Key Components for Successful LTSS Integration:
Case Studies of Ten Exemplar Programs

UnitedHealthcare ALTCS

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LTSS integration is the integration of medical, behavioral health and LTSS benefits in a single capitated program. This case study is part of a larger research project that hypothesizes that LTSS integration has the potential to improve outcomes and lower overall costs of care for people with substantial functional limitations and complex care needs. This body of research is intended to inform business decisions by health plans and other at-risk organizations considering LTSS integration, and to contribute to policy discussions on financing LTSS.

Ten programs that are experienced and successful in integrating medical care and LTSS were selected for this study. The programs vary in structure, population served, and geography in order to reflect the diversity of successful approaches to LTSS integration. Each case report provides an in-depth description of program characteristics and operations, as well as a discussion of key integration strategies and outcomes.

Background Information

The Arizona Long-Term Care System (ALTCS) is Arizona's Medicaid MLTSS program. ALTCS was established in 1989 and covers medical, behavioral, and LTSS for individuals who are elderly, physically disabled, or developmentally disabled. All ALTCS members require a nursing facility level of care and must enroll in a managed care plan to receive benefits.[1]

UnitedHealthcare (UHC), a national, for-profit insurance company, is one of three ALTCS contractors, and current covers 34% of elderly and physically disabled program beneficiaries statewide.[2] UHC is the sole ALTCS contractor in many of Arizona's rural counties.

ALTCS is a relatively small part of UHC's Medicaid portfolio in Arizona. The plan has nearly 500,000 members enrolled across all Medicaid products, only 9,800 of whom are ALTCS members. UHC operates a complementary FIDE-SNP in which they encourage dual eligible ALTCS members to enroll. About 2,800 members have enrolled in the FIDE-SNP; another 2,700 are eligible but choose to receive Medicare

[1] Please refer to Appendix B for more detail on the ALTCS Medicaid MLTSS program in Arizona.
[2] As of February 2016, *AHCCCS Population by Health Care Contractor* Report. Available at: https://www.azahcccs.gov/Resources/Reports/population.html

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coverage elsewhere. UHC also operates a separate D-SNP with 34,000 members in Arizona, but does not enroll ALTCS beneficiaries in this product.

UHC has a broad network of medical providers and requires network participants to serve members enrolled in any of the organization's products (e.g., commercial, Medicare Advantage, Medicaid, etc.). The plan uses a somewhat narrower network of HCBS and SNF providers for LTSS as part of a strategy to concentrate members with higher quality providers. The plan has less flexibility in choosing network providers in rural areas, where there are few providers to choose among. In those communities, UHC focuses even more intensely on network strategy, and sometimes develops specialty contracts to meet member needs. For example, the plan has recruited new providers to serve their population, in one case developing a behavior health practice in a rural area that had previously lacked access to care.

Medicaid MLTSS in Arizona	
Program Name	ALTCS
Year Established	1989
Covered Populations	Elderly, physically disabled, and developmentally disabled individuals Must require a nursing facility level of care
Population Carve-Outs	Developmentally disabled served separately by Arizona Department of Economic Security
Enrollment Approach	Mandatory
Statewide Enrollment	58,000[3]
Covered Benefits	Comprehensive (medical, behavioral, and LTSS)
Benefit Carve-Outs	None
Dual Eligible Population	83% of elderly and physically disabled 22% of developmentally disabled[4]

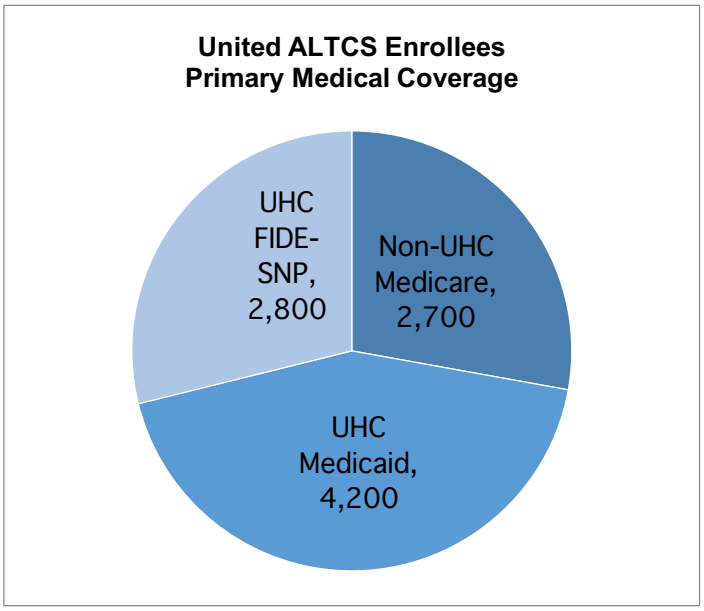
Care Management and Provider Organization

For members in UHC's ALTCS plan, care is fully integrated for all medical, LTSS, and behavioral health. Every member has a single care manager who is accountable for the entirety of their care in all settings, coordinating where necessary with medical and other providers. This comprehensive care management is provided to all ALTCS members, regardless of whether they receive their primary medical coverage from Medicaid or Medicare, or from UHC or another plan. The care manager manages a member's entire care experience through communication, comprehensive planning, and high-touch contact with the individual. Members are assigned to a care manager based on region, specialized language or high-risk behavioral health needs, and travel distance. About 90% of UHC's care managers are social workers. Care managers are supported by the plan's medical directors, as well as consulting pharmacists and behavioral health specialists.

All members receive a comprehensive face-to-face assessment within 12 days of enrollment. Prior to the assessment, the care manager calls the member to make sure that urgent needs are met and that the member has a PCP. At the in-person meeting, the care manager completes a comprehensive assessment

[3] As of February 2016, *AHCCCS Population by Category* Report. Available at: https://www.azahcccs.gov/Resources/Reports/population.html

[4] Arizona Health Care Cost Containment System (2012) *AHCCS Medicare/Medicaid Duals Discussion* Available at: https://www.azahcccs.gov/resources/Downloads/Legislation/Duals/6_Duals_DemonstrationPresentation3-6-12.pdf



using UHC's proprietary "Community Assessment" tool. This is a holistic medical-psychosocial tool that includes triggers for additional assessments for specific diagnoses (e.g., diabetes). The care manager completes the assessment using the plan's electronic case management system, CareOne, which automatically populates mandatory state assessment forms. Care managers use information in CareOne to complete the state's HCBS assessment tool manually. From the member's perspective, there is a single assessment process—the plan manages all the disparate paperwork behind the scenes. Per state contract requirements, community-dwelling members are reassessed in-person at least every 90 days and institutionalized members at least every 180 days. However, UHC will also conduct a full reassessment within two days of a hospital discharge, within ten days of a change in LTSS placement, or more often when there is a change in condition or if a member or their representative requests one.

The care manager begins the care planning process during the initial assessment. The goal of the meeting is to identify unmet member needs and outstanding problems and to implement solutions. While the state assessment tools create recommendations for hours of service, UHC has the flexibility to implement a customized service plan. The care manager coordinates all LTSS the member may receive, not just the services for which UHC pays. This can entail coordinating informal care, private duty nurses, and Medicare hospice and home health. UHC acts as the "payer of last resort" for LTSS by filling in around care provided informally or by other payers, avoiding duplication of services wherever possible.

Care managers are also responsible for managing members' medical care. The care manager's role is to communicate with all of a member's providers, and share information among those providers to coordinate member care. The member's PCP and other providers may have a separate care plan for each of the individual's medical diagnoses—the UHC care manager is accountable for coordinating all such plans to ensure the best outcomes for the member. Care management of medical care is somewhat easier when members have their medical coverage with UHC. For these members, the plan has ready access to diagnostic, treatment plan, and medication information and coordinating providers is less labor-intensive for the care manager.

Transitions

UHC's care managers are also critical to the plan's approach to managing member transitions between settings of care. The plan is notified quickly of member hospitalizations, either through the authorization process (for member's with UHC medical coverage), or through daily census reports from hospitals (for all members). For members who have medical coverage with UHC—either through Medicaid or the FIDE-SNP—inpatient utilization management nurses begin communicating with the member's care manager proactively as soon as they are admitted to coordinate care and begin discharge planning. For all

members, regardless of medical coverage, the care manager will closely follow their care during the inpatient stay. During the hospitalization, the care manager communicates with the member, their family, and the hospital's social worker. After discharge, the care manager meets with the member within 48 hours to implement an evidence-based model of transition management and adjust the LTSS service plan as needed.

The case review process is another tool UHC uses to manage member care. Anyone on a member's care team can call for a case review if they have concerns. Common triggers include care manager concerns, over- and underutilization trends, high-cost placements, non-compliant members, high volumes of medications, and frequent emergency room visits. The first part of the process brings together all plan staff involved in the member's care (care manager, medical director, etc.) to review the member's case. This team attempts to solve any identified problems internally, for example by arranging for needed medical equipment or LTSS. If necessary, the plan will engage the member's providers and may call an interdisciplinary team meeting to address any issues. Providers are generally responsive, but if necessary the medical director will reach out to providers directly to explain the importance of process.

Plan Incentives and Financial Results

For ALTCS members enrolled in UHC's FIDE-SNP, the plan receives two capitation payments: one from the state for Medicaid services and a one from CMS for Medicare services. The CMS payment includes an additional 10% payment as a frailty adjustment. Arizona's Medicaid rate-setting generally ensures that MCOs remain financially sustainable without reaping large profits, although there is no mechanism for clawing back profits within a contract year. The state uses encounter data to set rates, with annual adjustments based on trends and program changes. UHC pays for LTSS on a fee-for-service basis, based on state fee schedules. The plan also pays for most medical care on a fee-for-service basis. UHC is piloting shared savings programs with physician practices and some long-term care facilities, and has begun implementing value-based purchasing.

Moving individuals out of institutions and into the community has been a major objective of the ALTCS program since inception. As a result, Arizona is a national model for rebalancing. When the program was launched in 1989, 95% of members lived in nursing facilities.[5] In 2014, that rate was 27%.[6] This success is due partly to strong financial incentives for plans to move members out of institutions. Each year, capitation rates are set based on the projected share of the plan's membership that will use a SNF. The plan gets to keep any savings for the first 1% difference in the population institutionalization rate. The plan is also responsible for costs for up to 1% above the projected rate. The state captures savings and covers losses above the +/- 1% threshold. These incentives have led UHC to reintegrate between 1–2% of the population each year above the projection. The plan is now a leader in reintegration strategy among UHC plans nationally. The plan developed a SNF discharge readiness assessment that is being used by other UHC plans, and recently helped a plan in Tennessee launch a reintegration program.

UHC's ALTCS product is profitable, but this financial success is hard-earned. In 2006, the plan lost a bid with the state, and was not allowed to enroll new members in Maricopa County for five years. More

[5] J. Libersky and J. Verdier (2014) *Financial Considerations: Rate Setting for Medicaid (MLTSS) in Integrated Care Programs*. Available at: http://www.mathematica-mpr.com/~/media/publications/PDFs/health/dual_eligibles_ML_TSS_rate_setting.pdf

[6] Joint Legislative Budget Committee (2015) *Program Summary: Arizona Long Term Care System*. Available at: http://www.azleg.gov/jlbc/psaxsaltcs.pdf

than 60% of ALTCS beneficiaries live in that county, which includes Phoenix, and many observers did not expect the plan to stay in the program. As enrollment was frozen, the plan's membership aged and became more expensive. This coincided with the economic recession, during which the state cut capitation rates. Despite these challenges, today the plan is still in ALTCS and financially sustainable. This was only possible due to a concerted effort to review all care plans, right-size service packages, and decrease costs. The plan reduced services gradually, and members generally accepted the cuts based on the strength of their relationships with care managers. Over the course of this effort, UHC cut more than a thousand service plans, and only a dozen members appealed.

Utilization Management Strategy

For members in the ALTCS product, nursing home days drive 90% of UHC's costs, and thus utilization management focuses intensely on keeping members in the community. Secondarily, the plan looks to provide the most cost-effective set of services. One way the plan does this is by reviewing utilization reports to look for areas of over- and underutilization. This may be using more of a service than necessary (e.g., hours of respite), or using services that are more expensive per unit than necessary (e.g., using RNs as personal care aides). The population enrolled in the ALTCS plan is only a small share of the plan's total Medicaid and Medicare populations, and is not a major driver of hospital utilization.

The plan uses a strict cost threshold in determining how to support members in the community. Care managers conduct a cost effectiveness study on the full HCBS service package, and will support the member in the home so long as the cost does not exceed 100% of the average cost of institutional care. The plan has a great deal of flexibility in the services provided if they are within the cost threshold. If the cost of keeping members at home exceeds the threshold but the member refuses institutionalization, the family can substitute informal care for paid services and the care manager will try to arrange for other lower-cost services in the community. In these situations, the plan requires the member to sign a managed risk agreement that limits UHC's liability while supporting the individual's decision.

Despite aggressive reintegration of members to the community, UHC has not seen an increase in hospitalizations. The plan attributes this success to the work of care managers. Prior to a permanent move out of a nursing facility, individuals are sent home for a trial period to make sure everything is ready. When the member first moves home, they are given more service hours that are slowly decreased, and the care manager checks in frequently. Thereafter, the care manager checks that the placement remains safe and sustainable at quarterly in-person assessments.

For members living in the community, the care manager works with members and their families to design the most cost-effective service package to meet their needs. Services are targeted to members' current needs, not to worst case scenarios. The care manager also encourages family members to take some responsibility for the member's care, and assesses family caregivers for burnout at each visit.

Quality Metrics and Performance Management

The state withholds 1% of capitation payments to MCOs each year to fund a performance incentive program. For the ALTCS program, plans are assessed on a handful of quality metrics: emergency department utilization, 30 day readmissions, diabetes management, cholesterol management, and flu shots. Bonus payments are distributed competitively based on the plan's performance against minimum standards as well as relative to other plans. The state requires plans to report on other LTSS-specific

quality metrics, including inpatient utilization, functional status maintenance and improvement, advance directives, and the results of an HCBS satisfaction survey.

UHC's quality program focuses on physicians as the most influential factor for driving member outcomes. The plan currently has 30% of network physicians in value-based contracts in which practices receive bonus payments for achieving key quality metrics—the same measures on which the state holds the plan accountable. As part of this program, UHC shares detailed performance information with physicians on quality metrics, inpatient admissions and readmissions, total population costs, and total cost for individual patients. The plan offers additional resources to practices who are interested in sharing risk with the plan. For example, the plan will advance a practice the funds to hire a care coordinator, to be paid back only if the practice achieves savings. UHC is evaluating the potential to expand this program throughout the network to other provider types (e.g., nursing homes.)

UHC has a robust approach to care manager performance management. Care managers are rated on a 1 to 5 scale across a range of metrics. Several metrics align with the state's quality goals for the ALTCS contractors: flu immunizations, diabetic screenings, readmissions, and timely service initiation. Managers of care managers also use the results of quarterly chart audits (three charts per care manager) and annual member satisfaction surveys as performance management tools. The care manager is also assessed based on how many members have set personal goals. On top of these performance metrics, UHC has a range of mentoring, coaching, and member feedback processes in place to develop care management staff. The plan sees care management as the linchpin of their success in serving the ALTCS population, and the performance management process ensures that staff are well-trained and effective.

Person-centeredness is central to the organizational culture at UHC, with plan staff and management highly engaged in programs to improve member quality of life and to help members achieve personal goals. The plan's Member Empowerment (ME) program, launched in 2010, has been recognized as a best practice by the state. The ME program helps members set personal goals—like getting a job, volunteering, or going to school—and then supports the member in achieving that goal on their own. UHC is tracking the impact of the program; key metrics are whether members have set at least one goal and whether they have achieved at least one goal. To date, 70% of members have set a goal and 35% have achieved a goal. Care managers are accountable for asking members to set goals and ensuring that care plans are consistent with those goals. Plan staff are passionate about this program, and coordinate fundraisers to help members to reach their personal goals. Plan management believe the program also generates significant financial value through increased member retention and improved health outcomes. UHC has not measured these outcomes, but anecdotally the program increases member social engagement and fosters a sense of purpose—outcomes that are not only valid ends in themselves, but are also associated with better health. Additional, the ME Program has strengthened UHC's brand in Arizona with members, staff, providers, and the broader community.

Key Integration Strategies and Outcomes

UHC's integration strategy is executed through their comprehensive care management model, which aims to improve member medical outcomes and manage costs. Fundamentally, care managers partner with members and their families to engage members in their own care, promote a high quality of life, and support complex individuals safely and cost-effectively in the community. These are ambitious goals, and UHC has found that hiring the right care management staff is critical to success. The plan's success

in integration can be attributed to their ability to attract and retain care managers who are aligned with the program's mission and passionate about serving complex.

Plan leadership believes that a couple of unique attributes have contributed to their success. The first is the organization's focus on behavioral health. Every member's behavioral health is assessed, and all care managers are trained to recognize behavioral health needs and coordinate appropriate resources. Individuals with the most complex behavioral needs are followed by a specialized care management team. The second distinguishing attribute is the plan's culture of person-centeredness. The ME program described above was an outgrowth of a pre-existing mindset among case managers. A commitment to improving members' quality of life underpins the close relationship between care managers and members.

UHC aims to lower costs while improving outcomes and quality of life for their ALTCS members. Plan leadership do not have conclusive quantitative evidence of their outcomes, but point to a retention rate near 100% as one indication that they are achieving this goal. The plan also has many anecdotes from members, staff, and providers as evidence that the plan's person-centered efforts are dramatically improving the quality of member's lives.

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Long-Term Quality Alliance

Long-Term Quality Alliance (LTQA) is a community of organizations aimed at improving outcomes and quality of life for persons and their families who are managing functional limitations due to chronic health conditions. It draws member organizations from the full range of health care and social services delivery systems involved in provision, administration, innovation, policymaking, and advocacy for quality long-term services and supports (LTSS).

Organizations come together in the Alliance to share knowledge and experience needed to advance development and continuous improvement of high-quality systems of integrated, person- and family-centered LTSS. The Alliance serves as a convener of disparate private-sector and governmental organizations, with an eye to identifying and resolving the most significant challenges and advancing the replication of successful models that demonstrate the potential for more widespread adoption of person-centered LTSS integration.

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Advancing high-quality, person- and family-centered, integrated long-term services and supports

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