Key Components for Successful LTSS Integration:
Case Studies of Ten Exemplar Programs

ArchCare

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LTSS integration is the integration of medical, behavioral health and LTSS benefits in a single capitated program. This case study is part of a larger research project that hypothesizes that LTSS integration has the potential to improve outcomes and lower overall costs of care for people with substantial functional limitations and complex care needs. This body of research is intended to inform business decisions by health plans and other at-risk organizations considering LTSS integration, and to contribute to policy discussions on financing LTSS.

Ten programs that are experienced and successful in integrating medical care and LTSS were selected for this study. The programs vary in structure, population served, and geography in order to reflect the diversity of successful approaches to LTSS integration. Each case report provides an in-depth description of program characteristics and operations, as well as a discussion of key integration strategies and outcomes.

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.

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.

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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 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.

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[1]
Covered Benefits	LTSS
Benefit Carve-Outs	Medical and behavioral
Dual Eligible Population	N/A

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.

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.

[1] 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/

Care Management and Provider Organization

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[2]
Covered Benefits	Comprehensive (medical, behavioral, and LTSS)
Benefit Carve-Outs	None
Dual Eligible Population	90%[3]

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

[2] 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

[3] 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

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.[4] 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

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

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 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.

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

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