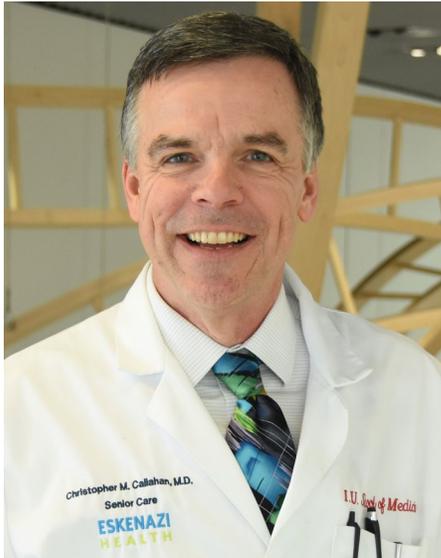


# INTEGRATION, THEMES 2 AND 3

## The Present and Future of Integrated Long-Term and Medical care

This session will address the integration of Themes 2 and 3, including innovations in the organization, financing, and delivery to support integration of medical care and long-term services and supports (LTSS) across the range of settings in which persons with AD/ADRD and their caregivers live and receive care.



Christopher Callahan, MD  
Chief Research and Development Officer  
Eskenazi Health  
Professor of Medicine  
Indiana University School of Medicine



Robyn Stone, PhD  
Senior Vice President  
for Research  
Leading Age

# OVERVIEW

Presentations by National Experts

Research Gaps and Opportunities

Panelist Perspectives

Question and Answer

# Presentations

## Building the Case for Integrating LTSS, Medical Care, and Financing

Kerry Branick, Deputy Director, Models, Demonstrations and Analysis Group  
Medicare-Medicaid Coordination Office  
Centers for Medicare & Medicaid Services

## Signals on Successful Approaches to Integrating LTSS and Medical Care

Bruce Leff, PhD  
Professor of Medicine  
Johns Hopkins University Schools of Medicine, Public Health, & Nursing

# Panelists

## Alice Bonner, PhD, RN, FAAN

Director of Strategic Partnerships for the CAPABLE Program  
Senior Advisor in Aging, Institute for Healthcare Improvement

## David Stevenson, PhD

Professor, Department of Health Policy  
Vanderbilt University School of Medicine

## Shari Ling, MD

Acting Chief Medical Officer  
Centers for Medicare & Medicaid Services

## Building the Case

Kerry Branick, Deputy Director

Models, Demonstrations and Analysis Group

Medicare-Medicaid Coordination Office

Centers for Medicare & Medicaid Services

# **Building the Case for Integrating LTSS, Medical Care, and Financing**

Kerry Branick (Kerry.Branick@cms.hhs.gov)

Medicare-Medicaid Coordination Office

Centers for Medicare & Medicaid Services

March 24-25, 2020

# Dually eligible beneficiaries

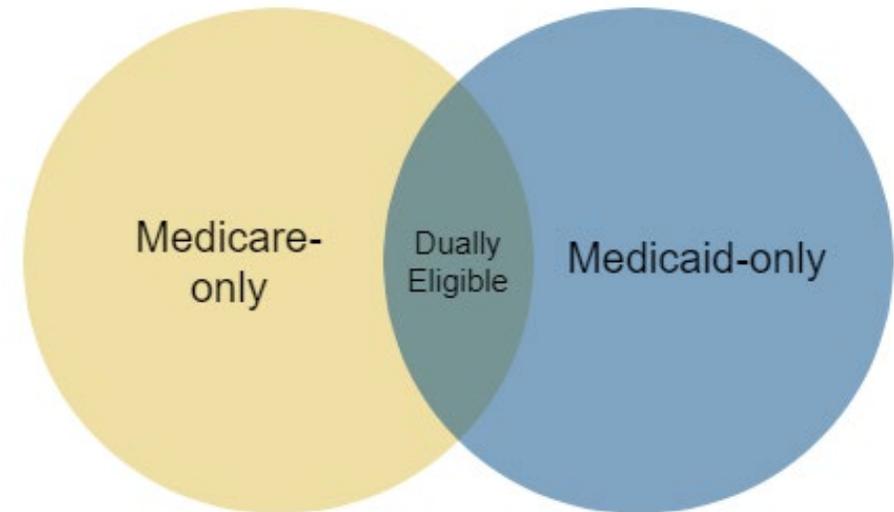
## The dually eligible population

- Higher incidence of chronic conditions, disability:
  - 41% have at least one mental health dx
  - 41% eligible for Medicare due to disability (vs. 8% for non-dual Medicare beneficiaries)
  - About half use long term services and supports
  - 19% have Alzheimer's or related dementia

## How it works

- Dually eligible beneficiaries navigate two separate programs:
  - Medicare for the coverage of most preventive, primary, and acute health care services and drugs
  - Medicaid for the coverage of long-term care supports and services, certain behavioral health services, and for help with Medicare premiums and cost-sharing
  - Where benefits overlap, Medicare is primary payer

**12 million individuals are simultaneously enrolled in Medicare and Medicaid**



# CMS' Better Care for Dual Eligible Individuals Strategic Initiative

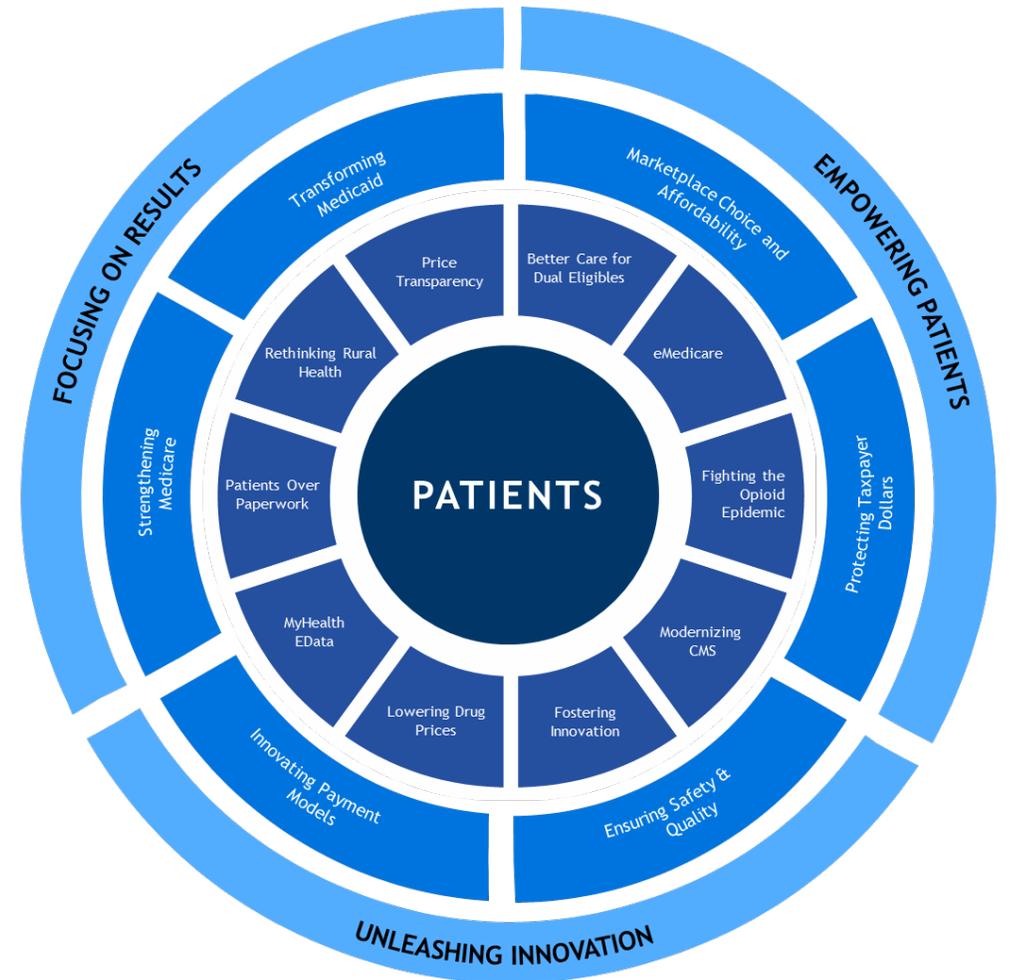
**Initiative Goal:** Improve quality, reduce costs, and improve the customer experience for people dually eligible for the Medicare and Medicaid programs.

## Modernizing the Medicare Savings Programs (MSPs)

- CMS–state data exchange
- Payment policy
- Reducing burden in eligibility processes

## Promoting integrated care to achieve better outcomes

- Strengthening Medicare Advantage and Medicaid alignment
- Modernizing requirements for the Programs of All-Inclusive Care for the Elderly
- Inviting states to partner to test approaches in serving dually eligible individuals



# Overview of the Financial Alignment Initiative

- A longstanding barrier to coordinating care for the dually eligible population is the financial misalignment between Medicare and Medicaid. That is, investments or disinvestments in one program may result in savings or costs to the other program.
  - Individuals with Alzheimer's and related dementias among populations that may feel that financial misalignment most acutely.
- CMS is testing models to integrate the service delivery and financing of both Medicare and Medicaid through federal-state demonstrations to better serve the population.
- Our goal is to increase access to quality, seamlessly integrated services for the dually eligible population.

# FAI demonstration models

## Capitated Model

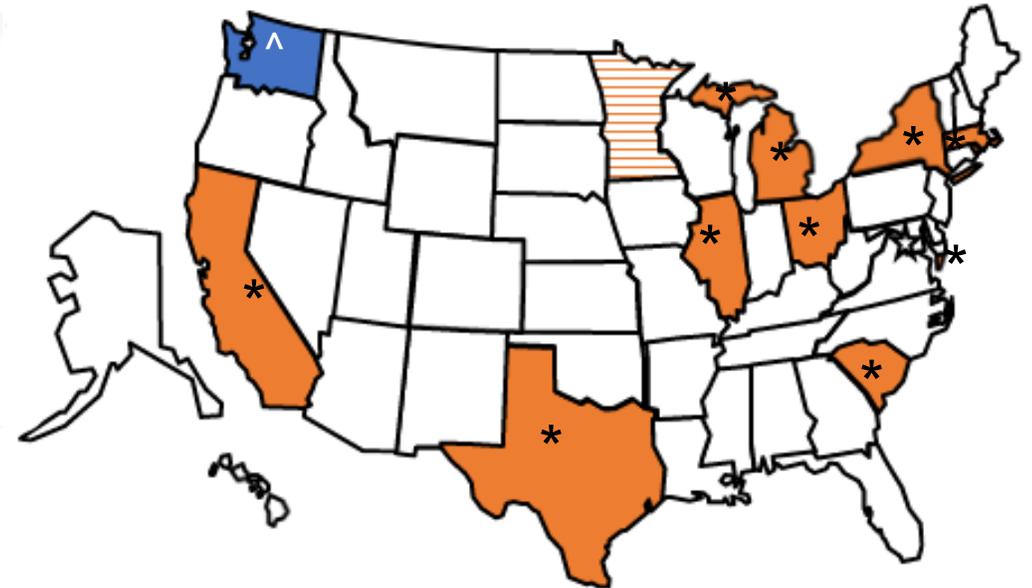
- Three-way contracts among states, CMS, and health plans (Medicare-Medicaid Plans) to provide comprehensive, coordinated care in a more cost-effective way

## Managed Fee-for-Service (FFS) Model

- Agreements between states and CMS under which states would be eligible to benefit from savings resulting from initiatives to reduce costs in both Medicaid and Medicare

## Informed by MN Senior Health Options (MSHO) experience

- 65+ program aligning home and community-based services (HCBS) with Medicare D-SNPs
- MSHO enrollees had lower hospital and ED use, greater use of primary care, and more likely to use HCBS but no more likely to use long-term NF admission<sup>1</sup>



- \* Capitated financial alignment demonstration (9 states)
- ^ Managed FFS financial alignment demonstration (1 state)

Note: CMS and NY operate two separate capitated demonstrations, both in the New York City area.

1. Assistant Secretary for Planning and Evaluation. Advancing Integrated Care: Lessons from Minnesota. December 2016. <https://aspe.hhs.gov/system/files/pdf/253311/MNLessonIB.pdf>

# Capitated model opportunities

- Integrating Medicare and Medicaid into one health plan product to align financial incentives
- Building in additional requirements into program design, health plan contracts with CMS/State
  - Dementia care specialists on care coordination staff (California, Rhode Island)
  - Process requirements for health risk assessments, care plans
  - Training for care coordination staff
- Reinforcement from CMS-State oversight teams to health plans
- Payment methodology includes ~3% withhold plans can earn based on performance on key metrics
- Benefit flexibility
- California-specific: Dementia Cal MediConnect Project
  - Administration on Aging grant to CA Dept of Aging, Alzheimer's Greater Los Angeles
  - Trained health plan care managers, specialized training for dementia care specialists
  - Developed toolkits and training materials for care coordination staff

# Promising practices

- Find and assess enrollees with dementia
  - Use of validated screening tool
  - Leverage claims data
  - Protocols and business processes built into plan systems
- Identify, screen, support care partner(s) as integral part of care team
  - Enrollee sets care goals, person-centered care plan
  - Integrate identification of care partner into plan systems
  - Screen, assess care partner needs
  - Train providers to support care partners, including better connections to LTSS
- Family-centered transitions of care
  - Care coordination protocols and communication tools and support
- Integrate community-based organizations in plan network

# Challenges

- Promising practices don't always translate into thorough implementation at health plan, even with contractual requirements
- Identification of at-risk beneficiaries
- Need models of true partnership between health plans and CBOs
- Identification and assessment of PLWD did not always result in referrals to CBOs or other supports
- Supports for care partners didn't fully materialize
- Navigating authorized representative and power of attorney
- Care coordination staff turnover
- Skill development opportunities and capacity in health plans
- Market complexity (California, New York)
- Transitions in care and flexibility to adjust to life course of the disease
- Cost-effectiveness

# Build the business case: translate to audience

- **Translate to the (growing) audience of states and health plans** implementing integrated care, investing in Medicare supplemental benefits, and growth:
  - State and local data on prevalence, costs
  - Demonstrate tools, data health plans can mine
  - Investments in LTSS can lead to reductions in ED/hospitalizations
  - Value in investing and integration in plan operations of evidence-based care coordination models for persons with dementia and integration
  - Supporting the care partner
  - Ongoing workforce and training
  - Value of CBOs
- **Growth in Medicare Advantage (MA)**
  - HCC codes for dementia (effective 1/1/2020)
  - Opportunities around flexibility in supplemental benefits
  - Growth in state interest to pull levers in state contracts with MA Dual Eligible Special Needs Plans

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- Cherry, D., Hollister, B., Schlesinger, J., Wilson, and Wilson, N. Dementia Cal MediConnect: Creating Partnerships between Health Plans and Alzheimer's Organizations to Improve Care in the Dual Eligibles Pilot. Public Policy and Aging Report. Vol. 27, Issue 1.
- FAI State-specific evaluation reports are posted at: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations>

## Signals on Successful Approaches



**Bruce Leff, MD**

**Professor of Medicine**

**Johns Hopkins University  
Schools of Medicine, Public  
Health, & Nursing**

# Signals on Successful Approaches to Integrating LTSS and Medical Care

Bruce Leff, MD

Professor of Medicine

Johns Hopkins University Schools of Medicine, Public Health, & Nursing

bleff@jhmi.edu

National Institute on Aging

**National Research Summit on Care, Services, and Supports for Persons with Dementia and Their  
Caregivers** Bethesda, MD

March 24, 2020

# Disclosures

- Honor (personal care services) – Clinical Advisor
- Dispatch Health – Clinical Advisor
- Medically Home – Clinical Advisor
- Institute for Healthcare Improvement – Faculty Advisory – Age-Friendly Health Systems
- Health Affairs – Consultant Advisor on Aging and Health Series
- Chair, Geriatric Medicine Board, American Board of Internal Medicine
- Recent work funded by: PCORI, John A. Hartford Foundation, West Health Institute, Alliance for Home Health Quality and Innovation, NIH (NIA), Optum Labs
- Past work – Institutional consulting on behalf of Johns Hopkins University School of Medicine to Welltower Inc (health care REIT – assisted living)

# My Approach Today...

- Will start by considering a critical feature of successful care delivery models and pose a few questions to consider in the context of considering integrated models for PLWD
- Then try to apply that construct to finding signals from the literature on successful approaches to integrating LTSS and medical care for PLWD
- All in service of identifying research gaps and opportunities in this space
- Will intentionally not talk about existing dementia-specific models of care – others will have presented them

# Critical Feature of Successful Care Delivery Models: They Line Up 3 Things



Targeted  
Population



Care Model



Outcome

# Population-based Dementia Care Model\*

## Risk Stratification

### 1st Tier (1%) 50 patients

- Many behavioral problems, severe functional impairment, minimal resources, comorbidities
- Frequent ED and hospital admissions

### 2nd Tier (2-1-5%) 199 patients

- Frequent behavioral problems, functional impairment, minimal resources, comorbidities
- Multiple ED and hospital admissions

### 3rd Tier (6-20% 746) patients

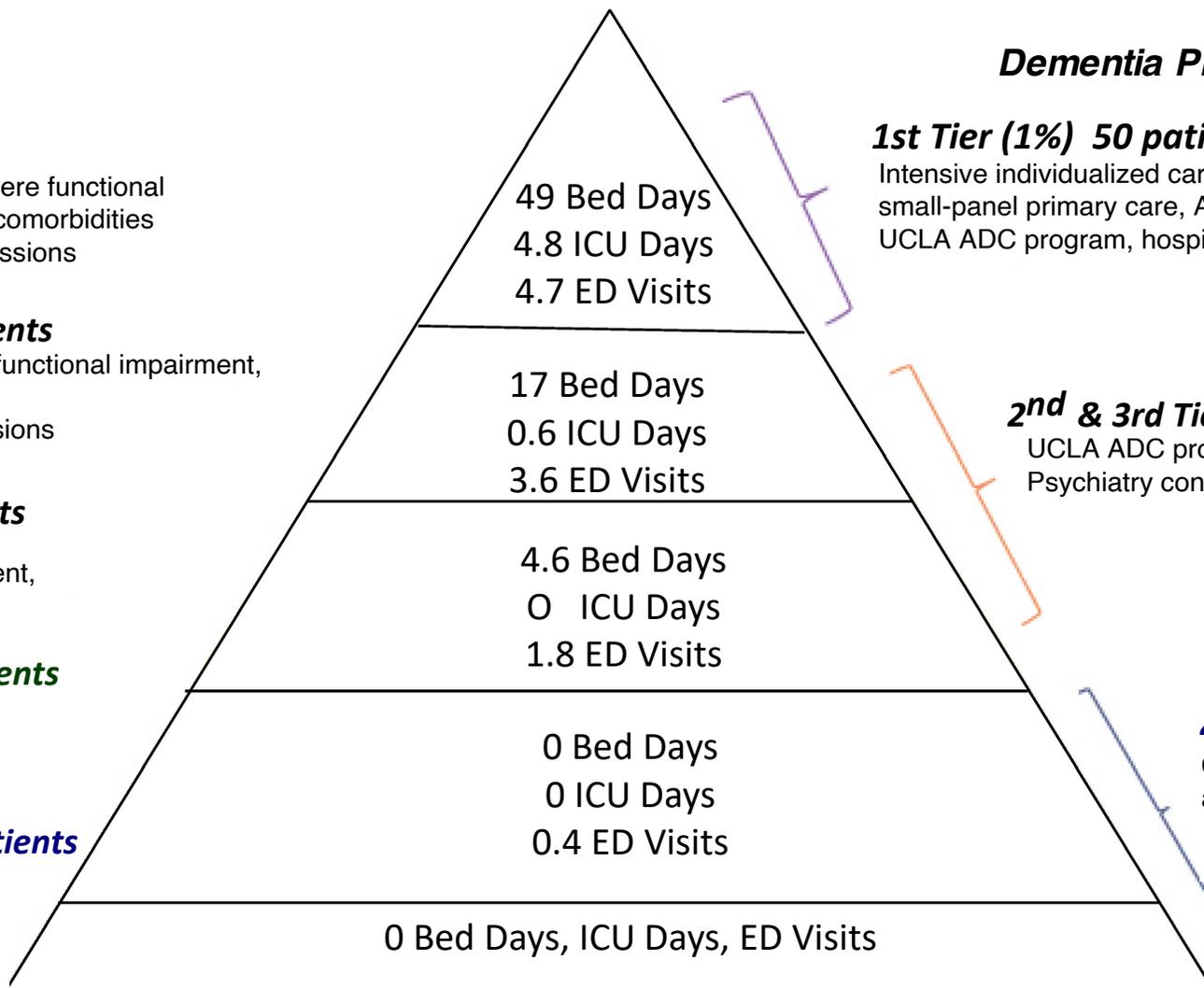
- May have behavioral problems and/or severe functional impairment, comorbidities

### 4th Tier (21-60%) 1990 patients

- Mild dementia
- Getting routine health care

### 5th Tier (61-100%) 1990 patients

- Mild dementia
- Getting routine health care



## Dementia Plan of Care

### 1st Tier (1%) 50 patients

Intensive individualized care, small-panel primary care, ACP, Palliative Care, UCLA ADC program, hospital strategies

### 2nd & 3rd Tier (2-20%) 945 patients

UCLA ADC program, ACP, Neurology, Psychiatry consultations as needed

### 4th & 5th Tier (21-100%) 3,980 patients

Caregiver education, referral and monitoring and usual care

**Total # & Yearly Minimum Utilization by Risk Tier**

\* Gupta, et al. *Academic*

*Medicine*. 2019;94:1337-1342.

Should severity play a prescriptive role?

Courtesy of David Reuben, MD

# Which LTSS Services and for Whom? What is Need? (*Nice to Have versus Must Have*)

- Personal care services
  - Case management
  - Round-the-clock services
  - Day services
  - Home-based services: aide, personal care, companion, homemaker, chore
  - Mental health and behavioral services, e.g. assessment, community tx, behavioral support
  - Health services, e.g. medication management, health assessment, skilled therapies
  - Financial management
  - Nutrition support
  - Transportation
  - Caregiver support, e.g. respite, counseling
  - And other services, etc
- **Important Associated Issues**
    - Assuring quality of services
    - Variability of services
    - State issues
    - How to dose LTSS?
    - How to mix LTSS?
  - Do services synergize? – positively or negatively?

# What Does it Mean to Integrate LTSS and Medical Care?

## What are we Integrating with What?

- What is being integrated?
  - Payment, services, providers?
- What does play look like?
  - Parallel play aware?
  - Parallel play unaware?
- Are playing together...
  - A little, a lot?
  - In synch or getting in each other's way
  - Who is the integrator?
- Integration may not guarantee results
- Integration may be needed, it may not - (may depend on the outcome)



# What Sort of Medical Care Are We Integrating With and in What Setting?

## Type and Setting Likely Matters a Lot!

- Ambulatory primary care?
- Home-based primary care? (USMM)
- Home-based palliative care?
- Hospital care?
- Skilled home health care?
- Nursing home?
- Assisted living?
- Within an integrated health system or the wild west?
- CVS and Walgreens?

# Successful Approaches to Accomplish What? What Outcome Are We Designing For?

- Health service utilization – hospital, ED, home health, drugs, etc
- Total costs of care
- Out of pocket costs of care
- Nursing home admission / long term care costs
- Medication costs
- Time at home (not in hospital, not in nursing home)
- Patient care experience
- Patient quality of life
- Caregiver quality of life
- Respite care costs
- Time to institutionalization
- Mortality
- Other non-traditional outcomes
  - Occupancy rate – Assisted Living

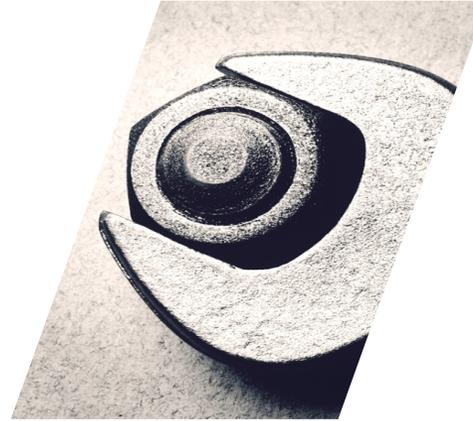
Examples and Additional Issues to  
Keep in Mind

# Integration to Little Effect & What Happens When Alignment Less than Perfect? The Example of Guided Care



Ambulatory  
Patients with High  
HCC Scores

**Targeted  
Population**



- **Embedded RN**
- Home visit, CGA
- Care planning w PCP, Pt, CG
- Monitoring
- Care coordination
- Transitional care
- CDSM
- CG support
- Access to community-based services

**Care Model**



- Functional health (SF-36)
- Quality of Care
- Utilization

**Outcomes**

# Integration to Substantial Effect: Home-Based Primary Care Integrated with Home and Community-Based Services (for PLWD)

	Dementia Prevalence	Long-Term Institutionalization	Mortality
<b>Integrated HBPC and LTSS (N=721)</b>	<b>63%</b>	<b>8%</b>	<b>26%</b>
<b>IAH Qualified with HBPC Not Integrated with LTSS</b>	<b>38%</b>	<b>18%</b>	<b>27%</b>

- HBPC addresses medical and social issues but needs LTSS to prevent long-term institutionalization
- Drivers:
  - 24/7 access – Peace of mind
  - Single source of medical care
  - Interrupted glidepaths
  - Addressing SDOH because access to the home puts SDOH front and center

*Valluru. Integrated home and community-based services improve community survival among IAH Medicare beneficiaries without increasing costs JAGS 2019; 67:1495*

# Drivers of High-Cost Status Among Dual-Eligible Medicare and Medicaid

	Persistent High-Cost	Transient High-Cost	Non-High-Cost
Age	56	66	63
# Comorbidities			
• 7-10	26%	32%	24%
• >10	24%	46%	8%
Chronic conditions %			
• <b>Cognitive impairment/Intellectual Disability</b>	<b>60%</b>	19%	8%
• Emphysema	15%	31%	14%
• Chronic Heart Failure	24%	45%	16%

- Little spending in persistent high cost related to preventable hospitalizations – **most related to LTC**
- When HCBS services made available at program level, it has been hard to restrict them to persons who would otherwise go to a nursing home
- Models that effectively target HCBS for dual-eligible people who would otherwise be admitted to NH have potential to decrease spending for high cost patients

*Figueroa JF Persistence and drivers of high-cost status among dual-eligible medicare and Medicaid beneficiaries. Ann Intern Med 2018;169:528*

# Value-Based Care and Quality Measures: Enabler or Barrier?

- Current quality measure sets for Medicare value-based care programs may create incentives for inappropriate care for certain PLWD and cause harm
  - HEDIS, MIPS, ACO measures, GPRO
- Need measures appropriate for sites of care and for vulnerable populations

# Conclusions

- The design of successful approaches to integrating medical care and social supports requires some discipline in defining the target population, the care model and what success looks like – not an easy task
- Sometimes success may require integration, sometime it may not
- If integration is needed, must carefully select the types of medical and LTSS and modes of integratoin
- Sometimes success may require an approach that focuses only on PLWD but most of the time it may be better to partner
- Optimizing approaches to quality measurement and performance reporting at the federal level could help move these efforts forward

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# Research Gaps and Opportunities

# Research Gap and Opportunity 1

In the context of integrated/coordinated long-term services and supports (LTSS) and medical care for persons with dementia, determine what services are appropriate for integration/coordination, in what manner, for whom, toward what end, and with what payer arrangements.

## Research Gap and Opportunity 2

Examine whether models of integrated/coordinated LTSS and medical care are best designed as carve out (separate) models or as add-in models integrated within the full health system; if separate models, clarify the (sub)populations of persons with dementia to whom they apply.

## Research Gap and Opportunity 3

Develop, evaluate, and optimize approaches to quality measurement in the context of value-based care initiatives, so as to encourage and support optimal care delivery models and approaches for persons with dementia.

# Panelist Perspectives



## Panelist Perspective

**Alice Bonner, PhD, RN, FAAN**

**Director of Strategic  
Partnerships for the CAPABLE  
Program**

**Senior Advisor in Aging, Institute  
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## Panelist Perspective



**David Stevenson, PhD**

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# Question and Answer

The Present and Future of  
Integrated Long-Term and Medical Care