

Integrating Long-Term Services and Supports (LTSS) Under Provider-Based Initiatives: A Strategy for Strengthening LTSS

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While many states are pursuing long-term services and supports (LTSS) integration through capitated managed care programs, several states have initiatives to better coordinate care management at the provider or care delivery level, either as an alternative to or in addition to Medicaid managed long-term services and supports (MLTSS) programs. Provider-based models seek to hold providers directly accountable for care coordination for multiple services, quality performance, and health outcomes—rather than placing accountability at the health plan level—and can be embedded in Medicaid fee-for-service or managed care environments. States may consider varied provider-based approaches for different subsets of the LTSS population and geographic regions, depending on their service needs, available infrastructure, and the most appropriate care model to deliver those services.

► Strategy Description

Provider-based LTSS integration models vary widely, but the most common model is PACE, which provides comprehensive medical and social services to beneficiaries by integrating LTSS with other services at the care delivery level. An interdisciplinary team of home-based and PACE center (typically an adult day health center) providers assist beneficiaries in fulfilling their care needs in the community rather than at a nursing facility.¹ Most PACE enrollees are dually eligible, and PACE providers receive a blended Medicare and Medicaid payment for dually eligible beneficiaries. Currently, 31 states have PACE programs (127 programs nationally), serving more than 45,000 enrollees.² Program flexibilities created by the PACE Innovation Act of 2015 may provide opportunities for states to expand these programs to new populations and sites of care. Twenty-two states and the District of Columbia are using health homes to enhance integration and coordination of primary, behavioral health (both mental health and substance abuse) and LTSS for high-need, high-cost Medicaid populations, including dually eligible beneficiaries.³ A few states are developing Medicaid ACOs for their Medicaid-only populations that provide comprehensive physical, behavioral health, and LTSS.

More LTSS Reform Strategies

Long-term services and supports (LTSS) enable more than 12 million Americans to meet their personal care needs and live with dignity and independence in a variety of community and institutional settings. With Medicaid LTSS expenditures of more than \$154 billion annually and the aging population projected to grow 18 percent by 2020, the increasing demand for LTSS is putting more pressure on Medicaid.

This LTSS reform strategy is part of a larger toolkit, *Strengthening Medicaid Long-Term Services and Supports in an Evolving Policy Environment*, which provides a menu of LTSS reform strategies adopted by state innovators that may be replicated by other states. It identifies concrete policy strategies, operational steps, and federal and state authorities that states have used to advance their LTSS reforms.



To learn more and view the full toolkit, visit www.chcs.org/ltss-toolkit.



► Implementation Mechanisms

While most states pursuing provider-based integration models are doing so through PACE, some states use other approaches to serve a broader population than is eligible under PACE. Virginia has incorporated PACE programs into its comprehensive LTSS integration strategy since the launch of its Blueprint for the state’s acute and long-term care delivery systems in 2007. Virginia launched the state’s first PACE sites that year, but was unable to implement the MLTSS component of its LTSS strategy due to stakeholder concerns in 2014 when it launched its first MLTSS program through the Commonwealth Coordinated Care (CCC) financial alignment demonstration.^{4,5} Massachusetts’ 1115 waiver extension created an entirely new ACO-based delivery system, in which non-dually eligible beneficiaries can enroll in one of three types of Medicaid ACOs to receive comprehensive physical health, behavioral health, and over time, LTSS.⁶ Maryland is considering developing a Medicare-Medicaid ACO for dually eligible beneficiaries as well.⁷ States use the Section 1945 state plan option to implement health homes. Washington is the only state currently using the state plan benefit to coordinate LTSS for its dually eligible population, and launched its program in 2013 using a managed fee-for-service financial alignment demonstration model. The program is jointly administered at the State level by the Washington Health Care Authority, which oversees the State Medicaid program, and the Department of Social and Health Services, which administers LTSS, developmental disabilities, and behavioral health services.⁸

► Results to Date

National PACE evaluations have found an association with reduced inpatient hospitalizations compared with fee-for-service LTSS programs, as well as improved care quality and lower mortality rates.⁹ However, estimates of cost savings across PACE programs are inconsistent, with some states experiencing savings and some experiencing higher costs compared to their fee-for-service programs. Additionally, PACE struggles with limited growth potential due to its adult day health center-based model of care, the finite beneficiary population, high start-up costs and scale needed for interested provider organizations, and potentially limiting state policies, such as enrollment caps. Given the recent implementation of Massachusetts’ ACO program, no savings or health outcomes are yet available. However, the Special Terms and Conditions in Massachusetts’ 1115 waiver requires an independent evaluator to conduct an assessment of the demonstration’s impact on costs, clinical quality, coverage, coordination of care, safety net capacity, and other performance metrics using a CMS-approved evaluation design. The interim evaluation will be submitted in June 2021 and the final evaluation within 500 days of the demonstration ending on June 30, 2022.¹⁰ An evaluation of Washington’s health home-based managed fee-for-service demonstration found gross Medicare savings of \$34.9 million in its first 18 months, \$30.2 million in the next 12 months, and \$42 million in the 12-month period after that; however, due to lags in Medicaid data availability, these figures do not include Medicaid savings or costs and will be updated when these data are available.¹¹ A portion of these savings will be shared back with the state.



► Key Lessons

Four key recommendations for states considering provider-led integration models based on others' experiences include:

- **Support efforts to enable PACE's growth, and actively monitor to ensure high-quality care.** Both for states new to the PACE model and those with years of experience, Medicaid directors have opportunities under existing program rules to increase PACE enrollment in their states. For example, states can eliminate caps on enrollment that limit the size of the program, especially for those states that have not assessed those limits in several years. States should also ensure provider reimbursement rates are sufficient and consistent, to the extent appropriate, across the state. Virginia noted the value of allowing competition if feasible in the state, for example if there is a city or area with sufficient capacity for multiple PACE providers, multiple providers may be encouraged to "apply" for those areas. Such competition is allowable under CMS regulations. Virginia emphasized the need to reduce administrative burden wherever possible by aligning state PACE requirements with CMS requirements. For example, the state's PACE auditing and monitoring unit conducts the audits alongside CMS, with state medical and administrative staff present, to streamline the process and avoid additional administrative burden for the PACE sites.¹² Finally, Virginia noted that its largest barrier to enrollment is beneficiaries' clear understanding of the varied benefits of the program. States can address this by improving direct-to-consumer marketing and communication of the program, as well as including the PACE option in beneficiary enrollment letters and other communication materials.¹³

In 2015, Congress allowed for-profit organizations to establish PACE programs.¹⁴ Although early studies found limited differences between for-profit and non-profit programs prior to congressional authorization, with a recent increase in the number and types of new PACE programs and enrollment, it is important for states to closely monitor enrollee satisfaction, outcomes, and provision of services to ensure that programs are focused on delivering high-quality care.¹⁵ Some states have raised concerns about PACE program accountability and transparency, compared to other MLTSS programs, given they operate primarily under federal statutory and regulatory schemes. Establishing a comprehensive oversight approach, similar to Virginia's, described below, is important for effective state monitoring.

- **View PACE as complementary to, not competitive with, MLTSS.** Virginia noted that PACE played a significant role in introducing managed care to the MLTSS market in the state, and currently serves as a vital option for 1,240 dually eligible individuals age 55 and older, and 82 non-dually eligible beneficiaries seeking coordinated care and an alternative to nursing home care so that they may remain in their homes and communities.¹⁶ States should not overlook PACE as a critical component of a comprehensive LTSS strategy for certain beneficiaries who want the experience of comprehensive provider-based integration approach, and a range of face-to-face beneficiary services in a single setting. Virginia highlighted the importance of protecting PACE as a beneficiary option alongside MLTSS as states transition to MLTSS, noting that it tends to be deprioritized given states' many competing priorities and its limited growth potential.¹⁷



- **Engage stakeholders early and often.** Massachusetts designed a comprehensive and open stakeholder engagement process to encourage broad perspectives into the design of the state’s restructuring of its care delivery system. MassHealth created eight work groups, each focused on a different topic within payment and care delivery transformation, including behavioral health and LTSS. The state selected the members of each work group based on their application, technical or subject matter expertise, and the likelihood of their being impacted by the work group topic’s policy decisions.¹⁸ Virginia was successful in addressing any potential concerns from nursing facility or home health worker groups regarding the launch of PACE sites in the state through targeted in-person communications on the program and its services.¹⁹ Other states may consider these approaches when implementing provider-based initiatives as opportunities to engage both consumer and provider stakeholders early in the design and implementation process.
- **Use program data to secure funding.** Data collection and analysis of the Washington health home demonstration was critical in demonstrating cost savings and improved health outcomes when funding was at risk midway through the program.²⁰ The state was able to use data analytics to calculate a real-time return on investment and performance results, and build a compelling, interim narrative for the legislature and administration to ensure continued funding for the program. States may consider the importance of continual data collection and interim evaluation of this data to be an opportunity to demonstrate program efficacy and request continued legislative or federal funding.

► Case Study

Virginia’s PACE Program Is a Key Component of a Comprehensive Integration Strategy. In 2006, the Virginia legislature passed a law with support from former-Governor Tim Kaine directing the Department of Medical Assistance Services (DMAS) to draft a Blueprint for the integration of the acute and long-term care delivery systems in the state, targeting seniors and individuals with disabilities who made up 30 percent of the Medicaid population yet 70 percent of the costs at the time.²¹ The Blueprint proposed two approaches to integrate acute and long-term care services for the state’s Medicaid enrollees: PACE and MLTSS. DMAS conducted community stakeholder meetings to solicit feedback on the Blueprint and the proposed approaches, including consumers, families, providers, other state agencies, and legislators.

Signaling its commitment to developing PACE in particular, the state allocated an initial \$250,000 in start-up funds to grow PACE, ultimately approving \$1.5 million for six sites. With strong support from the state administration, legislature, and DMAS executive leadership, Virginia implemented PACE in 2007, but was unable to launch MLTSS at the time due to stakeholder and consumer advocate concerns about restricted provider choice, limited availability of services, and decreased quality of care.²² To address stakeholder concerns with PACE in particular, including home health agencies viewing the model as competition, Virginia visited local social service departments and provider agencies to train and educate on the program, the benefits to beneficiaries and families, and how its services were complementary to those already being provided in the community. This stakeholder engagement was successful in mitigating concerns from nursing facility groups in particular,



and the launch of the sites was successful.²³ Non-profit, for-profit, and Area Agency on Aging provider organizations currently operate 11 PACE sites around the state, serving over 1,300 beneficiaries.²⁴

To be eligible for PACE in Virginia, participants must be 55 or older, reside in the PACE service area, and be able to live safely in the community. Participants must also be screened by a nursing facility pre-admission team using the Virginia Uniform Assessment Instrument (UAI) and Patient Choice Form and be determined to have a verified need for nursing home-level care.²⁵ Virginia reports that these screening teams will soon be required to complete mandatory training and certifications. Participants are able to dis-enroll from PACE and resume their traditional Medicare and/or Medicaid benefits at any time. PACE services provided by the state include all Medicaid and Medicare services as well as additional social and wellness services, including physical therapy, personal care, home health, prescription drug, medical, nursing facility, transportation, and assisted living facility services.²⁶

DMAS employs an entire unit within the Division of Aging and Disabilities dedicated to PACE to monitor PACE performance, oversee rate setting, perform quality reviews, collect and track data, and support providers. The auditing team that performs the annual quality management review utilizes a similar staffing model to the CMS team that oversees the PACE sites, with two clinical and two administrative analysts. Virginia emphasized the value of having clinical staff on the team to oversee PACE operations and provide guidance. Virginia has engaged in both a three-way agreement with CMS and the PACE sites that specifies regular communication between the parties, as well as an additional bilateral agreement between the state and the PACE sites to greater clarify state program expectations. The state strongly recommended the additional bilateral agreement.

Massachusetts' 1115 Waiver Extension Creates A System of Medicaid ACOs to Integrate Care for

Non-Dually Eligible Individuals. In November 2016, CMS approved an extension of Massachusetts' Section 1115 waiver, which governs its Medicaid program (MassHealth), to reform the MassHealth care delivery system to better integrate physical, behavioral health, LTSS and health-related social needs for roughly 1.2 million of the program's 1.8 million enrollees. The waiver created three new care delivery options for MassHealth's managed care-eligible population, which includes individuals under age 65 who are not in institutions and do not have third-party coverage, including Medicare. Individuals eligible for managed care, including roughly 68,000 children and adults who use LTSS, are required to enroll in either one of three new Medicaid ACO models, an managed care organization (MCO), or the state's Primary Care Clinician plan.²⁷

The three new ACO models—Accountable Care Partnership Plans, Primary Care ACOs, and MCO-Administered ACOs—vary in terms of their level of financial risk for services and their reliance on MassHealth managed care infrastructure for administrative and other support.²⁸ Primary Care ACOs directly contract with MassHealth and coordinate care across MassHealth's fee-for-service provider network, as well as MassHealth's capitated behavioral health contractor, the Massachusetts Behavioral Health Partnership. Accountable Care Partnership Plans, in which an ACO partners with a single MCO, and MCO-Administered ACOs, which can contract with more than one MCO, coordinate and deliver comprehensive care for their enrollees. Massachusetts first tested its ACO model in December 2016 through a one-year pilot program with six



ACOs managing the care of 160,000 members across the state. The state began delivering care through its ACOs in March 2018 and as of June 2018, ACO enrollment totaled 867,000.²⁹ Starting in July 2018, all ACOs and MCOs were required to contract with newly-created Community Partners, which are community-based entities that help to identify and coordinate care for an estimated 35,000 enrollees with complex behavioral health needs and up to 24,000 enrollees who use LTSS.³⁰

A primary goal of Massachusetts' reform is to base Medicaid payments on value and outcomes by requiring ACOs and MCOs to assume financial and performance accountability for their enrollees' comprehensive services. At the outset, the ACOs and MCOs will be responsible for an enrollee's physical health and behavioral health services, in addition to certain LTSS, including short-term nursing facility, home health services, therapies and durable medical equipment. During the five-year waiver period, MassHealth intends to integrate more LTSS into this arrangement, including personal care, adult day health, and adult foster care services. All of the ACO and MCO contracts include quality metrics to hold the contractors accountable for their performance across seven domains: (1) prevention and wellness; (2) chronic disease management; (3) behavioral health/substance use disorder; (4) LTSS; (5) avoidable utilization; (6) progress towards integration; and (7) member care experience.³¹

Some stakeholders have shared concerns with the delay in fully integrating LTSS into the ACOs' and MCOs' package of benefits, stating that it continues the state's current fragmented system of care, at a high cost to both beneficiaries and taxpayers. However, others cite it as an important opportunity for the state to adequately prepare for the eventual carve-in of LTSS, and for the ACOs and MCOs to gain valuable experience in caring for enrollees' complex LTSS needs through their relationships with LTSS Community Partners. Massachusetts intends to conduct a comprehensive state readiness review prior to fully carving in LTSS to assess whether the ACOs and MCOs have sufficiently built the necessary capabilities, including provider credentialing and contracting, IT systems, and grievance and appeals rules.³²

Washington's Health Home-Based Financial Alignment Initiative Demonstration Coordinates LTSS for its Dually Eligible Population.

Part of a larger state effort to improve care coordination for Medicaid beneficiaries with complex needs, Washington State received approval for two Medicaid State Plan Amendments (SPAs) on July 1, 2013 under the Section 1945 Health Homes state plan benefit created by Section 2703 of the Affordable Care Act.³³ The state's Financial Alignment Initiative demonstration, authorized via one of the Medicaid SPAs, used this Medicaid health home program as a foundation to provide comprehensive LTSS, primary, acute, and behavioral health services for dually eligible beneficiaries under a managed-fee-for-service model. The state targeted this high-cost, high-risk population in an effort to reduce costs and improve health outcomes using intensive care coordination and a person-centered care model. The demonstration is jointly administered at the state level by the Washington Health Care Authority (HCA), which oversees the state Medicaid program, and the Department of Social and Health Services (DSHS), which administers LTSS, developmental disabilities, and behavioral health services.³⁴



In the Washington health home program, beneficiaries are auto-enrolled to a health home lead entity that is responsible for coordinating their services, including LTSS, across both Medicaid and Medicare.³⁵ In an effort to improve health outcomes through enrollee engagement, health home care coordinators help enrollees to define their develop a Health Action Plan (HAP), using information about the individual's past service utilization stored in the state's web-based clinical support tool, Predictive Risk Intelligence System (PRISM), such as hospitalizations and medication usage.³⁶ The care coordinators help improve enrollees' self-management skills and identify necessary interventions or community supports that may be useful to the enrollees in achieving their goals.

Under the managed fee-for-service demonstration, beneficiaries have full choice of providers and services for both Medicaid and Medicare. However, enrollees have the option to dis-enroll from or change their assigned health home, and their Medicaid and Medicare services are not affected if they do so. Washington used a competitive Request for Application process to select the health homes, and used a phase-in process to implement the demonstration throughout the state over time.³⁷

In October 2015, the state planned to end the demonstration, citing questions regarding its projected savings and a challenging budget climate. HCA and DSHS compiled internal data on the program's projected savings and health outcome improvements, which were found to be significant.³⁸ As a result of this effective data analysis and advocacy the state legislature approved further payments to health homes that meet target goals.

ENDNOTES

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