Roundtable
"Integrating Long-Term Services and Supports: Advancing New Models for Care and Financing"
July 28, 2016

The Long-Term Quality Alliance (LTQA) hosted a Roundtable of stakeholders and experts on "Integrating Long-Term Services and Supports: Advancing New Models for Care and Financing" on July 28, 2016 in Washington, DC.

The Roundtable built on recent LTQA work developing a *Taxonomy of Long-Term Services and Supports Integration* and completing 10 case studies of exemplary programs integrating LTSS.

The Roundtable focused on developing an agenda to advance integrated approaches, building on a firm knowledge of what works. LTQA sought through the Roundtable to develop a greater understanding of:

- The most critical features of programs integrating LTSS, features that would need to be replicated in other contexts;
- Ways to overcome barriers to integration in the delivery system and in federal regulations and statute;
- Ways to drive more widespread adoption of what works, both through traditional vehicles, and through unusual programs in non-traditional settings.

Participants at the end of the Roundtable offered suggestions on next steps and initiatives LTQA could undertake to help drive growth in person-centered, integrated LTSS and to improve consumer and physician buy-in.

The proceedings are meant to capture the essence of the discussion and flag the most important issues for LTQA to address in working groups, forums, and policy briefing papers in the coming months.

Key components: What matters most in LTSS integration

Starting with the conclusions from LTQA's *Taxonomy* and 10 case studies, and from work previously done by other researchers, what are the key components of programs that integrate medical care and LTSS that would need to be replicated in other contexts for a successful integrated program?

- Culture
  - A medical approach that encompasses social dimensions
  - Collaborative practice
  - Self-determination for persons – through person-centeredness
- Structure
  - An accountable entity – at full financial risk
  - A comprehensive benefit package – including behavioral health
- Expertise and infrastructure
  - Building on the existing aging and disability network
  - Bringing risk management experience
  - Using data-driven, population-health-based approaches
- Service coordination and care management – the most important element
  - A Single point of contact
  - In-home, in-person – built on an understanding of the whole person
  - Well-managed transitions in care (post-acute)
  - Provider engagement
- Financing
  - Integrated payment (for duals – Medicare and Medicaid)
  - Flexibility in the use of funds

- Technology will be key to advancing integration – the ability to share electronic information across sectors – to share assessments, care plans, care delivery among members of the care team. Interoperability with LTSS providers is lagging because it is not funded -- LTSS information system development was not included in HITECH. LTSS providers still operating a largely paper system. Even with adequate funding, there would still be a lack of agreement on items and formats to exchange. Development of items, formats, quality measures is underway at NQF, NCQA, in the TEFT grants and other places.

- Comprehensive assessment– assessing across domains and understanding the person's goals and preferences, functional needs, medical and behavioral health issues, resources available, social, housing and environmental context – is key to supporting the person in their home and community and preventing or delaying medical or social crises that result in medical utilization and institutionalization. The tools exist but are not used widely. Different instruments use different measures so that data is not comparable across programs and states. Policymakers do not grasp the importance of functional needs or the impact of functional limitations on medical utilization or outcomes. Common instruments are needed that encompass functional need and LTSS.

- Leveraging the role that the family caregivers play – caregivers bring value that needs to be retained to the extent possible. Training, empowering, supporting, including the caregiver in the care team. They can be a force for integration around the person's goals, needs, and preferences.

- The care manager is the integrator – the locus of integration is service delivery. Care manager should be an employee of the integrated plan or program that holds the risk – full accountability for the member, exclusivity of focus. Other service providers are likely to be contracted – few examples (small scale) of organizations employing LTSS and medical service providers. The key to provider engagement is exclusivity – the larger the portion of a provider's panel that are members of the risk-bearing organization, the greater the provider engagement in the culture, priorities, etc. of the organization.

- Service delivery, policy and financing are interwoven. For duals, policy and financial integration at the nexus of Medicare and Medicaid are critical, but an integrator with the information and the authority across sectors is key.

- Financial integration – the opportunity for additional financing for LTSS may come from value-based purchasing and alternative payment models. Full capitation, though, makes it possible for alignment of incentives across sectors, it also encourages organizations that can recapture the health savings to provide non-medical services.

- Achieving health care savings – the greatest potential for savings is in targeting intensive care management and LTSS effectively. The target population is not the population that has been high utilizers, it is the population that will be high utilizers if there is no effective intervention. Anticipating and intervening at the right moment is key.

- Further developing the evidence base that LTSS integration lowers health care spending will be challenging. The assessment, encounter, and claims data sets are not connected – no entity has integrated data. There are methodological barriers: Randomized controlled trials (RCTs) are not possible. Multiple confounding variables will always make it difficult to develop dispositive evidence.

- What is the measure of success? Is it enough to improve outcomes without raising costs – to gain a better quality of life with better support systems and lower medical utilization – to expand services by achieving greater efficiency in health care spending?

Getting better results: Addressing delivery system, legislative and regulatory barriers to integration

Integrated financing is necessary but not sufficient. We have made a lot of progress toward financial integration, but there are still substantial barriers left, which will require political will to remove. Financial integration alone will not drive service delivery integration, organizations need to make the cultural shift toward person-centeredness and team-based care.

The greatest barriers to full financial integration for Duals are:

- Misaligned rules between Medicare and Medicaid. Need to harmonize the contracting and enrollment process for Medicaid, Medicare SNPs, and Medicare-Medicaid Plans (MMPs). Need to implement the lessons learned separately in MMPs and FIDE-SNPs across both – to align their goals, rules, and structures.

- Payment in MMP is not properly structured. Payment is inadequate, there is insufficient risk adjustment, and the required Medicare savings in early years makes it difficult to succeed – the investments are at the front end of the program, the savings are down the road.

- Most of the programs that allow for Medicare-Medicaid integration are permanently authorized – making their future uncertain and limiting interest. Very few states have been interested in participating in the integrated programs – the lack of permanence makes it likely that few more will. More effort is needed to provide support for states that want to try, and to encourage states that have not.

- High opt out rates from MMP, low voluntary participation in Medicare SNPs that aligned with the MLTSS plan. Requirements for choice of Medicare Advantage plan make it difficult to get financial alignment for a large percentage of the Duals population. The Medicare opportunity for monthly disenrollment creates churn in the integrated programs that reduces their effectiveness. Options should be developed that would that limit Medicare choice and disenrollment opportunities where integrated plans are available. Education for consumers and providers of the benefits of integrated managed care would improve participation. Complex eligibility and enrollment rules need to be simplified and communicated more effectively.

- Mistrust of managed care organizations by government hampers success. The cultural overhang from fee-for-service holds back progress. PACE, the most fully integrated program, is overregulated – limiting its scale. New regulations eliminating some of the restrictions may significantly expand PACE. MA plans are over-regulated, applying fee-for-service rules to capitation and micromanaging how plans care for members. Integrated plans are also limited in their ability to use Medicare funds for LTSS or other non-medical services, even though this might reduce health care expenditures. Lack of evidence of the impact of LTSS is a barrier – until there are adequate cost, quality and

outcome measures, government will remain skeptical. Provider-sponsored organizations have greater regulatory flexibility and may provide a path forward. Government needs to feel confident that were the plan (and not the government) is at risk, it needs to hand over the money, give the plans autonomy in how it manages and provides care, and hold the plans accountable for the overall cost per member and the health outcomes.

Duals Demos: What are we learning? Where do we go from here?

What have we learned from the Financial Alignment (Duals) Demo?

- CMS has built a product more integrated than D-SNP and more scalable than PACE. Even with the new tools in the Duals Demo, though, it is still not easy to do.
- Politically, there is bipartisan and lasting support for integrated care. The LTSS stakeholder world is complex, dynamic, and committed to integrated care. Stakeholders want these models to continue.
- Success requires provider engagement, provider role in maintaining enrollment, and beneficiary engagement. Plans have to work to earn the engagement of members.
- Beneficiaries value the care coordination – 85% in CAHPS surveys are very satisfied with the help they get. There are beneficiaries in the plans who are not getting care coordination.
- On payment – learned that the risk adjustment model was under-predicting costs for "full Duals" by 9% -- CMS just put in place a new risk model that will shift $1 billion to plans with a high percentage of the high cost/high need population.
- Start-up for the plans is expensive – they won't generate a profit in the early years – but they will eventually as they improve their performance over time.
- Doing a significant number of in-home assessments is a challenge. Plans are finding a substantial amount of unmet need – not related to health.

There continue to be challenges in trying to reach and meet the needs of the most complex and challenging populations. There continue to be people with physical disabilities who cannot get access. We need to motivate innovators to serve these populations – e.g., incent ACOs to tackle the challenges of serving the homeless. Plans are doing interesting things to reach hard-to-reach populations. The issues are invariably housing, transportation -- the non-medical social determinants.

We won't know if the Demos are saving or costing money until the evaluation studies are complete in a few years, but there should be substantial room for savings given the substantial expenditures ($330 billion a year) on the Duals population. Early indications of potential savings:

- CMS gave Washington State shared savings of $22 billion from their fee-for-service Duals Demo.
- RTI's recent report on Minnesota's old MSHO integrated model showed impressive results in reducing hospitalizations (a 48 percent reduction in risk of an inpatient admission and 26 percent fewer hospital admissions for those had a hospitalization), and ER visits (6 percent less likelihood of an ER visit and 38 percent fewer visits for those had visits), and a greater likelihood of receiving home and community-based services.

Scaling up: More widespread adoption as a base for financing LTSS

Managed Care as a Platform

- There is a real opportunity and an important role for managed care organizations to provide care coordination and integrate care through Medicaid managed LTSS (MLTSS). MLTSS has still only penetrated 50 percent of the LTSS market – LTSS is still provided in a very fragmented world.

- States see health plans providing LTSS as way to address the social determinants of health. Managed LTSS and managed behavioral health are good policies in themselves and are platforms for more fully integrating in the future.

- Roughly 70 percent of MLTSS beneficiaries are also covered by Medicare ("dual beneficiaries") and much of the benefit from managing LTSS appears in the Medicare program. The national plans are interested – they are pursuing MLTSS contracts in the states and are eager to integrate LTSS and medical coverage —every national carrier is participating in the MMP.

Growing Enrollment in Integrated Plans

- What is necessary to grow enrollment in D-SNPs, MMPs, and other integrated programs? The programs themselves need to be made permanent, and there needs to be better alignment between Medicare and Medicaid in the FIDE-SNPs and MMPs. The contracting and enrollment activities need to be aligned in the integrated programs.

- Talented and dedicated care management staff are critical to advancing integration.
    - For consumers and their families, the most attractive feature of a managed care plan is a continuing relationship with a single care manager.
    - Care managers are attracted by the mission and resources of integrated programs, regardless of whether those programs are operated by local non-profits or national for-profit plans.
    - Care coordinators have been around in the AAAs and the ADRCs, but expectations are changing and their needs to be more support through higher levels of training and more use of technology in the job.

- Growing the size of existing programs may be limited by an inadequate personal care workforce.
    - Labor tests can be a barrier to training personal care aides. If a plan provides training to the aide, they risk being classified as a "joint employer." ACL and CMS are aware of this issue and working on it with DOL
    - Use technology and remote monitoring to deploy aides in a more targeted way may be part of the solution to workforce shortages.
    - Family caregivers may be a good source of more personnel. If family members have a good experience in an integrated program, they often will continue working in the program after their loved one dies.

- Providers are key to advancing LTSS integration: Doctors, daughters, and personal care workers influence beneficiary choices. Consumers often opt-out or dis-enroll due to their reluctance to lose contact with their existing providers. The beneficiary is central in the move to managed care – person-centered planning and care delivery will advance integrated care.

- Many individuals—those who are not dual eligible—do not have access to an integrated program, as most are only open to Medicaid beneficiaries. What options are available to the non-Medicaid individual with LTSS needs?

- For all consumers, including dual eligibles, the choice set of integrated programs is incredibly opaque. There are many options but no good information on what's available or counseling about how to go about choosing a program. There may be too many choices, and some (like the D-SNP), are transitory. Furthermore, the system has no fluidity. There is no opportunity for a person to try out different models and see which works best for them.

"Scale up" or "Spread" Working Models

- Growing scale makes more sense for large national plans that contract with local networks of LTSS providers. There may be limited benefits to scale in integrated programs, though, in that LTSS providers are local. Also, there are limited financial savings from scale because the primary costs tend to be labor.

- Spreading may be a better technique for provider-based models. Provider-based models are local and limited by the range of the providers' practices. These models can be replicated in other locales – but for each new location, the implementation can be quite different. A lot of what PACE does is not scalable because there are not efficiencies of scale for any particular PACE program.

- There is room in the system for both scaling of the plan-based models and the spreading of provider-based models. Plan models may be better for some communities, while provider models work for others. The most successful programs have attributes matched to the needs of subpopulations.

Replicating the advantages of integration in an imperfect world

An Integrated Housing/Community-Based Model

- Erickson Living is a unique model based on a retirement community (a Continuing Care Retirement Community (CCRC)) that offers independent living, assisted living, and skilled nursing, and ensures a smooth transition between settings when a higher level of care is needed.

- Erickson provides primary care on campus and arranges for regular specialty care visits to the campus. Nearly all residents use the on-campus primary care practice. Erickson offers its own Medicare Advantage plan (through which it takes full risk for medical and post-acute care to its enrolled members) in which about 20 percent of its population is enrolled.

- Erickson's brand of integration brings together LTSS (some of which is provided by the CCRC and some is funded out-of-pocket by the resident) with its primary care practice. It serves a captive population at the CCRC with a staff that is connected to residents through their housing community.

- The model is a population health model. The physicians in the Erickson clinics work with a stable population and think proactively about preventing more serious disease or conditions and supporting residents in their own apartments as long as possible and out of the ER or hospital. The community itself supports an active and engaged lifestyle for its residents.

Replication

- Health care in the Erickson model was not intended to generate revenue, but was focused on promoting the health of their residents. Payment reforms in the Affordable Care Act (ACA) aimed at creating a value-based healthcare system are providing greater financial rewards now for this approach to care and improving the economics of the model for Erickson.

- Some PACE centers have been co-located with senior housing. PACE can serve non-Duals for a premium. Many of these eventually become Duals. "PACE without walls" initiatives in San Francisco – supporting people in their home and community.

- Critical elements are the flow of information around the individual –communication among the interdisciplinary team – along with regular in-person interaction between the PCPs, care managers, and residents. Provider centricity and engagement are also key -- having the provider place emphasis on functional need and not just medical issues.

- Scale matters for financial sustainability. Staffed models like Erickson require a critical mass of complex care patients to be successful. Similarly, in plan-based models, covering a

substantial portion of a physician's panel is key to effective partnerships between the plan and that provider.

- The Erickson model provides insight into the potential for integration for non-Dual populations – where the LTSS is financed, at least in part, out-of-pocket. The model could be replicated with Medicaid and assisted living facilities (ALFs) were it not for the new HCBS Settings Rule that outlaws Medicaid ALFs.

Next Steps: Follow-on activity to advance LTSS integration

Participants in the Roundtable proposed concrete steps organizations, including LTQA, can take to expand nationwide availability of the option to enroll in integrated plans and programs that include coverage for LTSS.

- Develop Evidence of the Impact of LTSS Integration:
    - The lack of quantitative evidence of the impact of integrated LTSS on health care costs, total costs, and member outcomes is a deterrent to more widespread adoption of LTSS integration as a policy solution. Credible studies of the impact of plans integrating LTSS are needed to promote LTSS and integration as ways to slow health care spending growth.
        - *LTQA is currently seeking funding for a quantitative study.*
        - *LTQA should compile and highlight the evidence that does exist.*
    - LTQA's Taxonomy of Integrated LTSS and its 10 case studies of exemplar plans provide important definitions and framing for integrated care.
        - *This information needs to be disseminated more broadly, and LTQA should drill down deeper into what works and why.*

- Develop Strategies to Expand What Works:
    - Develop strategies to "scale up" and "spread" existing integrated models that we know work.
        - Take what we know about successful models built around place [e.g., PACE, Erickson] and conceptualize ways to create an infrastructure to replicate it to serve people with high needs/high costs in a community-based setting. "Medicaring" could be one vision for doing this (for information see medicaring.org).
        - Pursue a diversity of models – take the essence of what works and adapt to a variety of contexts.
    - Advocate for improved payment methodologies for existing Medicare plans that serve Duals (I-SNPs, D-SNPs and MMPs) to better capture shared savings for States and Plans; greater flexibility in the use of funds; and better alignment of regulatory requirements for different types of SNPs and Medicaid.
    - Develop a strategy to advance provider risk models that better align PCPs with non-medical supports and services.
    - Research and advance models that integrate for non-Duals as well as Duals.
        - Identify and/or develop ACO-risk, community-based, population-health focused models.
            - *LTQA is developing a pilot in Boston to partner with an ACO and a large LTSS provider on a community-based approach to LTSS integration.*
    - Bring investors to the table and excite them about the possibilities of good, well-tested models for LTSS integration.

- Develop Strategies to Better Engage Consumers and Their Physicians
    - Engage physician organizations in dialogue around the advantages and disadvantages for physicians and their patients of enrollment in managed care plans that integrate medical care and LTSS.
    - Develop tools for physician education to improve buy-in to the advantages for physicians and their patients of integrated plans and reduce physician resistance to patient enrollment.
    - Develop tools for consumer education to improve understanding of the advantages and disadvantages of enrollment in an integrated plan with a goal of improving consumer buy-in and enrollment, and reduce opt-out and disenrollment rates. Consumer tools should be specific to different subpopulations of the aging and disability community.
        - *LTQA is seeking funding for a joint project with Autism Self-Advocacy Network (ASAN) to address consumer issues and develop materials to explain managed care organizations to persons with intellectual and development disabilities (IDD).*

- Support Efforts to Develop LTSS Quality Measures
    - Support ongoing efforts of NQF, NCQA, and TEFT grants to develop quality measures appropriate for person-centered, home and community based services.
    - Evaluate progress toward a universal assessment approach, including progress in developing common data items, an IT platform incorporating LTSS, and assessment-based quality metrics.
    - Develop an approach to measuring system performance that would evaluate community and population impact of integration generally (not specific to particular plans or providers).

- Develop a Comprehensive Strategy to Support Family Caregiving
    - Identify and promote best practices in integrated plans that provide training, support, and respite for family caregivers.
    - Identify and promote models (like VA's caregiver program) that expand coverage to include benefits provided to family caregivers (such as: mental health coverage, group therapy).

- Develop and Implement an Advocacy Agenda for LTSS Integration and LTSS Financing
    - Convene stakeholders to develop a vision of the endgame for LTSS Integration.
    - Consider specific policy changes for an advocacy agenda. Including:
        - Aligning Medicaid and Medicare regulatory requirements
        - Improving Medicare payment methodologies
        - Modifying the HCBS Settings Rule
        - Clarifying the role of CMS's Office of Medicare-Medicaid Coordination

        - Creating, under a separate Medicare title, a fully-integrated plan with pooled Medicaid and Medicare financing, available for a premium to Medicare only beneficiaries.
    - Provide LTQA research on integration and exemplar programs to inform effort to design a policy solution for financing LTSS.

Roundtable Participant list

Michael Akinyele
Laura and John Arnold Foundation

Scott Amrhein
Continuing Care Leadership Coalition

Larry Atkins
Long-Term Quality Alliance

Rich Bringewatt
SNP Alliance

Bruce Chernof
The SCAN Foundation

Katie Dunn
National Academy for State Health Policy

Tim Engelhardt
Medicare-Medicaid Coordination Office

Peter Fise
Bipartisan Policy Center

Peter Fitzerald
National PACE Association

Lauren Gavin
Medicare-Medicaid Coordination Office

Stephanie Gibbs
Center for Health Care Strategies

Howard Gleckman
Urban Institute

Katherine Hayes
Bipartisan Policy Center

Amy Herr
West Health

Jhamirah Howard
ASPE

Gail Hunt
National Alliance for Caregiving

Jennifer Kowalski
Anthem, Inc.

Teresa Lee
Alliance for Home Health Quality & Innovation

Andrea Maresca
National Association of Medicaid Directors

Michael Monson
Centene Corporation

Tracey Moorhead
Visiting Nurse Associations of America

Matt Narrett
Erickson Living

Terry O'Malley
Partners HealthCare

Lena O'Rourke
O'Rourke Strategies

Carol Raphael
Manatt Health Solutions

Carol Regan
Community Catalyst

Martha Roherty
NASUAD

Paul Saucier
Truven Health

Ronald Shumacher
Optum

Tanya Shah
The Commonwealth Fund

Xinyi Shen
Long-Term Quality Alliance

Lois Simon
L.Simon Solutions LLC

Leah Smith
Long-Term Quality Alliance

Anne Tumlinson
Anne Tumlinson Innovations

James Verdier
Mathematica

Jennifer Windh
Long-Term Quality Alliance

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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Contact

Long-Term Quality Alliance
(202) 452-9217
info@ltqa.org
www.ltqa.org