How Will LTSS and Medical Care Integrate to Provide Community-Based Care?

By Anne Montgomery and Sarah Slocum

Expanding PACE to other beneficiaries in Michigan, and partnering with a healthcare plan in Indiana.

Some aspects of the future are impossible to predict, but some are entirely certain, and the upcoming growth of LTSS demand is quite clear. In 2017, spending on long-term services and supports (LTSS) reached $348 billion, a 48 percent increase from 2008, when spending was $235 billion (Open Minds, 2018). An estimated 12 million Americans receive LTSS every year—older adults, individuals with physical disabilities, people with intellectual and developmental disabilities, and others at risk of institutionalization—and, by mid-century, that number will rise to an estimated 27 million (Norman, 2013).

Managed care already is transforming the Medicaid LTSS market, with twenty-four states in 2017 reporting that they were using managed LTSS plans to serve primarily older adult populations and adults with physical disabilities (Lewis et al., 2018). But the more interesting—and less predictable—part of this story involves new types of partnerships and emerging service delivery arrangements that the integration of medical care and LTSS is starting to produce, and how these arrangements can benefit communities.

This article discusses two scenarios: contracting opportunities for Program of All-Inclusive Care for the Elderly (PACE) organizations that want to expand their footprint into the Fee-for-Service (FFS) Medicare-only market, a population that can pay for LTSS out-of-pocket; and evolving arrangements from partnerships between Area Agencies on Aging (AAA) and managed care organizations (MCO) that serve commercial and Medicaid populations—and which may expand over the next several years into serving Medicare Advantage (MA) plan enrollees.

MA Flexibility Can Mean Business Opportunities for PACE

Some PACE organizations are starting discussions about the types of possible arrangements

→ABSTRACT The impending growth of long-term services and supports (LTSS) demand is clear. In 2017, LTSS spending reached $348 billion, a 48 percent increase from 2008. An estimated 12 million Americans receive LTSS every year, and that number will rise to an estimated 27 million by mid-century. Innovative plans and programs are emerging for older adults, a result of integrating LTSS into medical care. This article describes two community-based programs; one expands PACE to other beneficiaries, and another involves the aging network in integrated services arrangements with healthcare. **| key words**: *LTSS, PACE, CHRONIC Care Act, Medicare Advantage plans, Aging & In-Home Services*

with MA plans that could provide cost-effective, high-quality coordinated care for complex patients, including supplemental and supportive services. Both PACE and AAA providers

'Major MCOs are also taking a closer look at the PACE model.'

are authorized to serve designated geographic areas, and as the number of older adults grows in communities across the country, they are well-positioned to expand to serve more of this population, in part through contractual partnerships with larger MA plans and other MCOs and healthcare organizations.

In 2018, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act ushered in a new era in LTSS for the Medicare program. CHRONIC was incorporated into the Balanced Budget Act of 2018 (BBA) and signed into law on February 9, 2018. Also in 2018, the Centers for Medicare & Medicaid Services (CMS) amended long-standing policy on supplemental benefits to enable MA plans to have greater flexibility in providing optional services that are clearly LTSS-focused (see sidebar, below).

MA plans now have an opportunity to consider how to improve the quality and efficiency of care for their most complex enrollees by offering targeted, cost-effective supplemental LTSS.

Major MCOs also are taking a closer look at the PACE model. PACE organizations are chartered to serve certain geographic areas, and they build PACE centers in the communities in which they are anchored. A core asset of the PACE interdisciplinary team is its ability to monitor and rapidly adapt services to changing needs of participants, who are mostly frail and disabled older adults. As a subset of Medicare beneficiaries become frail, these attributes may prove attractive to MA plans that will increasingly have members needing ongoing medical management and LTSS.

The Changing Policy on LTSS Supplemental Benefits

On April 27, 2018, CMS issued a groundbreaking memo addressed to MA plans and Section 1876 cost plans. Titled "Reinterpretation of 'Primarily Health Related' for Supplemental Benefits," the memo states, "Organizations may decide to offer some items and services that may be appropriate for enrollees who have been diagnosed with needing assistance with Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL)" (CMS, 2018a).

Subject to approval by CMS, for the first time, MA plans may offer supplemental benefits that include adult daycare services, home-based palliative care, in-home support services, limited support for enrollees' caregivers, medically approved non-opioid pain management, stand-alone memory fitness education, home and bathroom safety devices and modifications, and transportation to obtain "non-emergent" covered items and services and over-the-counter medications.

The agency's "Call Letter" for calendar year 2019 announced that MA plans would have additional flexibility in the bidding process with regard to the scope of "healthcare benefits" that are offered as supplemental benefits (CMS, 2018b). The letter explained, "Under our new interpretation, in order for a service or item to be 'primarily health related' under our three-part test for supplemental health care benefits, it must diagnose, prevent, or treat an illness or injury, compensate for physical impairments, act to ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and healthcare utilization." CMS noted, "This will allow MA plans more flexibility in designing and offering supplemental benefits that can enhance beneficiaries' quality of life and improve health outcomes."

In 2020, the Balanced Budget Act (BBA) statutory language allows supplemental benefits to be offered to enrollees with chronic conditions as long as they can demonstrate a "reasonable expectation of improving or maintaining . . . health or overall function" (BBA, 2018).

One large MA plan in the Northeast is discussing a pilot program to identify high-risk enrollees who would benefit from significantly more care coordination, complex case management, and LTSS supports than most MA enrollees need. These members would be referred to a PACE plan for some services, and PACE practitioners would coordinate with the individual's community healthcare providers.

In another example, in Ypsilanti, Michigan, the Huron Valley PACE (HVP), which opened four years ago, is pursuing strategies to expand

Figure 1. Huron Valley PACE Supplemental Services Packages Proposed for Private-Pay, Not-Enrolled, Clients

and scale to serve FFS Medicare-only beneficiaries with LTSS needs. Toward that end and under the leadership of Executive Director Sonja Love Felton, HVP is developing supplemental LTSS services packages to offer to FFS Medicare-only beneficiaries. The three services packages (see Figure 1, above) are geared to varying needs, and include a baseline assessment. These packages also will inform discussions of possible LTSS services that could be offered to interested MA plans.

Development of the HVP supplemental services packages has experienced some challenges. To address these, HVP partnered with Altarum's Program to Improve Eldercare (tinyurl.com/ybn7kdb6). HVP and Altarum have identified the cost of prescription drug coverage as a major barrier in enrollment of FFS Medicare-only participants. Altarum is working to resolve these barriers for HVP and for other PACE plans, through PACE and Part D waivers presented to CMS. Also HVP and Altarum are exploring policy options for FFS Medicare-only beneficiaries whose incomes are slightly too high for enrollment in Medicaid, and who are unable to pay the full cost of needed LTSS.

Below are two figures illustrating how PACE organizations could partner with MA plans.

In Model Number 1, the PACE organization takes on comprehensive responsibility for Medicare-covered services, supplemental benefits, and supportive services for selected chronically ill enrollees referred by the MA plan. This MA plan would receive a capitation payment for each enrollee, but all health-related services (medical, supplemental, and supportive services) would be the responsibility of the PACE organization. The payment and risk-bearing terms would be negotiated and agreed upon in a contract. In this model, the MA plan collects the Medicare per member, per month payment, maintains the interface of reporting and regulatory compliance with Medicare, and performs other administrative functions, while the chronically ill Medicare beneficiary and his or her family view the PACE organization as their primary locus of care planning and service provision.

Figure 2. Model 1: PACE Responsible for Medicare-Covered Services

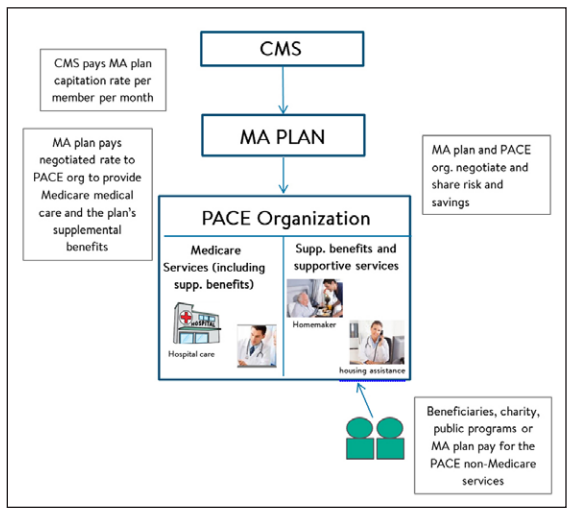
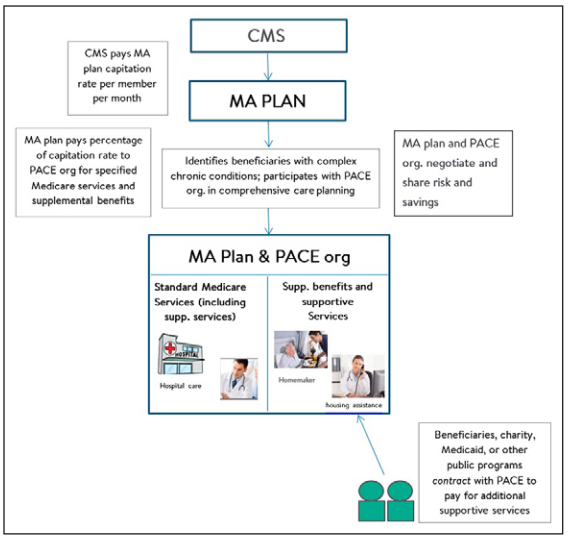


Figure 3. Model 2: MA Plan and PACE Both Provide Services



In Model Number 2, the MA plan and PACE organization both provide services, and the MA plan pays the PACE organization to provide a specific set of Medicare-covered services and supplemental benefits under contract. In this arrangement, some Medicare-covered services and supplemental benefits remain the responsibility of the MA plan, and some would be provided by the PACE organization. Supportive services that are not supplemental benefits in the MA plan would be the responsibility of the PACE organization, and their costs would be paid by the beneficiary, by a charity, by Medicaid, or by another public program.

Model Number 2 would most clearly fit a staff model MA plan that succeeds in providing customized care for Medicare beneficiaries living with advanced chronic illness. MA plan enrollees with chronic conditions would have the advantages of access to LTSS services at a PACE Center—services such as nutrition support, socialization, personal care and assistance, along with transportation, caregiver support, and extensive coordination of services and supports; parties would negotiate and contract for a shared financial and a shared clinical services arrangement. The MA plan and PACE organization also would establish an integrated care-planning team, and have shared access to interoperable records.

Community-Based Providers in Large Contracts with Managed Care Plans

In Fort Wayne, Indiana, Aging & In-Home Services (AIHS) of Northeastern Indiana, a leading AAA, is partnering with Preferred Population Health Management. AIHS has embraced a wide-angle vision of how the aging network can align its mission in the context of large-scale managed care delivery systems. Like other AAAs, AIHS gained valuable experience in working with high-risk patients within hospital settings during a pioneering five-year demonstration—the Community-based Care Transitions Program (CCTP) (*Journal of Healthcare Contracting*, 2017).

Since CCTP ended in 2015, AIHS and other AAAs have been leveraging the experience gained in working with hospitals to design new business opportunities with healthcare organizations—for care transitions interventions, complex case management, care coordination, and more. Technical assistance for AAAs to master new skills and protocols that these partnerships require has led to a public–private "business acumen" initiative, headed jointly by the Administration for Community Living and the National Association of Area Agencies on Aging (n4a). In 2016, n4a established a new center for this purpose, the Aging and Disability Business Institute (tinyurl.com/y7hh8mwk).

The program's development took twenty-six months and an investment of nearly $500,000.

In August 2018, AIHS launched a Managed Services Organization (MSO) for AAAs and other community-based organizations (CBO), called Preferred Community Health Partners (PCHP).

As of November 2018, the PCHP was operating in seven states, and n4a had agreed to invest as an equity partner in its operation. PCHP fully expects to expand to other states. In its launch, PCHP is contracting with Anthem plans serving individuals with commercial insurance, and the MSO has entered the Medicaid managed long-term services and supports market in one state. Ultimately, PCHP aims to contract with MA plans. The n4a views the equity stake in PCHP as centrally important in supporting AAAs to position their services for older adults through an entity that is based in the aging network and knows the community and its elders.

PCHP was established to deal proactively with common problems and challenges that AAAs have experienced when contracting with managed care plans. Managed care plans would like services on a bigger scale than many single AAAs can easily organize and provide, and they prefer to avoid multiple contracts with individual AAAs. Accordingly, PCHP provides a streamlined, standardized infrastructure for statewide networks of AAAs and CBOs in the following areas: contract management, financial oversight, standard agreements with states, standardized intervention across states, billing and claims support, protocols for tracking outcomes, and IT communication and analytics, including calculations of Return on Investment.

PCHP's development took twenty-six months and an investment of nearly $500,000 to establish initial legal agreements, secure Master Services Agreements (MSA), achieve certification of the health information technology (IT) platform, and structure an operating delivery system framework. The MSA is negotiated and executed at the corporate level and allows for work nationwide under one agreement.

When starting in a new state, PCHP initiates a contract with a managed care plan and commits to arranging for specific services packages to be provided to their members on the ground. The MSO simultaneously recruits AAAs and CBOs interested in delivering those services. One significant advantage to working with PHCP, Jim Vandagrifft, CEO of Preferred Population Health Management, notes that most AAAs still lack access to the IT that allows programs to share data about their shared clients—e.g., data on services use, such as for home-delivered meals and transportation, are in separate systems and do not share information about participants. AAAs also are unable to share data usefully with clinical providers. The PCHP circumvents these shortcomings.

Looking ahead, AIHS's President and CEO Connie Benton Wolfe believes that continued growth for the aging network is linked to shifts toward capitation and other value-based systems that increasingly hold providers financially accountable for providing cost-effective care, and for delivering high-quality services that meet an expanding array of performance metrics. The healthcare system, she said, still has substantial opportunities to reduce use of high-cost services through first—and preferentially—employing the most cost-effective interventions.

CBOs also may work with "age-friendly" and "dementia-friendly" health systems that are based in communities they serve.

Another opportunity on the horizon is a role for AAAs in providing supplemental services paid for by MA plans for their complex care members. Most likely, nutrition and transportation will be the first types of services in this arrangement (Super, Kaschak, and Blair, 2018). As of late 2018, no AAAs had MA contracts, but n4a expects this area to grow quickly. For example, PCHP has been working to secure a MA contract that would use the established infrastructure for service delivery to MA members. Another area for possible development is working with "age-friendly" and "dementia-friendly" health systems that are based in com-

munities they are committed to serving over the long term.

Conclusion

Contracts and partnerships that AAAs and CBOs are forming with MCOs are becoming more streamlined and organized, a trend that benefits community-based care. Similarly, PACE plans are well-positioned to begin outlining the parameters of arrangements with MA plans to improve the cost-effectiveness, quality, and reliability of services for frail older adults. To maximally benefit communities, contracts could consider specifying that a portion of savings realized from avoided high-cost care (i.e., inpatient hospitalization) be invested in community-based supportive service capacity–building, such as workforce recruitment and training, employer support of caregivers, and housing adaptations for disabilities, which generally decrease medical care costs over time (Montgomery, 2018).

These and other types of innovative arrangements will be tested as LTSS assume a more prominent role in healthcare delivery. To address rising demand in the frail elderly population, service capacity for LTSS will need to be steadily expanded in communities across the country. In turn, this may lead to collaborations between MCOs and LTSS providers that deliberately set out to capture savings from avoided high-cost care (primarily inpatient hospitalization), and which can be used to buttress local service capacity.

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