# Insights from Five New Case Studies of LTSS Integration


**Advancing high-quality, person- and family-centered, integrated long-term services and supports**

# Background

# Research Question

How do exemplar programs integrate medical care and LTSS?

# Round 1 Programs

| Program | Medicaid MLTSS | D-SNP | FIDE-SNP | I-SNP | MMP | PACE |
|---|---|---|---|---|---|---|
| **ArchCare** | X | | | X | | X |
| **Health Plan of San Mateo** | X | X | | | X | |
| **Superior STAR+PLUS** | X | X | | | X | |
| **United Arizona Long-Term Care System** | X | | X | | | |
| **United Senior Care Options** | X | | X | | | |

# Round 1 Key Findings

- Care management is central (and multi-faceted)
- Financial Integration = Alignment + Flexibility
- Aligning with providers is a challenge

More information on the first round of case studies:

- Taxonomy: http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//Taxomony-of-LTSS-Integration.pdf
- Working Paper: http://www.ltqa.org/wp-content/themes/ltqaMain/custom/images//LTSS-Integration-Working-Paper.pdf

# Round 2 Programs: Expanding the Field

- Provider organizations
- Programs for non-Medicaid populations
- IDD managed care program

| Program | Medicaid MLTSS | MA Plan | FIDE-SNP | I-SNP | MMP | Subcapitated Provider |
|---|---|---|---|---|---|---|
| **Erickson** | | X | | X | | X |
| **HealthPartners** | X | | X | | | |
| **Inland Empire Health Plan** | X | | | | X | |
| **Sunflower** | X | | | | | |
| **WellMed** | | | | | | X |

# Findings

# Culture is Foundational

*All exemplar programs were dedicated to the mission of serving their members*

- Why is culture so important?
  - Integration is hard! Getting there requires a vision
  - Helps organization attract and retain good staff
  - Enables organization to commit to a long-term investment – have to be able to wait for financial returns

# Financial Alignment Matters

1. More resources
   - Two capitations are better than one
   - Can capture both major sources of savings: Decreased hospital utilization, decreased institutional LTSS utilization
2. Comprehensive covered benefits: One stop shopping for members
   - LTSS but no Medicare: Can't order member's DME, home health, etc.
   - Medicare but no LTSS: Can't order personal care, meals, transportation, etc.
3. Contractual relationship with all of an individual's providers
4. Data
   - Medical claims major tool for identifying high-risk members and spotting gaps in care

# Partners / Contractors Can Be a Useful Tool

- Add new care management capabilities quickly
  - Inland Empire Health Plan – Charter and Landmark
  - Health Plan of San Mateo – Institute on Aging
  - Sunflower
- Partner for specialized expertise
  - Sunflower partnerships with LifeShare (IDD expertise) and Envolve People Care (behavioral health)
- Add clinical capabilities
  - HealthPartners palliative care team

# The Under 65 Population is Different

- Many of the exemplar programs focused on seniors
  - Best practices in caring for seniors are well known, just need to be executed *"It's not rocket science—it's just blocking and tackling." –Matt Narrett*
- Not much is known about how to expand to new populations
  - Care under traditional, fee-for-service models is not great
  - Just beginning to experiment with managed care for these populations—historically have been carved out of many managed care programs
- Person-centered, integrated LTSS is a good place to start
  - Especially important that medical care be aware of individual's social context
  - Programs should respond to the individual's most pressing needs—which are often social—AND ensure they receive good primary care

# Major Finding

*Exemplar Program Approaches to LTSS Providers*

# Forming Successful Partnerships is Challenging

- State rules often require plans to contract with all providers and set rates
- Large number of small providers with limited resources—barrier to contracting, communicating, quality programs, risk sharing
- Different organizational cultures and experiences—one counterparty is often a national for-profit health plan while the other is a mom-and-pop community provider
- Mutual suspicion
  - CBOs are sometimes concerned that managed care will drive them out of business, disregard the value of their experience
  - Plans sometimes lack confidence in the ability of these providers to provide high-quality, accountable, cost-effective care

# Exemplar Programs Understand the Value of Local Relationships

- All healthcare is local—doubly true of LTSS and social service / safety net providers
- Long-standing local plans have a head start
- National plans take different approaches
  - Acquire local / regional plans
  - Partner with aging services network for LTSS: United's partnership with AAAs in Massachusetts
  - Proactively build local relationships as an intentional strategy: Sunflower organized care management regionally, hired team with state experience

# Major Finding

*Successful Approaches to PCP Alignment*

# Alignment with PCPs a Challenge for Many of the Programs Studied

- Health plans often struggled to engage PCPs

- Barriers
  - High-need members are a small share of any individual PCP's panel
  - Competing priorities: PCPs have a lot to do, and limited time to do it
  - In some cases, no direct relationship between the program and PCP

Some programs are successful—and demonstrate that engaged PCPs can add a lot of value to integration

# What Matters to Achieving PCP Alignment?

| | |
|---|---|
| **Time with the patient** | • Panel size matters<br>• Importance of seeing patients face-to-face and building personal relationships<br>• Time for care coordination and population health management<br>• Ready access to PCP critical to preventing ER and hospital use |
| **Ability to specialize** | Share of patient panel that is high-need |
| **Vision and commitment to the care model** | • Programmatic vision<br>• Buy-in from individual PCPs |
| **Tools in the toolbox** | An adequate support structure to care for patients<br>• Ability to see into patients' homes: View "life outside the waiting room door"<br>• Someone you can hand things off to (e.g., care manager)<br>• Awareness of and influence over care in other settings (e.g., hospital, PAC facility) |

# Example of Provider Alignment: PACE

| | |
|---|---|
| **Time with the patient** | • Very small panels: Usually fewer than 200 patient per PCP<br>• See patients multiple times per week at the PACE center |
| **Ability to specialize** | All patients are seniors certified to require an institutional level of care |
| **Vision and commitment to the care model** | ☑ |
| **Tools in the toolbox** | • Full care team directly employed by PACE program, including transportation provider<br>• PACE nurses visit member at home and oversee personal care workers<br>• Special statutory status that allows flexibility in providing what patient needs<br>• Care team follows patient into hospital and other settings |

# Example of Provider Alignment: Erickson Medical Center Physician

| | |
|---|---|
| **Time with the patient** | • Small panels: 350 – 400 patients per PCP<br>• On site in community where patients live – can see patients immediately |
| **Ability to specialize** | All patients are seniors living on the CCRC's campus |
| **Vision and commitment to the care model** | ☑ |
| **Tools in the toolbox** | • Extensive care management support infrastructure<br>• Full range of LTSS available on site<br>• Security staff who check on residents daily + personal alert systems<br>• Inpatient nurse coordinator for hospitalized patients<br>• On-site rehab facility where medical center PCPs are attending physicians<br>• Tracking extensive quality metrics |

# Example of Provider Alignment: WellMed Staff Physicians

| | |
|---|---|
| **Time with the patient** | • Small panels: 450 – 800 patients per PCP<br>• Time in schedule for same day appointments and coordinating care<br>• Extended hour clinics (nights and weekends); On-call PCPs 24/7 |
| **Ability to specialize** | All patients are seniors |
| **Vision and commitment to the care model** | ☑ |
| **Tools in the toolbox** | • Extensive care management support infrastructure<br>• WellMed-employed hospitalists and “SNFists”<br>• Care managers who can do in-home assessments; palliative care team that can provide home-based medicine<br>• Senior activity centers + programs for family caregivers<br>• Tracking extensive quality metrics |

# But How Do They Pay for It?

Providing this level of primary care is a substantial investment

- Strategies across all programs:
  - Manage inpatient utilization with high access to PCP and engagement in care when patients are hospitalized
  - Manage post-acute utilization
- PACE gets special Medicare and Medicaid rates – and most services are covered benefits

# Programs Get Creative to Find Resources

- Commit to program as a long-term investment – willing to wait for returns
  - WellMed started as a single clinic by a doctor who believed the existing system was broken
  - Until recently, Erickson's medical centers were subsidized by the community as an amenity for residents
- Increase funding from Medicare
  - Thorough coding of patients' HCCs → Increase MA premium
  - Close attention to MA quality measures → Increase STAR Ratings → Increase rebate
  - Participate in available incentive programs
- Engage other resources
  - Erickson patients pay privately for LTSS
  - WellMed connects patients to existing community resources and raises substantial charitable funding