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Strategies to Address Long-Term Services and Supports

Brief Three: Integrating Medical, Behavioral and Long-Term Services and Supports Activities

Prepared for The Colorado Health Foundation
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Informing Policy. Advancing Health.

TCHF Goal

Promote the integration of medical, behavioral and long-term services and supports (LTSS) activities.

Potential Tactics

- Continue to support programs that focus on integrated care and payment reform via existing TCHF strategies.
- Support Regional Care Collaborative Organizations(RCCOs) in integrating LTSS, i.e., focus on dually eligible (Medicaid and Medicare) individuals as they transition into the Accountable Care Collaborative (ACC)

Defining the Problem

Most health care payment models in Colorado and across the nation maintain "siloed" reimbursement for medical care, behavioral care and LTSS. This structure creates disincentives to integrate care and instead results in fragmentation of services.

In Colorado

Coloradans needing medical care, behavioral care and LTSS are frequently covered by Medicare, which pays for medical/acute care, and Medicaid, which pays for LTSS and behavioral health care. These individuals are referred to as "dual eligibles." Approximately 60 percent of dual eligible Coloradans are ages 65 and older. Half of the approximately 70,000 dual eligibles in Colorado receive LTSS.[1]

In 2010, 1.9 percent of dual eligibles in Colorado were enrolled in Programs of All-inclusive Care for the Elderly (PACE). PACE receives a blended capitated rate from both Medicaid and Medicare. It is frequently described as a "fully integrated program" because it provides all services covered by Medicare and a state's Medicaid program.[2] The PACE model of care, age requirements (55 and older) and limited provider network may limit wide scale adoption of the model.[3]

Colorado is pursuing several strategies to integrate medical, behavioral and LTSS in Medicaid through the ACC. The ACC maintains a fee-for-service payment model but includes an additional per member per month payment to support care coordination activities provided by Colorado's seven RCCOs. Although LTSS are currently not part of the ACC, recent legislative changes will allow LTSS providers to serve as Primary Care Medical Providers within the model.

Through the ACC Payment Reform Initiative authorized by HB 12-1281, new payment proposals by the RCCOs will be evaluated on how care is coordinate among physical, behavioral, oral health and LTSS.

Colorado is also proposing to enroll dual eligible beneficiaries into the ACC through a demonstration grant to the Center for Medicare & Medicaid Innovation. Colorado's State Innovation Model (SIM) proposal would address integrating medical and behavioral health through the ACC. If Colorado receives both a SIM grant and CMS approval of its proposal to enroll dual eligibles into the ACC, the RCCOs will coordinate medical, behavioral and LTSS activities for beneficiaries.

Critical Success Factors

Successfully integrating medical, behavioral and LTSS services in Colorado will require critical success factors.

- Care management models can improve provider communication and support integration. Successful models frequently use interdisciplinary care teams, manage and focus on patient transitions across care settings and actively use health information technology.
- Engaging non-traditional providers, such as housing service providers, can expand the ability to provide medical, behavioral and LTSS services where beneficiaries live.
- Integration can be supported by giving a single payment to a network of providers, a health plan or a program that can provide or coordinate all three types of care. These payments can incentivize and fund effective care management activities and integrated care models that may not be possible with "siloed" funding.

Examples of Successful Innovations

Care Management

Colorado's proposal for enrolling dual eligible clients into the ACC emphasizes improved communication among providers. Several care management models are being tested to improve providers' communication and to facilitate integration of care across providers and settings. Two programs are highlighted below.

The Geriatric Resources for Assessment and Care of Elders (GRACE) model, developed by the Indiana University School of Medicine, provides continuous case management across multiple providers to low-income seniors, many of whom are dually eligible and most of whom have multiple chronic conditions. In-home assessments are provided by a team of a nurse practitioner and social worker which coordinates patient care and collaborates with an expanded team that is led by a geriatrician and includes pharmacists, physical therapists, community resource experts and mental health case managers (typically licensed clinical social workers or psychologists). The larger team develops care plan based on twelve evidence-based care protocols and reviews it regularly. The nurse two-person team conducts annual assessments and ongoing home visits. A two-year randomized controlled trial among adults ages 65 and over with incomes below 200 percent of the federal poverty level resulted

in fewer visits to the emergency department, hospitalizations and readmissions among the intervention group as well as reduced hospital costs. Enrolled patients reported higher quality of life and improvements in general medical care as well as geriatric-specific care including treatment of depression. GRACE was cost neutral by the first year and resulted in $1,500 of savings per enrolled high risk patient by the second year.[4]

In the Guided Care Model, specially trained nurses, known as Guided Care Nurses, work with primary care physicians to improve care for seniors with multiple chronic illnesses by coordinating care, facilitating transitions in care and acting as the patient's advocate across health care and social settings. Based in a primary care office, a Guided Care Nurse often works with the patient long-term, usually for life. Preliminary results from a research trial indicate that Guided Care improves the quality of patients' care, improves family caregivers' perception of quality, improves physicians' satisfaction with chronic care, improves nurses' job satisfaction, and may reduce the use of expensive services.[5]

Place-Based Activities

Place-based initiatives bring health and supportive services to seniors in their homes.

The Naturally Occurring Retirement Communities (NORC) Supportive Services Program is a community-based intervention designed to bring coordinated services to seniors so that they can age in place. Core program components include case management, social work services and health care management and assistance. Additional services may include adult day care, home and personal care services and mental health counseling.[6] NORCs minimize social isolation and loneliness, risk factors that have been linked to heart disease and Alzheimer's disease. Evaluation of NORC participants across the country found the majority are more likely to leave their homes or participate in activities or events.[7]

Jewish Family Services of Colorado, with funding support from Colorado foundations including The Colorado Health Foundation, sponsors a NORC in a low-income senior housing building in Edgewater. Staffed by a licensed social worker, the program offers social and recreational activities and provides case management services to connect residents with benefits and resources. Staff provides a range of programming to meet the needs of the residents, such as men's support groups and a weekly wellness clinic staffed by volunteer physician assistants.[8]

Vermont's Support and Services at Home (SASH) is a demonstration program funded by the Centers for Medicare and Medicaid Services that focuses on support for transitions after a hospital or rehabilitation facility stay, self management education and coaching for chronic health conditions, and care coordination. Part of Vermont's "Blueprint for Health", a state-led initiative to transform its health care delivery system, SASH brings together a "caring partnership" between health, long-term services and supports and housing providers to support aging at home.[9] SASH staff - including a full-time coordinator and a wellness nurse - is embedded in housing organizations or provide services to

Medicare beneficiaries in the community. SASH forms regional collaboratives among key agencies that provide acute, primary, mental health and long-term care services. Regional, multidisciplinary teams are formed from these collaborative members and teams participate in multi-week training programs and team building. Once trained, the teams meet twice a month to review the well-being of SASH participants.[10]

Payment Design

Opportunities for coordination are, in theory, enhanced by risk-based payments to managed care plans.[11] In addition to offering PACE, several states have integrated Medicaid managed long- term care services and supports programs that provide capitated payments to contractors that provide both Medicare and Medicaid benefits to enrollees.[12] Of the 26 states that submitted proposals to CMS to integrate care for dual eligible beneficiaries, 18 proposed to test a capitated payment model and three sought to test both capitated and managed fee-for-service models.[13]

Commonwealth Care Alliance, Inc. is a Massachusetts-based non-profit organization that receives capitated payments to provide fully integrated health care and related social support services to dually-eligible adults ages 65 and older and individuals with serious physical, cognitive or chronic mental illness. [14] Commonwealth Care's clinical system design includes interdisciplinary teams of nurse practitioners, social workers and behavioral health clinicians delivering and coordinating care in the home; individualized care plans; integrated durable medical equipment clinical assessment, management and individualized allocation; and web-based electronic medical record (EMR) support.[15] Commonwealth Care in 2009 scored in the 90th percentile or above on Healthcare Effectiveness Data and Information Set measures for comprehensive diabetes care, monitoring patients on long-term medication and access to preventive services.[16] Other evaluations and external surveys found high degrees of satisfaction and lower health spending among enrollees.

Wisconsin provides monthly per-member capitated payments to managed care organizations through its Family Care Partnership - an integrated care model for frail elderly and people with disabilities. The Partnership is a modified version of the PACE model that is less dependent on adult day health centers. The state contracts with managed care organizations (MCOs) operated by either single counties, a long-term care district established by a group of counties or private nonprofit organizations.[17] MCOs develop a network of community provider agencies. Benefits are managed and delivered through an interdisciplinary care team comprised of a registered nurse and social worker or independent living coordinator. In 2010, approximately 7.2 percent of frail elders enrolled in the Partnership or PACE had at least one preventable hospital admission. Due to a change in reporting methodology in 2010, quality or outcome data can't be compared.

Policy Considerations for Colorado

Colorado has few models that fully integrate payments for medical, behavioral and LTSS activities and is only beginning to consider capitated payment models through HB 1281. The ACC emphasizes medical home and care coordination but carves out payment for behavioral health to Colorado's Behavioral Health Organizations. Per member per month payments may not provide adequate resources to incentivize or support programs that integrate care.

Bringing together medical, behavioral and LTSS activities blends multiple providers into a network. However, these networks may have limited experience with LTSS, making oversight critical to ensure an adequate balance of acute, behavioral and LTSS activities for beneficiaries.[18] Many LTSS and behavioral health providers may lack the health information technology resources and infrastructure that medical providers are acquiring

Endnotes

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