister.gov/a/2014-00487

health and LTSS needs in a manner that reflects individual preferences and goals."[48]

LTSS leaders are also working to conceptualize and advance person-centeredness. Person-centeredness has been a hard concept for the LTSS community to standardize and define. In early 2015, the American Geriatrics Society, The SCAN Foundation, and the Keck School of Medicine at the University of Southern California convened an expert panel to define person-centered care and its essential elements.[49] According to the expert panel,

> 'Person-centered care' means that individuals' values and preferences are elicited and, once expressed, guide all aspects of their health care, supporting their realistic health and life goals. Person-centered care is achieved through a dynamic relationship among individuals, others who are important to them, and all relevant providers. This collaboration informs decision-making to the extent that the individual desires.

The programs in this study, like the LTSS community nationally, have found it difficult to define, operationalize, and evaluate person-centeredness. The programs vary in how they think about person-centeredness and how they put it into practice in their

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[48] CMS (2014) Home and Community-Based Services Fact Sheet. Available at: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-01-10-2.html

[49] The American Geriatrics Society Expert Panel on Person-Centered Care (2016) "Person-Centered Care: A Definition and Essential Elements," *Journal of the American Geriatrics Society* 64(1):15-16. Available at: http://onlinelibrary.wiley.com/doi/10.1111/jgs.13866/full

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Essential Elements of Person-Centered Care

I. An individualized, goal-oriented care plan based on the person's preferences.
II. Ongoing review of the person's goals and care plan.
III. Care supported by an interprofessional team in which the person is an integral team member.
IV. One primary or lead point of contact on the healthcare team.
V. Active coordination among all healthcare and supportive service providers.
VI. Continual information sharing and integrated communication.
VII. Education and training for providers and, when appropriate, the person and those important to the person.
VIII. Performance measurement and quality improvement using feedback from the person and caregivers.

Source: The American Geriatrics Society Expert Panel on Person-Centered Care

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care management systems. The programs have different approaches to incorporating person-centeredness in assessment and care planning, care delivery, quality measurement and assessment, and member feedback. Although the programs in this study conceptualize and implement person-centeredness differently, most believe that person-centeredness is a key contributor to achieving financial and quality outcomes. For example, most have found that supporting people in their homes in the community not only helps people achieve the goals that matter most to them, but is also cost-effective.

Behavioral Health Integration

LTSS integration is intertwined with behavioral health integration. Holistic, person-centered care addresses medical, behavioral health, and LTSS needs according to the goals and preferences of the person. In practice, the boundary between LTSS and

behavioral health is not always clearly defined. Many LTSS and behavioral health interventions are functionally very similar, but target different populations, with behavioral health focusing on severe and persistent mental illness and substance use disorders.

Programs in this study integrate LTSS with medical and behavioral health and take or share risk for the whole person's care. Several of the programs noted that their highest-risk, most complex patients were those whose primary diagnosis is a behavioral health issue, and many programs have specific strategies for addressing behavioral health needs and integrating behavioral health. While this study focuses on how LTSS integration can lower cost and improve quality, it is important to note that there is a substantial body of evidence supporting the effectiveness of behavioral health integration to achieve these same outcomes.[50]

The Center for Integrated Health Solutions—a joint effort between the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health and Resources Services Administration (HRSA)—"promotes the development of integrated primary and behavioral health services to better address the needs of individuals with mental health and substance use conditions, whether seen in behavioral health or primary care provider settings."[51] The Center is driving a shift towards better-integrated behavioral health by providing funding, training, and technical assistance to programs around the country. These programs integrate behavioral health in a variety of ways, from providing screening, navigators, and co-located services, to creating health home models and system-level integration.[52]

Programs that integrate behavioral health exist along a continuum of collaboration and integration. This continuum has been described in many ways, from three to ten levels of integration. The first classification of primary care-behavioral health integration was proposed in 1995 and included five levels from minimal collaboration to close collaboration in a fully integrated system.[53] In 2013, SAMHSA built on this model with a new six-level framework that added more nuance to the higher end of the integration continuum, and placing the six levels into three categories: coordinated care, co-located care, and integrated care.[54]

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[50] C. Croze (2015) *Healthcare Integration in the Era of the Affordable Care Act*, Report prepared for The Association of Behavioral Health and Wellness. Available at: http://www.integration.samhsa.gov/integrated-care-models/Healthcare_Integration_In_the_Era_of_ACA.pdf

[51] For more information on the Center's work and resources on behavioral health integration, see http://www.integration.samhsa.gov/

[52] The Kaiser Commission on Medicaid and the Uninsured (2014) *Integrating Physical and Behavioral Health Care: Promising Medicaid Models*, Issue Brief. Available at: http://www.integration.samhsa.gov/integrated-care-models/Kaiser_brief_on_integrated_health_2014.pdf

[53] Doherty et al. (1996) "Five levels of primary care/behavioral healthcare collaboration," *Behavioral Healthcare Tomorrow* 5(5):25-27.

[54] B. Heath et al. (2013) *A Standard Framework for Levels of Integrated Healthcare* Report prepared for SAMHSA-HRSA Center for Integrated Health Solutions. Available at: http://www.integration.samhsa.gov/integrated-care-

Although the shift towards behavioral health integration has been slow in the context of financial and administrative barriers, new state and federal developments are accelerating the process. Key initiatives include CMS demonstration programs that integrate behavioral health and medical care while increasing accountability for cost, Affordable Care Act requirements for plans to cover behavioral health, and new payment policies that hold providers accountable for the total cost of care across medical, LTSS, and behavioral needs.[55] State Medicaid agencies are also reforming administrative, purchasing, and regulatory changes to make it easier for plans and providers to integrate behavioral health.[56]

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models/A_Standard_Framework_for_Levels_of_Integrated_Healthcare.pdf

[55] S. Klein and M. Hostetter (2014) "In Focus: Integrating Behavioral Health and Primary Care," *The Commonwealth Fund Quality Matters Newsletter*. Available at: http://www.commonwealthfund.org/publications/newsletters/quality-matters/2014/august-september/in-focus

[56] D. Bachrach et al. (2014) *State Strategies for Integrating Physical and Behavioral Health Services in a Changing Medicaid Environment*, Report prepared for the Commonwealth Fund. Available at: http://www.commonwealthfund.org/publications/fund-reports/2014/aug/state-strategies-behavioral-health

Continuum of Behavioral Health Collaboration / Integration

COORDINATED Key Element: Communication		CO-LOCATED Key Element: Physical Proximity		INTEGRATED Key Element: Practice Change	
LEVEL 1 Minimal Communication	LEVEL 2 Basic Collaboration at a Distance	LEVEL 3 Basic Collaboration Onsite	LEVEL 4 Close Collaboration Onsite with Some System Integration	LEVEL 5 Close Collaboration Approaching an Integrated Practice	LEVEL 6 Full Collaboration in a Transformed / Merged Integrated Practice
Behavioral health, primary care and other healthcare providers work:					
In separate facilities, where they:	In separate facilities, where they:	In same facility not necessarily same offices, where they:	In same space within the same facility, where they:	In same space within the same facility (some shared space), where they:	In same space within the same facility, sharing all practice space, where they:
• Have separate systems • Communicate about cases only rarely and under compelling circumstances • Communicate, driven by provider need • May never meet in person • Have limited understanding of each other's roles	• Have separate systems • Communicate periodically about shared patients • Communicate, driven by specific patient issues • May meet as part of larger community • Appreciate each other's roles as resources	• Have separate systems • Communicate regularly about shared patients, by phone or e-mail • Communicate, driven by need for each other's services and more reliable referral • Meet occasionally to discuss cases due to close proximity • Feel part of a larger yet non-formal team	• Share some systems, like scheduling or medical records • Communicate in person as needed • Collaborate, driven by need for consultation and coordinated plans for difficult patients • Have regular face-to-face interactions about some patients • Have a basic understanding of roles and culture	• Actively seek system solutions together or develop work-a-rounds • Communicate frequently in person • Collaborate, driven by desire to be a member of the care team • Have regular team meetings to discuss overall patient care and specific patient issues • Have an in-depth understanding of roles and culture	• Have resolved most or all system issues, functioning as one integrated system • Communicate consistently at the system, team and individual levels • Collaborate, driven by shared concept of team care • Have formal and informal meetings to support integrated model of care • Have roles and cultures that blur or blend

Source: B. Heath et al. (2013) *A Standard Framework for Levels of Integrated Healthcare*, p 10. Report created for SAMHSA-HRSA Center for Integrated Health Solutions. Available at: http://www.integration.samhsa.gov/resource/standard-framework-for-levels-of-integrated-healthcare

Section II: Case Reports

ArchCare (New York)

ArchCare is a healthcare organization operated by the Archdiocese of New York. ArchCare provides faith-based holistic care and seeks to improve the quality of life for frail and elderly people unable to fully care for themselves. The organization cares for vulnerable New Yorkers through five skilled nursing facilities that offer both short-term rehabilitation and long-term residential care, a home health agency, several health plans, and community resources including parish integration and Timebank program. ArchCare's health insurance products include: ArchCare Advantage, a Medicare Advantage Special Needs Plan for the institutionalized (I-SNP) launched in 2008 (1,567 members); ArchCare Senior Life, a PACE program founded in 2009 (487 members); and ArchCare Community Life, a Medicaid managed LTSS plan established in 2012 (2,043 members). This report first addresses the PACE program, which is the most integrated ArchCare product and then describes the organization's managed Medicare and Medicaid programs.

Medicaid MLTSS in New York	
Program Name	Managed Long Term Care (MLTC)
Year Established	1998
Covered Populations	Medicaid beneficiaries age 21 and older who are certified to require a nursing
Population Carve-Outs	None
Enrollment Approach	Mandatory for dual eligible individuals, voluntary for non-dual eligibles
Statewide Enrollment	137,705[57]
Covered Benefits	LTSS
Benefit Carve-Outs	Medical and behavioral
Dual Eligible Population	N/A

ArchCare Senior Life: A PACE Program

Background Information

PACE—the Program of All-Inclusive Care for the Elderly—is a fully-integrated healthcare and insurance program for elderly individuals who live in the community and require a

nursing home level of care. PACE programs are responsible for all of participants' medical, behavior, and LTSS needs, which are delivered via a personalized life plan through an integrated, multi-disciplinary care model. In addition to receiving LTSS in the home, PACE participants attend adult day health centers several times a week, where their care is overseen by an onsite interdisciplinary team led by a physician. The model dates back to a Medicare-funded demonstration of integrated

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[57] As of December 2015, New York Department of Health "Medicaid Managed Care Enrollment Reports." Available at:
https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

LTSS and medical care at On Lok Senior Health Services in the 1980s. The demonstration found that On Lok improved individual's care

at a 15% lower cost than traditional fee-for-service care. As a result of this success, Congress passed legislation in 1986 that named the program PACE and authorized additional demonstrations. The program became a permanent part of Medicare and a state option for Medicaid programs in 1997. PACE programs are fully-capitated and at risk for all Medicare and Medicaid benefits—a unique provision in the Medicare and Medicaid statutes enables this joint capitation. Most PACE programs are small, community-based organizations, and ArchCare is no exception. Growth of PACE programs have been challenged by requirements for up-front capital investment and operational cash flow along with education of providers and the community regarding the benefits of PACE.

PACE enrollees are frail with participants required to meet the state's Medicaid eligibility criteria for institutionalization. The program is designed to provide continuous, intensive care management for a high-risk population. In ArchCare's program, the average member is 78 years old, has 3 to 4 co-morbidities, and takes more than 6 medications. About half of the population has some level of dementia. ArchCare has three PACE sites—one each in Manhattan, the Bronx, and Staten Island. In addition, the Bronx has an ambulatory extension site with Staten Island awaiting approval.

Program of All-Inclusive Care for the Elderly (PACE)	
Year Established	1986
Covered Populations	Individuals age 55 and older who are certified to require a nursing home level of care
Population Carve-Outs	None
Enrollment Approach	Voluntary
National Enrollment	33,000[58]
Covered Benefits	Comprehensive (medical, behavioral, and LTSS)
Benefit Carve-Outs	None
Dual Eligible Population	90%[59]

In the PACE product, ArchCare is both the payer and the provider of care. Most medical care is provided by the ArchCare-employed interdisciplinary team at the PACE site. The program contracts out for services they cannot provide in-house; for ArchCare, this includes personal care and homemaker services, institutional long-term care, hospital and post-acute care, and medical specialists. ArchCare is in the process of implementing a community-based physician waiver program supporting participation of non-PACE physicians through a nurse practitioner model of care.

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[58] Integrated Care Resource Center (2015) "PACE Enrollment by State and by Organization, September 2015" Technical Assistance Tool. Available at: http://www.chcs.org/media/ICRC-PACE-program-enrollment-September-2015.pdf
[59] National Pace Association (2013) "PACE in Your Community: Understanding Pace Operating

Experience and the Critical Success Factors." Available at: http://www.npaonline.org/sites/default/files/PDFs/PACE%20Critical%20Success%20Factors%20White%20Paper.pdf

Care Management and Provider Organization

At each PACE site, a physician with geriatric expertise leads an 11-member care team. The care team includes an RN, a social worker, occupational, physical, and recreational therapists, a dietician, the van driver, and program administrative staff. The team also makes use of a consulting pharmacist and geriatric psychiatrist retained by ArchCare. Every morning, each location has a brief full-team meeting to review any overnight events, the status of members, and clinic updates.

Every PACE participant receives a comprehensive in-home assessment using New York Medicaid program's Uniform Assessment System (UAS) tool. Members are reassessed with the UAS at least every six months or following a major event like a hospitalization, fall, or change in functional capacity or cognitive function.

The UAS assessment informs the care planning process and development of a single "life plan" for the member incorporating results of the functional assessment and LTSS needs along with known medical needs and concerns of the member, family and/or caregiver. ArchCare organizes the life plan around diagnoses, which are driven by clinical codes (i.e., ICD Codes). Additionally, PACE reviews and addresses the social determinants of health. The plan is created and maintained in a care management system inclusive of an electronic health record, to which all members of the interdisciplinary team have access.

The PACE care team is able to implement much of the care plan directly at the center. Personal care services, homemaker services, and home-delivered meals are contracted out to agencies. ArchCare contracts with more than 50 agencies for personal care services, although 85% of members are seen by 15 agencies. Personal care aides are not considered part of the care team, but are overseen by the PACE RN through monthly in-home supervision. Additional oversight for home and community-based services is provided via an Electronic Visit Verification system, quarterly audits, grievances, and direct feedback from the member and family.

Transitions

Member hospital stays are closely managed and monitored by the PACE physicians. ArchCare usually learns about hospitalizations quickly through a personal care aide, a call to the 24/7 nurse hotline, or an alert from the Personal Emergency Response system. During the inpatient stay, the PACE physician communicates with hospital physicians and guides care. This entails not only sharing information regarding the member's history, care plan, and goals, but more importantly focusing hospital staff on treating the problem for which the member was admitted. The overarching objective is to meet the member's life plan goals, provide high-quality care, focus services on discharge from the hospital to the community, while preventing under-treatment, over-treatment and use of costly, low-value services. The overall strategy is to provide the right care and service at the right place and time with the right experience and cost. The physician continues to actively manage care if the individual is discharged to a post-acute facility.

Plan Incentives and Financial Results

ArchCare's PACE program receives two capitated payment streams: one from Medicare, and one from New York for Medicaid members. The program also has private-pay

members who supplement the Medicare payment out-of-pocket. Both payments are risk-adjusted, and the Medicare payment receives an additional frailty adjustment payment. Within those capitation payments, ArchCare is at risk for all Medicare and Medicaid benefits, and has both flexibility and accountability for how funds are spent. ArchCare's provider contracts are primarily fee-for-service but they are beginning to model and pilot value-based payment programs.

Difficulties in expanding are not limited to ArchCare. PACE programs have struggled to scale up—despite nearly twenty years as part of Medicare, there are only 35,000 participants nationwide. Barriers to expansion of PACE programs include the high startup cost of establishing a day care center and limited consumer demand which is impacted by the requirement that members attend adult day care, the requirement to leave their primary care physician for a PACE physician, and a lack of affordability for individuals who do not qualify for Medicaid. As more states move to managed LTSS, increasing competition from other HCBS providers in the same market is a growing challenge to PACE programs. There have been numerous attempts to modify the program to encourage expansion. In June 2015, CMS announced that for-profit organizations would be allowed to operate PACE programs, which may improve access to capital to launch new programs. In November 2015, President Obama signed the PACE Innovation Act, which allows CMS to develop pilot programs that expand the PACE model to new populations, including younger individuals, people with multiple chronic conditions and disabilities, seniors who do not qualify for institutional care under Medicaid, and others.

Utilization Management Strategy

PACE physicians are responsible for managing the appropriate utilization of services: inpatient stays, transitions of care, behavioral health issues, dialysis, and behavioral health issues, all in consideration of the personalized care required to support the member's goals and life plan.

The PACE interdisciplinary team is accountable at all times for members' life plan including use of health care services. During the week, members can come to the PACE site for urgent care. After hours and on the weekends, members and their personal care aides are strongly encouraged to call a 24/7 hotline staffed by PACE nurses and administrative staff if they have a problem. On-call staff will contact physicians or arrange for a home visit as needed—the program is equipped and staffed to deliver a wide range of medical interventions in the member's home. Members are also held accountable for inappropriate emergency room use. The first few times the member goes to the emergency room, ArchCare will pay the bill and remind the member to call the hotline in the future. For non-emergency situations, if the PACE team determines that a hospitalization is necessary, they will transport the member to a partner hospital. In the event of an emergency, the PACE participant will be transported to the nearest hospital. In either case, the PACE physician will closely manage their inpatient utilization (as described in the *Transitions* section above).

Quality Metrics and Performance Management

ArchCare's quality program is aligned with both New York and federal quality goals and reporting requirements. One influential program is the New York State Consumer

Guide for Managed Long-Term Care.[60] This is a five-star rating system for the state's MLTSS plans based on safety measures, preventive measures, and consumer surveys. Internally, ArchCare focuses on a dashboard of key metrics designed to improve health and healthcare while managing cost. These metrics include emergency room visits, inpatient stays (currently achieving goal of <6%), readmissions (currently achieving for goal of <15%), falls prevention, immunizations, dental visits, pain management, advance care planning, grievances, and disenrollments. The plan further monitors member experience through satisfaction surveys, benchmarking their grievance rate to other plans in the region, and comparing their retention rate to other plans in each market. New York has implemented a quality incentive program that allows high-performing plans to earn additional premium.

ArchCare describes person-centeredness as encouraging, promoting and supporting members to retain their quality of life as we transition from a provider-centric healthcare system. Practically, this is implemented by managing clinical goals and care plans in the context of the individual's holistic health, behavioral, and social issues. Care team members explain the connection between healthy behaviors and member goals, and then share responsibility for outcomes with the member.

Key Integration Strategies and Outcomes

ArchCare's primary integration strategy for the PACE program is positioning the interdisciplinary team as a single point of accountability for member health and healthcare coordination to deliver measurable cost and quality outcomes. The team approaches member care holistically and strategically, using a problem-solving team approach. The team constantly evaluates its own performance to ensure high-quality, cost-effective care. Another key integration strategy is the team's efforts to identify the underlying causes of member outcomes and work to address those drivers. Oftentimes, the root cause is behavioral, and the team works to engage, educate, and empower members and caregivers for better self-management of health. These strategies are not only specific to ArchCare, but are to some extent intrinsic in PACE's team-based model of care.

A couple of distinguishing attributes underpin ArchCare's success in integration. The first is a strategic approach to selecting partners. ArchCare contracts or partners with organizations that share their goals of quality, access, and responsiveness, to deliver the full spectrum of care and support to members in the community, including home-delivered meals, personal care services, and specialist care. PACE itself is a specialty provider directly employing its interdisciplinary team based in the centers. Another key attribute supporting ArchCare's success is an evidence-based approach to interventions that extends beyond medical care to social services. For promising interventions—for example, music therapy for behavioral management in dementia patients—ArchCare conducts in-house studies to assess financial impact. Explicitly demonstrating the value of non-traditional services justifies investment in their sustainability.

ArchCare's PACE program has demonstrated value by achieving a Four STAR rating by both CMS and that state of New York. Along with these external measures, it has seen

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[60] For more information, see:
https://www.health.ny.gov/health_care/managed_care/mltc/consumer_guides/

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hospitalizations and institutionalization below industry benchmarks. Satisfaction measures indicate members are satisfied with the program—retention is very high subject to expiration of life. Plan management is desirous of engaging in a properly designed quantitative study to confirm the PACE program keeps members in the community meeting the life goals of its members through better health, better healthcare, quality, and satisfaction all at a lower cost of care.

ArchCare Managed Medicare and Medicaid Programs

Background Information

ArchCare also operates two insurance products in addition to the PACE program: ArchCare Advantage, an I-SNP launched in 2008 with 1,567 members and ArchCare Community Life, a Medicaid managed LTSS plan established in 2012 with 2,043 members.

ArchCare operates specialized Medicare Advantage products for members who reside in a nursing home (an I-SNP) and for members who require an institutional level of care but reside in the community (an IE-SNP). These plans cover Medicare benefits, which do not typically include LTSS.

ArchCare Community Life is a plan in New York's Managed Long Term Care (MLTC) program. A number of members participate in both I-SNP and MLTC which provides a venue for coordinating Medicaid and Medicare benefits and offering a comprehensive package of services with a person-centered focused.

Across the I-SNP, MLTC, and PACE products, ArchCare has different tools to manage member care. I-SNP and MLTC care coordination is not as streamlined as in the PACE program, but ArchCare's care

management systems are designed to coordinate care as best as possible. A key differentiator is not having the onsite participation of members in a social day care setting which PACE offers and needing to coordinate care with multiple primary care physicians in the community. Building trust through communication amongst and between members, families, care teams, physicians, therapists and all key stakeholders is integral to identifying life goals and successfully translating them into life plans for team members to support.

Care Management for Integrated Members

Each I-SNP and MLTC member has a dedicated ArchCare care team consisting of a social worker and a nurse. Members receive a comprehensive, in-home assessment using New York's UAS assessment which includes clinical status, functional needs, strengths, and individual goals and preferences. This assessment serves as input to clinical and social service teams as they meet and work with members, their physicians and caregivers to develop life plans reflective of the member's life goals. The life plans are shared with the member's primary care provider, with the goal of partnering for ongoing care coordination. Members are reassessed at least every six month or following a change in condition, hospitalization or a member request for additional services.

Following the initial assessment, all care management is telephonic through communication with the personal care aides, member and caregivers. Risk stratification determines the frequency of care manager contact with the member: high-risk members are called at least three times a week, moderate-risk members are called weekly, and low-risk members are called monthly.

Financial Incentives

For the MLTC plan, ArchCare is capitated and at risk for members residing in the community or a long term care facility requiring LTSS. New York is transitioning to value-based payments and has implemented a quality incentive program that offers high-performing plans the opportunity to earn additional premium dollars. New York is also requiring transition from fee-for-service to value-based payments to providers over the next several years.

The I-SNP plan receives a single capitation that covers Medicare part A and B services along with Part D pharmacy. This premium is also impacted by STAR ratings reflective of quality performance. This plan sub-capitates nursing homes for Medicare-covered post-acute skilled nursing stays, but otherwise pays providers on a fee-for-service basis.

The health and healthcare goals for each of these programs are similar with regard to management of hospital admissions and readmissions, emergency room visits, prevention and quality. However, the financial structures for premium, medical expense, administrative expense and return from

innovation are not aligned. For example, the value from investments in new programs and initiatives made through the MLTC program rarely returns to the MLTC program and more often accrue to the Medicare payer. This can become a barrier to quality performance improvement and innovation.

Barriers to Effective Care Management

Care management and coordination is more difficult for members who receive only part of their coverage from ArchCare whether it is only I-SNP or only MLTC. Managing transitions is difficult for MLTC members who receive medical coverage elsewhere as there are likely additional care coordinators involved potential causing confusion for members and duplication of effort. Hospitals are reluctant to share member information with ArchCare when they are not the payer for the admission. Similarly, ArchCare has difficulty in coordinating care for I-SNP members who receive Medicaid LTSS from a different organization. For these individuals, personal care aides are less likely to notify the ArchCare care manager if the member's condition changes, and discharge planning is particularly difficult since ArchCare is not paying for the LTSS.

Health Plan of San Mateo (California)

Background Information

Health Plan of San Mateo (HPSM) is a county-operated Medicaid plan in California that has been in operation since 1987. Nearly all Medicaid beneficiaries in San Mateo County receive their coverage through HPSM. The plan covers medical, LTSS, and some behavioral health. Behavioral health benefits for the severely mentally ill are carved out. For most Medicaid beneficiaries in the county, enrollment in the plan is mandatory for medical and LTSS coverage. Medicaid MLTSS is a recent development in California. Institutional LTSS was carved into HPSM's contract in 2010 and adult day health in 2012. Other community-based LTSS were only added in 2014 as part of California's Coordinated Care Initiative. The Coordinated Care Initiative is being implemented in seven counties (including San Mateo County), and consists of two components: (1) the launch of mandatory MLTSS for Medicaid beneficiaries, including dual eligibles, and (2) California's Duals Demonstration program—Cal MediConnect.[61]

145,000 individuals are enrolled in HPSM.[62] Approximately 5,500 members receive LTSS in the community, and an additional 1,200 are institutionalized. In addition to providing Medicaid coverage, the plan has operated a D-SNP for dual eligible members since 2006, and began operating an MMP in April 2014 as part of Cal MediConnect. Three-quarters of HPSM's dually eligible members, about 10,000 beneficiaries, have their Medicare coverage

Medicaid MLTSS in California	
Program Name	MLTSS
Year Established	2014
Covered Populations	Medicaid beneficiaries age 21 and older in seven CCI counties
Population Carve-Outs	Individuals under age 21 PACE and AIDS Healthcare Foundation Enrollees Residents of ICF/DD facilities
Enrollment Approach	Mandatory
Statewide Enrollment	Not available
Covered Benefits	Medical, LTSS, and some behavioral
Benefit Carve-Outs	Behavioral health benefits for the severely mentally ill
Dual Eligible Population	Not available

with HPSM. Most of these members are in the MMP, and only those who are not eligible for MMP remain in the D-SNP. The other 25% of dual eligible members who do not have their primary medical coverage with HPSM are enrolled in Original Medicare, a D-SNP operated by Kaiser Permanente, or other Medicare Advantage plans. Regardless of primary payer, HPSM manages all complex members with a unified care coordination model. For this study, HPSM described their overall care model for all members with LTSS needs, across products.

As the sole Medicaid plan in the county, HPSM has long-standing relationships with many regional medical providers. The plan actively engages with the provider network, identifying barriers to high-quality, cost-effective care

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[61] Please refer to Appendix B for more information on Medicaid MLTSS programs in California.
[62] As of December 2015. Source: Communication with HPSM.

and using their leverage as a payer to encourage improvements. Since becoming responsible for institutional care in 2010, the plan also works with 10 of the 11 SNFs in the county. Plan leadership has also engaged in extensive outreach and relationship-building with the county and community organizations that provide LTSS and behavioral health. The plan meets regularly with all of these partners, and the ongoing stakeholder engagement has proven valuable to achieving improvements in member care. As HPSM has engaged with the LTSS system in their region, they have been able to identify problems and address them directly with the managers of those services.

Care Management and Provider Organization

HPSM has reorganized to become more integrated internally, and this is most clearly seen in the care management team. The plan has eliminated silos between LTSS and medical care teams, improved information sharing, and decreased duplication. This has required significant growth of and a shift in focus for the care management function. In the past, most care managers were nurses with hospital experience and focused on utilization and inpatient management. Today, HPSM care managers have much broader responsibilities for care coordination. Social workers and unlicensed care coordinators have been added to the team. HPSM has made a cultural shift in the approach to staffing. The plan now emphasizes competency in addressing members holistically, and has shifted to hiring individuals with backgrounds in psychosocial issues.

California Duals Demonstration	
Program Name	Cal MediConnect
Initial Enrollment	April 2014
Covered Populations	Full-benefit dual eligibles in seven CCI counties
Population Carve-Outs	Individuals under age 21 ID/DD individuals Partial-benefit dual eligibles
Enrollment Approach	Passive with opt-out
Statewide Enrollment	125,257[63]
Opt-Out Rate	70%[64]
Covered Benefits	Medical, LTSS, and some behavioral
Benefit Carve-Outs	Behavioral health benefits for the severely mentally ill

All HPSM care management staff share a home organizationally—the function is "line of business blind." This means that all members are managed in the same system, and care management staff are overseen by the same leadership teams, irrespective of the member's primary payer. Care managers have access to clinical support from HPSM's medical directors, the Deputy CMO (a psychiatrist), clinical pharmacists, social workers, and nurses.

All HPSM members are eligible for care management. There are three tiers of risk: routine, moderate, and high-need. All members receiving LTSS are in routine care management, or more intensive care management if necessary. Members are identified for care management through HRAs, care coordination requests, data on transitions, and patterns of over- or underutilization. HRAs are administered upon

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[63] As of January 2016: http://www.calduals.org/wp-content/uploads/2016/02/CMC-Enrollment-Dashboard-January-Final.pdf

[64] As of January 2016: http://www.calduals.org/wp-content/uploads/2016/02/CMC-Enrollment-Dashboard-January-Final.pdf

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enrollment and annually for dual eligible members in the MMP, D-SNP, and for Medicaid-only members who are seniors and persons with disabilities.[65] For members at the lowest level of need, the plan provides telephonic outreach and coordination, primarily using unlicensed care coordination technicians. Members with a moderate level of need receive more intensive care management, including home visits, with a nurse or social worker taking the lead. Generally, about 500 members are in this intermediate level of care management at any time. This level of care is intended to be short-term and intensive, with members returning to routine telephonic management once their transitional needs are addressed. A small number of the most complex individuals are identified as high-need. These members are enrolled in a very intensive case management program, the Community Care Settings Pilot, described in more detail below.

A care plan is developed for every member in care management. Care plans are organized around function and need, not diagnosis. This approach to care planning is based on the plan's experience that high-risk members are not necessarily those suffering from serious chronic illnesses or multiple co-morbidities. Many of those individuals may be stable and managing their health well. In contrast, the highest-risk members are those who are not connected to the services and providers they need.

Plan staff implement care plans by leading the care team, working with the member and their PCP, and coordinating county and community

LTSS providers. HPSM is not a provider organization, and instead sees the plan's role as supporting the PCP-member relationship. Care management staff steer members towards providers with whom the plan has a strong relationship—like the Ron Robinson Senior Care Center—which facilitates information sharing and care coordination. HPSM has also created formalized relationships with LTSS providers, which helps the plan to quickly meet member needs and coordinate care. Essentially, the plan has vertically integrated with local LTSS providers, and in this way is able to influence care.

Transitions

HPSM requires that hospitals notify the plan quickly of member admissions. Plan management has engaged with hospitals directly to reinforce the importance of timely notification, and in some cases has leveraged contract power to ensure hospital compliance with this request. Hospitalized members are managed by a dedicated inpatient review and care transitions team. This team follows members from admission through 30 days post-discharge, working closely with a unit focused on prior authorizations. The inpatient team provides concurrent inpatient review and discharge planning assistance during the inpatient stay, and then manages transitions using the Coleman model[66] after discharge. If

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[65] California's Seniors and Persons with Disabilities (SPD) Medicaid category corresponds to what most states refer to as the "aged, blind, and disabled" population. Their coverage is often closely linked to eligibility for the federal SSI program.

[66] The Care Transitions Program (http://www.caretransitions.org/) was developed by Dr. Eric Coleman to improve care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as they move from hospital to home, the Care Transitions intervention is composed of: 1) a patient-centered Personal Health Record that contains all essential care elements, 2) a structured Discharge Preparation Checklist, 3) a session with a Transitions Coach in the hospital prior to discharge, and 4) follow-up visits and phone calls from the Transitions Coach in SNF or in home.

the member has ongoing care management needs beyond 30 days post-discharge, they are referred to the general care management team. If no ongoing needs are identified, the case is closed.

Community Care Settings Pilot

HPSM launched the Community Care Settings pilot in late 2014. This intensive transitional management program combines intensive care management with housing coordination services to move institutionalized members back in to community-based settings. The plan uses predictive analytics to target the intervention to a small set of members, and in the first year was able to move 53 members out of institutions. The pilot recovered its full start-up costs in the first year of operation through direct savings, and returns are expected to increase as the program further matures. The program is growing quickly, and in addition to 87 clients in the active caseload, there are about 100 individuals on the waiting list.[67]

Four groups of members are targeted for the pilot program. In order of priority, these are dual eligible institutionalized members, dual eligible members in rehabilitation facilities as risk of long-term institutionalization, Medicaid-only institutionalized members, and community-dwelling members at risk of institutionalization. Once members are enrolled in the program, they receive a comprehensive in-person assessment and six months to a year of intensive care management services—care managers typically follow only 15 to 20 individuals. Social workers serve as care managers for the program, with support from HPSM's clinical staff as needed. Members also receive specialized housing coordination services to locate and secure appropriate,

affordable housing in the community. HPSM contracts with Institute on Aging (IOA) for care management services and Brilliant Corners for housing coordination services. The program is overseen by the "Core Group," which includes HPSM's clinical leadership, representatives from county behavioral health and LTSS providers, and IOA's care management staff. The Core Group meets frequently to review member's cases and address barriers to care, with a special focus on challenges with county systems and providers.

Plan Incentives and Financial Results

For individuals receiving acute care and LTSS, HPSM receives capitated payments either from Medicare and Medicaid (for dual eligible members), or a single capitated payment from Medicaid (for Medicaid-only members). Within this capitation, the plan is at risk for medical, LTSS, and some behavioral health. Behavioral health benefits for the severely mentally ill are carved out. A portion of the capitation is at risk contingent on the plan achieving quality metrics specified by CMS and the state. The plan does not share financial risk with providers.

For the Duals Demonstration, rates are set based on five individual categories that are aggregated to create a blended population rate: institutionalized individuals, members using adult day care, high-need members using HCBS, all other members using HCBS, and community well. This rate-setting methodology creates incentives for HPSM to transition members from institutions to HCBS. If the plan beats the expected rate for institutionalization, they can keep any savings until a new blended rate is set the following year. For Medicaid-only members, however, rates are experience-based. This means there are no financial incentives for moving these

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[67] Caseload data as of October 2015.

members into the community as the state captures all savings of any shift away from institutions.

HPSM is "mission-driven, not margin-driven," and thus only needs to break even to be financially sustainable. Nevertheless, plan management believe their care model could be profitable in any market due to the value it generates system-wide. The benefits of the plan's integration efforts extend beyond the healthcare system, and spill over into the region's criminal justice system, human services, and emergency services, just to name a few. This value is significant enough that venture capital and private equity firms routinely approach the plan.

Utilization Management Strategy

HPSM's utilization management strategy for members with LTSS needs is based on a clear theory of change for improving outcomes for this population. Plan leadership believes that coordinating care and connecting members to needed LTSS drives clinical outcomes and member satisfaction, and keeps members in the community. Those intermediate outcomes lead to financial results.

Moving members out of institutions is HPSM's most significant utilization management tactic. Historically, the plan has had a higher rate of institutionalization than peers. This problem is compounded by a regional shortage of SNF beds and the lack of affordable housing in the Bay area. A year of care in a SNF costs $150,000 while the plan can serve high-need members in the community for $20,000 annually. The success of the Community Care Settings pilot in moving more than 50 members out of institutions has therefore generated more than $6.5 million in annual cost avoidance for the plan.

Quality Metrics and Performance Management

California requires that Medicaid managed care plans participate in state quality programs, which focus on measures related to population health, including prenatal care, tobacco cessation, and diabetes management.[68] More relevant to HPSM's efforts on LTSS integration are the quality incentives in the Duals Demonstration. The federal government is withholding a portion of the capitation rate for plans participating in demonstrations across the country based on the achievement of certain quality metrics. In the first year, plans are being assessed based on completion of initial assessments within 90 days of enrollment, creation of a consumer advisory board, customer service surveys, timely submission of encounter data, and timeliness of appointments and care.[69] Beyond these federal requirements, California is collecting additional metrics as part of state-specific quality withhold program. Metrics for California Duals Demonstration plans are documentation of care goals, coordination with behavioral health providers, individualized mental health care plans, member contact with care coordinator, physical access compliance, and additional encounter data specifications.[70]

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[68] The most recent state performance report for HPSM can be found here: http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/0914PlanSpecificPerfEvals/2013-2014PlanSpecPerfEvals/HPSM_CA2013-14_PerfEval_Report.pdf

[69] See this CMS guidance for more detail: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidance060614.pdf

[70] See this CMS guidance for more detail: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-

HPSM is closely monitoring these demonstration metrics.

HPSM anchors their quality strategy on the Triple Aim: care outcomes, member experience, and cost outcomes. In addition to looking at three key performance indicators tied to the Triple Aim, the plan monitors a large number of measures that cascade under each of the three branches. Most of the measures the plan tracks are process measures. In addition to Duals Demonstration and Triple Aim measures, HPSM leadership monitor utilization rates, Medicare Star ratings, and HEDIS results.

Care manager performance is assessed largely with process measures. These measures include care plan completion timeliness, timely handling of care coordination requests, documentation appropriateness and timeliness, and member experience.

Person-centeredness has been a long-standing value at HPSM. Although the plan only recently became responsible for LTSS, the plan has always tried to provide a seamless experience for members. Historically, the plan has advocated for limiting carve-outs and worked to provide a holistic benefit package. Today, the plan uses the principles of human factor design to create processes that best meet member needs. Plan leadership seeks to organize the business around the member, which in some cases has required major deviations from standard health plan operations.

Key Integration Strategies and Outcomes

HPSM's integration strategy is predicated on a deeply-held cultural commitment to addressing the full person, with a special focus on LTSS, behavioral, and social needs. This is operationalized by limiting carve-outs and offering a benefit package that is as holistic as possible. HPSM also works to identify member needs proactively, and then to provide services based on member needs. Although this is a simple idea, it can be challenging to achieve in practice. Historically services were provided more on the basis of state program rules than on individual member needs. The plan's care model is facilitated by the fact that, unlike many other states, California does not specify the approach to member assessments and targeting in contracts with managed care plans. This has allowed HPSM the flexibility to iteratively develop and refine their approach to care management. Another key enabler of HPSM's integration strategy has been the investment in an electronic case management system. This platform allows the plan to do the risk stratification and care coordination at the core of the care model. The system was installed in 2014, laying the foundation for financial results, which the plan expects to achieve in 2016.

HPSM leadership recognizes that addressing the full person requires more than the coordination of Medicaid and Medicare benefits. Instead, it is necessary to coordinate all community resources an individual receives, to ensure that incentives are properly aligned. The plan's status as an independent government organization serving San Mateo County has allowed them to take a leadership role in this coordination effort for the region. HPSM is accountable to the public and has been deeply embedded in the community for years, and as such has been able to act as an organizing entity for stakeholders and broker of relationships. The plan provided necessary leadership for an effort that was already consensus and commitment to within the regional social services and public health

Office/FinancialAlignmentInitiative/Downloads/DY1 QualityWithholdGuidanceCA.pdf

community. HPSM has been able to bring other entities—like hospitals and other providers—to the table through their role as a major payer. Personal relationships among staff who have moved between the different organizations have also facilitated the effort.

The result of HPSM's leadership has been to create an "ecosystem of trust" among the various stakeholders. This is prerequisite to coordinating community resources and aligning incentives. Specifically, the relationships have allowed the plan to address barriers to care and achieve better results for members. The Community Care Settings pilot has been a key test of this process. The direct savings of the pilot have been substantial, averting more than $6 million in nursing facility costs in the first year of implementation. HPSM believes that the pilot is also generating tremendous indirect value. Plan management have used the project to engage with providers on identifying system issues, testing solutions, and quickly systemizing solutions that prove effective. The true value of the pilot has been its effectiveness in changing the culture of the community around the plan, influencing county agencies and medical, LTSS, and behavioral health providers. As a result, HPSM is not only advancing integration within the plan, but is also promoting a culture of integration in the broader community.

Superior STAR+PLUS (Texas)

Background Information

STAR+PLUS is Texas's Medicaid MLTSS program for people age 21 and older with disabilities and those age 65 and older. STAR+PLUS is a mandatory program, which means that eligible individuals must enroll in a managed care plan in order to receive Medicaid benefits. The program covers a comprehensive benefit package that includes medical, LTSS, and behavioral health. Institutional LTSS was carved into the STAR+PLUS program in early 2015. LTSS for individuals receive IDD-waiver services are carved out and managed by the state.[71]

Superior HealthPlan, a Centene subsidiary, has participated in the STAR+PLUS program since 2007, and in 2015 had approximately 148,000 members in the plan.[72] About half of the plan's members are dual eligible, but only a few hundred have Medicare coverage with Superior. Most of Superior's dual eligible STAR+PLUS members receive their primary medical coverage from Original Medicare (i.e., fee-for-service) or from Medicare Advantage plans operated by other organizations.

Medicaid MLTSS in Texas	
Program Name	STAR+PLUS
Year Established	1998
Covered Populations	Disabled adults age 21 and older
	All Medicaid beneficiaries age 65 and older
Population Carve-Outs	None
Enrollment Approach	Mandatory
Statewide Enrollment	524,730[73]
Covered Benefits	Comprehensive (medical, behavioral, and LTSS)
Benefit Carve-Outs	IDD Waiver services
Dual Eligible Population	214,328[74]
Population Using LTSS	71,239[75]

For medical services, Superior operates a preferred provider network that helps members choose higher quality and lower cost physicians and hospitals. The plan cannot operate a preferred provider network for LTSS, because the state has required the plan to contract with all traditional providers during

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[71] Please refer to Appendix B for more information on the STAR+PLUS Medicaid MLTSS program in Texas.

[72] As of June 2015. Author calculations from *Texas Medicaid and CHIP Financial Statistical Reports for 2015*. Available at: http://www.hhsc.state.tx.us/medicaid/managed-care/financial/

[73] Texas Health and Human Services System (2015) *2015 Texas HHS Fact Book*, page 40. Available at: http://www.hhsc.state.tx.us/reports/2015/fact-book.pdf

[74] Texas Health and Human Services Commission (2012) *Texas Dual Eligibles Integrated Care Demonstration Project: Application*, page 7.

Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/TXProposal.pdf

[75] As of June 2012. B. Jackson et al. (2013) *Quality in MLTSS Programs* Report for ASPE Office of Disability, Aging and Long-Term Care Policy. Available at: https://aspe.hhs.gov/report/quality-managed-long-term-services-and-supports-programs

the first few years of the program. Under these rules, even terminating a contract for poor performance can be challenging.

Care Management and Provider Organization

The core care team for STAR+PLUS members receiving LTSS consists of the member and their informal caregivers, their service coordinator (a Superior staff member), their PCP, and paid caregivers (Superior contractors). Members who have primary medical coverage with Superior (i.e., non-duals) are required to select a network PCP when joining the plan, who is then responsible for authorizing services. The service coordinator is responsible for communicating with the other members of the team, and may also draw on the expertise other specialists on Superior's staff as needed, including behavioral health specialists, health coaches, pharmacists, and medical directors. Engaging PCPs in the LTSS care plan is a major challenge for the plan, especially for dual eligible members who have primary medical coverage through Original Medicare or another Medicare Advantage plan. For these individuals, members may not have a PCP, or may see a PCP who is not in Superior's network. It can be very difficult to engage non-network providers in care management.

Superior's care management process (also known as "service coordination") is largely organized around fulfilling state contract requirements.[76] The state has specified three tiers of complexity for managing members. The most intensive tier—Level 1—includes any individual who is receiving a waiver-covered

service,[77] as well as all institutionalized members.[78] The middle tier—Level 2—includes members who are receiving any LTSS service. All remaining members are assigned to the least intensive tier—Level 3. This service-specific stratification process can sometimes lead to situations where relatively stable and low-risk individuals are assigned to the most intensive level of management because they have previously received a home modification, which is a waiver-covered service. Similarly, very complex individuals who are not receiving any services might be classified to Level 3 under these criteria. To remedy this situation, Superior assigns all individuals they identify as complex and high-risk to Level 1. A little less than half of Superior's STAR+PLUS population is in Levels 1 and 2, and a little more than half is in Level 3.

All Superior STAR+PLUS members are assigned to a service coordinator employed by the plan, whose background is determined by the tier in which the member is stratified. Level 1 individuals are managed by an RN, Level 2 by a social worker or an LVN, and Level 3 by an unlicensed coordinator with appropriate relevant experience. The plan further assigns members to service coordinators with special

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[76] For more details on the state's requirements for contractors, see the most recent STAR+PLUS contract available here: http://www.hhsc.state.tx.us/medicaid/managed-care/contracts/STARPLUS-MRSA-contract.pdf

[77] Many states offer Medicaid beneficiaries non-institutional LTSS through Section (§)1915(c) HCBS Waiver Programs, which enable states to target services by age and diagnosis and to offer them on a less than statewide basis. For more information on waiver programs, see J. O'Keeffe et al. (2010) *Understanding Medicaid Home and Community Services: A Primer* Report for ASPE Office of Disability, Aging and Long-Term Care Policy. Available at: https://aspe.hhs.gov/sites/default/files/pdf/76201/primer10.pdf

[78] Institutional LTSS was carved into the STAR+PLUS program in early 2015, and administrative processes for these members continue to evolve and are still being integrated.

training (e.g., behavioral health specialists) as needed.

Outreach is attempted for all members to complete an initial health risk assessment (HRA) within 30 days of enrollment. In addition to this HRA, the state requires that Superior complete lengthy, paper-based, service-specific assessments in order for members to receive LTSS.[79] These forms are not designed to create a holistic view of member needs and goals, but are oriented more towards appropriately authorizing covered benefits. These assessments are conducted when members or their providers first request services, and reassessments are done annually as authorizations expire. A change in member condition or an acute event may lead to a provider or member request for additional services or hours, which will trigger a new assessment. For institutionalized members, the service coordinator's role is somewhat different. For these individuals, the service coordinator primarily reviews facility assessments and care plan. The service coordinator is also responsible for assessing members who are candidates for repatriation and ensuring that resources are in place members when they transition to the community.

For individuals who receive waiver-covered services, the state requires service coordinators to create an individualized service plan that lists all of the services the member receives. These service plans are created in an electronic record system and can be shared electronically with PCPs and other providers through a web-based portal. State assessments are attached to the record as scanned PDFs.

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[79] The Texas basic Needs Assessment Questionnaire can be accessed here: https://www.dads.state.tx.us/forms/2060/

Service coordinators meet with members in accordance with state contract requirements. Institutionalized members must receive four face-to-face visits from the service coordinator annually, community-dwelling Level 1 members must receive two visits, Level 2 members receive one visit, and Level 3 members may be managed by telephone. Beyond these requirements, the service coordinator has discretion in how they manage the member, and may do more frequent outreach to coordinate the member's care. Service coordinators are also responsible for overseeing care, and follow-up with members directly to confirm that services are being delivered. The state requires the plan to submit attestation forms for receipt of services signed by the member. Texas is also planning on implementing EVV for service monitoring, which will enable greater plan oversight of LTSS providers.

Superior has a more intensive level of care management for the most complex, highest-risk members. This care management process is not part of state contract requirements, but is something the play does to improve the quality and manage the cost of care for high-risk individuals. The plan's care model for this population follows NCQA's standards for complex care management. The plan identifies members for this level of management using predictive analytics and a risk stratification process. These high-need individuals are assigned to a Level 1 RN for care management, who completes a holistic assessment of the member and creates a comprehensive care plan organized around the member's needs. That member is then followed by the RN with a much higher level of outreach, coordination, and care management until they are stable. Most members in this intensive level of management are stabilized

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within six months, although some may need more or less time.

Transitions

Superior typically learns of hospitalizations fairly quickly for members who have medical coverage with Superior. For these members, hospitals contact the plan for admission authorization—Superior requires hospitals to preauthorize elective admissions and to report urgent/emergent admissions within one business day. If the member receives their primary medical coverage from Original Medicare or another Medicare Advantage plan, Superior may not be notified of hospitalizations.

Once an individual is hospitalized, they are followed by Superior's medical management team. This team also manages discharge planning and transition services, but will involve the service coordinator to the extent that new assessments and additional LTSS are required following the hospitalization. The named service coordinator assists in discharge planning and resumes full responsibility for the member at discharge.

Plan Incentives and Financial Results

For the STAR+PLUS plan, Superior receives a two funding streams from the state: one payment for medical and LTSS, and a separate payment for pharmacy benefits. The plan is at full risk for providing medical, behavioral, and community-based LTSS. For community-dwelling members, there are four different rate categories: dual eligible receiving waiver services, other dual eligible, non-dual eligible receiving waiver services, and other non-dual eligible. The rate is based on encounter data from the previous year, trended forward based on the growth in medical costs and adjusted to incorporate any provider rate enhancements and benefit package changes.

The medical part of the premium is risk adjusted based on the plan's population acuity, but the LTSS part of the premium is community-rated—every plan receives the same rate, regardless of how many of their members require LTSS or the intensity of their LTSS need. The plan reimburses providers on a fee-for-service basis using Medicaid rates set by the state, and does not sub-capitate or otherwise share financial risk with providers.

Texas carved institutional LTSS benefits into the STAR+PLUS program in 2015. The state pays a separate capitation rate for institutionalized members than those receiving community-based LTSS. If an individual moves from one setting to another, the capitation payment is adjusted the following month. Because of this rate structure, there is no financial incentive for plans to keep individuals in the community or to move individuals out of institutions and back into the community. However, the state does offer some incentives for HCBS through the quality incentive program—one of the measures plans are accountable for is nursing home admissions.

Texas has an experience rebate program with managed care plans that limits profit margins. The state evaluates Superior's margin across all products, with a target of a pre-tax net income of two percent. The plan can keep the first three percent of profits, but must return a share of any profit above that. The share returned to the state increases on a sliding scale until 12 percent profit, at which point the plan must rebate all additional earnings. If Superior is unprofitable, however, the state does not share in any downside risk.[80] This program limits plan incentives to invest in

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[80] For more details on the experience rebate program, see this policy brief: http://www.ahcancal.org/advocacy/issue_briefs/Issue%20Briefs/MLR_IB_final.pdf

cost-saving innovations, as the state quickly captures most of the financial benefits. Additionally, the state limits plan administrative expense, both setting a cap on total expense and specifying categories of allowable and non-allowable expenses. This further influences plan behavior by limiting investment in services that might be considered administrative but that ultimately increase cost-effectiveness.

Superior has experienced strong enrollment growth since joining STAR+PLUS, and is now one of the largest plans in the program with 27 percent market share.[81] Plan leadership also notes that the organization has succeeded in slowing the capitation growth rate without sacrificing quality of care. In the recent past, Superior's rates have risen more slowly than average healthcare costs in the state.

Utilization Management Strategy

Superior's overarching utilization management goal is to shift spending away from hospital and the emergency department care and toward primary care, preventive care, LTSS and other lower cost services. The plan has a range of utilization management strategies, including preauthorizations for inpatient admissions and other high-cost outpatient services (e.g., outpatient surgery, high-tech imaging, therapies, etc.). The plan also uses concurrent review, discharge planning, and

transition management as tools to improve the quality of care.

Superior's LTSS utilization management strategy is predicated on matching services to unmet needs—this requires not only identifying member needs but also evaluating which needs are already being met through personal and community resources. The plan also uses a cost threshold as a tool for limiting the total cost of LTSS service plans. Within the cost threshold, the plan allows service coordinators greater flexibility in authorizing additional services for the member. As the member approaches the threshold, the service coordinator can leverage additional resources from the community and informal caregivers. Above the cost threshold, the plan may strategically provide services on a case-by-case basis to avoid hospitalization, delay institutionalization, or improve quality of life for the member. Regardless of the results of the cost threshold analysis, members always receive the necessary services to remain healthy and safe in the community.

The plan's intensive care management approach for high-risk individuals described above is an important tool for managing costs and improving outcomes. The plan analyzes financial and clinical data to identify members at the highest risk of high-cost outcomes, and then targets greater levels of outreach, care coordination, and services to these individuals. These members' service coordinators work to proactively identify interventions that improve the quality and reduce the cost of care. Data sources for risk stratification include HRAs, medical and pharmacy claims, authorizations, and quality gaps in care. This strategy relies on access to medical data, and is consequently not feasible for dual eligible members who do not have Medicare coverage with Superior.

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[81] Texas Health and Human Services Commission (2015) *Texas Healthcare Transformation and Quality Improvement Program: Section 1115 Quarterly Report,* page 6. Available at: https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Healthcare-Transformation-and-Quality-Improvement-Program/tx-healthcare-transformation-qtrly-rpt-oct-dec-2015.pdf

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Quality Metrics and Performance Management

Texas has robust quality measurement and reporting programs for Medicaid managed care, including the STAR+PLUS program. MCOs must share encounter data, HEDIS measures, CAHPS survey data, and measures of potentially preventable admissions, readmissions, and emergency department visits. Measures specific to LTSS include the number of STAR+PLUS members entering a nursing facility as well as the number who return to community services. The state operates a web portal where MCO and state staff can view quality results by health plan, service area, provider, and demographic subpopulations. The state does not have this data for dual eligible individuals with Original Medicare coverage. Following a legislative mandate, the state began publishing MCO report cards on the state website.[82]

The state has established a number of financial incentives and penalties related to quality. A share of each MCO's capitation payment is placed at risk based on quality outcomes—in 2015 and 2016, four percent of Superior's STAR+PLUS revenue was at risk in the quality program. If any MCOs fail to earn back the full at-risk share of their capitation, the remaining amount is used to fund bonus payments to reward plans with higher performance.

Superior actively monitors financial, clinical, and member experience outcomes. The primary financial metrics of interest are the health benefits ratio and capitation growth rate. Clinical measures the plan tracks include

hospitalizations, readmissions, potential preventable events, diabetes measures, medication adherence, and HEDIS scores. For member satisfaction, the plan relies on CAHPS data. The plan's quality management approach is not limited to compliance with state requirements. Superior also collects data on outcomes that are not required but are meaningful for the STAR+PLUS population like risk of falls, medication review, and pain management.

The state requires MCOs to conduct quality oversight of PCPs and other providers. Plans are required to create provider-specific reports, establish benchmarks, and provide feedback to individual providers on their performance. Beyond this requirement, Superior has a program to reward physicians for managing key utilization measures for their patient panel, including their generic fill rate, emergency room use, and inpatient admissions.

The plan did not share specific information on how service coordinator performance is tracked and managed.

Superior promotes person-centeredness by developing comprehensive care plans for high-risk individuals in collaboration with the member. Assessments include questions about individual's goals, which serve as a way to engage members in the process. The plan believes that member buy-in is critical to the success of a care plan, and members who refuse to engage in the care planning process are closed out of intensive care management. Superior does not have an approach for systematically measuring person-centeredness.

Other Integrated Products

In addition to the STAR+PLUS plan—a Medicaid MLTSS product—Superior operates a

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[82] Superior's report card for the STAR+PLUS plan can be seen here: http://www.hhsc.state.tx.us/QuickAnswers/health-plans/STAR+/Superior-Health-Plan-Profile-StarPlus-English.pdf

Texas Duals Demonstration	
Program Name	Texas Dual Eligible Integrated Care Project
Initial Enrollment	April 2015
Covered Populations	Full dual eligibles age 21 and older in six participating counties
Population Carve-Outs	Individuals receiving IDD, HCBS, CLASS, DBMD, or TxHmL waiver services
Enrollment Approach	Passive with opt-out
Statewide Enrollment	24,741[83]
Covered Benefits	Comprehensive (medical, behavioral, and LTSS)
Benefit Carve-Outs	None

D-SNP for dual eligible individuals. Superior first launched this product because Texas required all STAR+PLUS contractors to operate a D-SNP as a condition of participation. However, less than 5% of eligible members are enrolled plan. This is somewhat lower than it used to be because some D-SNP members have been moved into Superior's Duals Demonstration plans, but enrollment was never high.

In March 2015, Superior launched an MMP in their three largest urban counties as part of the Texas dual demonstration program. Statewide, there are 24,741 individuals enrolled in the demonstration,[84] about 9,500

of whom are in Superior's MMP.[85] Between March and October of 2015, the state Medicaid agency and CMS moved dual eligible STAR+PLUS members in the pilot counties to the MMP. Members receiving waiver services and those enrolled in Original Medicare (i.e., fee-for-service) stayed with Superior for the MMP. Members who had Medicare coverage through another plan participating in the pilot were enrolled in that plan's MMP. The benefit packages are very similar for MMP members and STAR+PLUS members who have both LTSS and medical coverage with Superior. Superior manages the MMP separately from the rest of the STAR+PLUS program, because they demonstration has a different set of requirements for the care model. In general, there are higher regulatory and administrative requirements for the MMP care model compared to STAR+PLUS.

The fact that Superior operates these three different products—the STAR+PLUS plan, the D-SNP, and the MMP—means that different subpopulations within their membership receive different levels of integration. Non-dual (i.e., Medicaid-only) STAR+PLUS members are fully financially integrated within one Superior product. Dual eligible individuals in the MMP, or who are enrolled in both Superior's STAR+PLUS plan and their D-SNP receive comprehensive coverage with Superior with two payers (the state for Medicaid benefits and the federal government for Medicare benefits). Finally, dual eligible members enrolled in STAR+PLUS who are enrolled in Original Medicare or another Medicare Advantage plan are not financially integrated. This variation presents the opportunity to compare how financial

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[83] Texas Health and Human Services System (2015) *2015 Texas HHS Fact Book*, page 40. Available at: http://www.hhsc.state.tx.us/reports/2015/fact-book.pdf
[84] Texas Health and Human Services System (2015) *2015 Texas HHS Fact Book*, page 40. Available at: http://www.hhsc.state.tx.us/reports/2015/fact-book.pdf

[85] As of December 1, 2015. Source: Communication with Superior HealthPlan.

integration affects care within a single organization.

Key Integration Strategies and Outcomes

Superior pursues three main goals for the STAR+PLUS program. First, the plan aims to address member needs holistically across medical, behavioral, and LTSS. Second, the organization seeks to balance cost and quality in member care. Finally, the plan hopes to shift spending from emergency department and hospital care to preventive care, primary care, LTSS and other lower cost services.

The plan pursues a range of integration strategies to achieve these goals. Leveraging data is a key element of their strategy. Superior analyzes financial, clinical, and other data to identify the highest-risk individuals in their plan and carefully target enhanced care coordination and services to these members. Lack of access to comprehensive data for members who receive Medicare coverage elsewhere is a critical barrier to achieving success with the dual eligible population. A second integration strategy is the plan's flexible benefit design. Once high-risk members have been identified, Superior can deploy a wide range of resources to support them in the community. The benefit package includes state Medicaid benefits (e.g., medical care, pharmacy, and care management), HCBS waiver services for institutionally-qualified members (e.g., home delivered meals, minor home modifications, and assisted living facility costs[86]), and plan-specific value-added services (e.g., emergency response services, phone minutes, and allowances for over-the-counter medications). Beyond this, the plan

funds additional needs on a case-by-case basis out of the administrative budget to improve quality-of-life or avoid a hospitalization. Finally, the plan achieves financial results by being strictly needs-driven, calibrating the necessary services to support members without duplication or overprovision, and leveraging informal and community resources where available. Awareness of the total cost of care focuses the organization on providing a well-coordinated and cost-effective set of services to members.

Superior identifies the comprehensive care model that addresses high-risk members' medical, behavioral, and LTSS needs as the foundation of program success. In addition to the care model, the plan's health IT systems are critical in giving team members access to a wealth of member information (including service plans), and enabling team collaboration in member care.

Although the plan has compelling anecdotal cases of individuals whose quality and cost of care has improved through the program, they do not have data that demonstrates the aggregate impact of the program. The plan also lacks historical data on member outcomes prior to integration, hindering assessment program impact. However, the fact that member costs are better controlled with length of enrollment suggests that integration is succeeding. Despite the absence of direct evidence, Superior leadership believes that integration improves quality and helps to control costs, and that if outcomes could be adequately measured and risk-adjusted, populations for which they have full financial integration would have better results in terms of cost and quality.

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[86] For a complete list of STAR+PLUS HCBS Waiver services, see:
https://www.dads.state.tx.us/handbooks/sph/6000/6000.htm

UnitedHealthcare ALTCS (Arizona)

Background Information

The Arizona Long-Term Care System (ALTCS) is Arizona's Medicaid MLTSS program. ALTCS was established in 1989 and covers medical, behavioral, and LTSS for individuals who are elderly, physically disabled, or developmentally disabled. All ALTCS members require a nursing facility level of care and must enroll in a managed care plan to receive benefits.[89]

UnitedHealthcare (UHC), a national, for-profit insurance company, is one of three ALTCS contractors, and current covers 34% of elderly and physically disabled program beneficiaries statewide.[90] UHC is the sole ALTCS contractor in many of Arizona's rural counties.

ALTCS is a relatively small part of UHC's Medicaid portfolio in Arizona. The plan has nearly 500,000 members enrolled across all Medicaid products, only 9,800 of whom are ALTCS members. UHC operates a complementary FIDE-SNP in which they encourage dual eligible ALTCS members to enroll. About 2,800 members have enrolled in

Medicaid MLTSS in Arizona	
Program Name	ALTCS
Year Established	1989
Covered Populations	Elderly, physically disabled, and developmentally disabled individuals
	Must require a nursing facility level of care
Population Carve-Outs	Developmentally disabled served separately by Arizona Department of Economic Security
Enrollment Approach	Mandatory
Statewide Enrollment	58,000[87]
Covered Benefits	Comprehensive (medical, behavioral, and LTSS)
Benefit Carve-Outs	None
Dual Eligible Population	83% of elderly and physically disabled
	22% of developmentally disabled[88]

the FIDE-SNP; another 2,700 are eligible but choose to receive Medicare coverage elsewhere. UHC also operates a separate D-SNP with 34,000 members in Arizona, but does not enroll ALTCS beneficiaries in this product.

UHC has a broad network of medical providers and requires network participants to serve members enrolled in any of the organization's products (e.g., commercial, Medicare Advantage, Medicaid, etc.). The plan uses a somewhat narrower network of HCBS and SNF providers for LTSS as part of a strategy to concentrate members with higher quality

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[87] As of February 2016, *AHCCCS Population by Category* Report. Available at: https://www.azahcccs.gov/Resources/Reports/population.html

[88] Arizona Health Care Cost Containment System (2012) *AHCCS Medicare/Medicaid Duals Discussion* Available at: https://www.azahcccs.gov/resources/Downloads/Legislation/Duals/6_Duals_DemonstrationPresentation3-6-12.pdf

[89] Please refer to Appendix B for more detail on the ALTCS Medicaid MLTSS program in Arizona.

[90] As of February 2016, *AHCCCS Population by Health Care Contractor* Report. Available at: https://www.azahcccs.gov/Resources/Reports/population.html

**United ALTCS Enrollees
Primary Medical Coverage**

UHC FIDE-SNP, 2,800

Non-UHC Medicare, 2,700

UHC Medicaid, 4,200
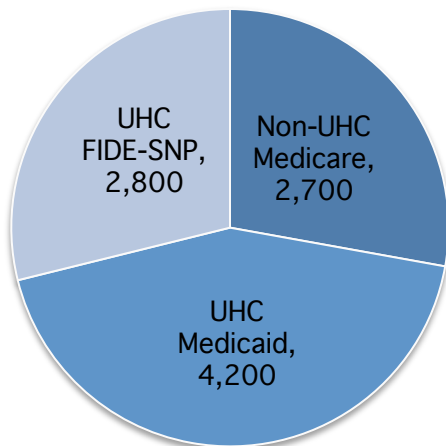
providers. The plan has less flexibility in choosing network providers in rural areas, where there are few providers to choose among. In those communities, UHC focuses even more intensely on network strategy, and sometimes develops specialty contracts to meet member needs. For example, the plan has recruited new providers to serve their population, in one case developing a behavior health practice in a rural area that had previously lacked access to care.

Care Management and Provider Organization

For members in UHC's ALTCS plan, care is fully integrated for all medical, LTSS, and behavioral health. Every member has a single care manager who is accountable for the entirety of their care in all settings, coordinating where necessary with medical and other providers. This comprehensive care management is provided to all ALTCS members, regardless of whether they receive their primary medical coverage from Medicaid or Medicare, or from UHC or another plan. The care manager manages a member's entire care experience through communication, comprehensive planning, and high-touch

contact with the individual. Members are assigned to a care manager based on region, specialized language or high-risk behavioral health needs, and travel distance. About 90% of UHC's care managers are social workers. Care managers are supported by the plan's medical directors, as well as consulting pharmacists and behavioral health specialists.

All members receive a comprehensive face-to-face assessment within 12 days of enrollment. Prior to the assessment, the care manager calls the member to make sure that urgent needs are met and that the member has a PCP. At the in-person meeting, the care manager completes a comprehensive assessment using UHC's proprietary "Community Assessment" tool. This is a holistic medical-psychosocial tool that includes triggers for additional assessments for specific diagnoses (e.g., diabetes). The care manager completes the assessment using the plan's electronic case management system, CareOne, which automatically populates mandatory state assessment forms. Care managers use information in CareOne to complete the state's HCBS assessment tool manually. From the member's perspective, there is a single assessment process—the plan manages all the disparate paperwork behind the scenes. Per state contract requirements, community-dwelling members are reassessed in-person at least every 90 days and institutionalized members at least every 180 days. However, UHC will also conduct a full reassessment within two days of a hospital discharge, within ten days of a change in LTSS placement, or more often when there is a change in condition or if a member or their representative requests one.

The care manager begins the care planning process during the initial assessment. The goal of the meeting is to identify unmet member needs and outstanding problems and to

implement solutions. While the state assessment tools create recommendations for hours of service, UHC has the flexibility to implement a customized service plan. The care manager coordinates all LTSS the member may receive, not just the services for which UHC pays. This can entail coordinating informal care, private duty nurses, and Medicare hospice and home health. UHC acts as the "payer of last resort" for LTSS by filling in around care provided informally or by other payers, avoiding duplication of services wherever possible.

Care managers are also responsible for managing members' medical care. The care manager's role is to communicate with all of a member's providers, and share information among those providers to coordinate member care. The member's PCP and other providers may have a separate care plan for each of the individual's medical diagnoses—the UHC care manager is accountable for coordinating all such plans to ensure the best outcomes for the member. Care management of medical care is somewhat easier when members have their medical coverage with UHC. For these members, the plan has ready access to diagnostic, treatment plan, and medication information and coordinating providers is less labor-intensive for the care manager.

Transitions

UHC's care managers are also critical to the plan's approach to managing member transitions between settings of care. The plan is notified quickly of member hospitalizations, either through the authorization process (for member's with UHC medical coverage), or through daily census reports from hospitals (for all members). For members who have medical coverage with UHC—either through Medicaid or the FIDE-SNP—inpatient utilization management nurses begin communicating with the member's care manager proactively as soon as they are admitted to coordinate care

and begin discharge planning. For all members, regardless of medical coverage, the care manager will closely follow their care during the inpatient stay. During the hospitalization, the care manager communicates with the member, their family, and the hospital's social worker. After discharge, the care manager meets with the member within 48 hours to implement an evidence-based model of transition management and adjust the LTSS service plan as needed.

The case review process is another tool UHC uses to manage member care. Anyone on a member's care team can call for a case review if they have concerns. Common triggers include care manager concerns, over- and underutilization trends, high-cost placements, non-compliant members, high volumes of medications, and frequent emergency room visits. The first part of the process brings together all plan staff involved in the member's care (care manager, medical director, etc.) to review the member's case. This team attempts to solve any identified problems internally, for example by arranging for needed medical equipment or LTSS. If necessary, the plan will engage the member's providers and may call an interdisciplinary team meeting to address any issues. Providers are generally responsive, but if necessary the medical director will reach out to providers directly to explain the importance of process.

Plan Incentives and Financial Results

For ALTCS members enrolled in UHC's FIDE-SNP, the plan receives two capitation payments: one from the state for Medicaid services and a one from CMS for Medicare services. The CMS payment includes an additional 10% payment as a frailty adjustment. Arizona's Medicaid rate-setting generally ensures that MCOs remain financially sustainable without reaping large profits,

although there is no mechanism for clawing back profits within a contract year. The state uses encounter data to set rates, with annual adjustments based on trends and program changes. UHC pays for LTSS on a fee-for-service basis, based on state fee schedules. The plan also pays for most medical care on a fee-for-service basis. UHC is piloting shared savings programs with physician practices and some long-term care facilities, and has begun implementing value-based purchasing.

Moving individuals out of institutions and into the community has been a major objective of the ALTCS program since inception. As a result, Arizona is a national model for rebalancing. When the program was launched in 1989, 95% of members lived in nursing facilities.[91] In 2014, that rate was 27%.[92] This success is due partly to strong financial incentives for plans to move members out of institutions. Each year, capitation rates are set based on the projected share of the plan's membership that will use a SNF. The plan gets to keep any savings for the first 1% difference in the population institutionalization rate. The plan is also responsible for costs for up to 1% above the projected rate. The state captures savings and covers losses above the +/- 1% threshold. These incentives have led UHC to reintegrate between 1–2% of the population each year above the projection. The plan is now a leader in reintegration strategy among UHC plans nationally. The plan developed a SNF discharge readiness assessment that is

being used by other UHC plans, and recently helped a plan in Tennessee launch a reintegration program.

UHC's ALTCS product is profitable, but this financial success is hard-earned. In 2006, the plan lost a bid with the state, and was not allowed to enroll new members in Maricopa County for five years. More than 60% of ALTCS beneficiaries live in that county, which includes Phoenix, and many observers did not expect the plan to stay in the program. As enrollment was frozen, the plan's membership aged and became more expensive. This coincided with the economic recession, during which the state cut capitation rates. Despite these challenges, today the plan is still in ALTCS and financially sustainable. This was only possible due to a concerted effort to review all care plans, right-size service packages, and decrease costs. The plan reduced services gradually, and members generally accepted the cuts based on the strength of their relationships with care managers. Over the course of this effort, UHC cut more than a thousand service plans, and only a dozen members appealed.

Utilization Management Strategy

For members in the ALTCS product, nursing home days drive 90% of UHC's costs, and thus utilization management focuses intensely on keeping members in the community. Secondarily, the plan looks to provide the most cost-effective set of services. One way the plan does this is by reviewing utilization reports to look for areas of over- and underutilization. This may be using more of a service than necessary (e.g., hours of respite), or using services that are more expensive per unit than necessary (e.g., using RNs as personal care aides). The population enrolled in the ALTCS plan is only a small share of the plan's total Medicaid and Medicare

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[91] J. Libersky and J. Verdier (2014) *Financial Considerations: Rate Setting for Medicaid (MLTSS) in Integrated Care Programs*. Available at: http://www.mathematica-mpr.com/~/media/publications/PDFs/health/dual_eligibles_ML_TSS_rate_setting.pdf

[92] Joint Legislative Budget Committee (2015) *Program Summary: Arizona Long Term Care System*. Available at: http://www.azleg.gov/jlbc/psaxsaltcs.pdf

populations, and is not a major driver of hospital utilization.

The plan uses a strict cost threshold in determining how to support members in the community. Care managers conduct a cost effectiveness study on the full HCBS service package, and will support the member in the home so long as the cost does not exceed 100% of the average cost of institutional care. The plan has a great deal of flexibility in the services provided if they are within the cost threshold. If the cost of keeping members at home exceeds the threshold but the member refuses institutionalization, the family can substitute informal care for paid services and the care manager will try to arrange for other lower-cost services in the community. In these situations, the plan requires the member to sign a managed risk agreement that limits UHC's liability while supporting the individual's decision.

Despite aggressive reintegration of members to the community, UHC has not seen an increase in hospitalizations. The plan attributes this success to the work of care managers. Prior to a permanent move out of a nursing facility, individuals are sent home for a trial period to make sure everything is ready. When the member first moves home, they are given more service hours that are slowly decreased, and the care manager checks in frequently. Thereafter, the care manager checks that the placement remains safe and sustainable at quarterly in-person assessments.

For members living in the community, the care manager works with members and their families to design the most cost-effective service package to meet their needs. Services are targeted to members' current needs, not to worst case scenarios. The care manager also encourages family members to take some

responsibility for the member's care, and assesses family caregivers for burnout at each visit.

Quality Metrics and Performance Management

The state withholds 1% of capitation payments to MCOs each year to fund a performance incentive program. For the ALTCS program, plans are assessed on a handful of quality metrics: emergency department utilization, 30 day readmissions, diabetes management, cholesterol management, and flu shots. Bonus payments are distributed competitively based on the plan's performance against minimum standards as well as relative to other plans. The state requires plans to report on other LTSS-specific quality metrics, including inpatient utilization, functional status maintenance and improvement, advance directives, and the results of an HCBS satisfaction survey.

UHC's quality program focuses on physicians as the most influential factor for driving member outcomes. The plan currently has 30% of network physicians in value-based contracts in which practices receive bonus payments for achieving key quality metrics— the same measures on which the state holds the plan accountable. As part of this program, UHC shares detailed performance information with physicians on quality metrics, inpatient admissions and readmissions, total population costs, and total cost for individual patients. The plan offers additional resources to practices who are interested in sharing risk with the plan. For example, the plan will advance a practice the funds to hire a care coordinator, to be paid back only if the practice achieves savings. UHC is evaluating the potential to expand this program

throughout the network to other provider types (e.g., nursing homes.)

UHC has a robust approach to care manager performance management. Care managers are rated on a 1 to 5 scale across a range of metrics. Several metrics align with the state's quality goals for the ALTCS contractors: flu immunizations, diabetic screenings, readmissions, and timely service initiation. Managers of care managers also use the results of quarterly chart audits (three charts per care manager) and annual member satisfaction surveys as performance management tools. The care manager is also assessed based on how many members have set personal goals. On top of these performance metrics, UHC has a range of mentoring, coaching, and member feedback processes in place to develop care management staff. The plan sees care management as the linchpin of their success in serving the ALTCS population, and the performance management process ensures that staff are well-trained and effective.

Person-centeredness is central to the organizational culture at UHC, with plan staff and management highly engaged in programs to improve member quality of life and to help members achieve personal goals. The plan's Member Empowerment (ME) program, launched in 2010, has been recognized as a best practice by the state. The ME program helps members set personal goals—like getting a job, volunteering, or going to school—and then supports the member in achieving that goal on their own. UHC is tracking the impact of the program; key metrics are whether members have set at least one goal and whether they have achieved at least one goal. To date, 70% of members have set a goal and 35% have achieved a goal. Care managers are

accountable for asking members to set goals and ensuring that care plans are consistent with those goals. Plan staff are passionate about this program, and coordinate fundraisers to help members to reach their personal goals. Plan management believe the program also generates significant financial value through increased member retention and improved health outcomes. UHC has not measured these outcomes, but anecdotally the program increases member social engagement and fosters a sense of purpose—outcomes that are not only valid ends in themselves, but are also associated with better health. Additional, the ME Program has strengthened UHC's brand in Arizona with members, staff, providers, and the broader community.

Key Integration Strategies and Outcomes

UHC's integration strategy is executed through their comprehensive care management model, which aims to improve member medical outcomes and manage costs. Fundamentally, care managers partner with members and their families to engage members in their own care, promote a high quality of life, and support complex individuals safely and cost-effectively in the community. These are ambitious goals, and UHC has found that hiring the right care management staff is critical to success. The plan's success in integration can be attributed to their ability to attract and retain care managers who are aligned with the program's mission and passionate about serving complex.

Plan leadership believes that a couple of unique attributes have contributed to their success. The first is the organization's focus on behavioral health. Every member's behavioral health is assessed, and all care managers are trained to recognize behavioral

health needs and coordinate appropriate resources. Individuals with the most complex behavioral needs are followed by a specialized care management team. The second distinguishing attribute is the plan's culture of person-centeredness. The ME program described above was an outgrowth of a pre-existing mindset among case managers. A commitment to improving members' quality of life underpins the close relationship between care managers and members.

UHC aims to lower costs while improving outcomes and quality of life for their ALTCS members. Plan leadership do not have conclusive quantitative evidence of their outcomes, but point to a retention rate near 100% as one indication that they are achieving this goal. The plan also has many anecdotes from members, staff, and providers as evidence that the plan's person-centered efforts are dramatically improving the quality of member's lives.

UnitedHealthcare Senior Care Options (Massachusetts)

Background Information

The Senior Care Options (SCO) program is a program in Massachusetts that integrates Medicare and Medicaid benefits for the elderly dual eligible population in the state. SCO is a comprehensive program that covers all Medicaid and Medicare-covered benefits, including medical, behavioral, and LTSS. Those age 65 and older who are eligible for Medicaid may enroll in the program. Enrollment is voluntary, but individuals must choose to receive both Medicare and Medicaid coverage from the same SCO plan. Non-dual eligible individuals (i.e., Medicaid-only beneficiaries) receive the same benefits as dual eligibles; the state pays SCO contractors a higher capitation rate for these members to compensate for the lack of Medicare reimbursement. Members and providers experience SCO as a single set of services and benefits that covers everything under Medicare and Medicaid; the integration is seamless to the members. The SCO program was a precursor to the development of both the Duals Demonstrations and the FIDE-SNP.[96]

UnitedHealthcare (UHC) has been a SCO contractor since 2004. UHC operates the largest SCO plan in the state, covering about

Senior Care Options in Massachusetts	
Program Name	Senior Care Options (SCO)
Year Established	2004
Covered Populations	Medicaid beneficiaries age 65 and older
Population Carve-Outs	Individuals with ESRD, residents of ICF/MR facilities, and inpatients in a chronic or rehabilitation hospital
Enrollment Approach	Voluntary, but participants must enroll in the same plan for Medicaid and Medicare coverage
Eligible Population	91,876[93]
Statewide Enrollment	38,672[94]
Covered Benefits	Comprehensive (medical, behavioral, and LTSS)
Benefit Carve-Outs	None
Dual Eligible Population	92% of members[95]

39 percent of individuals in the program.[97] The SCO plan is the only UHC product in Massachusetts that integrates LTSS. The insurer also operates Medicare Advantage and Commercial plans in the state. UHC's SCO plan is regulated by CMS as a Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP), and receives two separate capitated payment streams—one from the state and one from CMS. Massachusetts is part of the Duals

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[93] As of June 2015, http://www.mahp.com/unify-files/HMAFinalSCOWhitePaper_2015_07_21.pdf p 10

[94] As of June 2015, http://www.mahp.com/unify-files/HMAFinalSCOWhitePaper_2015_07_21.pdf p 10

[95] As of January 2014, http://www.mahp.com/unify-files/HMAFinalSCOWhitePaper_2015_07_21.pdf p 8

[96] Please refer to Appendix B for more information on the SCO program in Massachusetts.

[97] As of June 2015, http://www.mahp.com/unify-files/HMAFinalSCOWhitePaper_2015_07_21.pdf p 9

Demonstration with OneCare, an integrated program for dual eligible individuals between the ages of 21 and 64. UHC is not participating in OneCare at this point.

UHC's SCO plan covers approximately 15,600 individuals throughout Massachusetts. All members are age 65 or older and eligible for Medicaid, and the majority (88 percent) are dual eligible. 89 percent of members live in the community, 11 percent in institutions. 65 percent of members do not speak English; the most common non-English languages are Spanish (28 percent of members) and Chinese (13 percent).

UHC SCO has a very broad network of medical providers, including many choices for primary care providers (PCPs), hospitals, pharmacies, specialists, and other providers. The plan subcontracts with Aging Service Access Points (ASAPs)—Massachusetts' Area Agencies on Aging—for almost all HCBS, and works with only a small number of HCBS vendors directly. In turn, the plan helps the ASAPs with more complex administrative processes, like billing and claims.

Care Management and Provider Organization

UHC SCO has a comprehensive care management model that addresses the needs of members whether they are residents of long-term care nursing facilities or live at home in the community. The goal of the model is to help members live in the least restrictive setting, supported by the appropriate level of LTSS. The model is focused on frequent member interaction and coordination with each member's PCP and extended care team, including family members and other informal supports.

Residents of Long-Term Care Nursing Facilities

For members who are residents of nursing facilities, the primary goal of UHC SCO is to promote and support a high quality of life by focusing on treating in place to avoid unnecessary hospitalizations and other transfers. About 1,700 members of the plan live in long-term care nursing facilities.

The UHC SCO care management model leverages primary care to improve outcomes for nursing home residents enrolled in the plan. Plan-employed nurse practitioners (NPs) and physician assistants (PAs) work closely with each member's PCP and facility nursing staff, and act as leaders of the health care team by serving as collaborator, clinician, coordinator, advocate, and coach. NPs/PAs visit patients as often as needed to help avoid trips to the hospital.

NPs/PAs are assigned a member panel at between two to four different facilities. The consistent assignment of one NP/PA to members at a few facilities enables them to establish long-term relationships with facility nursing staff, interdisciplinary team members, and management. The NP/PA serves as an advocate for members with facility staff, and provides oversees member care through frequent on-site visits. This regular presence and proactive communication between plan and facility staff facilitates collaboration and increases the degree to which facilities align with UHC's integration goals. Facilities appreciate the support of UHC staff and work together to improve the quality of care provided to UHC SCO members.

NPs/PAs conduct a comprehensive (medical, functional, and behavioral), in-person assessment of the member within five business days of joining the plan. The member is reassessed every 60 days or more

frequently if there is an acute event or status change. In between assessments, NPs/PAs are in the facilities and provide ongoing follow-up and oversight of the member.

The NP/PA generates an individualized care plan as part of the comprehensive assessment process, and upon completion shares the plan with the PCP and extended interdisciplinary care team to get their agreement. The NP/PA acts as the gatekeeper and coordinator for the member as the care plan is implemented. Under the oversight of the NP/PA, facility staff carry out the elements of the care plan. The NP/PA coordinates and runs family meetings to establish goals of care and individual preferences, and leads advance care planning conversations. The NP/PA also acts as a communication hub for the family, facility staff, and the PCP.

The NP/PA communicates regularly with the member's PCP via face-to-face meetings and telephonically, but has the training to provide independent clinical judgment as well. For example, the NP/PA can write orders for medications and therapies.

In the event a member is hospitalized, the NP continues to coordinate care. The NP calls the hospital and talks to the emergency room doctor before the member arrives, and ensures that the member's chart is transferred. Throughout the hospitalization, the NP continues to monitor the member, communicate with the hospital regarding diagnosis, treatment, and patient care preferences, and keeps the family informed. Upon the member's return to the nursing facility, the NP meets them and manages the transition process.

Community-Dwelling Individuals

The overwhelming majority of UHC SCO members (89 percent) live in the community.

For these individuals, the plan's goal is to support the member safely in the community as long as possible (that is, to delay institutionalization). The plan has a great deal of flexibility in using the capitated payment for services that will support the member at home.

The core team for a member in the community is the member, their care manager, and their PCP, and depends on the member's level of complexity. Less complex members with minimal LTSS needs are managed telephonically by plan staff trained to provide care coordination services. Members with low to moderate LTSS needs are managed by Geriatric Social Service Coordinators (GSSCs)—specialized staff based out of ASAPs. Members with moderate LTSS needs coupled with Alzheimer's disease or chronic mental illness are managed by a GSSC with support from an RN. Finally, members with an institutional level of need who live in the community are managed by an RN with support from a GSSC. The care manager is responsible for coordinating all of a member's care: medical, LTSS, behavioral, and any other supports that may be necessary. As part of this coordination, the care manager collaborates regularly with the PCP around changes in member condition and plan of care. Care managers provide PCPs with necessary information about the members' home and psycho-social context—information that often impacts member medical care and progress.

There are multiple assessments beginning with the member's first call to the plan. During the sales process, individuals who are already receiving LTSS are triaged for immediate in-home assessment to avoid any disruption in services. Within the first thirty days of enrollment, an HRA is conducted by phone for every member, which helps to determine the

member's level of complexity and appropriate care management staffing. Following the initial HRA screening, a comprehensive, in-home assessment is done for every member. Assessments include evaluation of clinical, functional, and nutritional status, in addition to physical well-being. These assessments also include screenings for mental health conditions, tobacco, alcohol and drug use, and the need for LTSS, including the availability of informal support. Depending on the level of LTSS required by a member, reassessments occur either telephonically or face-to-face at least every three to six months. In practice, the complexity of the enrolled population means that most members are reassessed more frequently due to changes in status or acute events that trigger reassessment.

During a home visit, the care manager develops a comprehensive, individualized care plan built around the member's disease states, with a treatment plan for each condition. The care manager coordinates implementation of all elements of the care plan, and follows up with the member on an ongoing basis to ensure that services are being delivered. Member assessments, care plan, and other information are documented in a centralized, electronic record that is available to all members of the care team.

Transitions

If a community-dwelling member is hospitalized, a nurse on UHC's inpatient care management (ICM) team follows the member and coordinates with the admitting facility, member, assigned care manager and family. Prior to discharge, the ICM nurse conducts a readmission risk assessment with the member. Members who are identified as high risk receive a more intensive level of transition management following discharge. The ICM nurse works with the member's care manager

and the facility's discharge staff on discharge planning. Within two business days of discharge, the care manager contacts the member by phone to ensure needed services are in place. Within seven days of discharge, the care manager conducts a post-hospital assessment to determine whether changes are necessary to the care plan, and updates the plan as necessary.

Similarly, if the member has a short stay in a skilled nursing facility, the care manager will follow them throughout their stay, ensure that discharge is safe, and work closely with the member, family, PCP and interdisciplinary care team to ensure a successful transition back to the community.

Plan Incentives and Financial Results

For dual eligible members, UHC SCO receives capitated payments from both Medicare and the state. For Medicaid-only beneficiaries, the plan receives a larger capitated payment from the state. The plan is at risk for all Medicare and Medicaid-covered services, including medical, behavioral, and LTSS. The plan does not share risk with medical or LTSS providers. Instead, providers are reimbursed on a fee-for-service basis. The plan does have shared savings/quality programs in place for some nursing homes and is beginning to incorporate other alternative payment models in primary care and other settings that tie to quality outcomes.

The SCO program incentivizes plans to keep members in lower-cost community settings rather than in institutions. Plans receive community-level rates for the first 90 days a member resides in an institution, and receives institutional-level rates for the first 90 days after a member is repatriated from an institution to the community.

UHC is the largest SCO participant and has grown rapidly, with enrollment tripling in the last three years. Although the plan did not share financial data, they did report that the program operates at a profit and entered into a new five-year contract with the State effective January 2016.

Utilization Management Strategy

UHC SCO's utilization management strategy is best viewed in light of the overarching goals of program: (1) help community-dwelling members live in the least restrictive setting, supported by the appropriate level of LTSS, and (2) support quality of life for members living in long-term care facilities by avoiding unnecessary hospitalization and procedures. The plan's primary tools for managing utilization are the care management staff and the comprehensive and flexible set of services available to support the member.

Care managers use a two-fold approach to utilization management. First, care managers work to understand the service needs of their members, whether in the community or in nursing facilities. Standardized clinical assessments along with clinical experience help care managers develop service plans that take into account not only current needs but also future needs that may arise due to aging in place or worsening of existing conditions. Services that do not add additional value to accomplish the goals of each member's care plan are slowly reduced or eliminated with the consent of the member and PCP. Changes to the service package—whether increases and decreases—are implemented gradually. When increasing services, the care manager starts with the least expensive option (e.g., one hour of homemaking weekly), and then evaluates the impact and further escalates if necessary.

For community-dwelling members, HCBS is explicitly viewed as a tool for preventing

exacerbations and high-cost events, like hospitalizations. The plan focuses on the most complex members to manage these outcomes. A Significant Episodes of Cluster Activity (SECA) report is used to identify the 1 to 2 percent of population that drives overall plan costs. The plan actively tracks and monitors these high-risk members over time. Care managers follow these members very closely and check on them regularly for any changes or deterioration. Particularly challenging cases are brought to interdisciplinary team meetings including medical directors, behavioral health specialists, and pharmacists to problem solve and share best practices. In addition to these reports, the plan uses data from initial and subsequent assessments to identify high-risk members and anticipate ER and hospital admissions. By comparing changes in member assessments over time, the plan is able to identify new HCBS needs and provide services that could prevent unnecessary ER or hospital admissions. A third tool the plan uses is Interdisciplinary Care Review (IDCR), which is a case conference where the plan medical director and other members of the interdisciplinary care team discuss enrollees who are readmitted to the hospital within 30 days. Finally, the plan averts some hospitalizations via a 24/7 hotline staffed by an on-call team of NPs that members can call for assistance before calling 911 or going to the emergency room.[98] UHC uses NPs on staff to answer the hotline.

When members are hospitalized, a centralized UHC inpatient utilization management team works with the hospitals, checking in on a daily basis to monitor the services being used and assist in discharge planning. After discharge,

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[98] This hotline is a requirement of the plan's contract with the state, but has also proven to be a useful tool for preventing hospitalizations.

RNs provide transition management home visits to members identified as being at high risk of readmission based on the Coleman model.[99] For lower risk members, transition management is telephonic.

Quality Metrics and Performance Management

UHC SCO's quality measurement activities are very medically focused—75 percent of the measures they track are clinical indicators, while 25 percent assess quality of life, social supports, and member satisfaction. Compliance drives the plan's quality program, with a focus on HEDIS, Medicare Star Ratings, and other measures required for D-SNPs. The plan also administers a survey to measure functional health and well-being from the patient's point of view.

UHC conducts chart audits on all care managers monthly to measure adherence to the care model. These audits include timely initial member assessments, timely ongoing member assessments, health risk assessments generating appropriate care plans, communication with interdisciplinary care team, and other elements. The plan's clinical management team also conducts regular field-based visits with the staff to monitor adherence to corporate guidelines.

UCH SCO does not use person-centeredness as an organizing principle for their care model. Although care plans are individualized and oriented to individual needs, they are also organized around the member's disease states. Member goals and preferences are reflected in the care plan, but are constrained by what is realistic for the individual to achieve.

Key Integration Strategies and Outcomes

UHC SCO's integration strategy is grounded in their ability to offer a comprehensive suite of services. The plan presents the benefits to the member as a single, complete package, and coordinates all care so that the member experience is seamless. A single care manager is responsible for coordinating the entire package of services for each member, serving as a single point of contact for that member's medical, LTSS, and behavioral needs. The care model is truly needs-based and customized for each member, with care management staff carefully titrating services to effectively support the individual in the community. Coordinating an effective package of supports may mean increasing or decreasing services— the emphasis is on filling members' unmet needs. UHC SCO also hires linguistically and culturally competent staff. Although this may seem like a minor point, it has actually proven critical to serving their diverse membership.

UHC SCO further attributes their success to several distinguishing attributes. Primary is the close relationship with ASAPs, who are experts on the LTSS provider network and play a key role in connecting members with appropriate resources. The plan also points to effective management of care management staff as an important contributor to successful integration. Finally, the SCO care model

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[99] The Care Transitions Program (http://www.caretransitions.org/) was developed by Dr. Eric Coleman to improve care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as they move from hospital to home, the Care Transitions intervention is composed of: 1) a patient-centered Personal Health Record that contains all essential care elements, 2) a structured Discharge Preparation Checklist, 3) a session with a Transitions Coach in the hospital prior to discharge, and 4) follow-up visits and phone calls from the Transitions Coach in SNF or in home.

leverages UHC's years of experience of caring for residents of long-term care facilities.

The plan focuses on results that reflect their primary goals: helping members live in the least restrictive setting, supported by the appropriate level of LTSS services, and supporting a high quality of life for members in nursing facilities by focusing on treating in place. A state evaluation of the SCO program shows that the program has succeeded in keeping members in the community and decreasing the utilization of SNFs.[100] UHC SCO also points to its low disenrollment rate (less than 2 percent) and strong membership growth as indicators of how well their plan is doing.

The plan was able to point to many anecdotal successes of managing members cost-effectively, but does not have robust quantitative data on program outcomes. There are several reasons that it is difficult to quantitatively demonstrate impact. One is the lack of adequate quality measures for LTSS, especially HCBS. Second, by the time individuals enroll in SCO, they are often in deteriorating health and increasing needs for care. Therefore, a time-series analysis would not be expected to show improving health and cost after enrolling in time. Finally, it is difficult to identify an appropriate comparison group against which to benchmark the results of the program. There are significant differences between the population enrolled in SCO and the fee-for-service Medicare population, which makes it challenging to compare data on outcomes between the two groups.

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[100] Jen Associates (2013) "Massachusetts Senior Care Option 2005-2010 Impact on Enrollees: Nursing Home Entry Utilization." Available at: http://www.mass.gov/eohhs/docs/masshealth/sco/sco-evaluation-nf-entry-rate-2004-through-2010-enrollment-cohorts.doc

Section III: Analysis

Program Organization and Structure

> - Success for our study programs in integrating the delivery of medical care, behavioral health, and LTSS and achieving cost and quality goals appears to depend equally on factors that are:
>   - external to the organization and influence the program's structure and operations;
>   - rooted in the organization's own history, culture, and structure; and
>   - shaped by the characteristics of the enrolled population.
> - These factors define key differences among the programs selected for this study.

This analysis compares and contrasts five integrated programs that were selected by the Expert Panel for this study as exemplifying LTSS integration. The programs differ in how they are organized and structured—in part as a result of differences in their funding authorities, state requirements, the types of health plans that operate them, and their own history and culture.

Factors Influencing Program Operations

A program's success in integrating medical care, behavioral health, and LTSS and implementing an effective care model is a function of a number of factors, some of which are external to the organization and some of which come with the organization's own history, structure, and culture. Factors that influenced the variation in how the programs integrated LTSS and the challenges they faced in doing so were:

State Medicaid Requirements

Medicaid requirements dictate major aspects of program operations and these differ in every state. State regulations dictate covered benefits, whether enrollment in managed care is mandatory or voluntary, provider payment rates, program data collection and quality metrics, administration spending limits, and a number of standards for care management, including specific assessment instruments, qualifications of care managers, the timing for initial contact and involvement of the care manager, the maximum caseload, and the triggers for reassessments or modifications to the care plan. The variation in state requirements is overlaid by federal Medicaid rules for home and community-based services, including regulations that define and require "person-centered planning."

Almost every state now provides Medicaid through contracts with private managed care organizations. In most states, Medicaid services (including LTSS) for seniors and persons with disabilities are carved out of managed care, although this trend is reversing and today 26 states contract with private managed care plans to provide managed LTSS. These contracts also dictate major aspects of program structure and operations.

Culture of the Parent Organization

The culture of the parent organization is defined by the origins, private or public and for-profit or non-profit. This differed for the

five programs we studied. One organization is a county health plan – a public organization that is the sole health plan for Medicaid participants in the county. Another organization is a faith-based non-profit organization operating nursing facilities and health plans. Two of the programs are in state plans that are part of the same for-profit, national managed care organization. The other program is a subsidiary of a national for-profit, managed care organization that contracts with state Medicaid programs. The public/private non-profit/for-profit variation explains differences in the mission, governance, incentives, and accountability of the organization. These programs also differ in the scale and location of their operations – whether they exist solely within a county or metropolitan area and manage with limited public or charitable resources, or operate across multiple states at a national level with more substantial resources and access to capital.

Type of Health Plan

All five of the programs we studied were operated by managed health care plans and all were at risk for medical care and LTSS for their enrolled and capitated population. Provider organizations that hold medical care and LTSS risk for a population (e.g., accountable care organizations) were not included in these case studies. The five programs differed in whether they provide direct services themselves or manage and pay for services provided by a network of contracting agencies and providers. Only one—ArchCare's PACE program—provided services directly to enrollees through employed professional staff, although they relied on a mix of staff and contractors. The others were all managed care organizations employing care managers to coordinate and manage networks of contracted providers.

Population

The population covered by the integrated program—and the share of LTSS recipients as part of the parent organization's covered population—is a major factor influencing the kind of care model the program develops.

In this study, program participants are typically Medicaid and dual eligible (Medicaid and Medicare) beneficiaries. The programs vary considerably, however, in the subpopulation of the Medicaid or dual population they cover.

Some programs in this study cover only Duals age 65 and older, while others also cover younger persons (age 18 and older) with disabilities. There are few integrated LTSS programs that specialize in the younger population with disabilities – the One Care Dual Demonstration program in Massachusetts is one state initiative that does. Indeed, among the younger population, states frequently carve out Medicaid or dual eligible beneficiaries with specific types of disabilities, most often intellectual and developmental disabilities (I/DD), from Medicaid managed LTSS.

Some programs in this study cover only beneficiaries with substantial long-term care need—defined by Medicaid as needing an institutional level of care—who may be in an institution or in a Medicaid Home and Community Based Services (HCBS) waiver. Other programs cover dual beneficiaries for all medical care, behavioral health, and LTSS, the majority of whom have no LTSS needs and receive only medical and behavioral health through the program. In the latter case, the population receiving LTSS may be only a small portion of those covered, and LTSS integration may be a lower priority concern and area of focus for the health plan. The dual beneficiaries covered by the program may have their Medicaid benefits through the plan but receive their Medicare benefits from another Medicare Advantage plan or fee-for-service Medicare. In this case, the population

enrolled in the program for all of their care may be a subset of the participants receiving LTSS through the plan.

The Programs in the Study

ArchCare (New York)

Archcare is a non-profit, faith-based healthcare system serving vulnerable individuals in the New York City area. ArchCare operates five skilled nursing facilities, a home health agency, and three health plans that are profiled in this study. These plans are a PACE program with 487 members established in 2009, a Medicaid MLTSS plan with 2,043 members established in 2012, and a Medicare I-SNP with 1,567 members established in 2008. All of the members in these plans require some LTSS.

State Medicaid Environment

New York is an early adopter of Medicaid managed care and of MLTSS in particular (called MLTC in NY). Their MLTC program, launched in 1998, covers only LTSS—not medical and behavioral health. In 2006, the state established two additional programs for Dual Eligibles (Medicaid Advantage and Medicaid Advantage Plus) to provide comprehensive coverage by combining Medicaid MLTC with a Medicare D-SNP. New York also actively promotes PACE as a managed care option for Medicaid beneficiaries. New York requires Medicaid beneficiaries to enroll in managed care.[101]

New York is participating in the Duals Demonstrations, but has had little success enrolling beneficiaries. Of the 60,000 individuals who were passively enrolled in demonstration plans, only 7,450 participants were still enrolled by the end of 2015. Several MLTC plans have also dropped out of the program, including ArchCare.

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[101] Refer to Appendix B for more details on the state Medicaid environment in which each of the study programs operates.

Culture

ArchCare's culture is influenced by the fact that it is a community-based Catholic health care organization with a tradition of caring for vulnerable seniors. It is a non-profit, mission-driven organization that serves seniors in New York City through a combination of direct service provision and managed care plans.

Types of Health Plans

ArchCare operates two different integrated health programs. The PACE program comes with its own unique culture, based on the program pioneered by the On-Lok community center in California. It is both a senior day center and "staff model" health plan. PACE must by statute be facility-based with its own primary care physician and highly-integrated care model serving small numbers of high-need patients. PACE is a small-scale program that is unique in its degree of financial and organizational integration.

In its MLTC and I-SNP programs, ArchCare's role is closer to that of an insurer, taking financial risk for a group of Medicaid participants with LTSS needs and managing a network of service providers.

Population

PACE enrollment is limited to beneficiaries 55 and older who have complex care needs and meet the institutional level of care standard.

ArchCare has a larger Medicaid managed long-term care (MLTC) program that has some overlap in membership with its Medicare Institutional SNP, enabling an integrated approach for a subpopulation of their MLTC membership. All participants in the I-SNP meet the state's institutional need threshold, but the integrated subpopulation (MLTC+ I-SNP) is a fraction of ArchCare's total MLTC membership.

Health Plan of San Mateo (California)

Health Plan of San Mateo (HPSM) is a county-operated health plan that covers nearly all Medicaid beneficiaries in San Mateo County, California. 145,000 individuals are enrolled in the plan, most of whom do not require LTSS. The plan was established in 1987, began covering institutional LTSS in 2010, and added community-based LTSS and an MMP in 2014 as part of California's Duals Demonstration. The plan has also operated a D-SNP since 2006, and three-quarters of dually eligible members have Medicare coverage with HPSM.

State Medicaid Environment

California has a long history of managed care in Medicaid (called Medi-Cal in California). Until recently, LTSS and behavioral health benefits were carved out of managed care. California's Coordinated Care Initiative, launched in 2014, made managed LTSS mandatory for Medicaid beneficiaries, including Dual Eligibles, and established California's Duals Demonstration program—Cal MediConnect.

Medicaid managed care is organized at the county-level in California. Some counties have only a single plan operated by the county, some counties have one county-operated plan and one commercial plan, and some counties have more than two plans in which beneficiaries can enroll.

Plans participating in the Coordinated Care Initiative cover LTSS, medical care, and most behavioral health. Fewer than half of the dual eligible beneficiaries in the state are eligible for Cal MediConnect and these are automatically enrolled in a demonstration plan, with the ability to opt-out. The California Duals Demonstration has had some challenges with enrollment, with about 70 percent of eligible beneficiaries opting out or disenrolling from demonstration plans for Medicare coverage.

Culture

HPSM is a quasi-governmental organization that was established by the county health commission in 1986 to serve Medicaid eligible and underserved residents of the county. As the only Medicaid plan in the county, HPSM has strong relationships with area hospitals and with county agencies and other service providers. It is a health plan that has only in recent years taken on responsibility for LTSS, and now offers integrated coverage for dual eligibles.

Type of Health Plan

HPSM is a county-based Medicaid plan. It purchases Medicaid services from local providers and employs its own care management staff that organize and manage care across all lines of business. HPSM has over 145,000 members. HPSM also operates a D-SNP and MMP that provide Medicare coverage for dual eligible members. There are currently 9,800 have enrolled in the MMP, and less than 1,000 in the D-SNP.

Population

HPSM covers nearly every Medicaid participant in the county. About 5 percent of its enrolled population receives LTSS, and 85 percent of this population lives in the community.

HPSM's membership includes many Dual Eligibles, three-quarters of whom have their Medicare coverage with HPSM. Most of these members are in HPSM's Duals Demonstration plan.

Superior STAR+PLUS (Texas)

Superior STAR+PLUS is a Medicaid managed care plan operated by Superior, a Texas subsidiary of Centene, a national for-profit, managed care company with a focus on Medicaid and CHIP populations. Superior serves a diverse Medicaid population across the state. The plan participated in this study with their STAR+PLUS product—part of Texas's Medicaid MLTSS program for the elderly and

physically disabled. Not all STAR+PLUS beneficiaries require LTSS. Superior launched the plan in 2007, and currently has about 148,000 members enrolled. Superior also operates a D-SNP, which enrolls some of their STAR+PLUS membership, and an MMP as part of the state's Duals Demonstration.

State Medicaid Environment

Texas launched a pilot of its MLTSS program—STAR+PLUS—in 1998, and later expanded it statewide, first to urban areas between 2007 and 2012 and then to rural areas in 2014. The program covers Medicaid beneficiaries with disabilities and those age 65 and older. A separate managed care program—STAR—covers Medicaid eligible children and families (and CHIP for non-Medicaid eligible families). Enrollment in a managed care plan is mandatory in order to receive Medicaid benefits.

STAR+PLUS plans cover medical, LTSS, and behavioral health. Institutional LTSS was not part of the STAR+PLUS program until 2015. The state pays a different capitation rate for institutionalized members but does not encourage rebalancing in payment, although it does have quality incentives related to nursing home admissions.

More than half of STAR+PLUS beneficiaries are Dual Eligibles. The state requires STAR+PLUS contractors to operate a D-SNP for dual eligible members, but most beneficiaries enroll in Original Medicare instead. Texas is one of the states in the Duals Demonstration, and began enrolling participants in early 2015. Superior is participating in the demonstration in several of their large urban markets.

Culture

Superior is a subsidiary of Centene Corporation, a national for-profit health care enterprise that contracts with states to provide Medicaid managed care products. Centene offers Medicaid managed care and MLTSS products in 19 states, along with

Medicare D-SNPs or MMPs in 10 of those states. Superior has been contracting with Texas for Medicaid and Children's Health Insurance products since 1999, and has been a STAR+PLUS contractor since 2007.

Type of Health Plan

Superior is a state-level network model, Medicaid managed care plan, offering distinct products in the STAR, CHIP, and STAR+PLUS markets. In its STAR+PLUS product for adult disabled and seniors, Superior contracts with a network of preferred providers for health services and with community provider organizations and paid caregivers to provide LTSS. Superior employs service coordinators to manage that care.

Superior also offers a Medicare D-SNP for Dual Eligibles, which it sought to align with its MLTSS dual eligible enrollees. It recently launched a Medicare-Medicaid Plan (MMP) for dual eligibles, and sought to move its MLTSS population that were in its D-SNP to the MMP.

Population

Superior STAR+PLUS covers adult disabled and senior Medicaid participants. Half of the participants are dual eligible beneficiaries, only a small proportion of whom are also in Superior's Medicare D-SNP. About half of Superior's STAR+PLUS population are receiving LTSS at any given time.

Superior and has moved many of its D-SNP enrollees and other Dual Eligibles in its MLTSS to the MMP it is operating as part of the state's Duals Demonstration. It currently has about 9,500 enrollees in its MMP.

UnitedHealthcare ALTCS (Arizona)

UnitedHealthcare Community Plan is a Medicaid managed care plan offered by UnitedHealthCare (UHC), a national for-profit health insurance company with commercial, Medicare, and Medicaid products in many states.

UHC serves a diverse Medicaid population of nearly 500,000 members across Arizona, including in rural areas. This study profiles UHC's Arizona Long-Term Care System (ALTCS) plan—a Medicaid MLTSS plan for the elderly and physically disabled. All members of ALTCS meet the institutional level of need for LTSS. The plan was opened in 1989 and has 9,800 members. About half of the plan's 5,500 dual eligible members are enrolled in a complementary UHC FIDE-SNP for Medicare coverage.

State Medicaid Environment

Managed care has been a major part of Medicaid in Arizona since the state joined the program in 1982. Arizona was the first state to implement a MLTSS program—ALTCS—established in 1989 to serve individuals who require a nursing facility level of care due to aging, physical disability or developmental disability. ALTCS covers medical, behavioral, and LTSS. Of the 58,000 ALTCS beneficiaries statewide, 29,000 are elderly or physically disabled and are mandated to receive benefits through managed care companies

Arizona has sought to support home and community-based care and reduce the institutionalized population. The state has successfully lowered the share of beneficiaries living in nursing facilities from 95 percent in 1989 to 27 percent today.

Arizona has made an effort to align Medicare and Medicaid coverage through the same company for dual eligible beneficiaries. The state requires program contractors to offer a complementary D-SNP for dual eligible ALTCS members and has acted on two occasions to change their Medicaid coverage to the company through which they have Medicare coverage. The state has succeeded in enrolling about one-third of Dual Eligibles into the same plan for Medicare and Medicaid. Arizona is not currently participating in the Duals Demonstration.

Arizona has also advanced value-based purchasing through its Payment Modernization Plan in Medicaid. In 2013, the state required ALTCS managed care plans to have sharing savings and value-based purchasing arrangements with its providers – for 5 percent of its spending, growing to 50 percent by 2017.

Culture

UHC is a large, national for-profit managed care organization with a major national presence in the Medicare Advantage market, offering Medicaid products and Medicare special needs plans for dual eligible (D-SNPs) in 32 states and the District of Columbia. The company works with large networks of providers, emphasizing the use of data to drive provider and consumer behavior. UHC has a long history of participating in Arizona's Medicaid managed care programs and in ALTCS.

Type of Health Plan

UHC is a national network-model health plan that contracts with and manages the services provided by independent health care providers. UHC operates Medicaid Managed Care and Medicare Advantage plans in Arizona. It contracts through Arizona's Medicaid LTSS program (ALTCS) to provide comprehensive services for a subset of Medicaid eligible persons living in nursing facilities and in the community who have an institutional level of need for care. The plan contracts with a network of select home and community-based and nursing facility providers, and manages care through care managers on staff.

Population

Participants in ALTCS must meet the State's institutional level of need standard. UHC's Medicaid managed care plan in Arizona has 500,000 members, of whom only 9,500 are in ALTCS. Less than a third of UHC's ALTCS members are also enrolled in UHC's complementary FIDE-SNP.

UnitedHealthcare SCO (Massachusetts)

UnitedHealthcare offers a Senior Care Options (SCO) plan in Massachusetts. SCO is a Medicare FIDE-SNP that combines Medicare and Medicaid benefits, including LTSS, for dual eligible individuals age 65 and older. The UHC SCO plan was launched in 2004, and currently has 15,600 members across the state. UHC operates other Medicare Advantage and commercial health insurance plans in the state.

State Medicaid Environment

Massachusetts has had managed care in Medicaid since 1997, but continues to provide fee-for-service coverage for many Medicaid participants with long-term care needs. In 2004, the state launched the Senior Care Options (SCO) demonstration program to align Medicare and Medicaid coverage for dual eligible beneficiaries via a single-three-way contract between the state, the federal government, and participating health plans. In 2009 the SCO program was made a permanent option for dual beneficiaries.

SCO enrollment is limited to Medicaid participants age 65 and older, not all of whom are Medicare eligible. Enrollment in SCO is voluntary for Medicaid participants. Dual eligible individuals who enroll receive Medicare and Medicaid coverage from the plan. As of June 2015, there were nearly 38,700 individuals enrolled in SCO programs across Massachusetts, about 30 percent of the population eligible to enroll. A subset of these need LTSS.

The SCO program incentivizes plans to keep members in lower-cost community settings rather than in institutions. A 2013 evaluation of SCO found that the program significantly decreases nursing home admissions compared to fee-for-service Medicaid.

Massachusetts is participating in the Duals Demonstration with the One Care program, which combines Medicare and Medicaid benefits for dual eligible individuals between the ages of 21 and 64. Participating plans began enrolling members in October 2013.

Culture

UHC is a large, national for-profit managed care organization with a major national presence in the Medicare Advantage market; offering Medicaid products and Medicare special needs plans for Dual Eligibles (D-SNPs) in 32 states and the District of Columbia. The company works with large networks of providers, emphasizing the use of data to drive provider and consumer behavior. UHC's SCO program is operated under the Community Plan division of UHC which oversees Medicaid and D-SNP plans and is distinct from Medicare Advantage program management.

Type of Health Plan

UHC operates its national networked managed care model in Massachusetts, providing Medicare Advantage plans and commercial health plans in the state. UHC offers a FIDE-SNP integrated Medicare-Medicaid plan for elderly Medicaid and dual eligible populations through SCO. The FIDE-SNP enables enrollees to get coverage for fully integrated medical care, behavioral health, and LTSS from a single plan. Massachusetts does not have managed Medicaid plans aside from SCO and the One Care Duals Demonstration for younger disabled persons.

UHC's SCO program contracts with UHC's network of health care providers for medical and behavioral health, and with the Aging Service Access Points (ASAPs) to provide LTSS through its network of community organizations and service providers. UHC contracts for less intensive care management through staff of the ASAPs and employs its own staff with higher levels of training (NPs, PAs, and RNs) to manage members with more complex care needs.

Population

The population enrolled in SCO is a limited to seniors, nearly all of whom are Dual Eligibles. Not all SCO members have LTSS needs.

About 30 percent of dual eligible seniors in Massachusetts are enrolled in SCO and about 40 percent of these are in UHC's SCO. UHCs SCO, with 15,600 members, is a relatively small plan compared to UHC's other Medicare Advantage (42,000 members) and Commercial managed care (78,000 members) plans in the State.

Care Model

> - Programs in the study employ similar care models for their members with LTSS needs. Despite similarities, care models in these programs differ in the extent to which they vary the intensity of care management in relation to the member's need or risk, engage and share or pool information with medical providers, and rely on multidisciplinary care teams.
> - Study programs pursue a number of common strategies to achieve desired cost and quality outcomes. These include:
>   - comprehensive assessment;
>   - risk stratification and variation in care management and services based on risk;
>   - designating care managers as a single point of accountability for the member;
>   - titrating services and supports;
>   - managing hospital and institutional utilization; and
>   - managing care transitions.
> - Care management is, in and of itself, a valuable benefit for members and their families and a key tool for achieving cost and quality outcomes. Care management appears to contribute significantly to unlocking the value of LTSS in achieving desired cost and quality outcomes for the member and reducing utilization of high-cost medical services.

The care model in an integrated plan is at the heart of what the plan or program does to organize services and supports to meet an individual member's needs, goals, and preferences and to manage the total costs of providing care and obtain the outcomes the plan seeks.

Our research hypothesis is that the activities of a program that integrate LTSS and medical care—what we call the "components of integration," which are different in a program that integrates LTSS than in a program that does not integrate LTSS—are key to the plan or program's success in achieving lower overall costs and better outcomes. The component of integration that is central to everything the program does to manage care is the care model.

Care Model Definition

The care model encompasses the interaction between the plan or program personnel and the member and member's caregivers to arrange and provide medical care and social services and supports for the member across settings. The care model includes:

- *Risk stratification:* the approach the plan or program takes to stratifying the eligible population on the basis of level of need or risk;
- *Care management:* the assignment of a care manager to the member and the timing and protocol for engagement of the care manager with the member and family (whether in-home or telephonic);
- *Functional assessment:* the timing and process for assessing the member's functional capacity and need for services, and the comprehensiveness of the assessment;
- *Care planning:* the process for preparing, implementing, and amending a care plan for the member – and the comprehensiveness of the care plan;
- *Care manager authority:* the scope of the care manager's responsibilities and relationship to and influence with medical and LTSS providers, and whether the care

manager is a single point of accountability for the member;

- *Care coordination:* the process of identifying and making arrangements with service providers, engaging the member and family and service providers in making decisions about care, and maintaining effective communication regarding the member and care plan among service providers and across sectors;
- *Interdisciplinary care team:* the use of interdisciplinary teams or other means for coordinating care with providers across sectors, and whether the team meets face-to-face or virtually;
- *Care transitions:* the approach to care transitions and the connection the plan or program has with the member in a hospital or nursing home and with the discharge planning and other activities intended to provide a smooth and sustainable transition for the member from setting to another; and
- *Quality measurement and accountability:* the method for evaluating the care plan, the delivery of care, and the impact on goal attainment and specified outcomes for the member.

Care Management Process

The care model and it's approach to care management is an essential component of a managed care plan that holds risk for LTSS. It is not only an important tool to integrate care delivery, but also a valuable LTSS-related benefit for members who enroll in plans that cover LTSS. The majority of Medicare beneficiaries with LTSS-level need are in traditional, fee-for-service Medicare and lack insurance coverage for LTSS. These beneficiaries and their families either manage their care themselves or hire someone to do it for them.

The programs we studied employed generally similar care models for members with LTSS needs. Members are assessed upon enrollment to determine their functional capacity and

level of need, and, at least for those with a moderate-to-high level of need, a care plan is prepared. A care team, including a care manager, is designated to coordinate care and assist the member in implementing the care plan. The member's care manager takes overall responsibility for the member's care across settings, identifies and engages service providers on behalf of the member, coordinates care and communicates with the member's primary care provider and other service providers, monitors the member's condition and progress in achieving the care plan, and works with the family and caregivers on making adjustments to the plan.

Despite the general similarities, the care models in these projects varied in the extent to which they applied a uniform care model across their entire LTSS population or varied it according to the member's level of need. They also varied in the extent to which they engaged medical providers and shared or pooled information with the medical team. And they varied in size, composition, and frequency of convening of the care team.

Assessment and Care Planning

The programs we studied conduct an initial assessment with new members and periodic assessments thereafter to identify medical and functional needs and to develop and modify an individualized care plan for the member. Members typically complete a health risk assessment initially, the results of which may be used to stratify members for care management. The programs also do some form of functional assessment to determine LTSS need.

Some of the programs we studied do a comprehensive assessment (which would include health and mental health needs, functional capacity, family support, and environmental resources, strengths and goals, and other domains) for all of their members, while others do a comprehensive assessment on only a subset of their members – usually

those who are already receiving LTSS, have the most complex needs, or have the highest risk of need for services. Comprehensive assessments are typically done by the care manager, in-person in the member's home, to get to know the member and more accurately assess the member's social and physical environment and available resources.

In some states, Medicaid rules require programs to conduct comprehensive assessments on every member. The programs participating in the Medicare's financial alignment ("Duals") demonstrations are required to complete on every member an in-person comprehensive assessment that includes medical, behavioral, functional, and social needs.

Care Management

The programs we studied focus a great deal of attention on the care management personnel and process. Typically, the programs assign a single care manager to take responsibility across sectors for developing and executing a single care plan and to be accountable for a member's cost and quality outcomes.

Effective care management can achieve cost savings and quality outcomes by aligning services with the goals and preferences of the person and family, gaining the person and family's trust and their compliance with the care plan, supporting family caregivers, and coordinating care among providers to align it with the care plan and avoid costly and unnecessary use of services. Effective care management can also identify and address, early on, circumstances or issues that could affect the member's stability in their home setting, and arrange services and supports to enable the member to remain in place longer and defer hospitalization or institutionalization.

The reach and authority of the care managers was another important variable. In some of the programs we studied, care managers had the authority to oversee and coordinate care comprehensively – encompassing medical and behavioral health, and LTSS – for members who had both medical and LTSS coverage from the same health plan.

Programs that did not have every member for both medical and LTSS typically assumed a looser approach to care coordination and communication with the medical providers. In some cases, medical utilization management and oversight was handled by a different unit than the Medicaid LTSS unit, although the LTSS care managers coordinated with this unit and with the medical providers. One of the programs with many of its Medicaid managed LTSS members in a different arrangement for medical care (either in Medicare Fee-for-Service or another MA plan) had difficulty getting basic information from the medical care plan on their members' primary care providers and utilization of medical services. By contrast, in a different program, with LTSS members also covered in other Medicare plans, the care manager had overall responsibility across sectors and engaged the medical providers, even on behalf of LTSS members with medical coverage through another plan.

Similar hand-offs occurred in some plans covering both nursing facility and home and community-based care, which managed care in the each setting through care managers unique to the setting. Institutional care managers were assigned to a particular nursing facility and worked with the facility's personnel to manage cases within that setting, while community-based care managers organized around the individual members in their home setting. The advantage of this approach is that the institutional care managers develop strong relationships with the facilities and facility staff and have greater leverage to influence decisions on behalf of their members. However, for members that transition across settings, care managers must coordinate care across these administrative

divisions and there is not a single point of accountability.

Care Coordination and Care Teams

A key component of the care management process is care coordination among the various providers involved in a member's care. Care coordination is accomplished through communication between the care providers, facilitated by a care manager. Care coordination can be in response to a particular event or ongoing in relation to a member with complex care needs. It typically involves a care team that can be a standing core team comprised of a care manager, one or more providers and the member and member's caregiver. Care coordination for members with more complex care needs will involve a broader array of providers and professionals brought together virtually or in-person as an interdisciplinary care team.

Care coordination is an effective tool in programs that integrate medical care and LTSS for aligning the care manager, the various providers, and the member and member's caregivers around a single care plan, managing the implementation of the plan, and reducing the potential for unnecessary care, duplication of services, or gaps in care. It minimizes the potential for discontinuity and omissions in the care process, and enables feedback to providers on the outcomes of the care provided. Care coordination can be facilitated by the capacity to share, electronically or otherwise, information on the member's assessments, care plan, and services that are provided.

Most of the programs we studied had interdisciplinary care teams of one form or another that oversaw care plans and were vehicles for care coordination. We saw only a few examples, though, of standing interdisciplinary committees that met in-person, reviewed cases, and solved problems or closed gaps in care. The standing committees we saw had overall responsibility

for a small high-risk/high-need population, that met regularly, to review cases and respond to issues as they arose. PACE, for example, employs a diverse 11-member team that meets daily and regularly reviews the status of all its small number of members. The Health Plan of San Mateo maintains an interdisciplinary "core group" that meets regularly and reviews cases of the members in its Community Care Settings pilot.

Other than these instances, most standing care teams were small core teams, consisting of a care manager, one or more providers, and the member and member's caregiver, assigned to a specific caseload. The types of professionals engaged in the core team might vary depending on the member's primary condition and level of need. The core team could interact virtually (by phone or e-mail) or in-person. A broad array of specialists from other disciplines were available to be brought into the mix to address a specific issue for a specific member. This extended care team would most likely operate virtually.

Two of the programs we studied had the capacity to connect a member's LTSS information and electronic medical record, and to make that combined record available for members of the care team and other providers to view and enter information on services. The capacity to create and share an integrated electronic record within the member's circle of providers can be of great value in coordinating care for the member. Most of the programs we studied did not have an integrated record across medical care and LTSS, and sharing information within the core or extended care team involved some paper transfer.

Outcomes and Quality

Monitoring implementation of the care plan, measuring progress toward goal attainment and the effect on the member's quality of life, and making adjustments where necessary to improve outcomes are important aspects of the care model. In the programs we studied,

individual performance measurement and accountability is built into the care model and is a subject of discussion by care teams and in case reviews. While the programs we studied appear to be thinking about quality metrics that might be appropriate for LTSS, particularly home and community-based care, there are no independently developed quality metrics in use today to get at these issues. We did not see evidence in these programs of a formal monitoring and quality improvement process linked to individual members and their care plans, outside of the process for evaluating performance of care managers.

The programs we studied are collecting and reporting to the state and CMS an array of outcomes measures. Some of the states have well-developed quality measurement programs, in some cases tied to payment. The measures reported to the states and CMS are aggregate measures of clinical and financial outcomes and consumer satisfaction, including HEDIS and CAHPS scores. These measures focus on health measures and standard clinical outcomes and do not relate to the transactions or outcomes that are relevant for populations with functional limitations.

Some of the programs we studied go beyond the state and CMS requirements and measure, for their own purposes, aspects of care more directly related to the LTSS population, such as risk of falls. There are efforts within the parent organizations of the some of the programs we studied to develop measures that would be of value in measuring progress and outcomes on both an individual and a program level.

Outcome and quality measurement on a national scale relevant to LTSS and integrated care is generally lacking and in need of development. The Dual Demonstrations are testing a set of metrics related to integrated care delivery for dual eligible beneficiaries. These include process measures related to aspects of care planning and care

coordination. A number of national projects are underway at various quality-focused organizations to develop quality measures for home and community-based services, but there has been no significant movement toward LTSS outcomes measures to date.

Care Management Strategies

The programs we studied were focused on meeting members' needs and enabling members to remain in the appropriate setting for as long as possible. Providing a high level of care management, care coordination, and supports and services in the home is an expensive proposition. All of the programs were additionally motivated by either the overall financial risk they bore for the cost of care or by specific financial incentives in their payment rates, to manage care to achieve savings. Savings could occur either in LTSS expenditures through efficiencies in LTSS delivery (supporting members needing LTSS in less expensive settings or with less intensive services), or in a reduction in total expenditures for the member through strategic use of LTSS to avoid expensive or intensive medical or institutional settings and services.

It appears likely that LTSS can be cost effective in the context of full capitation when well-targeted and regularly adjusted to meet specific needs. Programs report being able to maintain members in their homes and in the community with less hospitalizations and institutionalizations when LTSS are managed so that they are provided when and where they can have the most benefit.

According to exemplar plans, the key to achieving member outcomes and savings in programs that integrate LTSS involves one or more of the following tactics:

Comprehensive Assessment

The programs we studied use a comprehensive assessment to develop a complete view of the member: their history,

goals and preferences; their medical, behavioral, nutritional, and functional needs; and their individual, family, and environmental resources. Often this assessment occurs in the person's home to gain a better understanding of the whole person in their setting. This comprehensive view enables the program to identify and address factors in the member's circumstances or environment that contribute to the health and functional capacity of the member and that would not be surfaced in a traditional health risk assessment or service needs assessment. It also enables the care manager to identify opportunities to incorporate family caregivers in the care plan or wrap around resources available in the community and thereby minimize the amount of paid care needed.

Most of the programs we studied used a comprehensive assessment with members who were previously identified as high-risk or high-need through a health risk assessment or initial screening. Programs that serve only a high-risk/high-need population do a comprehensive assessment on all of their members.

Some programs that serve a broad population choose to do a comprehensive assessment on every member as a preventive strategy – identifying potentially significant needs before they develop and bringing an array of social services to bear on situations before they develop into more acute medical problems. Comprehensive assessments for all members, while expensive to administer, can potentially enable programs to identify and address members' lower level needs before they become more complex and costly to manage. It also enables the program to provide supports to stabilize members in their home and avoid the admission to a hospital or a nursing home stay that can then trigger more complex care needs.

Comprehensive assessment and care planning also enable the care team to identify a broad

array of existing resources, including family and community supports, and address supports to enable these to remain in place and avoid use of more costly paid services to support the member.

Some of the programs we studied use assessment data along with medical utilization data to determine each member's level of need and likelihood of changes in that need that can be predictive of future costs of care. This predictive data serves as the basis for risk stratification and targeting of services.

Risk Stratification and Targeting

Intensive care management and the provision of LTSS can be costly and produce a limited response if provided generally to a large population. One of the strategies integrated programs use to manage costs and improve outcomes for members with complex care needs is targeting high intensity care management on a subset of high-risk members. Targeting assures that the volume and intensity of services are appropriate for the level of need, and are not more intensive or of longer duration than necessary.

The programs we studied assess functional capacity and level of assistance needed for program members and grade the level of care management and LTSS needed for a particular time. The level of need is reassessed and adjusted over time. The programs in our study identified a subpopulation of members who would benefit most from an intensive care management program. This is typically the subpopulation that will be highest users of care and account for a substantial portion of the program's medical care expenditures.

Some of the programs use a form of predictive analytics to identify community-based members at highest risk for a medical event, hospitalization, or institutionalization in the near future. One program we studied uses a "Significant Episodes of Cluster Activity" (SECA) data analysis in addition to data from

its assessments to identify the 1 to 2 percent of its membership that will have the greatest impact on overall plan costs. The plan monitors these members carefully for changes or deterioration in condition and intervenes with an interdisciplinary team to solve problems and prevent unnecessary ER or hospital admissions.

Variation in Care Management

The programs in our study that made intensive care management and care coordination with interdisciplinary teams generally available to its members had a membership exclusively of high-risk/high-need persons. In the programs that served a broader population, the intensity of care management (e.g., the level of professional certification of the care manager, the frequency of contact with the member, the amount and breadth of care coordination and communication among providers) varied substantially in relation to the level of the member's needs or perceived risk. These programs stratified the population and targeted high intensity care on the basis of risk, need, or utilization.

State requirements often dictate levels of care and minimal requirements for care management and caseload at each level of need. Programs in the study went beyond minimal requirements in staffing and coordinating the most intensive level of care. A typical structure in the programs we studied employed three levels of care management:

1) A low intensity or routine level of care need may follow from a hospital discharge or other event. Many states require that every person who receives any HCBS be assigned a care manager and contacted periodically. Care management may be provided by trained care coordinators through periodic telephonic contact and may continue as long as there are ongoing needs. Post-discharge, more-intensive care management may be provided by a special

transition team only until the member is stabilized in the home. If needs continue after stabilization, care for the member may be managed for a longer period of time through telephonic contact.

2) A moderate level of need may result in more-intensive care management, with a nurse or social worker and may include periodic home visits. This level of care is intended to be short-term -- care management will continue at this level only so long as there is an ongoing moderate level of need.

3) Intensive care management is usually provided for a specified period and targeted to members transitioning to their home and community from institutional care or at high risk of needing institutional care. The level of care management may involve a high level of team-based care coordination with a care manager with the authority to command services for the member across settings.

Single Point of Accountability

One of the benefits of an integrated approach that enables care coordination across sectors is the capacity to have a single care manager (working with an interdisciplinary care team, a single plan of care and an integrated information system) to be the primary contact and advocate for the member, manage cross-sector interactions to ensure a seamless process for the member, and assume primary responsibility for monitoring and evaluating all member care. Some of the programs in our study provided a care manager, assigned to the member, with responsibility and authority to oversee all parts of the system of care.

The designation of a single point of accountability assures that for each member there is a person responsible for overseeing the interaction of that member with the array of services and professionals and monitoring

the progress of the member in relation to their own goals and preferences. This function has the greatest potential to avoid duplication and adverse interaction of care or simply loss of attention to the member and the member's care plan.

Utilization management

The programs we studied are most successful when they minimize hospital admissions and readmissions and nursing facility admissions, and sustain members in their homes and communities. Utilization management (UM) in the programs we studied employs many of the UM techniques used in managed health care generally to manage admissions, stays, and discharges. These programs seek to prevent unnecessary or inappropriate hospitalizations or nursing home placements for members and seek to encourage discharge to a nursing facility or home setting as soon as appropriate. Some of the programs we studied that hold medical risk use prior authorization for hospitalizations and expensive procedures, and employ concurrent review, discharge planning, and transition management to shorten stays and ensure stable transitions to home and community-based settings.

Some of the programs we studied have strong state-provided incentives to reduce nursing home utilization and to transition those nursing home residents able to be supported in their homes to the community. Arizona's ALTCS program has successfully encouraged participating managed LTSS programs to provide more substantial home and community-based care to enable more of the population in institutions to transition to the community. Health Plan of San Mateo launched its Community Care Settings Pilot in 2014 to employ intensive services and supports to successfully move plan members from institutions to community-based settings and to sustain community-dwelling members at high risk of institutionalization in their current setting.

Some of the programs we studied also use utilization management to ensure the LTSS provided are appropriate and that the program makes the best possible use of personal, family, and community resources. One of the programs we studied uses cost thresholds for LTSS services that effectively provides the care manager with a budget within which there is flexibility to authorize additional services for the member. As the member approaches the limit the care manager can leverage additional family or community resources. The program can authorize services above the threshold if necessary to maintain a member in their home and prevent or delay institutionalization.

Titrating Services and Supports

The needs of members change over time. Active review and management of care ensures high value use of LTSS and avoids the potential for long-term use of unnecessary or inappropriate or excess levels of care. The programs we studied conduct an initial assessment and then periodic reassessments and adjust the amount and type of LTSS as members needs change. Intense services may be needed to support a person's transition to the community and then reduced as the person and family stabilize in their home. The program will work with the person, the primary caregiver, and key family members to reduce the level and type of paid services and supports and encourage family members as the person stabilizes in the home. Care management can help avoid over-medicalizing care by making more aggressive use of LTSS when it can reduce or avoid medical care that might otherwise be needed. In other cases, the programs may initially provide a limited amount or least expensive option for services and evaluate its impact and then gradually increase the amount or type of service if needed. Programs will also periodically review care plans and make adjustments as needs change.

In one of the programs in our study, care managers review services with members, families, and PCPs periodically or when members' needs change. Care managers, with the consent of the member and PCP, may reduce services, gradually eliminating services that do not add value to achieve the member's goals, or increase the amount or type of service to better meet needs or anticipate future needs.

Managing Hospital or Nursing Home Utilization

The admission of a member to a hospital or nursing home significantly increases the program's expenses for that individual. In many cases, a hospital or nursing home is not the most appropriate setting for care for the person, and the admission is the result of a failure to provide adequate support in the home. The program that covers hospital care, nursing home care, and home and community-based care can work with physicians, hospitalists, and community providers to ensure adequate care is available in the home, physician orders are appropriate, and members are admitted and retained in a hospital or nursing home only when necessary and only for as long as is necessary.

Some programs in this study use gatekeeping functions – either through a care manager who oversees care in all settings, through a primary care provider with authority to write orders, or through another mechanism (e.g., a hotline for members to call during an emergency). PACE has an employed physician who must authorize a hospital admission unless there is an emergency. Some programs in the study also have or coordinate with an inpatient utilization team that monitors services and works with the discharge planner. Some programs have an interdisciplinary team that reviews readmissions to identify services and supports that could reduce the need for future readmissions.

Managing Care Transitions

A key element of care management is management of transitions between care settings to ensure members are stabilized in the new setting and not at risk for a return to the prior setting. Programs manage transitions for various populations between hospitals, skilled nursing facilities, and home and between other institutions and home.

Important elements of transition management that have an impact on how well-stabilized a member will be in the new setting are: early notification to the care manager of an initial change in setting (ER visit, hospitalization, nursing facility admission), engagement of the care manager and the member's family in discharge or transition planning, coordination through an interdisciplinary care team to arrange services and supports in advance of the transition, a short period of intensive services and supports post-transition, and monitoring and follow-up by the care manager to adjust services and supports once the member is established in the new setting.

The programs in this study all have care transition management, and a few put additional effort into identifying and solving problems that are causing a high number of re-hospitalizations. Several of the programs we studied followed an evidence-based model for transitions in care, such as the Coleman Model, that have been demonstrated to reduce hospital readmissions and costs resulting from transitions.

The programs we studied that covered and reimbursed medical care and LTSS were most likely to have a process for early notification to a care manager of a change in the member's setting, and to have an inpatient utilization management team in place in a medical or nursing facility to initiate transition planning and coordinate with the care manager. The programs that did not cover the medical care for an LTSS member were not likely to be alerted to a change in setting until

the start of discharge planning for the member. Coordination with the hospitalist or discharge planner was also more challenging with regard to a member for whom the program only held LTSS risk.

Impact of the Care Model

Programs we studied believe they achieve success through care management and their care models in lowering costs and improving quality outcomes for populations that have the most complex care needs and are high users of expensive LTSS and medical care.

The most integrated of the programs we studied—ArchCare's PACE program— relies heavily on the interdisciplinary team that coordinates care for all members, has a problem-solving focus, and is the single point of accountability for member cost and quality outcomes. All of the members in PACE are at the institutional level of need. ArchCare believes reliance on the PACE team-based model combined with ArchCare's strategic approach to partnering with select LTSS providers and its evidence-based approach to interventions provides better-targeted and more effective LTSS that reduces hospitalizations and institutionalization.

ArchCare has less capacity to manage outcomes in its I-SNP and MLTC programs, largely because of the population enrolled in one or the other of these plans they have only a small subset enrolled in both. For the population enrolled in both programs, they believe they are effective in managing care and achieving quality outcomes. For this group enrolled in both, they can get the information they need on diagnoses and treatment, they are notified earlier of hospitalizations and can better manage transitions, and with better health information can intervene earlier to prevent hospitalizations. Nevertheless, they see the added value of the PACE program and its integration of the employed physician in the care process.

Health Plan of San Mateo has measured success in reducing institutionalization with its Community Care Settings pilot. The program is designed to assist institutionalized members who could transition to the community and members in the community who are at highest risk for institutionalization. It provides intensive short-term care management to enable the member to stabilize in their home and community. The program has measured savings of $6 million from intervening with 50 institutionalized members.

UnitedHealthcare of Arizona points to its focus on behavioral health and its Member Empowerment (ME) initiative as keys to success in managing costs and improving outcomes and quality of life with its institutional level of care members. UHC assesses all members for behavioral health needs and assigns members with the most complex needs a specialized care management team. Its ME initiative creates a culture of person-centeredness that fosters a close and trusting relationship between the member and the care manager and contributes to a high rate of member goal attainment and an unusually high retention rate in the plan.

Superior STAR+PLUS in Texas presents its comprehensive care model that integrates medical care, behavioral health, and LTSS as the foundation for its success in improving quality and controlling costs. Key factors are the plan's stratification of risk and targeting of enhanced care; its flexible benefit design that provides non-traditional services as needed funded either as value-added benefits or under the administrative budget; and its calibration of services to members' needs to avoid duplication or overprovision and to leverage existing family support and community services.

UnitedHealthcare of Massachusetts emphasizes its high degree of Medicare and Medicaid alignment, comprehensiveness of its benefits, and oversight by a single care

manager who has responsibility for the full range of care: medical, behavioral, and LTSS. Its care model also builds off of the plan's years of experience with integrated care for nursing facility residents. A state evaluation of SCO shows program success in keeping members in the community and reducing SNF utilization. UHC also has a high member retention rate and strong membership growth.

All of these programs reference anecdotal evidence to support their belief in the success of their models. A comparison of the medical utilization and quality outcomes of members in these programs with similar data for the Medicare fee-for-service population would inform a better understanding of the impact of these integrated care models on overall costs of care and member outcomes.

Provider Alignment with Program Objectives

- Programs need to align incentives and work collaboratively with network medical and LTSS providers in order to achieve cost and quality objectives for integrated LTSS.
- Alignment of coverage and financing for program enrollees covered by multiple funding sources greatly enhances the potential to align incentives and collaborate with providers. However, a program's influence with providers can be diminished by inadequate market penetration as well as by state law restricting selective contracting or preferred provider arrangements.
- There are a variety of tolls that a program can employ to strengthen provider alignment. These include: employing providers, selecting and designating preferred providers and narrowing networks, leveraging contractual requirements, providing financial incentives, and engaging in proactive and frequent communication with providers. Forging strong relationships with providers and having a provider champion for program can be particularly effective.

Introduction

Medical and LTSS care providers play pivotal roles in an integrated program's capacity to achieve cost and quality objectives. Providers make decisions on and authorize care, monitor care and outcomes, and evaluate and adjust care plans. In order to ensure the best possible cost and quality outcomes for their members, integrated programs must align incentives and work collaboratively with providers.

A variety of providers play significant roles in integrated care delivery. *Primary care providers (PCPs)*, many of which are physicians, have lead responsibility for the member's medical care and can play a central role in overseeing the totality of care in an integrated program. Often, however, PCPs are poorly prepared to make judgments on and manage non-medical services. *Hospital and nursing facility staff* control decisions about services and costs for members who are admitted, often with limited involvement from other professionals in the member's care team. The way staff of these institutions manage patient transitions and respond to

adverse events can have a significant impact on overall outcomes and costs for the member. Coordination and communication among all of the providers caring for an individual across settings can improve results for members, but can be very difficult to achieve. *In-home personal care providers* also play an important role in integrated programs. These providers can serve as the "eyes and ears" on the member for an integrated program, offering day-to-day observations on the individual's status and needs. Other less frequently used providers—*assisted living, behavioral health, specialists, therapists, and meals and transit providers*—may also offer important information that creates unique opportunities for programs to improve member care. However, in order for these benefits to be achieved, programs must effectively engage providers in care management and align provider incentives with program objectives.

Most of the programs engaged in LTSS integration, including most of those in our study, are operated by managed care health plans that contract for services through

networks of independent providers and provider organizations. In most cases, these plans do not have exclusive relationships with the providers, although they may have significant volume in their practices. These models rely on a variety of tools the program controls, including payment incentives and utilization management, to align independent providers with the program's objectives and assure high levels of coordination. A relatively small number of programs have a staff model for care delivery, in which many of the care providers are employed by the program. ArchCare's PACE program is an example of this model, providing much of its member care through staff physicians and other clinicians.

External Factors that Effect Program Alignment with Providers

A program's success in aligning provider and program incentives and engaging providers effectively in care management and coordination depends on the significance of the program's payment decisions to providers across settings—including physician, hospital, and institutional and community-based LTSS. Several factors outside of a program's control can constrain or enhance their ability to do this. These include the extent to which medical and LTSS coverage is aligned in the program population, the program's share of individual provider's patient panels, and state and federal regulation.

Alignment of Medical and LTSS Coverage

Few of the programs we profiled provided both medical and LTSS coverage across their entire enrolled membership. ArchCare's PACE program and United's SCO plan in Massachusetts are the exceptions—in these programs, every member receives all of their medical and LTSS coverage from the program. In the other programs, a share of the population is enrolled for only medical or only LTSS coverage. Often, dual eligible members who have Medicaid LTSS coverage with the program have their Medicare medical coverage

elsewhere, either through Original Medicare (i.e., fee for service) or another organization's Medicare Advantage plan.

To effectively integrate care, programs need the capacity to align providers across the spectrum of care, not just medical care or LTSS providers. Control over payment for services is central to the relationship between a health plan and its providers. The programs in this study often struggled to engage providers with whom they did not have a payment relationship.

A major factor interfering with coverage alignment is federal policy that guarantees an individual's right to choose where they receive their Medicare coverage, whether that is in a Medicare Advantage plan or Original Medicare. Some states have adopted policies that increase alignment of medical and LTSS coverage for Medicaid beneficiaries without compromising the individual's right to choose. In Massachusetts, dual eligible individuals can only enroll in the SCO program if they choose to receive both Medicaid and Medicare coverage from the program. Arizona's state Medicaid agency periodically moves dual eligible beneficiaries' Medicaid coverage to the plan where they are enrolled for Medicare Advantage coverage. Federal programs have also been developed that address this constraint. PACE programs, FIDE-SNPs, and programs in the Duals Demonstration all require that members receive both Medicare and Medicaid coverage from the same program.

Share of Individual Provider's Patient Panels

Medical provider engagement with an integrated program may be affected by the share of their patient population enrolled in the program. When a significant share of their panel is in the program, providers are more likely to be familiar with the program, respond to care manager outreach, and be collaborating clinically with the program and aligned with the program's goals.

A number of factors drive the concentration of program members across providers. To a large extent, market share within a geography dictates program influence. Health Plan of San Mateo, for example, covers nearly all Medicaid beneficiaries and the large majority of the dual eligible population in their region, while United's SCO program covers only about 12% of dual eligible individuals age 65 and older across the entire state of Massachusetts.[102] A program can also exert influence on providers through market share of their parent organization. In Arizona and Massachusetts, United does not just cover members of the integrated program, but also has large Medicaid, commercial, and Medicare Advantage populations. The organization's widespread presence means that it contracts with almost all hospitals in states where it operates, and can leverage these relationships to improve member care. For example, the United plan in Arizona receives daily census reports from hospitals across the state, and is thereby notified of admissions for their ALTCS program members, even those who have medical coverage with another plan.

Regulation

State and federal regulation prescribing elements of the relationship between providers and integrated programs can constrain integrated programs' ability to work with a limited group of providers and thus have greater member concentration with and engagement from its providers. Network adequacy requirements—for both Medicare and Medicaid—may also limit program flexibility to operate a smaller preferred provider network. Additionally, some state Medicaid agencies set the payment rates that plans pay providers, and may dictate that plans must contract with "Any Willing Provider." In Texas, for example, plans in the

STAR+PLUS program were required initially to contract with all traditional LTSS providers, preventing them from developing a preferred provider network for HCBS or institutional care, at least in the early stages.

Some states are supporting financial alignment and strengthening plan influence by promoting the use of payment incentives to reward provider performance. In Arizona, the state Medicaid agency is leading an effort to move towards a value-based healthcare system. As part of this effort, Medicaid managed care plans are required to have a share of their providers in value-based purchasing arrangements. Consequently, United's Arizona plans currently have 30% of network physicians in value-based contracts that award bonus payments to practices that achieve key quality metrics.

Other External Factors

Sometimes, other conditions mean that programs cannot always influence or align with providers. In rural areas, for example, programs usually have no choice of providers and must rely on other approaches to engage providers in program activities.

Program Tactics to Align with Providers

Integrated programs use a variety of approaches to achieve alignment with providers. These include the direct provision of care; selective provider networks; contractual requirements; financial incentives; and proactive and frequent communication.

Direct Care Provision

Achieving provider alignment can be simpler and more successful for programs that directly employ providers on staff. All of the programs in our study employ care managers in some capacity to oversee care planning, care management and care coordination and to hold accountability for the member's care. In the network-model plans, the care managers work with large networks of contracted medical and LTSS providers and

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[102]As of June 2015, http://www.mahp.com/unify-files/HMAFinalSCOWhitePaper_2015_07_21.pdf Author calculations from data on pp 9-10

programs for direct care delivery. These programs purchase services from existing practices, facilities and community-based providers rather than attempt to create internally their own team of service providers. Provider-sponsored managed care organizations are another type of model. Accountable care organizations, which weren't included this study, would have an exclusive relationship with its medical providers and may employ many of them on staff. These organizations would most likely contract with existing community-based organizations for LTSS.

The one program in our study that is different is the staff model PACE program that operates. The PACE program employs a PCP and other interdisciplinary team members who provide care to enrollees in the context of a program-owned facility. ArchCare contracts out the personal care services provided to enrollees in their homes, relying largely on existing personal care workers chosen by the member. Employment of the PCP and facility staff ensures that many elements of the care plan can be executed directly by the staff, including making medication changes, ordering medical equipment, and providing therapies. Additionally, the PACE adult day health facility provides the bulk of members' medical care, decreasing the need to rely on hospitals and other outpatient providers. Employing the PCP ensures their capacity to oversee all of a member's care, including hospital admissions. ArchCare is able to leverage the PCP for strategic utilization management during inpatient stays and for transition management. PCP engagement in these processes can be a powerful tool for effecting cost and quality outcomes, but it is rare for health plans to get this degree of engagement from their network providers.

UnitedHealthcare in the SCO program employs an NP to coordinate and lead member care in the institutional setting. The NP communicates with the member's family, PCP,

and facility staff; oversees facility care; and provides preventive, primary, and basic acute care. Although this is a costly intervention, United has found that this approach pays for itself by reducing hospitalizations and attracting new members to the plan. Another plan in our study cautioned, however, that inserting a plan practitioner into fully-staffed facilities had the effect of dis-intermediating the facilities' resident clinicians and absolving them of their responsibility for patient outcomes. This plan focuses instead on supporting the relationship between the member and their providers, and on holding providers accountable for cost and quality outcomes.

Selective Provider Networks

Several of the programs in our study selectively contract with providers and have mechanisms that encourage members to choose providers who are more closely aligned with the program's goals. This is one way that programs can increase their share of individual provider's panels. For example, Superior operates a preferred provider network with higher-quality, lower-cost physicians and hospitals. The plan has successfully engaged these providers using creative contracts that offer participants incentives and referrals. Although Health Plan of San Mateo contracts with a broad network of providers in the county, care managers encourage complex members to choose providers with whom the plan has a strong relationship. A majority of the plan's highest-risk members receive primary care at a senior clinic run by the county, and many members receive behavioral care through the county-run Behavioral Health and Recovery Services. The plan collaborates closely and frequently with these providers, which facilitates information sharing and care coordination for members.

The programs in our study rely for institutional and home and community-based LTSS on existing networks of community-based

providers. On the continuum from "buy" to "build," we had no instances outside of the PACE program of managed care organizations building their own LTSS care system. Plans in our study contracted on a fee-for-service basis with existing provider organizations, with no evidence of preferred provider arrangements or quality or financial incentives differentiating LTSS providers.

We also saw little evidence among the programs in our study of plans selectively contracting with LTSS providers or narrowing the network of LTSS providers they work with. Laws in some states aim to protect the existing system of nursing homes and other LTSS providers. Texas requires plans to contract with "any willing provider" in the LTSS network, at least initially. In Massachusetts, the SCO plans contract with the area agencies on aging (ASAPs) to coordinate and provide care through local LTSS providers for members with low and moderate LTSS needs.

Contractual Requirements

Health plans can employ significant tools to engage providers through contractual obligations. Contracts can require providers to participate in care team meetings, share member medical records, or achieve certain quality outcomes. The plan may not even have to enforce the contract provisions to influence providers—simply having clearly articulated expectations and the threat of enforcement may be enough to ensure that providers align more closely with program goals.

United in Arizona has a number of elements in their contracts with providers that support integration. The plan requires providers to participate in interdisciplinary team meetings called by the core care management team, and to share member medical records with the plan. United also has compliance mechanisms in place. A quality management department monitors provider compliance and a provider services department focuses on provider

education and training. Health Plan of San Mateo also leverages contract power to actively manage providers and improve member care. For example, the plan requires hospitals to quickly notify them of member admissions, and successfully ended the costly hospital practice of discharging members to SNFs without adequate transition planning.

Simply having obligations spelled out in the contract, however, may not be sufficient to fully and sufficiently engage the provider, particularly if other factors conflict, such as a state regulations or a limited share of the provider's panel. Furthermore, proactive communication and in-person contact can be effective in engaging and aligning providers even in the absence of contractual obligations.

Financial Incentives

Programs are increasingly employing or experimenting with provider payment approaches that share risk and incentivize providers to deliver higher-quality, lower-cost care. These are typically layered on a fee-for-service payment mechanism.

Several programs currently offer or are considering bonus payments to providers who achieve quality outcomes and align with program goals. Superior rewards PCPs in the STAR+PLUS program for the generic fill rate, emergency room use, and inpatient admissions rate for their patient panel. United in Arizona offers bonuses to physician practices that help them achieve goals set by the state for emergency department utilization, 30 day readmissions, diabetes management, cholesterol management, and flu shots. One plan, however, cautioned against these kinds of financial incentives, on the basis that they can make provider relationships more contentious. This can be the outcome if quality metrics are insufficiently sophisticated or risk-adjusted, and lead to disputes regarding the fairness of the payments.

United in Arizona is also experimenting with shared savings arrangements with physician practices. If the practice is able to decrease the total cost of care for their United patients, the plan will let them keep part of the savings. There is no downside risk to the providers—if spending goes up, United does not hold them responsible for additional costs. The plan serves as a resource for participating providers, sharing information about extra supports available to the practice's patients, data on member quality, cost, and utilization outcomes, and will even help the practice to hire a care coordinator. United is currently evaluating the potential to expand the program to other types of providers.

Financial incentives clearly drive provider behavior in one situation across programs: hospital admissions. When members have medical coverage through the program, hospitals contact the program immediately to have admissions authorized. Emergency room visits and inpatient admissions are significant events in terms of member costs and health outcomes, and learning about these incidents quickly is a critical to effective care management. Several plans expressed difficulty learning about hospitalizations when they only covered a member's LTSS benefits, and that this makes it more difficult to support the member and effectively coordinate care immediately following discharge.

LTSS providers are reimbursed on a fee-for-service basis in the programs we studied, for the most part. One of the programs did have a shared savings payment approach tied to quality measures for some of its nursing homes. Another plan had experimented unsuccessfully with quality bonuses with LTSS providers. Otherwise, we saw little evidence of performance-based payment, shared savings arrangements, or other financial incentive arrangements between the plans and the LTSS providers. While these arrangements may come into place over time, it appears there is still a lot of work that needs to be done with the LTSS service providers to develop the capacity to manage risk.

Proactive and Frequent Communication

An important way that programs engage providers in member care management and integration goals is through frequent, proactive communication between program staff and providers. Having a clinical champion for integration among the providers can be the key to engaging other providers. In both United plans studied, for example, care managers reach out to PCPs and other providers to share assessment information, solicit input on care plans, and address member problems and needs as they arise. Providers are generally responsive to this outreach from care managers, but if not, the program medical director contacts the provider directly and explains the importance of their participation in care team decisions. This medical director contact is very effective in engaging members' doctors. Health Plan of San Mateo has established regular, in-person meetings between plan management and key provider organizations, including meetings with county LTSS and behavioral health providers and hospitals in the region. These meetings are a place to collaboratively identify systemic issues, test potential improvements, and quickly systematize solutions. In effect, the plan has created a formal process for engaging providers on problems, and improved the quality and efficiency of the region's healthcare system.

For some programs, effective communication is built on long-term relationships and familiarity between program staff and providers. United in Massachusetts does this through consistent assignment of staff to providers. United NPs serving as care managers for institutionalized members are staffed to between two and four facilities, where they develop ongoing relationships with the nursing staff, interdisciplinary team

members, and management. United subcontracts HCBS to regional AAAs, with staff at those AAAs serving as care managers for the program's community-based members. These AAA care managers are experts on the local HCBS provider network, and have worked with these providers for many years. For inpatient management, the program uses the central United utilization management team, which consistently assigns inpatient management nurses to particular hospitals. These nurses are therefore familiar with the individual hospital's processes and staff. Staff relationships also facilitate Health Plan of San Mateo's communication with providers. Plan staff are co-located with the management of several key providers in the same office building. This, along with a history of staff moving between the organizations, strengthens relationships.

Beyond proactive communication, some programs have found that in-person contact between program staff and providers can improve care and advance integration. In Massachusetts, United's NPs visit nursing facilities with performance problems more frequently, and find that their increased presence improves performance. In Arizona, United's medical director for the ALTCS product visits physician practices personally to promote the shared savings pilot. This personal contact helps convince providers of the value of collaborating with the plan on patient care.

Program success in influencing providers through proactive communication about systemic problems and member needs suggests that many providers will respond to someone taking initiative and being accountable for cost and quality outcomes. Integration may be effective in part because programs offer leadership to a disorganized system of care. However, some providers may be responding more to the threat of financial and contractual penalties than program leadership. Most likely, it is the combination of multiple tactics—proactive communication, contractual obligations, and financial incentives—working together that influence provider behavior.

Impact of Financial Alignment and Integration

- Financial integration is crucial for creating incentives and the capacity to manage the whole member experience; this includes:
    - coordinating multidisciplinary care teams;
    - managing care across sectors and settings; and
    - creating a seamless experience for the individual.
- Financial integration is not only alignment of financial risk for medical care and LTSS, but also includes:
    - the ability to use funds flexibly for both covered and non-covered services;
    - accountability for the entirety of costs and member outcomes; and
    - the degree to which programs are required to disaggregate and report on their spending in a compartmentalized way.
- Financial integration is a necessary but not sufficient tool for achieving cost and quality outcomes. A program trying to integrate and manage care across sectors without financial alignment encounters substantial obstacles to achieving better outcomes and lower medical costs.

The overarching empirical question behind this study is whether incorporating well-managed long-term services and supports (LTSS) in a capitated, integrated health plan results in sufficiently-reduced or avoided health and institutional care costs to offset the added costs of the LTSS. In other words, can plans that hold financial risk for a population's health care utilization adopt a strategy of addressing social and environmental determinants of health and supporting functioning for members with complex care needs without increasing the total cost of care for which they are at financial risk?

To find programs that have experience integrating LTSS with physical and behavioral health today, we have to look among the managed care programs serving the population with coverage for those services – Medicaid-only and dual Medicare-Medicaid beneficiaries. The evidence we are looking for is reductions and avoidances of utilization of high-cost health care and institutional services – ER visits, hospital admissions and readmissions, nursing home stays – for enrollees who have access to integrated and well-managed LTSS.

As we look at this question, we need to look at whether financial integration is essential for program and care integration.

In theory, financial integration aligns the incentives for plans to invest in a care model that manages the full member experience. By taking financial risk for both the health care and LTSS costs, a plan can realize savings in health care spending from its spending on LTSS integration. Holding the financial risk and payment authority for both health care and LTSS enables the plan to have leverage with medical and social service providers to influence how care is delivered. Plans can get the attention and, hopefully, cooperation of providers, coordinate care across sectors, and create a more seamless experience for beneficiaries.

All of the programs we studied received funding from both Medicare and Medicaid.

Their populations that were candidates for integrated care were either eligible for Medicaid only (e.g., younger low-income Medicaid enrollees not eligible for Medicare), in which case Medicaid covered the health and LTSS services; or were dually eligible for both Medicare and Medicaid, in which case Medicaid covered the LTSS and Medicare covered physical, behavioral health, and prescription drugs.

Components of Financial Integration

We observed that there are three components to integration: financial alignment, flexibility and pooled accountability.

Financial Alignment

A starting point for financial integration is financial alignment – which occurs when an organization is holding the financial risk for both health care and LTSS for a reasonably large portion of its membership. Financial alignment allows the plan to receive and "pool" resources from both Medicare and Medicaid (and private sources if needed) that cover the full scope of medical, behavioral health, and LTSS. Financial alignment supports investment in the care management activities necessary to arrange for and coordinate care across all sectors.

Flexibility in Use of Funds

Flexibility occurs when, for practical purposes, the health plan has the ability to use resources from its different funding sources interchangeably for any covered services that are needed, and to use these resources for items and services that are not covered but are considered by the care manager to be necessary to adequately meet the needs of the member.

Pooled Accountability

Accountability is the obligation to report to funding sources on the use of funds. Pooled accountability refers to the extent to which plans or programs receiving a per capita amount per member are able to pool funds and use them flexibly to meet the needs of members with latitude in how they report the use of funds. The alternative is specific accountability, in which plans or programs are required to disaggregate funding by source and account separately to each funder for use of funds in distinct funder-specific units of service or encounters.

Continuum of Integration

In the programs we studied, the authorities we encountered, state policy decisions and plan operations, we observed financial integration along a continuum from low to full integration.

Low Financial Integration

The integrated programs that started from an MLTSS base and sought to enroll their MLTSS members in their D-SNP or I-SNP experienced the most challenges due to challenges in enrolling a critical mass across SNP and MLTSS products. Duals mandatorily enrolled in one organization's MLTSS plan are often unwilling to choose that organization's Medicare SNP, electing to remain in Medicare fee-for-service or enroll in another organization's MA plan. Federal legislation in 2008 required D-SNPs to contract with states to provide Medicaid LTSS. In addition, a number of states have attempted to improve alignment through a variety of strategies – for example, Arizona changed some members' MLTSS enrollment to align it with their Medicare MA plan. To date, these efforts have had limited success.

Programs that are attempting to apply care management across the full scope of services have found the large number of dual MLTSS enrollees for whom they do not provide Medicare coverage a barrier to integrating care.

For the subset of Duals members for whom programs in our study do have alignment, the funding for Medicare and Medicaid services comes through separate plans – D-SNP and MLTSS – operated by the organization with

restrictions on the use of D-SNP funds for non-Medicare services, participation of the D-SNP in the bid process with MA plans, and requirements to disaggregate and separately report units of service provided under each authority. The separation of financing in separate plans, complete lack of flexibility in the use of funds, and requirements to disaggregate and separately report units of service complicate program efforts to manage members' care comprehensively.

Moderate Financial Integration

Two Medicare authorities appear to provide better support for integrating federal and state funding: Financially-Integrated Dual Eligible Special Needs Plans (FIDE-SNPs) and the Financial Alignment ("Duals") Demonstration. These authorities aim to improve financial alignment by directing separate Medicare and Medicaid capitation amounts to a single plan and making enrollment in the entire integrated program optional to the beneficiary—thereby ensuring that all enrollees are being served for all of their Medicare and Medicaid benefits. UHC's Senior Care Options (SCO) plan in Massachusetts is a FIDE-SNP. UHC in Arizona also offers a FIDE-SNP. SCO achieves financial alignment because everyone enrolled in a SCO plan is enrolled for both Medicare and Medicaid. The plans have a contract with the state for Medicaid services and receive separate capitation amounts from the Medicaid and Medicare. FIDE-SNPs have greater flexibility in the use of Medicare funds and can offer supplemental benefits approved by CMS to pay for non-covered services. The fact that enrollment is optional means that only about 30 percent of senior Medicaid dual beneficiaries elect a SCO plan, the remainder are in fee-for-service Medicaid. While FIDE-SNP is more financially integrated than a regular D-SNP, the two components (SNP and Medicaid) still operate separately – requiring the SNP to go through the MA bid process, limiting the

use of MA dollars, and requiring separate reporting.

The Financial Alignment ("Duals") Demonstration is modeled after the early dual demonstrations, including SCO, and is similar in many respects. A Medicare-Medicaid plan (MMP) is a single, integrated entity with a three-way contract with the federal government and the state. Unlike FIDE-SNP, the Medicare part of the plan does not participate in the MA bid process to determine the federal payment. The MMP has flexibility in how funds may be used across funding streams and on non-covered services, although there is disagreement among practitioners about the degree of flexibility in the use of Medicare dollars for non-Medicare-covered services. Regardless, units of service still need to be disaggregated and reported separately. MMPs can passively enroll members in their plans, but must allow members to opt-out or disenroll, and MMPs have generally struggled with high opt-out and disenrollment rates. While MMPs have full financial alignment, they have achieved that for only a portion of the Duals population. Limitations appear to remain in the plan's ability to use funds flexibly and in the requirement for separate reporting.

Highest Financial Integration

PACE authority allows for the highest level of financial integration – achieved through a separate part of the statute in the Medicare law – that allows complete flexibility in the use of funds for covered and uncovered services in addition to requiring members to be enrolled for both their acute and LTSS as a condition of enrollment. PACE plans are also better financially integrated because they are not required to disaggregate and separately report use of funds by program (i.e. Medicare or Medicaid). Enrollment in PACE is voluntary, and limited by law to beneficiaries at the institutional level of need. As a result, PACE is able to achieve the highest level of financial

integration only for a subset of the highest-cost dual eligible population.

The Effect of Financial Integration on Incentives and Approaches to Care Management

Financial integration is only one factor in achieving integration of medical care, behavioral health, and LTSS. How critical is full financial integration to the successful operation of the care model, integration of the experience for the beneficiary, and the attainment of intended cost and quality outcomes?

Based on our experience with the programs included in this study, we make the following observations about the relative importance of full financial integration and the incentives that exist within a plan that integrates medical care and LTSS to achieve savings in health care spending.

1) *Financial integration is a necessary but not sufficient tool for achieving optimal care delivery for high cost populations.*

   Financial alignment and flexibility alone without an effective care model do not necessarily result in lower costs and better outcomes. A managed care organization's origins and culture, state policy in its home state, and other factors also influence the extent to which the organization can integrate medical care and LTSS and the effectiveness of its integrated care model.

   a. **Plan culture may have more influence on how plans approach care management than financial integration.**

      We observed our exemplar plans adding value to members' lives through significant amounts of coordination across medical and LTSS sectors, even for members for whom they did not

hold the health care risk, regardless of the level of financial integration or the authorities or the state health policy arrangements under which they were operating. Despite lacking flexibility in the use of funds, the exemplar plans we studied manage the regulatory environments in a manner that enables them to be creative on behalf of their members and add value. For example, Superior arguably operates in the least financially integrated environment of any of our exemplar plans. The state has only recently included nursing home services in the Star+PLUS program and maintains a rate methodology that does not encourage deinstitutionalization efforts. Further, while half of Superior's enrollees are dual eligible, only a few hundred receive their primary medical coverage from Superior.

And yet the plan analyzes financial and clinical data to identify members at the highest risk of high-cost outcomes, and then targets greater levels of outreach, care coordination and services to these individuals. It's challenging to identify high-risk members whose medical coverage exists outside of their system, but once they do, Superior can deploy a wide range of resources to support someone in the community. On a case-by-case basis out of administrative funds, the plan will provide needed services and supports that fall outside of the traditional Medicaid benefit package. Similarly, for members in UHC's ALTCS plan, where very few of its members enroll in combined UHC products, comprehensive case management is provided to all ALTCS members, regardless of whether they receive their medical coverage from Medicaid

or Medicare, or from UHC or another plan. The care manager manages a member's entire care experience through communication, comprehensive planning, and high-touch contact with the individual.

b. **The state historical and regulatory context for a managed care plan's operations heavily influences its approach to care management.**

Health plans that have operated historically and for a long period of time as primarily Medicaid plans or MLTSS plans have a different emphasis than the plans that start as integrated plans with the Medicare risk for most or all of their members. HPSM in California, UHC in Arizona and Superior in Texas operate in environments in which the program history and emphasis is around managing Medicaid LTSS. These plans have offered Medicare products to Medicaid plan enrollees fairly recently in the program history. For example, HPSM and UHC in Arizona are uniquely focused on moving institutional residents back into the community. HPSM contracts with the Institute on Aging to run a special intervention targeted to institutional residents specifically to move them back to the community. In talking to these plans, they emphasize reductions in long stay nursing home utilization as a very important goal -- perhaps even more than reductions in hospitalizations. Even though ArchCare's PACE and UHC's SCO are incentivized and work to prevent or delay institutionalization, they are at risk for healthcare for every one of their members and have been from the beginning of the program. And, so they focus on reducing hospitalizations, ER

use and they use home and community-based services to help them do it.

2) *Just taking the risk for LTSS, in the context of a Medicaid managed care plan, appears to provide opportunities to manage the Medicaid LTSS services at a lower cost with the potential for better outcomes*.

Typically in MLTSS, the state is capitating the pre-existing, fee-for-service LTSS spending and creating incentives for the plans to manage that care to achieve equivalent or better outcomes at a lower level of spending. A major benefit of MLTSS is the introduction of care management to develop a care plan with the member, arrange for care, and coordinate care across settings and programs. This process alone can reduce spending and improve outcomes by improving the fit of services to the member's needs, reducing unnecessary or duplicative LTSS, and improving the member's adherence to the care plan.

If the state includes nursing facility and institutional care in the MLTSS, the plan may have a strong incentive to prevent institutionalization or move institutionalized members to lower-cost home or community settings. The state may create financial incentives for plans tied specifically to avoiding institutionalization or reducing institutional populations. Arizona has been particularly successful at reducing its institutionalization rates (going from 95% of its managed LTSS population in nursing facilities in 1989 to 27% today). The state agency allows plans to keep a portion of the savings it generates when it exceeds its institutionalization rate target for the year. Health Plan of San Mateo operates a

pilot program (Community Care Settings) focused specifically on identifying members either in or likely to be in institutions, who can be reintegrated or maintained in the community, and moving them with transitional support into sustainable community settings.

3) *A plan or program trying to integrate and manage care across sectors without moderate to full financial integration encounters substantial obstacles to achieving better outcomes and lowering medical costs.* .

The programs in our study that have funding from different sources for the full range of services but do not have full financial alignment and the ability to co-mingle financing face obstacles in applying an integrated care model and in achieving better outcomes and lower costs.

a. **Plans with MLTSS members who were dual eligible and were not aligned in their D-SNP plan cited difficulties in integrating medical care and LTSS and achieving quality and cost results for these members:**

Programs cited to us difficulties when members in their MLTSS plan were not in their MA plan related to:

o Getting basic medical information on a member from the member's MA plan or providers in order to coordinate care – not knowing diagnoses, treatment plans, prescriptions, or hospitalizations.

o Accessing data on claims, authorizations, medications, health risk assessments needed for risk stratification and determination of appropriate level of outreach and intervention.

o Obtaining the information and participation needed to develop a single care plan for the member.

o Interacting with the member's primary care providers, involving the medical providers in the member's care team or in coordinating with the care team.

o Receiving timely notification of an ER visit, hospitalization, or change in medical condition.

o Realizing the benefits in lower health care utilization resulting from care management and delivery of long-term services and supports for the member.

b. **Programs that have multiple funding sources and cannot co-mingle funds face challenges with flexibility in using funds and accountability that interfere in efforts to fully integrate care.**

The FIDE-SNPs and the Financial Alignment ("Duals") Demonstrations are designed to improve financial alignment and flexibility by providing Medicare and Medicaid funds to a single plan and combining Medicare and Medicaid benefits within that plan. This provides a high degree of alignment and the potential for a seamless experience for members who elect their Medicare coverage through that plan. These plans are allowed greater flexibility in the use of Medicare funds to cover non-Medicare benefits, within strict limits.

Even when Medicare and Medicaid funds are provided to the same plan through a single contract between the plan, the state, and CMS, there remain separate coverage rules governing the two pots of money and strict, service-specific accountability back to the

separate funding sources on the use of funds. Where plans are able to achieve comprehensive care management, care coordination across sectors, and an integrated, seamless experience for the beneficiary, they are still required to disaggregate and account separately for specific units of service. The remaining limitations on flexibility and requirements for service-specific accountability do limit the capacity of the programs to exercise their professional judgment on the best way to meet the needs of their members.

4) *Financial alignment creates incentives for plans to manage the totality of care for each member in a way that restrains costs and achieves quality outcomes, although the incentives may be muted by payment methodologies and problems of churn.*

Another important factor, which we have not fully addressed in this study, is the incentives for the plans and programs that are created in the way payments are calculated and adjusted for risk. This is an extremely complex area, and the data collection for this study was not sufficient to address this question in the proper detail.

We do, however, hazard the following observations from our research:

When plans can align the Medicare and Medicaid coverage for dual enrollees, the potential for profits is more substantial. The savings relative to the capitated payments occur primarily on the Medicare side in avoided ER visits, hospitalizations and re-hospitalizations, and attendant medical and drug treatment costs. The incentive to provide more intensive care management and more LTSS is limited in the context of a fixed Medicaid premium

(except for the subset of the Medicaid LTSS population that has Medicaid for both health and LTSS coverage) but the premiums will rise as plans report their experience. In the context of a combined Medicare and Medicaid premium, higher investment in intensive care management and home and community-based LTSS in the short-term term may be more than offset by savings in health care. Financial integration enables plans to spend more on managing social determinants of health, including paying services and supports not normally covered under either Medicare or Medicaid that would reduce the possibility of high medical costs.

An important factor in the equation that pairs spending on LTSS with savings on health care is the time dimension. The value of short-term LTSS spending that reduces future health spending may be reduced by the difficulty that plans have in retaining members long enough for the payback in health savings to be realized. Although the churn in the health insurance market may be less substantial for seniors, who tend to be more comfortable with the arrangements they have than are younger members, there is a more substantial attrition from mortality that reduces the horizon for recapturing savings. This reality, even in relatively stable markets, forces plans to use a significant discount rate when measuring future health care savings.

Separating Medicare and Medicaid payment/accounting – and the risk for medical care and LTSS – reduces the ability to pool these results and fund LTSS with captured medical care savings, especially if Medicare savings are recaptured by the government.

Governments pursue these models as a means for lowering the rate of growth in their overall health spending. However, the

pressure for states and the federal government to show immediate savings from these programs can limit the program's flexibility to achieve results, and also make the investment in experimental integrated models unattractive or unprofitable for organizations.

Even when financing is integrated, separate reporting of Medicare utilization and Medicaid utilization makes it possible for each of the funding entities to recapture savings from their own payments through rate setting or shared savings activities. Plans with integrated financing that increase home and community interventions in an effort to lower medical utilization may find it difficult to apply the medical utilization savings from Medicare services to offset the added Medicaid LTSS expenses if Medicare payments are determined in a way that harvests this savings for the federal budget. PACE does not experience this problem, since payment calculation and accounting for costs are applied in the aggregate and do not sort activities into separate Medicare and Medicaid buckets.

Based on our research to date, it appears that the goals of lower costs and improved quality for beneficiaries with complex care needs enrolled in integrated programs is best served if the funders focus on getting the payment amount right, and let the organizations use those combined resources as creatively and constructively as possible to obtain the best results at the lowest cost.

Conclusions

> - Integrating LTSS with medical and behavioral health care enables programs to reduce medical care utilization and costs by anticipating risk for exacerbations of chronic conditions and providing well-managed LTSS to support members and their family caregivers more efficiently in their homes and communities.
> - Care management is central to how programs integrate LTSS with medical and behavioral health care and is a powerful tool for improving cost and quality outcomes, even when programs face significant financial and other barriers to LTSS integration.
> - Targeting intensive care management and additional resources to the highest-risk population is key to achieving cost and quality outcomes.
> - Significant challenges remain for programs seeking to integrate LTSS with medical and behavioral health care. These include statutory and regulatory barriers as well as the siloed structure of the respective delivery systems.

The Movement to Integrate LTSS

The way we provide long-term care in the United States has changed dramatically over the last 20 years, but the transformation has really only just begun. Medicaid only requires states to cover long-term care in nursing facilities and other institutions, and originally few states covered any home or community-based services. The 1999 Supreme Court decision in *Olmstead* required states to make reasonable accommodation to enable persons with disabilities to receive services in the most integrated setting appropriate to their needs.[103] In the wake of the *Olmstead* decision, states pursued Medicaid waivers to provide Home and Community Based Services (HCBS), and Medicaid spending began to shift substantially away from institutional care toward home and community-based care. While 80 percent of Medicaid LTSS spending was for institutional care before 2000, today only about half of Medicaid LTSS spending is for institutions. This shift has been the most dramatic for younger disabled Medicaid beneficiaries using LTSS, 80 percent of whom today are predominantly in community-based settings. However, while most seniors state a strong preference for remaining in their own homes and communities, half of senior Medicaid LTSS beneficiaries still receive their support in an institution.[104]

Enactment of the Affordable Care Act expanded HCBS options for the states. In addition, many states have sought to manage LTSS spending, improve quality of care, and encourage a more pronounced shift to home and community-based care by contracting with managed care companies to manage Medicaid LTSS. Today, 19 states are contracting with and providing capitated payments to private health plans to enroll Medicaid LTSS participants and manage the LTSS benefits. In many cases, plans with Medicaid managed care contracts for medical benefits are adding LTSS, and, with regard to

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[103] *Olmstead v. L.C.* 527 U.S. 581 (1999).

[104] Erica L. Reaves and MaryBeth Musumeci. Medicaid and Long-Term Services and Supports: A Primer. The Henry J. Kaiser Family Foundation. December 15, 2015. http://kff.org/mediciad/report/medicand-and-long-term-services-and-supports-a primer/

the portion of the Medicaid population that is also eligible for Medicare (Duals), seeking to bring together the Medicare and Medicaid managed care dollars and benefits to manage care for beneficiaries across the spectrum of services and settings.

The Center for Medicare and Medicaid Services (CMS) has accelerated the movement toward LTSS integration with a demonstration launched in 2014 to test integrated care and financing models for Medicare and Medicaid dual enrollees (so-called Duals Demonstrations). Nine states currently participate in capitated models that involve a blended Medicare and Medicaid payment rate that is outlined in a three-way contract between the State, CMS, and participating managed care organizations (Medicare-Medicaid Plans (MMPs)).

The movement to integrate medical and LTSS financing and care seeks to achieve several objectives:

 I. Create a seamless experience for the individual.
 II. Provide a higher level of support to enable the individual to remain in their home and in the community.
 III. Support and build on the care that families already provide.
 IV. Avoid unnecessary nursing home and hospital admissions.
 V. Enable people discharged to stabilize in the home and community.
 VI. Reduce high medical costs associated with high-risk individuals.
 VII. Attain better health and quality of life outcomes.

We selected programs in five organizations around the country that have experience integrating LTSS and medical care and are held to be successful examples of LTSS integration (so called "Exemplar Programs"). While some of these organizations operate MMPs as part of the Duals Demonstration, our focus for this study was on programs involving LTSS

integration that had been in place for some time.

Five Cases of LTSS Integration

The purpose of taking risk for LTSS in the first place, and integrating LTSS, medical care and behavioral health is to more effectively manage member and family experiences with care to enable individuals to remain in their homes and community as long as possible, maintain their quality of life, and reduce the inappropriate use of expensive institutional and hospital care. Integration enables the organizations to manage and coordinate care more effectively across the spectrum and realize the savings on the medical side from greater investment on the LTSS side.

We studied five different types of programs that were integrating LTSS and medical care in different ways to understand whether and how they were achieving their objectives. Our conclusions are based on our observations and a comparison of the different approaches. In this study, we have not collected empirical evidence of cost or quality outcomes.

What Matters Most

In observing and comparing these five programs, there are several activities that seem to matter the most in affecting outcomes for members and overall costs of care:

• Anticipating needs and providing enough support in the home and community early enough to reduce the risk of an inappropriate use of ER services, hospitalization, or nursing home admission.

• Arranging for critical supports and services (the social determinants of health: e.g., housing, employment, personal assistance, medication management) that enable medical and behavioral health professionals to earn the trust of the member, address health needs, and elicit the behavioral

response from the member needed to make treatment effective.

- Eliminating, through communication, coordination, and a single point of accountability, the conflicts, gaps, and inconsistencies in treatment that arise when multiple professionals perform their work in individual siloes, each interacting with an individual member and that interfere with a successful response to treatment.

- Supporting members through transitions of care, particularly in moving from more intensive, higher cost to less-intensive, lower-cost settings for care with the early intervention and planning so that supports and services are in place to stabilize them in that setting and reduce the risk of them moving back.

The Challenges and the Opportunities for LTSS Integration

Our comparative analysis of five of the "Exemplar Plans" with experience integrating care and financing for medical care and LTSS led us to draw several conclusions, which we intend as a solid base of understanding for a more empirical study of costs and outcomes of LTSS integration.

Our five case studies led us to the following observations:

1) *Care management is at the heart of what integrated programs do to integrate LTSS and medical care and is key to achieving results.*

Care management is a Medicaid benefit that is an essential component of a managed care plan holding risk for LTSS. By itself, care management is a valuable benefit for members who enroll in managed LTSS programs – planning care, arranging services, and coordinating care. Persons and families with LTSS needs who do not have access to Medicaid MLTSS must perform these functions

themselves or purchase the services of a care manager. It is also a critical tool for programs to manage integrated care delivery.

The assignment by the program of a care manager with overall responsibility for the member and the member's quality of life and experience in the care system is a critical element in achieving cost and quality objectives. A care manager with overall responsibility for the member can make more efficient use of paid care, engage the member and family more effectively, and maintain the member in a lower-cost appropriate setting than would be the case in a fee-for-service environment with minimal or no care management.

Even in programs that are not able to align financial resources, care management is a powerful tool that enables programs to implement a comprehensive care plan and coordinate care for a member across sectors without necessarily having control over all of the payments. Even the programs with the greatest challenges to integrating care employ care management across sectors to manage costs and improve outcomes.

In one program we studied, care managers had overall responsibility and managed care for their clients across all sectors without regard to whether the plan held the medical care risk for those clients. Other programs, however, had difficulty coordinating care across LTSS, behavioral health, and medical care effectively for LTSS members who were not enrolled in the organization's health plan.

Programs in our study, in most cases, relied on a single care manager with overall responsibility for the member to:

- Provide a single point of contact and accountability for the member that avoids the potential for multiple care managers with conflicting objectives resulting in excessive, duplicative, or uncoordinated

services that raise the expense of care with little effect on quality of life or outcomes.

- Complete a comprehensive assessment and care plan that addresses the full range of medical, behavioral health, and functional care needs and the physical and social environment, including existing family and community resources; enabling identification of lower-level needs that can be addressed before they develop into higher-level needs that become more complex and costly to meet. Comprehensive assessment and care planning also enable the care team to identify and rely on an array of existing resources including family and community supports, and address supports to enable these to remain in place and avoid use of more costly paid services to support the member. The enable the program to provide only those services and supports needed to stabilize members in their home and avoid the admission to a hospital or nursing home that can then trigger more complex-care needs. Engage the member and the member's family in care planning and, as part of the care team, in implementing the plan, to ensure greater alignment with the members own goals and preferences, greater involvement of the member's family, and overall greater adherence to the plan.

- Maintain communication and engagement with the member and the member's primary caregiver to monitor conditions and identify emerging needs early enough to provide services and supports in the home that would avoid a more serious event and possible ER visit or hospital or nursing home admission.

- Manage and coordinate community and medical services either through an interdisciplinary care team involving key providers (of which they are team leader) or independently to ensure that various care

plans and providers are aligned to eliminate conflict, duplication, and gaps in care.
- Monitor and assess the effectiveness of the care plan in meeting member and care team objectives for cost and quality of care.

2) *Targeting is key to achieving outcomes and savings.*

There is a very small population accounting for almost half of all health care spending that could, through effective care management, experience appreciable reductions in health care utilization and significant savings.[105] A closer look at this subpopulation with the highest health care spending reveals that functional limitation and the need for LTSS is a defining characteristic.[106]

It is, therefore, to be expected that the population with this intersection of high medical cost/risk and functional limitations is quite small and may be buried in a health plan serving a much larger population. The programs we studied fell in two categories:

- Programs that serve a small population already identified as high-risk/high-need members (such as the ArchCare PACE or UHC's ALTCS), and;

- Programs that exist within a larger Medicare Advantage or Medicaid managed care plan and stratify their membership, providing a more intense level of care only to its high-risk members. Medicare Advantage (MA) plans, in particular, have a small subset of the population that uses LTSS and an even smaller subset that would be consider high-risk/high-need at any point. Even Managed Medicaid plans may have less than half of their members receiving LTSS, only a portion

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[105] Only five percent of the population accounts for almost half of health care spending in the U.S.
[106] On a per capita basis, individuals with chronic conditions and LTSS need cost Medicare more than twice as much as those with chronic conditions alone.

of whom are high-risk/high-need. The subset of these for which the plan holds both medical and LTSS risk may be even smaller.

The programs we studied that serve a larger population focus the most intensive resources where they anticipate the need will be greatest, as early as possible in advance of the need, with a focus on stabilization and then maintenance. These plans direct intensive care management, sometimes on a time-limited basis, to the highest-risk group, and provide less-intensive care management – for example, occasional telephonic contact to monitor a member's condition and identify signs of a change in condition - to the lowest-risk levels.

Risk stratification of the member population and direction of the most intense resources to the highest-risk portion of the population is a cost-effective approach for providing LTSS and one that has the greatest potential for generating offsetting reductions in health care spending.

3) *Integration of medical care and LTSS is difficult to achieve. Statutory and regulatory reforms affecting financing and the siloed nature of the service delivery system are needed to remove barriers that make integration difficult.*

a. **Statutory and Regulatory Barriers**

The balkanization of financing for health care and long-term care in our system makes it difficult to combine financial resources, allocate resources flexibly and efficiently to achieve outcomes, and manage care across service delivery sectors. Several areas of concern need to be address to reduce this balkanization:

i. Achieving scale with integrated programs requires overcoming the limitations that Medicare and Medicaid place on enrollment. CMS and the states have tried to address the

challenges of increasing the scale of LTSS integration in the context of statute requiring choice of plan in the Medicare program.

The plans in our study all have programs that integrate medical care, behavioral health, and LTSS successfully for some group of enrollees. In most cases, the integrated programs have relatively small numbers of enrollees and are limited in scale by the challenges they face in getting members to enroll in both their Medicare- and Medicaid-financed vehicles.

Success in integrating medical care, behavioral health, and LTSS for an enrollee depends upon aligning (i.e., providing, through the same organization) the medical and non-medical coverage for the enrollee (which, in the case of dual beneficiaries, involves both Medicare Advantage (MA) and MLTSS).

It is surprising, in states that are moving toward integrated LTSS, that managed care organizations frequently succeed in enrolling only a small proportion of their MLTSS enrollees in their MA plan. As much as the state may be seeking Medicare-Medicaid integration, the rules that define these programs make it hard to achieve it on a large scale.

Choice in the Medicare program makes it difficult to integrate benefits when dual beneficiaries do not have choice on the Medicaid side. Many state Medicaid programs mandate enrollment in a managed care plan and auto-enroll participants in particular plans, with an "opt-out" from that plan. Enrollees assigned to a particular plan on the MLTSS side have an affirmative choice on the Medicare side to remain in

traditional fee-for-service Medicare or enroll in any of the MA plans in the area.

Changing enrollment on the Medicare side (either moving from fee-for-service to an MA plan or changing MA plans) often requires the enrollee to change their primary care provider (PCP). People reluctant to give up a long-standing provider relationship are unlikely to make this change. If beneficiaries are passively enrolled in a different plan, they are often vulnerable to physician, home health, or other provider advice to opt-out or disenroll. As a result, they often end up split between different plans. The combination of mandatory and voluntary enrollment is a significant barrier to achieving integration.

The Medicaid MTLSS programs in our study that were trying to align the Medicare coverage for dually eligible beneficiaries had difficulty getting sufficient numbers of their Medicaid enrollees to enroll in their Medicare MA or SNP plan to achieve critical mass and effectively integrate care and financing. In Texas, Superior Star+PLUS had only a small subset of their MLTSS enrollees in both their Medicare and Medicaid plans. A state requirement that MLTSS plans offer a companion D-SNP resulted in little gain in alignment. Texas is now participating in the Duals Demonstration that offers an integrated plan – Medicare-Medicaid Plan (MMP) - as a choice and Superior has moved eligible enrollees in its D-SNP to its MMP to achieve better alignment. UnitedHealthcare of Arizona also had challenges with its alignment, but was aided by Arizona's Medicaid agency action changing the Medicaid plan for 8,000 dual beneficiaries to align it with their existing Medicare D-

SNP, an action the State is repeating this year for another 6,000.[107]

The role of Medicare choice in limiting scale worked differently in the programs in our study that combined Medicare and Medicaid funding and benefits and made enrollment in the total package voluntary. The PACE and SCO programs in our study are integrated programs that dual beneficiaries can choose. Each have their own challenge with achieving scale. Integration of benefits is facilitated by the fact that Duals who choose to enroll in one of these programs have to enroll with a single organization for the entire integrated program (MA plus Medicaid managed care).

Choice still operates in these integrated programs to limit scale. PACE serves a small population of high-need beneficiaries. One of a number of limiting factors in the program is the requirement that enrollees use the PACE-employed physician as their primary care provider. Beneficiaries unwilling to transfer from their current PCP will not enroll in the program. The Massachusetts SCO program, which is an option for all senior Duals in the state, has been more successful with scale -- enrolling currently about a third of the senior Duals in the state,[108] and is studying ways to improve this participation rate. The breadth of the physician network offered by UnitedHealthcare (in our study) and other SCO plans minimizes the need for enrollees to change physicians.

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[107]https://www.azahcccs.gov/resources/Downloads/Legislation/Duals/1_DualEligibleUpdateMay2015(Dual%20Alignment).pdf
[108] http://www.chiamass.gov/enrollment-in-health-insurance

Participation in the Duals Demonstrations has also been voluntary, although the Demonstration has used passive enrollment to achieve higher levels of participation. Passive enrollment automatically enrolls a member in the MMP but allows the member to opt-out before the plan is launched or to disenroll later. Achieving scale with passive enrollment has also been challenging because medical and LTSS providers will encourage their patients/clients to opt out in order to continue their relationship. In some states, opt-out and disenrollment rates have significantly shrunk the population in the MMP program.

- Superior launched an MMP in 2015 and moved 12,000 of its dual members to the MMP, 30 percent of whom opted-out before the MMP launched and another 10 percent since. The high opt-out/disenrollment rate was most likely a result of enrollee preference for fee-for-service, counseling by their physicians to disenroll, or loyalty to a different MA plan. It now has 9500 members in the MMP.

- Health Plan of San Mateo (HPSM), however, has been an exception. HPSM, a county Medicaid plan with mandatory LTSS that moved its dual beneficiaries into its MMP in 2014, has had a low opt-out rate. Three-quarters of HPSM's Dual members are now covered through the MMP, and fewer than 20 percent of their MMP enrollees have opted out, a rate far lower than the rest of California, which has seen

more than half of those enrolled opt-out or disenroll.[109]

ii. Programs that successfully integrate care must overcome the limitations and administrative complexity imposed by the separation of Medicare and Medicaid payments, the distinct requirements of each, and complexity of the administrative mechanisms and accounting associated with meeting these requirements.

Generally, programs that integrate medical services and LTSS for dual beneficiaries receive two separate sets of payments: Medicaid from the state and Medicare from CMS. The state and CMS payments fund distinct services, cannot be used to pay for non-covered services, and the programs they fund must track and report utilization separately. The funds cannot be co-mingled and used for services not covered under the existing authorities. These rules are designed to protect program integrity and prevent substantial increases in program costs. However, they prevent plans that are at financial risk from the flexibility needed in providing services to most effectively meet members' needs.

The programs that we studied were able to overcome some or all of these limitations in different ways. In the ArchCare PACE program (and PACE generally), these two streams of funding are combined into a single payment to the plan, with the flexibility for the program to provide needed services, whether covered by Medicaid or Medicare or not covered by either. PACE is unique in that it has its own

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[109] http://www.calduals.org/wp-content/uploads/2016/02/February-2016-CMC-Enrollment-Dashboard.pdf

section of federal law providing for a single payment of pooled federal and state funds and has no requirement to report encounter data (detailing specific services provided) to CMS or to the state.

While UHC's Senior Care Options program in Massachusetts, and the plans operating MMPs receive separate payments from CMS and the state, they have some flexibility to pool the funds— using funds from one source to cover services normally covered by the other source.

However, all of the programs we studied other than PACE, including SCO and the MMPs, are required to sort care that the programs provided holistically into unique Medicare- or Medicaid-covered services and report these encounters separately to the state and federal regulators. Interviewees in one program we studied pointed out that despite efforts to create a holistic approach to care and to train care management teams to provide care holistically, care managers still, at the end of the day, had to sort individual units of service by source of coverage and report them separately. While the cost and administrative burden of this practice is substantial, program executives we interviewed felt it did not reduce their care teams' ability to effectively coordinate services for members.

b. Service Delivery System Impediments

A related challenge in integrating LTSS and medical care is overcoming the siloed structure of the service delivery system. Medical care and LTSS are provided in unique systems that rarely intersect. Integrated models strive to coordinate care across these sectors,

relying on care management, shared information, and communication to align the activities of the sectors with a single care plan for a member. Only in the most integrated models, though (PACE in particular) is the primary care provider an active participant in the member's core care team, which PACE achieves by employing physicians and requiring members to use the PACE physician as their primary care provider. Other programs rely on the care manager to coordinate care across sectors. Coordination is easier for the care manager to achieve for members for whom the plan controls reimbursement for both medical care and LTSS.

i. The administrative structure of the organization providing the program can affect the ability of the plan to implement an integrated approach and achieve its objectives.

Most of the plans we studied are "network model" plans that manage care by contracting with providers and reimbursing for services. Again PACE is an exception in that it organizes its care around an adult day center and employs much, though not all, of its care delivery system. ArchCare's PACE program contracts with agencies to provide personal care services in members' homes.

In most cases, the programs are purchasing LTSS on a fee-for-service (or in the case of institutional care – a per diem basis) from a range of existing community agencies and relying on employed care managers to plan, arrange, and coordinate this care. The programs we studied relied on a wide range of existing community providers, with no concerted effort to build preferred provider relationships or

shrink the network. Nor were any of the programs we studied sharing financial risk with any of its community providers.

UHC's SCO program in Massachusetts was somewhat of an exception in its reliance on the Aging Services Access Points (the Massachusetts Area Agencies on Aging) - contracting directly with them to arrange and coordinate care for their members with lower levels of LTSS need, though no shared financial risk arrangement is involved.

Some of the programs we studied were situated within a larger managed care plan. In these instances, the subpopulation for which LTSS and medical care are integrated is a small subset of the population enrolled in the organization's managed care plan. Even though its members may account for a disproportionate share of health care spending, the integrated LTSS program's population may be too small to drive overall plan incentives and procedures or to influence medical or community-based provider decisions.

Organizational structure in some of the larger plans may also affect the capacity of the care managers to coordinate across sectors. In some of the plans, separate medical utilization teams associated with the Medicare plan manage cases that are in the hospital, leaving the care managers in the program we studied to coordinate with those teams on matters affecting their clients.

Eventually, as integrated plans work to extend risk-sharing, value-based purchasing, and other types of incentives for financial alignment to the medical and community-based providers, they will build a more effective framework for managing and coordinating care, and achieve a greater impact on spending and outcomes through care management.

ii. Financial opportunities in managing LTSS and medical risk are substantial, but factors in the design of rate setting, payment arrangements, and risk adjustment need to be addressed to insure the incentives are sufficient to support scaling up workable models of LTSS integration.

Just managing the existing risk in Medicaid LTSS provides a good business opportunity that is attracting managed care plans to the MLTSS market. Capitation the plans receive initially from the states is based on pre-existing fee-for-service rates and utilization, providing ample room for managed care entities to realize savings from supporting people in the lowest-cost appropriate settings, providing care management, and managing LTSS expenditures.

While managing LTSS risk alone is attractive to many organizations, the opportunity for upside benefit is limited. Many states provide a cap on margins that limit the benefit plans can realize from aggressively managing LTSS. In addition, managing LTSS separately without managing the medical risk for the same individuals does not have the incentive to increase spending on supports and services—particularly for the high-risk/high-need beneficiaries—than can generate substantial medical savings.

Theoretically, plans should be able to greatly increase their overall margins by assuming the Medicare risk for their MLTSS dual eligible enrollees. The potential for savings on the Medicare side is substantial given the opportunity

through well-managed LTSS to avoid unnecessary ER use, hospitalization admissions, and post-acute SNF stays; particularly if the plan is already capitated for the LTSS.

However, the amount of return possible in the form of medical savings is a function of the per-member capitation amount that is paid to the plan as a consequence of both Medicare's approach to rate-setting and to adjusting those rates to reflect the actual risk of the population the plan is managing. Currently, the per capita Medicare payments to Special Needs Plans (D-SNPs and FIDE-SNPs,) and Duals Demonstrations are calculated and risk-adjusted on the same basis as payments to regular MA Plans. There has been no further modification to take into account the greater expense in serving the dual eligible population. However, CMS has indicated recently its interest in exploring ways to increase Medicare payments to compensate plans for the full or partial Duals they serve.

The relationship between payment methods and the incentives to manage health care and LTSS costs is complicated. This is particularly true for plans that are integrating care and responding to a mix of payment arrangements and ways of allocating savings presented by state and federal payers.

- MA plan payments are derived through a bidding process, in which the payment to the plan is a function of the average bid of all bidding plans. Savings the plans achieve relative to the rate are capped by the statutory limit on the plan's medical loss ratio, and, beyond that margin, must be used to reduce beneficiary premiums or increase

benefits. Over the long-run, savings factor into subsequent bids and lower future federal government payments to the plans.

- State Medicaid MLTSS rates are typically derived by reference to per capita costs Medicaid's fee-for-service LTSS spending that existed prior to managed LTSS. Those rates are then adjusted annually – usually based on plan-reported utilization (encounter data), so that future payments increase with greater Medicaid utilization and decrease if plans reduce spending. States may also impose a margin cap that limits the plan's share of savings to a fixed percentage of revenues, with savings above some level going to the State.

Government payers are often dealing with competing goals for these programs: wanting, on the one hand, to encourage private plans to enter this market, assume and manage health care and LTSS risk, and be incented to lower overall per capita costs; and, on the other hand, to capture the savings from these efforts in order to reduce their own spending. If the goal of federal rate-setting is to encourage plans to invest in achieving better outcomes with these populations, then the payment rates should provide a more generous margin for the plans to start with, and the methodology should allow plans to keep a large share of the savings they realize. If the goal is to reduce Medicare spending, then the rate-setting methodology has to tie payments to the plan's experience or "claw back" health care savings from the plan. The problem with the latter approach is that it punishes plans that successfully lower costs, reducing plan incentives to achieve savings

Even if the rate-structure encouraged short-term spending on LTSS in order to reduce longer-term medical spending, the incentive for plans to seek long-term savings on health care spending is undercut by the churn in membership that dilutes the benefits plans may realize from lower future health costs. Churn occurs when health insurance is provided by competing independent health plans and enrollees can move between fee-for-service and managed care or among managed care plans. This movement may accelerate due to changes in pricing or quality of service or intense competition among the plans. Increased churn may also result from state actions changing enrollees' Medicaid plans to improve the alignment of medical and LTSS risk. Most of the plans we studied had comparatively stable memberships, with low disenrollment rates. Greater financial alignment and integration along with a transformation of managed care plans from a focus on utilization management and claims payment to holistic patient-centered clinical and care management would increase the stability of member-plan relationships and the ability of plans to capture health care savings from LTSS spending.

We noted in interviews with the programs we studied that our interviewees did not view use of LTSS as a strategy for reducing medical spending by their plans. It appeared to us that they saw the management of complex care for people receiving LTSS as their primary focus in its own context, with targets around maintaining people in their homes, calibrating the level of services correctly, and avoiding falls, institutionalization, ER visits, or other specific events. They did not appear focused on LTSS in relation to its impact on medical care utilization or overall health care spending.

Overall the incentives for integrated programs to provide LTSS and reduce health spending are muted by the multiplicity of payment buckets, rate-setting methods, and accounting requirements. Consolidating payment streams into a single per capita payment, setting that payment rate at a level with room to build capacity and innovate, eliminating the connection of payment to experience that punishes savings, and creating a equitable shared savings arrangement with government could incent programs to use LTSS creatively to lower medical spending.

Conclusion

We found many ways in which programs that take risk for and integrate LTSS and medical care influence the utilization of LTSS and medical services to both manage LTSS spending and to avoid and reduce medical care expenditures for those members at highest risk for health care spending. It is reasonable to assume there would be substantial health care savings resulting from an intensive approach to a particularly expensive subset of the population. However, we were not able to obtain empirical evidence from these programs to support a claim that these programs actually do reduce health care and LTSS spending relative to a population not benefiting from a capitated, integrated, managed care approach.

Future Study Needed

Our next step is to explore the potential to develop empirical evidence of savings and quality outcomes attributable to integrated LTSS. This study and the *Taxonomy* provide the framework for measuring the impact of integrated LTSS. What has stymied more quantitative analysis in the past has been the lack of a control group against which to compare the utilization and outcomes of the study group.

We propose to build a population model from CMS claims records and population surveys that can project the health care utilization for a population in traditional fee-for-service Medicare as a benchmark against which to compare claims records from the integrated programs and draw conclusions about the return on investment from LTSS integration at varying degrees of "integrated-ness."

Appendices

Appendix A: Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is a fully-integrated healthcare and insurance program for elderly individuals who live in the community and require a nursing home level of care. The program provides continuous, intensive care management for a high-risk population. PACE programs are fully-capitated and at risk for the entirety of members' Medicare and Medicaid benefits—including medical, behavioral, and LTSS. Typically, participants attend adult day health centers operated by the PACE program several times a week, where their care is overseen by an onsite interdisciplinary team led by a physician.

PACE programs enroll individuals who are Medicare beneficiaries, age 55 or older, live in a PACE service area, and certified using a state instrument to need nursing home-level care. The typical PACE participant is similar to the average nursing home resident: an 80-year-old woman with eight medical conditions and limitations in three activities of daily living. Nearly half (49 percent) of PACE participants have been diagnosed with dementia. Despite a high level of care needs, more than 90 percent of participants live in the community.[110]

Most PACE programs are small, community-based organizations and serve a relatively small population—there are only 33,000 participants nationwide.[111] Despite its small scale, PACE is an important part of the policy landscape of LTSS integration. In many ways, PACE programs are the most integrated programs currently available to dual eligible individuals with LTSS needs. Programs act as both the insurer and provider of care. Programs also have a unique degree of financial integration in the form of a joint capitation payment for all benefits from the federal and state government. This study includes a PACE program operated by ArchCare in New York.

Program History

The PACE program dates back to a Medicare-funded demonstration in the 1980s of integrated LTSS and medical care at On Lok Senior Health Services in Northern California. The demonstration found that On Lok improved the quality of participants' care and had 15% lower costs than if the participants had chosen Original Medicare. As a result of this successful demonstration, Congress passed legislation in 1986 that named the program PACE and authorized additional demonstrations. The program became a permanent part of Medicare and a state option for Medicaid programs in 1997. PACE is only available in the 32 states that offer it as a Medicaid benefit. PACE programs are fully-capitated and at risk for all Medicare and Medicaid benefits—federal statute includes a

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[110] PACE participants must reside in the community at the time of enrollment, but if they develop a need for nursing home care, the program will pay for it and continue to coordinate the individual's care. National PACE Association website: http://www.npaonline.org/pace-you

[111] Integrated Care Resource Center (2015) "PACE Enrollment by State and by Organization, September 2015" Technical Assistance Tool. Available at: http://www.chcs.org/media/ICRC-PACE-program-enrollment-September-2015.pdf

provision that enables this joint capitation, which is unique to PACE.

There have been numerous attempts to modify the program to encourage expansion. Historically, federal regulation only allowed non-profit organizations to operate PACE programs. In June 2015, the federal government began allowing for-profit organizations to operate PACE programs, after a CMS study found that for-profit programs did not enroll less frail populations, have higher Medicare or Medicaid costs, or have worse access to or quality of care than not-for-profit programs.[112] This expansion to for-profit operators may improve access to capital to launch new programs. In late 2015, President Obama signed the *PACE Innovation Act*, which authorized pilot programs that expand the PACE model to new populations, including younger individuals, people with multiple chronic conditions and disabilities, seniors who do not qualify for institutional care under Medicaid, and others.

Barriers to Growth

Despite many years of operation, PACE programs have not achieved significant terms of covering the eligible population. A major barrier to growth has been lack of access to capital to create and expand PACE programs. Establishing a new PACE program is expensive due to the requirements to employ a full team of health professionals and to operate a dedicated adult day health center. It can take over a year to hire the care team, contract with other providers, and specify the program's administrative processes and formal care model. Expanding existing programs is easier, but still requires capital to increase PACE center capacity.

Another barrier to growth has been limited consumer demand for the PACE program. Enrollment has been constrained many programs' requirement that members attend the adult day health center, the requirement to have the PACE employed primary care physician serve as the individual's PCP meaning that most participants need to leave their primary care physician to enroll in the program, and a lack of affordability for individuals who do not qualify for Medicaid.[113] PACE programs must compete with other community-based LTSS providers that do not operate under these constraints.

Evidence of the Impact of PACE on Cost and Quality Outcomes

The PACE program has been extensively studied—several major evaluations and comprehensive literature reviews of the program have been conducted over the years. A 1998 evaluation by Abt Associates found that PACE participants had lower rates of nursing home utilization and in-patient hospitalization, higher utilization of primary and preventive care services, and reported better health status and quality of life than comparison group members.[114] The benefits appeared to be greatest for the frailest

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[112] U.S. Department of Health and Human Services (2015) "The Centers for Medicare & Medicaid Services' Evaluation of For-Profit PACE Programs under Section 4804(b) of the Balanced Budget Act of 1997," Report to Congress. Available at: http://innovation.cms.gov/Files/reports/RTC_For-Profit_PACE_Report_to_Congress_051915_Clean.pdf

[113] Gross, Diane L., Helena Temkin-Greener, Stephen Kunitz, and Dana B. Mukamel. (2012) "The Growing Pains of Integrated Health Care for the Elderly: Lessons from the Expansion of PACE." *Integrated Health Care for the Elderly* 82(2): 257-82. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690172/

[114] Chatterji, P., Bustein, N. R., Kidder, D., & White, A. (1998) "Evaluation of the Program of All-Inclusive Care for the Elderly (PACE) demonstration: The impact of PACE on participant outcomes." Final report to the Health Care Financing Administration. Abt Associates. Available at: https://www.cms.gov/Medicare/Demonstration-Projects/DemoProjectsEvalRpts/downloads/PACE_Outcomes.pdf

individuals. A 2009 literature review also found that PACE programs improved member's access to and quality of care. Major outcomes include "greater adult day health care use, lower skilled home health visits, fewer hospitalizations, fewer nursing home admissions, higher contact with primary care, longer survival rates, an increased number of days in the community, better health, better quality of life, greater satisfaction with overall care arrangements, and better functional status."[115] This review also found that PACE has the greatest impact for the frailest enrollees, and that the program eliminated the disparity in outcomes between black and white members.

In 2014, the Office of the Assistant Secretary of Planning and Evaluation (ASPE) at the Department of Health and Human Services commissioned a comprehensive and rigorous review of the evidence on PACE.[116] This review used strict inclusion criteria for studies and evaluated the strength of the evidence. The report found somewhat different results than earlier studies and concluded that:

- PACE enrollees have fewer inpatient hospitalizations than their fee-for-service counterparts, but have higher rates of NH admission.
- PACE improves certain aspects of care quality.

- PACE enrollees have a lower mortality rate.
- PACE enrollees are satisfied with their care.

Contrary to previous reports, the ASPE review found that PACE increases the total cost of care for participants, as a result of significantly higher Medicaid costs than the fee-for-service comparison group with a lack of offsetting Medicare savings.

Many evaluations of PACE suffer from major methodological shortcomings. There have been no randomized, controlled trials of the program, and the intensity of the intervention makes it unlikely that any will be conducted. The biggest challenge in evaluating the program has been the lack of an appropriate comparison group, due to the very complex, high-risk nature of the population being served. Researchers can never be certain that individuals enrolled in PACE programs do not differ in important ways from the comparison group. Most studies also cannot control for differences in unmet need between PACE participants and comparison groups. It is reasonable to suspect that PACE participants have lower rates of hospital admission, institutionalization, and better health outcomes than similar individuals who do not receive the program. However, this hypothesis cannot be conclusively supported without an adequate comparison group.

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[115] Hirth, V., Baskins, J., and Dever-Bumba, M. (2009). "Programs of All-Inclusive Care (PACE): Past, present, and future," *Journal of the American Medical Directors Association,* 10(3), 155–160. Available at: http://www.dhcs.ca.gov/provgovpart/Documents/Waiver%20Renewal/PACE_Article_JAMDA_091.pdf
[116] U.S. Department of Health and Human Services Assistant Secretary for Planning and Evaluation Office of Disability, Aging and Long-Term Care Policy (2014) "Evaluating PACE: A Review of the Literature." Available at: http://aspe.hhs.gov/daltcp/reports/2014/PACELitRev.pdf

Appendix B: Background on Medicaid MLTSS Programs in Study States

All of the programs participating in this study are operated by managed care organizations contracting with states to provide Medicaid benefits, and almost all of the individuals enrolled in these programs are Medicaid beneficiaries. Medicaid is the primary route by which people access integrated care, and state Medicaid programs have shaped the current landscape of LTSS integration.

Each of the organizations in this study operates a program that participates in a Medicaid Managed LTSS (MLTSS) program. Each program has been shaped by the state environment in which they are situated and their approach to integration is influenced by that environment. For more information on national trends in Medicaid MLTSS, see the Study Context chapter of this report. This appendix provides greater detail on the specific state policy and regulatory context for each program in this study.

Arizona

Managed care has been a major part of Medicaid in Arizona since the state joined the program in 1982. Arizona was the first state to implement a Medicaid MLTSS program when they established the Arizona Long-Term Care System (ALTCS) in 1989. ALTCS serves individuals of all ages who require a nursing facility level of care due to aging, physical disability or developmental disability. Enrollment in a managed care plan is mandatory to receive program benefits. ALTCS covers medical, behavioral, and LTSS. There are about 58,000 ALTCS beneficiaries statewide: 29,000 in the developmentally disabled population who are served through a contract with the Arizona Department of Economic Security, and 29,000 in the elderly

and physically disabled population whose care is contracted to managed care companies.[117]

One of Arizona's key objectives for the MLTSS program is to move individuals out of institutions and into the community. Since the program launched in 1989, the share of beneficiaries living in nursing facilities has declined from 95 percent to 27 percent.[118] This success has been driven partly by strong financial incentives for program contractors to reintegrate members to the community. Each year, capitation rates are set based on the projected share of the plan's membership that will use a nursing facility. The plan gets to keep any savings for the first 1 percent difference in the population institutionalization rate. The plan is also responsible for costs for up to 1 percent above the projected rate. The state captures savings and covers losses outside of this 1 percent risk corridor.

Currently, three organizations hold contracts with the state to provide MLTSS—Mercy Care Plan, a private non-profit plan serving 40 percent of the enrolled population; UnitedHealthcare (UHC), a for-profit plan with 33 percent of the enrolled population; and Bridgeway Health Solutions, a for-profit

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[117] As of February 2016, *AHCCCS Population by Category* Report. Available at: https://www.azahcccs.gov/Resources/Reports/population.html

[118] J. Libersky and J. Verdier (2014) *Financial Considerations: Rate Setting for Medicaid (MLTSS) in Integrated Care Programs*. Available at: http://www.mathematica-mpr.com/~/media/publications/PDFs/health/dual_eligibles_ML_TSS_rate_setting.pdf; and, Joint Legislative Budget Committee (2015) *Program Summary: Arizona Long Term Care System*. Available at: http://www.azleg.gov/jlbc/psaxsaltcs.pdf

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Centene subsidiary with 19 percent of the enrolled population.[119] The remaining 8 percent of the population receive services from community-based tribal contractors. In each rural county, only one contractor operates an ALTCS plan—UHC is the ALTCS plan contractor in the larger rural counties, and Bridgeway covers the smaller rural counties. UHC's ALTCS plan participated in this study.

Arizona makes a concerted effort to coordinate dual eligible beneficiaries Medicare and Medicaid benefits. The state requires program contractors to offer a complementary D-SNP for dual eligible ALTCS members. Additionally, the state tries to align dually eligible individuals' coverage whenever possible by transferring their Medicaid coverage to the plan where they have Medicare coverage. The state has succeeded in enrolling about one-third of dual eligibles into the same plan for Medicare and Medicaid.[120] Arizona is not currently participating in the Duals Demonstration.

In 2013, Arizona began implementing the Payment Modernization Plan for the state's Medicaid program.[121] This plan builds on the state's experience with Medicaid managed care to slow the growth of healthcare costs. The primary goal of this payment reform effort is to quickly move Arizona to a value-based healthcare system. The first phase, beginning in October 2013, required ALTCS

MCOs to enter shared savings and value-based purchasing arrangements for at least 5 percent of spending across their state Medicaid and federal D-SNP contracts.[122] The amount required to be in these arrangements increases annually, until 2017 when plans must have 50 percent of spending in value-based arrangements. Plans must meet these thresholds in order to compete for performance incentives in the capitation withhold program.[123]

California

California has a long history of using managed care in Medicaid, and first began contracting with managed care plans in the early 1970s.[124] However, MLTSS is a recent development in California. Until recently, many LTSS and behavioral health benefits were carved out of the state's managed care contracts. This changed in 2014 with California's Coordinated Care Initiative. The Coordinated Care Initiative is being implemented in seven counties, and consists of two components: (1) the launch of mandatory MLTSS for Medicaid beneficiaries, including dual eligibles, and (2) California's Duals Demonstration program—Cal MediConnect. Plans participating in the Coordinated Care Initiative cover LTSS, medical, and most behavioral (behavioral health benefits for the severely mentally ill are carved out.) About 456,000 of the 1.1 million dual eligible beneficiaries in the state are

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[119] As of February 2016, *AHCCCS Population by Health Care Contractor* Report. Available at: https://www.azahcccs.gov/Resources/Reports/population.html

[120] AHCCCS (2012) "AHCCCS Medicare/Medicaid Duals Discussion," Presentation slides. Available at: https://www.azahcccs.gov/resources/Downloads/Legislation/Duals/6_Duals_DemonstrationPresentation3-6-12.pdf

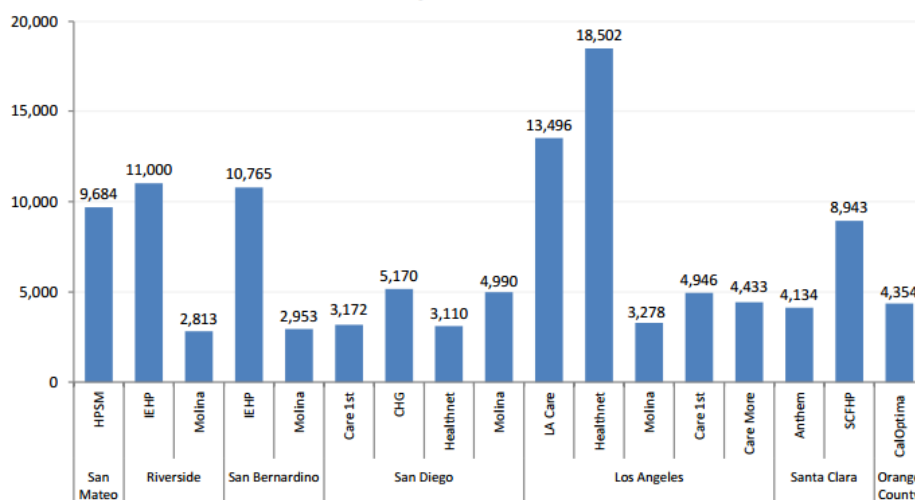[121] AHCCCS (2014) "AHCCCS Payment Modernization Plan." Available at: https://www.azahcccs.gov/reporting/Downloads/PaymentModernizationPlan_SFY2014.pdf

[122] For more detail on the design of the program, see section 318 of the AHCCS Contractor Operations Manual, available at: https://www.azahcccs.gov/shared/ACOM/

[123] AHCCCS (2013) "Strategic Plan State Fiscal Years 2014-2018." Available at: https://www.azahcccs.gov/AHCCCS/Downloads/Plans/StrategicPlan_14-18.pdf

[124] CMS (2014) "Managed Care in California." Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/california-mcp.pdf

Total Active Enrollments Effective December 1, 2015
By Plan

eligible for CalMediConnect.[125] Dual eligible beneficiaries are automatically enrolled in a demonstration plan, with the ability to opt-out. Those who opt-out are still required to enroll in a managed care plan for Medicaid coverage. The California Duals Demonstration has had some challenges with enrollment. About 70 percent of eligible beneficiaries have opted out or otherwise disenrolled from demonstration plans for Medicare coverage.[126]

The rate-setting methodology for dual eligible individuals in CalMediConnect creates financial incentives to transition individuals out of nursing facilities to live in the community. Five rate categories are aggregated to create a blended population rate: institutionalized individuals, members using adult day care, high-need members using HCBS, all other members using HCBS, and community well. If a program contractor beats the expected rate for institutionalization, they keep any savings

until a new blended rate is set the following year. In contrast, Medicaid rate setting for non-dual eligible individuals is experience-based. This means the state captures all savings of any shift away from institutions.

Medicaid managed care is organized at the county-level in California. Some counties have only a single plan operated by the county, some counties have one county-operated plan and one commercial plan, and some counties have more than two plans in which beneficiaries can enroll. Each arrangement is represented in the demonstration, as can be seen in the chart below.[127]

Health Plan of San Mateo (HPSM)—a county-operated Medicaid plan—participated in this study, and several of their products are relevant to the topic of LTSS integration. HPSM is part of the Coordinated Care Initiative, and therefore operates a Duals Demonstration plan and a MLTSS plan for Medicaid beneficiaries. Only 22 percent of eligible beneficiaries have opted out or otherwise disenrolled from HPSM's CalMediConnect plan, the lowest rate for any plan participating in the demonstration.[128] HPSM also operates a D-SNP for dual eligible

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[125] CalDuals.org (2016) "About CalDuals." Available at: http://www.calduals.org/background/about-calduals/

[126] California Department of Health Care Services (2015) "Cal MediConnect Monthly Enrollment Dashboard: December 2015." Available at: http://www.calduals.org/wp-content/uploads/2016/01/CMC-Enrollment-Dashboard-December-Final.pdf

[127] Ibid.

[128] Ibid.

individuals who are not eligible for the demonstration.

Massachusetts

Massachusetts first implemented Medicaid managed care in 1997, but still provides fee-for-service Medicaid to many beneficiaries with long-term care needs.[129] In 2004, the state made a major foray into managing Medicaid LTSS through a capitated payment with the launch of the Senior Care Options (SCO) demonstration program. SCO covers LTSS, medical, and behavioral health, and was designed to align Medicare and Medicaid coverage for dual eligible beneficiaries via a single-three-way contract between the state, the federal government, and participating health plans. In 2009, the demonstration concluded and the SCO program was made permanent.[130] SCO enrollment is limited to Medicaid beneficiaries age 65 and older. Beneficiaries do not need to be eligible for Medicare, and not all participants require LTSS. Dual eligible individuals who enroll in a SCO plan must enroll for both Medicare and Medicaid coverage from the plan, which means that every member of a SCO plan receives all of their coverage from that plan. This is possible because enrollment in SCO is voluntary for Medicaid beneficiaries—they retain the option to receive fee-for-service Medicaid. As of June 2015, there were nearly 38,700 individuals enrolled in SCO programs

across Massachusetts, about 30 percent of the population eligible to enroll.[131]

The SCO program incentivizes plans to keep members in lower-cost community settings rather than in institutions. Plans receive community-level rates for the first 90 days a member resides in an institution, and receive institutional-level rates for the first 90 days after a member is repatriated from an institution to the community. This means that the plan is at risk for three months' worth of costs or savings generated by the placement of the member. A 2013 evaluation of SCO found that the program significantly decreases nursing home admissions compared to fee-for-service Medicaid.[132]

Six contractors participate in the SCO program. UnitedHealthcare (UHC), a national for-profit plan, operates the largest SCO plan, covering about 39 percent of individuals in the program. The other plans are Senior Whole Health (a for-profit plan with 29 percent of SCO enrollment), Commonwealth Care Alliance (a not-for-profit with 18 percent of enrollment), Fallon Community Health Plan (a not-for-profit with 11 percent of enrollment), Tufts Health Plan (a not-for-profit with 3 percent of enrollment), and beginning in 2016, Boston Medical Center Health Plan. UHC participated in this study with their SCO plan, which opened in 2004.

Coordination of Medicare and Medicaid benefits for dual eligible beneficiaries was one of the primary motivators of the initial SCO

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[129] CMS (2014) "Managed Care in Massachusetts." Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/massachusetts-mcp.pdf
[130] The three-way contract structure was dissolved at the end of the demonstration, and today there are two separate contracts: one between the state and plans, and one between the federal government and plans.

[131] Health Management Associates (2015) "Value Assessment of the Senior Care Options (SCO) Program." Available at: http://www.mahp.com/unify-files/HMAFinalSCOWhitePaper_2015_07_21.pdf
[132] Jen Associates (2013) "Massachusetts Senior Care Option 2005-2010 Impact on Enrollees: Nursing Home Entry Utilization." Available at: http://www.mass.gov/eohhs/docs/masshealth/sco/sco-evaluation-nf-entry-rate-2004-through-2010-enrollment-cohorts.doc

demonstration. Contractors participating in SCO are required to operate a D-SNP to cover members' Medicare benefits. The success of the initial demonstration led to the creation of FIDE-SNPs—a specialized subcategory of D-SNPs for plans that provide both Medicare and Medicaid benefits—in the *Affordable Care Act.* All SCO plans are FIDE-SNPs.

Massachusetts is participating in the Duals Demonstration with the OneCare program, which combines Medicare and Medicaid benefits for dual eligible individuals between the ages of 21 and 64. Participating plans began enrolling members in October 2013.[133]

New York

New York began experimenting with Medicaid managed care in the 1960s, and had wide scale enrollment by the 1990s.[134] The state launched its first Medicaid MLTSS program—the Managed Long Term Care (MLTC) program—in 1998. MLTC only covers LTSS benefits—medical and behavioral health are not part of the program. In 2006, the state established two additional MLTSS programs for dual eligible individuals—Medicaid Advantage and Medicaid Advantage Plus. These programs combine the Medicaid LTSS coverage of MLTC with a D-SNP for Medicare coverage.[135] New York also actively promotes PACE as a managed care option for Medicaid beneficiaries, and it is the only Medicaid program that covers all medical, behavioral, and LTSS. Enrollment in a managed care plan

is mandatory for most Medicaid beneficiaries, with exceptions for individuals living in a few rural regions of the state. As of December 2015, there were 137,705 individuals enrolled in a MLTC plan, 15,717 enrolled in Medicaid Advantage and Medicaid Advantage Plus plans, and 5,491 enrolled in PACE programs.[136]

A large number of plans participate in New York's MLTSS programs, including national for-profit plans, local for-profit plans, and local non-profit plans. As a result, the managed care market in the state is not very concentrated. The largest contractors in terms of enrollment are all local, non-profit plans: GuildNet (11 percent of MLTC enrollment), the Visiting Nurse Service of New York (10 percent of MLTC enrollment), HealthFirst (9 percent of MLTC enrollment and 24 percent of Medicaid Advantage / Medicaid Advantage Plus enrollment), and Fidelis (8 percent of MLTC enrollment).[137] ArchCare—a faith-based, not-for-profit organization serving the New York City area—participated in this study with their PACE and MLTC programs. ArchCare's PACE program launched in 2009, and currently enrolls 444 individuals, and their MLTC plan opened in 2012 and covers 1,603 members.

New York is participating in the Duals Demonstration—the program is called Fully Integrated Duals Advantage, and began enrolling beneficiaries in early 2015. The program has achieved relatively low enrollment levels among the eligible population.[138] ArchCare initially participated in

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[133] To learn more about OneCare, see: http://kff.org/report-section/early-insights-from-one-care-massachusetts-issue-brief-8725/

[134] CMS (2014) "Managed Care in New York." Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/managed-care/downloads/new-york-mcp.pdf

[135] For more information on the numerous Medicaid managed care programs in New York, see "New York's Medicaid Advantage Programs: Integrated Care Models for Dual Eligible Beneficiaries" Available at: http://www.chcs.org/media/Kalaijian-NY.pdf

[136] New York Department of Health "Medicaid Managed Care Enrollment Reports" Available at: https://www.health.ny.gov/health_care/managed_care/reports/enrollment/monthly/

[137] Ibid. Author calculations from December 2015 enrollment data.

[138] V. Dickson "CMS will aid New York's struggling duals demonstration," *Modern Healthcare* (October 21, 2015). Available at: http://www.modernhealthcare.com/article/20151021/NEWS/151029983

demonstration, but exited the program in September 2015.

Texas

Texas first began experimenting with managed care in Medicaid in 1993.[139] The first pilot of STAR+PLUS—Texas's Medicaid MLTSS program—was launched in Houston in 1998. Between 2007 and 2012, STAR+PLUS was expanded to other urban areas of the state, and finally expanded to rural areas in September 2014. The program covers Medicaid beneficiaries with disabilities and those age 65 and older (regardless of LTSS need). Enrollment in a managed care plan is mandatory in order to receive Medicaid benefits in Texas. STAR+PLUS plans cover medical, LTSS, and behavioral health. Until March 2015, nursing home care was carved out of the program, but is now included. In 2015, there were 524,730 individuals enrolled in STAR+PLUS across Texas.[140]

Institutional LTSS was not part of the STAR+PLUS program until 2015. The state pays a different capitation rate for institutionalized members than those receiving HCBS, and does not offer financial incentives for program contractors to move individuals out of institutions and back into the community. However, the state does measure nursing home admissions as part of a quality incentive program for STAR+PLUS plans.

Five contractors participate in the STAR+PLUS program, all of which are national, for-profit insurance companies: Amerigroup (covers 27 percent of the enrolled population across the state), Superior, a Centene subsidiary (27

percent), UnitedHealthcare (19 percent), Molina (18 percent), and Cigna (9 percent).[141] Superior participated in this study with their STAR+PLUS plan.

More than half of STAR+PLUS beneficiaries are dual eligible.[142] The state requires STAR+PLUS contractors to operate a D-SNP for dual eligible members, but most beneficiaries enroll in Original Medicare instead. Only 8 percent of the dual eligible members of STAR+PLUS are enrolled for Medicaid and Medicare coverage with the same plan.[143]

Texas is one of the states in the Duals Demonstration, and began enrolling participants in early 2015. Superior is participating in the demonstration in several of their large urban markets.

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[139] For a detailed history of Texas Medicaid and managed care, see: http://www.hhsc.state.tx.us/medicaid/about/PB/Chapter7.pdf

[140] Texas Health and Human Services System (2015) *2015 Texas HHS Fact Book*, page 40. Available at: http://www.hhsc.state.tx.us/reports/2015/fact-book.pdf

[141] Texas Health and Human Services Commission (2015) "Texas Healthcare Transformation and Quality Improvement Program: Section 1115 Quarterly Report." Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/tx/Healthcare-Transformation-and-Quality-Improvement-Program/tx-healthcare-transformation-qtrly-rpt-oct-dec-2015.pdf

[142] According to the Duals Demo application, 327,530 individuals in Texas were fully dually eligible in 2011, and almost all of these people are in the STAR+PLUS program. See: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/TXProposal.pdf

[143] MOU between CMS and the State of Texas Regarding the Texas Dual Eligibles Integrated Care Demonstration Project, p 2. Available at: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/TXMOU.pdf