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# Bridging Medical Care and Long-Term Services and Supports: Model Successes and Opportunities for Risk-Bearing Entities

***Bridging medical care and long-term services and supports (LTSS) is a critical component to meeting the needs of individuals with chronic conditions and functional limitations, and improving system outcomes. Risk-bearing entities present a unique avenue to pursue this integrated vision. This brief examines the current disconnect between medical care and LTSS, highlights models with demonstrated success in linking these two systems, and describes how integrated care can benefit both individuals and risk-bearing entities.***

## Re-Visioning the System of Care for Individuals with Chronic Conditions and Functional Limitations

In an ideal system, individuals with chronic health conditions and functional limitations would have access to a readily-available network of affordable options that provides high quality care and supports, allowing these individuals to live well and safely in their homes and communities. Individuals, and family caregivers when appropriate, would be actively engaged in choosing, planning, implementing, and monitoring the effectiveness of care decisions and advocating for change as needed. The needs, values, and preferences of these individuals and their family caregivers would be honored by the providers, organizations, and delivery systems that serve them. Health care providers would be knowledgeable about long-term services and supports (LTSS),[1] connecting people with available options to help them live functional lives. An array of community-based service providers would exist to help individuals navigate options for care and provide the tangible LTSS. Community-based service providers would be knowledgeable about an individual's clinical needs and their health care providers, and would link accurate and timely information back to them, enabling individuals to use services in the most appropriate and cost-effective manner. All providers would focus on making and maintaining key integrated connections between the main service platforms – primary, acute, behavioral, and rehabilitative care with LTSS – and place the individual in the center of the care experience. Overall in this ideal system, the right providers would engage with individuals at the right time and right place,

involving family as appropriate and creating a rational plan of care that puts the person's needs, values, and preferences first.

While a few small scale and somewhat idiosyncratic examples exist, the vision of integrated care delivery described above is not currently available on a wide scale. In an era of shrinking budgets and constrained resources across medical care and LTSS systems, creative solutions are necessary to meet the needs of individuals living with chronic health conditions and functional limitations in a higher quality and more cost-effective manner. However, a number of historical, logistical, and financing factors have contributed to a chasm between the medical care and LTSS worlds, leaving vulnerable adults and their families lost, frustrated, and overwhelmed with confusing, often inaccessible, and disconnected encounters in both systems. Much of the care these individuals receive is medically oriented, ignoring the often necessary supports that help people live fulfilling lives while addressing their physical and/or mental health needs.

For a variety of reasons, major policy shifts at the state and federal levels offer new opportunities to make delivery systems closer to the ideal described above. These proposals rely on traditional risk-bearing entities, such as managed care plans and capitated delivery systems, as well as new models such as Accountable Care Organizations (ACOs) and enhanced medical/health homes, all of which have both quality of care requirements and financial incentives to improve the lives of adults with chronic conditions and functional limitations.

There is a growing realization that the lack of coordination of services for this population represents an important opportunity to improve both health and functional outcomes and provide programmatic savings. While almost all of the funding streams and programs currently operate in a siloed fashion, some innovative efforts have been successful at better coordinating services, with risk-bearing entities pivotal in delivering these results. This brief examines the basis for the current disconnect between medical care and LTSS, incentives for risk-bearing entities to bridge these domains, and models that have demonstrated success in linking these two domains that benefit both individuals and the health care system.

## The Current State of Fragmented Care

For the average person who is eligible for both Medicare and Medicaid and develops serious chronic medical problems that limit daily functioning, costs for acute medical care are generally covered by Medicare through either traditional fee-for-service or managed care plans. Beyond short-term post-acute care, Medicare does not generally pay for LTSS (Appendix 1) that assist with daily functioning, a common misconception.[2] LTSS are generally paid for through one or more of four possible routes: 1) personal savings; 2) support from family; 3) Medicaid for those with limited income and assets; and/or 4) privately purchased long-term care insurance.

When signed into law in 1965, Medicare and Medicaid, as separate funding streams, created the framework for today's medical care and LTSS systems.[3] Medicare's objective was to mitigate the high cost of acute and episodic hospital care, protecting older adults from "financial ruin."[4] Medicaid, developed separately for certain low-income individuals and particularly for children and women of child-bearing age, initially provided necessary medical care and long-term nursing home care for older adults and adults with disabilities.[5] Today, Medicaid is the primary payer of LTSS, accounting for just over 62 percent of spending on both institutional care and home- and community-based services.[6] Without a more comprehensive financing mechanism for LTSS, Medicaid is poised to take on more of this cost with increasing life expectancy, increasing prevalence of chronic conditions and functional limitations at older ages, and low savings rates of baby boomers.

Typically, individuals with chronic conditions and resulting functional limitations require support from both the medical care and LTSS systems to live in the community and avoid costly institutionalization (which is most people's preference). Without accessible and appropriate LTSS to meet daily living needs, chronic health conditions can worsen and create a spiral of functional decline leading to costly emergency department visits, hospitalizations, and nursing home entry, as well as impoverishment as individuals exhaust their resources to pay for these services. Many of these increased expenditures are driven by the acute care

system because of the lack of access to, knowledge of, and/or coordination with community-based LTSS providers. Ultimately the state, and by extension, tax payers, bear the risk once low-income individuals with functional limitations require LTSS that is often institutionally-based and paid for through Medicaid. By exploring novel approaches to integrating medical care and LTSS with an emphasis on home and community-based services, there is great potential to maximize independence for these individuals and increase efficiencies for the medical care and LTSS systems as a whole.

## Role of Risk-Bearing Entities

Risk-bearing entities, such as managed care plans, physician groups, and ACOs, hold the responsibility for meeting a specific set of care needs for a defined population (see Exhibit 1). The range of care needs generally consist of primary, acute, and post-acute rehabilitative care from a medical perspective. Risk-bearing entities traditionally focus on the services for which they are responsible ("the benefit package") and not the clinical and financial implications of ineffective transitions across lines of responsibility they do not hold. At this time, most risk-bearing entities do not receive payment to cover LTSS, creating a serious challenge to fully manage the health and supportive care needs of individuals with chronic health conditions and functional limitations. Given the increased prevalence of health decline and disability as people age, risk-bearing entities will have a growing number of adults with chronic conditions and functional limitations among their enrolled populations. Risk-bearing entities that successfully integrate care across the medical care and LTSS divide, while also delivering the right services (medical and/or supportive) for these high-needs individuals, can achieve system efficiencies while improving person-level quality outcomes.

**Exhibit 1: What is a Risk-Bearing Entity?**

Risk-bearing entities in health care are those that receive an inclusive payment for an enrolled population, which covers either a group of services (e.g., all inpatient and outpatient services) or an episode of care (e.g., organ transplant). This inclusive payment, often called a "capitated" payment, fixes the rate by a given time frame (a "per member, per month" rate) regardless of the actual amount of services utilized. These entities often receive funding on a capitated basis and in turn may use capitation payments for hospital and professional services provided by medical groups. Using this payment structure, risk-bearing entities share both the responsibility (the "risk") of care provided to their enrolled population as well as financial return for any savings obtained. Examples of risk-bearing entities include traditional health maintenance organizations (HMOs), Medicare Advantage (MA) or Special Needs Plans (SNP), Accountable Care Organizations (ACOs), multispecialty medical groups, and the Program of All-Inclusive Care for the Elderly (PACE).

Successful care coordination models engage individuals to develop a person-centered plan that maximizes the use of medical care and LTSS in the context of the individual's preferences and available supports. For risk-bearing entities, this is fundamentally a different, much broader care coordination role that pushes beyond the usual benefit package to consider and involve other resources and services that can help an individual achieve his/her daily living goals. At present, individuals pay for these care coordination services out-of-pocket, from long-term care insurance benefits (if a policy had previously been purchased), or access Medicaid-funded programs in a timely fashion. Several models described below have demonstrated that the structured use of LTSS at critical points in care, such as the discharge from a hospital, can decrease unnecessary hospital use and institutionalization, as well as improve health outcomes. The savings accrued from the avoidance of hospital admissions, emergency department use, and other institutional care can be reinvested to pay for care coordination staff and the purchase of services that have not typically been provided by risk-bearing entities, such as LTSS and transportation.

## Successful Models that Link Medical Care and LTSS: Options for Risk-Bearing Entities

The Institute for Healthcare Improvement (IHI) established the "triple aim" of health care – improved experience of care, improved population health, and reduced per capita costs – as the enduring vision for a better, more responsive health care system.[7] For individuals with multiple chronic conditions and functional limitations, this means recognizing the vital role that LTSS play in collaboration with medical services to maintain daily functioning and manage complex health needs.

Public and private sector entities have tested various models to achieve the person-centered vision described at the beginning of this paper.[8-10] Evidence suggests that the "triple aim" of health care can be realized in part through innovative system designs that better connect and financially integrate medical care with LTSS. Table 1 provides examples of replicated, organized models of care that risk-bearing entities could use to bridge the medical care/LTSS divide for high need/high utilization populations. These examples show demonstrated success in both health and financial outcomes. This list is not exhaustive, but rather provides a landscape of options that risk-bearing entities can consider in order to meet "triple aim" goals.

**TABLE 1** Examples of Replicated Models of Integrated Care

| Program Model | Description | Findings |
|---|---|---|
| *GRACE/HealthCare Partners* [11,12] | The Geriatric Resources for Assessment and Care of Elders (GRACE) program provides continuous care management and coordination of care across multiple providers and settings and is targeted to low-income seniors with multiple chronic conditions. It focuses on optimizing health and functional status, decreasing excess health care use, and preventing nursing home placement. GRACE uses a nurse practitioner and a social worker who perform an in-home assessment to create individualized plan of care with the larger GRACE team consisting of a geriatrician, pharmacist, physical therapist, mental health social worker and a community-based services liaison.<br><br>This model was disseminated and evaluated in homebound Medicare beneficiaries age 70 and older who receive medical care by HealthCare Partners Medical Group in Southern California. Over a 6-month period, the GRACE model was implemented for 174 homebound patients. | **Service Utilization:** In the HealthCare Partners dissemination, emergency department use declined 22 percent and hospital admissions declined 34 percent in the 12 months post-implementation.<br><br>**Patient Satisfaction:** Over 90 percent of survey respondents agreed that GRACE increased overall patient satisfaction and quality of life, and was very helpful in providing comprehensive person-centered care to older patients. |

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| *Commonwealth Care Alliance Senior Care Options*[13] | The Commonwealth Care Alliance, a Massachusetts-based non-profit health plan and provider organization, operates Senior Care Options, a Special Needs Plan that uses nurses, social workers, and behavioral health specialists to conduct comprehensive assessments of individuals' medical, social, behavioral, and other LTSS needs. The program receives capitated payment and delivers services through Commonwealth Care Alliances' facilities and affiliated provider groups.<br><br>Senior Care Options serves patients age 65 and older in six Massachusetts counties, many of whom are "dual eligibles," and nearly 70 percent of whom are certified for nursing home placement. | **Service Utilization:** Resulted in lower hospital days (55 percent) and number of nursing home placements (30 percent) among Senior Care Options members compared to seniors in fee-for-service in 2007.<br><br>**Spending:** Slowed growth in medical spending for nursing home-eligible Senior Care Options members (2.1 percent from 2004-2009) and for ambulatory members (0.02 percent per year from 2006 to 2009).<br><br>**Quality & Patient Satisfaction:** In 2009 Commonwealth Care Alliance scored in the ninetieth percentile or above on Healthcare Effectiveness Data and Information Set (HEDIS) measures for comprehensive diabetes care, monitoring for patients on long-term medication, and access to preventive services. An external survey found high member satisfaction in the Senior Care Options program. |
| *Summa Health/ Area Agency on Aging 10B/Geriatric Evaluation Project (SAGE)*[14,15] | SAGE is a chronic disease management and transitional care intervention based in Ohio and targeted to high users of emergency department and/or hospital services age 65 years and older with chronic conditions. As part of the intervention, a care manager conducts an in-home assessment, develops an interdisciplinary care plan, and maintains regular contact with the enrollee's provider to report status in meeting plan goals. Currently underway, the After-Discharge Care Management of Low-Income Frail Elder (AD-LIFE) Randomized Trial of 530 participants is evaluating the effectiveness of the SAGE model. | **Service Utilization:** A pilot of SAGE showed that hospital admissions among participants declined by 10 to 20 percent, with a cost savings of between $600 and $1,000 per participant per month.<br><br>**Patient Satisfaction:** 70 percent of participants felt that the program improved their health. No participant reported a decline in health status over the initial year of evaluation. |

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| *Program of All-Inclusive Care of the Elderly (PACE)*[16-18] | Modeled after the On Lok program in San Francisco, PACE exemplifies integrated service delivery. PACE provides medical services and LTSS to individuals 55 or older who are certified to need nursing home care but can live safely in the community. PACE centers on a day center care model but also covers attendant services and supports in the home. It is a capitated benefit that integrates service delivery under Medicare and Medicaid. | **Service Utilization:** PACE sites that provided more intensive day center care had fewer hospital admissions. Overall, PACE participants experience significantly lower rates of hospital, nursing home, and emergency department utilization, lower overall rates of inpatient days than participants in comparison groups.<br><br>**Quality:** PACE enrollees experience better pain management and are more likely to receive routine preventive care than their non-PACE peers.<br><br>**Patient Satisfaction:** PACE enrollees report better self-rated health and are more likely to report ease in getting the care they need. |
| *Adult Day Health Care** | Beyond these innovative models that have some degree of demonstrated success, there are novel and as-yet untested opportunities that could employ LTSS service providers in nontraditional ways as part of care transitions. A potential example of a community-based resource that connects medical and LTSS, is the Adult Day Health Care (ADHC) model. Through targeted use, ADHC could assist risk-bearing entities with acute care transitions and community-based monitoring for high-risk/high use individuals. | ADHC has already demonstrated its value as the core of the PACE model, which has been shown to reduce utilization of other high-cost services, including hospitalizations, and improve outcomes.[19] |

***** In California, Adult Day Health Care has been a Medi-Cal benefit but was recently eliminated as a state plan optional benefit and reintroduced into California as Community Based Adult Services (CBAS), which is now a waiver-funded service offered through managed care plans.

Common questions that follow from a review of the models described in this paper are: 1) "What are the costs associated with the intervention?" and 2) "What are the cost savings that result?" While documenting potential savings has been difficult, the models described in this paper have demonstrated reductions in hospitalizations and/or emergency room use from their efforts. These gains have been particularly realized among services carefully targeted to individuals with greatest need,

generally those with multiple chronic conditions and functional limitations.[20] For example, the dissemination of the Geriatric Resources for Assessment and Care of Elders (GRACE) model in a multispecialty medical group has demonstrated savings post-hoc by reducing emergency room and hospital admissions for seniors with chronic health conditions and substantial functional limitations.[11,12]

## Considerations: Next Steps for Linking Medical Care and LTSS

The care models highlighted above suggest that it is possible to improve outcomes of care and potentially lower costs for populations with chronic conditions and functional limitations by substantially linking medical care and LTSS. The common features of these innovative models include many of the following:

- Interdisciplinary team care – use of a variety of providers to achieve care goals;
- Care management – identifying need, planning coordinated service delivery, implementing the plan of care, and ongoing monitoring with the individual and, when appropriate family members;
- Home visits – providers going to the home to address care needs instead of requiring an office visit;
- Medication optimization – use of technologies designed to manage medication information, dispensing, adherence, and tracking;
- Caregiver education and support; and/or
- Management of transitions across care settings (e.g., hospital to home).[21]

Additionally, each of the models described is successful in part because they have targeted services to a high-need, high-utilizing population using functional information and not just disease states, while allocating resources efficiently to produce positive outcomes in a financially feasible manner.

Given constrained resources across the medical care and LTSS systems, and a growing population of individuals with chronic conditions and functional limitations, there are opportunities for creative partnerships between risk-bearing entities and LTSS providers to improve and provide cost-effective

daily living support for vulnerable adults. At the same time, the Patient Protection and Affordable Care Act (ACA) provides additional opportunities, moving the health care delivery system away from fee-for-service arrangements toward higher quality, coordinated models of care that integrate financing and service delivery. These include:

- Duals Integration Demonstrations through the Centers for Medicare and Medicaid Services (CMS) Medicare-Medicaid Coordination Office;
- Shared savings models among hospitals, doctors, and other providers that form ACOs that share in the risks and rewards of more coordinated, efficient care;
- CMS Innovation Center initiatives to improve coordination of care across providers;
- Care transitions resources to hospital/community-based organization partnerships to reduce re-hospitalizations;
- Medicaid home- and community-based service expansions and improvements;
- Bonuses to Medicare Advantage plans that meet quality metrics;
- Bundled payment pilots between hospitals and post-acute care;
- Medical/health homes; and
- Other care coordination demonstrations such as Independence at Home.[22,23]

In moving forward with novel approaches to bridge medical care and LTSS, there are two important questions to consider: 1) "How can a risk-bearing entity take steps to narrow the medical care/LTSS divide programmatically?" and 2) "How will the services be financed?" From the programmatic perspective, these entities must first target the subset of individuals who would benefit substantially from an intervention, such as individuals who are frequently admitted to the hospital, seen in the emergency room, have known functional limitations paired with multiple chronic conditions, use high numbers of medications, etc. Next, they need to develop and execute formal coordinated care plans for this targeted subset in partnership with the individual and, as appropriate,

family members. The care plan should explicitly include home- and community-based service linkages and not simply covered medical services. Finally, entities need to determine where services should be delivered in the community. For most individuals, these services will be delivered in the home. However, there are other novel solutions that a risk-bearing entity might consider, including an enhanced medical home based in physicians' offices or federally qualified health centers, as well as community service sites like adult day health care centers that are specifically organized to provide a mix of medical and supportive services.

Financing for robust care coordination of a much broader benefits package beyond medical care (e.g., LTSS, behavioral health) needs to be factored into the rate setting calculation. Risk adjustment based not only on clinical need, but also on functional status, is a critical piece necessary to the rate development process, as is done in models such as PACE.[24] Functional status reflects one's capacity to perform activities of daily living (e.g., walking, bathing, dressing, etc.), instrumental activities of daily living (e.g., medication management, meal preparation, etc.) and cognitive function. Including functional status into risk adjustment methodologies will improve the accuracy of predicted costs for the population. It will also require that risk-bearing entities routinely collect this information from the enrolled population using consistently defined measures. Risk adjustment that considers both clinical and functional need is important because Medicaid beneficiaries, and dually-eligible beneficiaries in particular, have a highly variable need for resources. Some beneficiaries will require few resources to address their needs, some will require moderate resources, and still some others will require substantial resources. Without risk adjustment, risk-bearing entities would face strong incentives to select the least costly services, contract with a more narrow range of providers, or potentially cherry-pick the beneficiaries they enroll in order to keep their costs down. Risk-bearing entities serving only those with the highest need would most certainly be underpaid, creating an unsustainable model of care.[25]

## Conclusions

The value of bridging medical care with LTSS for individuals with chronic conditions and functional limitations is that LTSS lies not in one program or model, but in a range of services and supports that can be designed around the individual in order to meet their unique set of needs. Despite present challenges, existing innovative models such as the examples provided here illustrate the benefits of system integration. Furthermore, new opportunities emerging for system integration through the ACA specifically break down the financial and programmatic silos that have traditionally separated the acute and LTSS systems. Taken together, these promising developments represent transformative opportunities to bring siloed funding streams and service delivery structures together in ways that put the individual and their loved ones back in the center of the system of care and provide a more cost-effective and humane service set than the current fragmented "non-system" of medical care and LTSS.

## APPENDIX 1 Long-Term Services and Supports

This table outlines a range of LTSS funded to some extent by Medicaid that help address an individual's functional needs.[26]

| Long-Term Service/Support | Description |
|---|---|
| *Care Coordination* | Also referred to as care or case management, care coordination is provided by nurse or other trained care manager to first identify individual needs and then to help coordinate a set of services that meet individual needs. |
| *Personal Care Services / Attendant Services & Supports* | Assistance with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs)<br><br>May include hands-on assistance, supervision, cueing or standby assistance.<br><br>Provided by paid or unpaid caregivers |
| *Caregiver Support* | Information, education, respite care planning and support for family and friends caring for individuals with chronic, disabling health conditions. |
| *Assistive Technology* | Any item used to increase, maintain, or improve functional capacity.[27]<br><br>Examples: computers programmed to talk for individuals who cannot speak; large screen computers for individuals with visual problems; and remotely-operated devices that operate lamps, radios and other appliances. |
| *Durable Medical Equipment (DME)* | Medical equipment that is ordered by a doctor for use in the home.[28]<br><br>Examples: walkers, wheelchairs, or hospital beds, and hearing aids. |
| *Home Modification* | Converting or adapting the environment to make tasks easier, reduce accidents, and support independent living.[29]<br><br>Examples: lever door handles; handrails; ramps for accessible entry and exit; walk-in shower; grab bars; and hand-held showerhead. |

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