Integrated Service Delivery: A LeadingAge Vision for America's Aging Population

LeadingAge®

INTEGRATED SERVICE DELIVERY: A LEADINGAGE VISION FOR AMERICA'S AGING POPULATIONS

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About LeadingAge

The mission of LeadingAge is to be the trusted voice for aging in America. Our 6,000+ members and partners include not-for-profit organizations representing the entire field of aging services, 39 state partners, hundreds of businesses, consumer groups, foundations, and research partners. LeadingAge is also a part of the Global Ageing Network (formerly the International Association of Homes and Services for the Aging), whose membership spans 30 countries. LeadingAge is a 501(c)(3) tax-exempt charitable organization focused on education, advocacy, and applied research.

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Executive Summary

Addressing the needs of a rapidly growing older population could be considered one of the major challenges facing the United States over the next few decades.

Bolstered by the aging of the baby boomer generation, the older population will increase 56% by 2030, when 72 million Americans will be 65 or older.[1] Roughly 80% of these older Americans will live with multiple chronic conditions that require interaction with multiple health care providers, according to the Agency for Healthcare Research and Quality. About 50% of the 65+ population will need help with many of life's basic activities sometime during their lifetimes.[2]

LeadingAge is cognizant of this looming challenge. But we also see our nation's changing demographics as an unprecedented opportunity to redesign the current system for delivering health care and long-term services and supports (LTSS) to older adults. We envision a new system that will be far more efficient, and will take a far more comprehensive view of each older adult's need for medical care, housing, social supports and financial security. Our members are well-positioned to play a central role in this new system.

Two System Failures

LeadingAge's mission is to be the trusted voice for aging. We have observed that the American health care system fails older adults in two ways:

1. The current delivery system offers little guidance to older adults and their families as they attempt to coordinate, navigate and manage our complex and fragmented system of medical care and LTSS. When families tackle this overwhelming challenge alone, it often results in unmet needs, inefficient use of available dollars, and poor outcomes.
2. The LTSS financing system offers no protection against the severe economic consequences that often accompany the need for expensive services and supports, particularly over long periods.

LeadingAge believes these two failures are related. Therefore, we have identified two key strategic solutions to address these failures. These solutions are designed to ease the fragmentation perpetuated by our fee-for-service payment system, which rewards providers for providing more, not more-coordinated or even better quality services. Recent federal demonstration programs to test alternative payment models have pursued promising approaches to easing this fragmentation, but these efforts have been limited in size and scope.

We urge policy makers to take two steps to truly reform our system:

- *Develop and support an integrated service model for older adults.* This paper describes LeadingAge's vision for a person-centered, integrated service delivery model that views and addresses the needs of older adults in a holistic fashion, uses available public and private resources more efficiently, achieves better health outcomes, and helps Americans live better lives, regardless of age. We urge policy makers to initiate large-scale, national demonstrations to test, refine and encourage widespread adoption of this model for all older adults.

1 Administration on Aging Projected Future Growth of the Older Population, https://www.acl.gov/Aging_Statistics/future_growth/future_growth.aspx
2 Favreault, M. M., & Dey, J. (2016). Long-Term Services and Supports for Older Americans: Risks and Financing. Washington, DC: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/106211/ElderLTCrb-rev.pdf

- *Develop a universal LTSS insurance system* to provide important financial support for this integrated service model. A companion paper from LeadingAge describes the critical need for, and the basic elements of, this new LTSS insurance program.[3]

Integrated Service Model: An Overview

The integrated service model that LeadingAge envisions will address the needs of all older adults, not just those with high needs and high costs. The ultimate goal of this broader population focus is to reduce the number of older adults who develop high needs and high costs, while also slowing the growth of Medicaid and other public financing.

A key component of the integrated service model is its holistic approach to service delivery. The model would not view a person's need from a narrow medical or symptomatic perspective. Rather, the model would deliver a comprehensive and coordinated set of services and supports at the community level to address the needs and goals of the whole person.

The integrated service model would be implemented by an organized, community-based "hub" of providers working collaboratively to deliver services and supports to individuals. The hub could be directed by any group of providers: not just a health plan, hospital, health system or doctor, but also a community-based LTSS organization. Providers in the hub would be financially aligned to work together across services and settings, and would employ a person-centered approach to addressing each person's needs in a comprehensive way.

The integrated service model's primary features would include:

- *Pooled funding and risk sharing:* Success of the integrated service model depends on the ability of hub providers to pool all sources of funding – public and personal – and to be free from the existing fee-for-service structure. Working together, hub providers would offer a full range of coordinated services and supports designed to help an individual maintain health and achieve personal goals. Hub providers would assume a portion of the risk for outcomes and total cost of care.
- *Single point of contact:* A single "service facilitator" would work with the older adult, his or her family, and the hub's interdisciplinary care team to answer questions and identify and coordinate needed services, supports and resources across settings. The facilitator would serve as a liaison between the individual and his or her family and provider hub.
- *Assessment and single service plan:* The hub's interdisciplinary provider team would conduct a comprehensive assessment of each older adult, and use its findings to develop a universal aging service plan in collaboration with the older adult, his or her family, and all identified care and service providers. The service plan would address all of the older adult's needs for services and supports, not just his or her medical needs. To meet this broad range of needs, the hub would pool Medicare funds with a variety of other available dollars – such as Medicaid, HUD, Older Americans' Act dollars and, where available, personal funds – to offer any service or support that optimizes health or functional status for beneficiaries, as long as those services addressed needs identified in the aging service plan.
- *Comprehensive service coordination:* Comprehensive service coordination would be a key strategy for improving outcomes for the older adult, and enhancing the effectiveness of the hub providers. To facilitate this coordination, providers, the hub service facilitator, older adults and families would have real-time access to the individual's health information and aging service plan. Technology tools would be used to share information, improve access to services and supports, enhance wellness and independence, and facilitate predictive modeling to improve outcomes and identify best practices.

3 LeadingAge. (2017). A New Vision for Long-Term Services and Supports. Washington, DC: Aaron Tripp.

- *Quality assurance:* The integrated service framework would define measures of quality that gauge the satisfaction of the older adult and his or her caregivers. Quality measures would also be tied to achievement of the individual's goals, as identified in the aging service plan.

Interim Recommendations

Laws and regulations can provide a framework for the integrated service model that LeadingAge envisions, as long as those laws and regulations do not stifle creativity by being overly prescriptive.

We acknowledge that a few providers, including some LeadingAge members, have found ways to work within the confines of the existing regulatory and funding infrastructure to create an integrated service model in their communities. We applaud their efforts, which represent laudable examples of what is possible.

However, there remains a strong need to reform our entire delivery system so that these promising examples can reach their full potential, and similar initiatives can become far more widespread. We must work together to ensure that all older adults have access to the full breadth of medical, social and long-term services and supports needed to live a healthy and independent life.

We understand that implementing the comprehensive approach outlined in these pages would require widespread reform of systems and payments, as well as a change in our way of thinking about the delivery of health and LTSS services. This widespread reform is, clearly, a long-term goal. Therefore, this report also recommends a menu of interim steps that policy makers could take to move our delivery system toward integration, and incentivize providers to adopt a more holistic approach to the work they do.

Our Long-Term Goal

LeadingAge and its members stand ready to work with policy makers to create a framework for an integrated service model. Being successful in this endeavor means nothing less than creating a society in which all older adults can age with dignity while enjoying the health and quality of life we all desire.

Introduction: The Challenge

Not all Americans automatically become ill or develop cognitive or physical impairments at age 65. However, nearly 80% of adults who are 65 and older will develop a chronic condition sometime during their lifetime, and about half will eventually lose their ability to care for themselves because of physical impairments and/or cognitive decline.[4]

With frailty comes an array of needs for ongoing services and supports that address medical needs while supporting an individual's ability to carry out daily activities like bathing, dressing and grooming, cooking, paying bills, and cleaning and maintaining the place called home.

Typically, older adults who experience frailty require an increasing number of visits to primary care physicians and specialists, and services from LTSS providers. These growing needs typically come at a time when older adults find themselves living with diminished financial resources, as they retire from full-time work and begin relying on accrued savings.

Today, families and older adults often are ill-prepared for this stage of life. They have no single or unbiased source of information to help them understand and evaluate the availability, quality and cost of services. As a result, they have difficulty making proactive, informed and meaningful choices that weigh the costs and benefits associated with meeting the older adult's needs most effectively.

To make matters worse, our system rarely fosters communication and coordination among providers of services and supports. Nor does it encourage the development of an overarching aging service plan that follows the individual across settings. Without this coordination, care and services become fragmented. Resulting gaps can lead to personal hardship and unnecessary hospitalizations.

The Scourge of Fragmentation

Fragmentation is at the root of our current system's failure to address the needs of our aging population. This fragmentation exists and is perpetuated by two fundamental aspects of health care policy:

1. The Fee-for-Service Payment System

The fee-for-service system, through which providers receive payment for every service they provide, is marred by significant inefficiencies and tremendous variation in average total costs around the country.[5] Under this system, providers generally earn more revenue if they provide more services, not if they coordinate care and develop comprehensive service plans. In addition, Medicare and Medicaid pay only for a defined list of eligible services. No list can capture or anticipate the countless ways in which an older adult's needs may be met, since each person has a unique set of needs and circumstances.

Federal policy makers know that the inefficiencies of the Medicare and Medicaid financing systems are unsustainable, especially in light of the growing number of older adults and the corresponding growth in costs associated with addressing this population's need for health care and daily living supports. These policy makers have taken steps to shift payment incentives through initiatives like the Hospital Readmission Reduction program, Bundled Payments for Care Improvement (BPCI), and Medicare Accountable Care Organizations (ACO). These and other value-based payment models:

4 Favreault, M. M., & Dey, J. (2016). Long-Term Services and Supports for Older Americans: Risks and Financing. Washington, DC: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/106211/ElderLTCrb-rev.pdf

5 Newhouse, J. P., & Garber, A. M. (2013). Geographic variation in Medicare services. New England Journal of Medicine, 368:1465-1468.

- Allow a variety of Medicare providers to receive a bonus, or earn back a reduction in their fee-for-service payment, if they deliver better quality and cost efficiency.
- Reward providers for reducing re-hospitalizations, lowering average Medicare beneficiary costs, and improving patient experiences.
- Ask groups of providers to assume additional financial risk and accountability for improving and managing the costs of quality care.

These alternative payment models, and other models tested by the Center for Medicare and Medicaid Innovation (CMMI), represent important first steps in reforming our health care system. However, there are several reasons why these models have not done enough to motivate providers and payers to coordinate care and address the full range of needs experienced by the most vulnerable Medicare beneficiaries.

First, broad adoption of new value-based models has been slow because providers can still receive higher revenue by generating fee-for-service volume than they can by earning "rewards" for generating greater value.

Second, under current alternative payment models, the Centers for Medicare and Medicaid Services largely continues to pay providers through the fee-for-service system. Only months later do these providers share in some of the "savings" achieved by the model. As such, alternative payment models do little to support innovative practices, or to offer the flexibility needed to change how we deliver services and supports to older adults who experience a complex mix of chronic conditions, functional impairments and behavioral health needs.

Third, much of the focus of these models has been on holding providers accountable only for the Medicare-covered medical care provided to an individual, with little regard for LTSS and other services paid by Medicaid or with personal funds. However, it is these non-medical services that help to preserve one's health and independence, thereby lowering utilization of high-cost services.

2. Uncoordinated Sources of Funding

Services and supports for the older adult population are currently paid largely through some combination of Medicare, Medicaid and personal funds. Medicare covers hospital services, physician services, clinic visits, laboratory tests and prescription drugs, but not LTSS. LTSS services are paid through a combination of personal funds, Medicaid, and/or Older Americans Act dollars. Roughly three-quarters of older adults who receive LTSS-related help with activities of daily living rely exclusively on unpaid family caregivers.[6]These funding sources have different eligibility criteria, cover different services, and can vary in their availability around the country. For example, some states use their Medicaid waivers to cover LTSS provided in assisted living settings, while others do not.

Because there is no single payer responsible for all services and supports, no one entity is accountable for managing the total cost of all the services and supports that are provided. As a result, cost-shifting between payment sources often occurs, and decisions about duration of care frequently correlate to reimbursement limits rather than clinical decisions. For example, if an older adult returns home after a hospitalization without post-acute care services, then Medicare or the Medicare Advantage plan no longer incurs any cost. However, if that person resides in a nursing home, his or her care is now paid for by Medicaid or out of personal funds. If one entity were responsible for addressing all the needs of the individual, that entity would determine the best combination of services and supports, based on optimal outcomes and cost.

6 O'Shaughnessy, C. V. (2013, January 11). Family caregivers: The primary providers of assistance to people with functional limitations and chronic impairments. (Background Paper No. 84). Washington, DC: National Health Policy Forum. Retrieved from: http://www.nhpf.org/library/background-papers/BP84_FamilyCaregiving_01-11-13.pdf) and Freedman, V. A., & Spillman, B. C. (2014). Disability and care needs among older Americans. The Milbank Quarterly, 92(3), 509-541.

CMMI has encouraged and tested models to break down fragmentation in the health care system. However, these efforts have their limitations, either because health systems only integrate the care provided by physicians and hospitals, or because services and supports for older adults are integrated only after a hospital admission. The latter policy misses an important opportunity to prevent a high-cost hospitalization in the first place.

Clearly, today's fragmented system results in less investment in cost-effective solutions such as prevention, wellness, social service supports and population health initiatives.

Our Vision for an Integrated Service Model

LeadingAge believes it is time to redesign our current delivery system and clear away barriers so the nation can more aggressively pursue integration models that respect older adults by taking a more holistic approach to meeting their needs and achieving high-value results. While we have made some progress in this area, we must move faster and do more to address the comprehensive needs of our aging population.

We propose a new, integrated service model that begins in the community with screenings and early interventions designed not only to identify and treat an individual's health and chronic care needs, but also to understand the origins of high-risk conditions so their long-term impact on the person's health can be mitigated. By starting in the community, instead of the hospital or doctor's office, we can:

- Keep people well and functionally able for longer.
- Help people address such social determinants of health as financial security, nutrition, housing and transportation.
- Coordinate these early interventions with any needed medical care and social services. This approach can delay or prevent the need for emergency department (ED) or inpatient hospital care, post-acute care, and long-stay nursing home care. It can also promote appropriate and timely use of palliative and hospice care, and other essential services and supports.

The integrated service model described below would build on existing models like the Program of All-Inclusive Care for the Elderly (PACE) and Financially Integrated Dual Eligible (FIDE) Special Needs Plans (SNPs). But the new model would go further than these programs, and would achieve greater results because it would not start with a medical event. By taking an early, proactive and holistic view of the individual, the new integrated service model would optimize our use of available financial and workforce resources while achieving better outcomes for older adults. This new model would truly support all of us as we age, and enable all of us to live our best lives.

A Hub of Providers

The integrated service model would be implemented by an organized "hub" of providers delivering services and supports at the community level to all older adults. Providers in the hub would be financially aligned to work collaboratively across services and settings, and would take a person-centered approach to holistically addressing an individual's needs.

The new model would feature the following elements:

Pooled Resources and Assumption of Risk

The success of the integrated service model depends on the ability of hub providers to pool all sources of funding—public and personal—and to be free from the existing fee-for-service structure. The model calls for payers to adopt and deploy risk-based payment methodologies that would incentivize groups of collaborating providers to integrate the full-range of services and supports necessary to help an individual maintain health and achieve personal goals. These pooled Medicare, Medicaid and personal funds would be deployed flexibly in service of a wide range of individual needs.

Hub providers would conduct comprehensive risk assessments and assume some portion of the risk for outcomes and total cost of care. This approach would encourage hub providers to be accountable for the total cost of care and services for the older adult, and to use the most cost-effective strategies to achieve optimal outcomes.

Inclusivity and Flexibility

The integrated service model would not place limits on which providers could lead the hub, and where services could be provided. Existing models like ACOs and SNPs can only be led by health plans, hospitals, health systems and doctors. The integrated service model would allow other community-based providers, including LTSS providers, to serve as the accountable entity/hub for older adults.

Single Point of Contact and Accountability

Integration is most successful when there is a single care manager, single care plan and single point of contact for individuals and their families.[7] Therefore, the integrated service model would feature a single "service facilitator" who would be assigned to an individual by the community-based hub. Individual providers, health plans or sites of service would no longer employ their own care manager, thus eliminating the confusion and additional cost of this duplicative function.

The service facilitator would play a pivotal role within the hub. The role of this individual could be similar in purpose to a medical or health care home, but also might share some elements of the Medi-Caring Communities concept developed by Dr. Joanne Lynn.[8]

The service facilitator would be:

- A *resource* who identifies and explains available care and service options to help older adults and their families proactively address the older person's needs and understand the associated costs.
- A *coach* who engages older adults as active participants in their health. Older adults and their families have firsthand knowledge about the older adult's needs, changes in condition, preferences and resources. Better health outcomes and compliance with the aging service plan are more likely to occur when older adults and their families are engaged in self-managing their chronic conditions and achieving the goals of their aging service plan.[9]
- A *translator* who serves as a liaison among hub providers and between the individual and the hub's interdisciplinary care team. The service facilitator obtains answers, clears up confusion and ensures optimal outcomes.
- A *navigator* who helps older adults and their families navigate health care and support systems by setting up appointments or arranging for selected services to ensure needs are met in a timely manner.

Comprehensive Assessment

The hub's interdisciplinary provider team would perform a comprehensive assessment of each older adult. The assessment would ensure that current needs are addressed and changing conditions are caught early, before more costly services are necessary. This assessment would not only identify the older adult's medical needs. It would also identify the individual's:

- Functional and cognitive capabilities.
- Health-related social needs, including housing, transportation and nutrition.
- Current living and support environment.
- Existing providers engaged in addressing the older adult's needs.

7 Windh, J., Atkins, G. L., Simon, L., Smith, L., & Tumlinson, A. (2016, April). Key components for successful LTSS integration: Lessons from five exemplar plans. Washington, DC: Long-Term Quality Alliance.
8 Lynn, J. (2016). MediCaring communities: Getting what we want and need in frail old age at an affordable cost. Ann Arbor, MI: Altarum Institute.
9 https://report.nih.gov/nihfactsheets/Pdfs/Self-management(NINR).pdf

Collaboration on the Aging Service Plan

The hub's interdisciplinary team, in collaboration with the older adult and his or her family, would use findings from the comprehensive assessment to develop a universal aging service plan. The plan would describe:

- The expected evolution of the older adult's health and needs.
- Existing and potential resources to address those needs as they evolve.
- Any gaps or hazards that may be encountered.
- How these issues will be addressed.

The unified aging service plan would be developed, and modified as needed, in collaboration with the older adult, his or her family, and all identified current and new service providers. All hub providers would contribute to the plan for each older adult they serve. Providers, older adults and their families would work together as new situations arise, and would consider solutions that take into account the whole person and his or her service providers and support network.

Timely Access to a Full Range of Services and Supports

The hub would be allowed to offer any services and supports that "optimize health or functional status" for certain beneficiaries.[10] Services and supports would not be limited to the current list of Medicare or Medicaid-covered services. Instead, Medicare and Medicaid or personal funds would be combined and used to pay for services that can be tied back to the needs identified in the individualized aging service plan.

The hub would be responsible for implementing the service plan. This would involve contracting with other providers of services and supports, facilitating the sharing of individuals' health information across settings, and connecting older adults with service and support providers that could address emergent needs. Hub providers would establish ongoing communication channels and work together to create clinical pathways, best practices and protocols that follow the person across settings.

Older adults would be able to access services and providers in a timely way so that unnecessary hospitalizations could be avoided. Services would be provided efficiently and, when possible, hub providers would use telehealth to address issues as they arise. The level of services and supports would increase and decrease to meet changing needs.

Comprehensive Care Coordination

Care coordination is a key strategy for improving the health care system's effectiveness and outcomes for the older adult. But coordination must go beyond the medical to encompass all services and supports received by older adults. A 2015 Institute of Medicine report shows that poor communication among providers leads to diagnostic errors, and that today's reimbursement models do not support needed care coordination.[11]

Coordination of all services and supports would help to:

- Improve the older adult's quality of life.
- Eliminate service duplication and unnecessary hospitalizations, thus reducing costs.
- Reduce poor outcomes from delayed services, conflicting care plans or poor communication.
- Ensure that individuals can access services and supports at the right place and time, and often for a lower cost.

10 Fise, P. (2017, April). Improving care for high-need, high-cost Medicare patients. Washington, DC: Bipartisan Policy Center.
11 Institute of Medicine. (September 2015). Improving diagnosis in health care: Quality chasm series. Washington, DC: National Academy of Sciences. Retrieved from: http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2015/Improving-Diagnosis/DiagnosticError_ReportBrief.pdf

- Identify the best interventions, based on the wisdom of the entire service team.
- Facilitate early assessment and intervention, which can extend an older adult's independence, and help that person delay or avoid use of high-cost care settings and faster spenddown of their personal resources.

Health Information Access and Sharing

A 1999 Institute of Medicine report suggests that when individuals see multiple providers in different settings, and those providers don't have access to complete information about the individual, "it becomes easier for things to go wrong."[12] To avoid this scenario, the integrated service model would give hub providers and families real-time access to health information and to an individual's aging service plan. This access would:

- Ensure continuity of services.
- Avoid duplicative information collection and diagnostic tests.
- Help providers make informed decisions about treatments, medications and daily supports based on a full picture of the individual.
- Facilitate coordination and communication by helping providers consult with one another.
- Make doctor visits more efficient by placing a focus on trends and changes in condition.

Technology Tools

Technology tools would be used within the integrated service model to help hub providers, older adults and their families:

- Achieve greater information sharing.
- Improve access to services and supports through virtual visits and telemonitoring.
- Engage providers, older adults and families in activities to support wellness and independence.
- Facilitate predictive modeling to improve outcomes and identify best practices.
- Expand access to preventive and chronic disease management tools.

Quality Assurance

The integrated service framework would define measures of quality. At a minimum, these measures would gauge the satisfaction of the older adult and his or her caregivers. Measures would also be risk-adjusted, would account for socio-economic status, and would be tied to the achievement of the individual's goals, as identified in the aging service plan.

The Role of Aging Services Providers

Many LeadingAge members around the United States have firsthand knowledge of and demonstrated success offering integrated service models like the one described above.[13] Unfortunately, regulatory and financing barriers limit the ability of LeadingAge members to fully realize and scale these models.

As LTSS and post-acute care providers, LeadingAge members play a critical role in helping older adults extend their independence, manage their chronic conditions, and meet their daily needs. Many members use funds from Medicare, Medicaid, commercial insurance and the individual to offer a full spectrum of services and

12 Institute of Medicine (November 1999). To Err is Human: Building a Safer Health System

13 Specifically, many of these members have participated in the Model 3 Bundled Payment for Care Improvement initiative and the Medicare Accountable Care Organizations program.

supports to older adults and individuals with chronic conditions, either directly or in collaboration with other providers.[14]

LTSS providers are in an ideal position to initiate an integrated service model in conjunction with other community-based providers of services and supports. For example:

- LTSS providers have regular, on-going interactions with older adults in their own homes. This onsite presence helps providers build trust and develop personal relationships with older adults.
- LTSS providers witness firsthand the daily struggles, environmental challenges and changes in condition that older adults experience. This allows them to respond more rapidly to changes in the individual, and to communicate with that individual's providers and caregivers. In contrast, physicians and hospital-based providers see an older adult outside the home and only for a short office visit or an episode of care.
- LTSS providers ensure that the large proportion of older adults who live independently receive proactive and preventive services, including wellness and chronic disease management. These interventions can significantly lower health care costs by reducing the need for more expensive acute, post-acute and long-term care.[15]
- LTSS providers engage in screening and early intervention. They also work to help mitigate more high-risk needs by taking steps to prolong individuals' functionality, address their social determinants of health, and coordinate their medical, social and daily-living services.

Overcoming Barriers: Three LeadingAge Member Examples

The LeadingAge members profiled here have implemented three different integrated service models that illustrate the powerful role that providers of aging services in a variety of settings can play in redesigning care and service delivery for older adults. These members did not implement their new models overnight. On the contrary, their progress in integrating service delivery was often hindered by existing payment and regulatory barriers that have kept many other providers from succeeding in similar endeavors.

Policy changes could help remove some of the barriers faced by these providers, while speeding up the integration process for other providers seeking to follow in their footsteps. In this way, an integrated service model could be made available to all Americans, especially those living with chronic conditions and functional limitations.

PACN

In 2011, two Cincinnati-based life plan communities—Episcopal Retirement Services and Life Enriching Communities—joined with Home Care by Blackstone to establish the Post-Acute Care Network (PACN).[16] Their goal was to develop protocols and practices to transform care delivery for older adults, while positioning their organizations for success under new value-based payment models. " Today, PACN includes 11 organizations that collaborate despite the fact that they are competitors in the same marketplace. The group offers:

- Assisted living.
- Palliative and hospice care.
- Home health care.

14 These services and supports include: rehabilitation, housing, home and community-based services, adult day services, assisted living, life plan communities, home care, home health, hospice, home-delivered meals, memory and custodial care, Program of All-Inclusive Care for the Elderly, transportation, and senior centers.

15 http://www.leadingage.org/affordable-senior-housing-plus-services-program-slows-growth-medicare-costs ; http://www.leadingage.org/chps/tools/evaluating-support-and-services-home-program

16 http://postacutecarenetwork.com/

- Rehabilitation.
- Nursing care.

PACN members work collectively to review performance data and share best practices as they strive for continuous quality improvement. They follow "prescriptive" care paths and care redesign processes to ensure that successful care transitions lead to cost-effective, high quality care delivery.

PACN's recent results have garnered the attention of area ACOs, health systems and payers interested in working more closely with the group. Results for 2014-2016 include:

- Average episode cost reduced by 10%.
- Skilled nursing length of stay shortened by 9%.
- Hospital readmissions reduced by 39%.[17]

The PACN model encompasses many of the critical elements of LeadingAge's proposed integrated service model. PACN:

- Brings together services and supports for older adults.
- Serves as a bridge as older adults transition between sites of service.
- Follows older adults across settings.
- Optimizes care and services.

PACN partners have demonstrated success under the BPCI program, but only because they piece together disparate Medicare, Medicaid and private dollars to finance their model.[18] However, current financing policy continues to work at cross-purposes with PACN's goals to integrate services and improve health outcomes. Under the current fee-for-service system, which rewards volume, PACN providers are penalized as they reduce the volume of post-acute care by successfully reducing skilled nursing facility lengths of stay, substituting home health services for other types of post-acute care, and eliminating unnecessary hospitalizations.

TANDEM365[19]

TANDEM 365 was established in 2009 by two LeadingAge members seeking to reduce hospital readmissions by closing service gaps for older adults who are age 55 and have complex care needs and high costs. Today, this in-home integrated care model is delivered by four LeadingAge members who are competitors, and a local ambulance company.

Like LeadingAge's proposed integrated service model, TANDEM365 takes a team approach to customizing care for the older adult. The model also provides a single point of contact—a nurse or social work navigator—who helps the older adult access needed services and supports so he or she can remain at home. Like the LeadingAge model, TANDEM 365 features an aging service plan (called a "life plan") that the interdisciplinary team develops in collaboration with the older adult.

17 http://postacutecarenetwork.com/resources/bundled-payments/
18 https://innovation.cms.gov/Files/reports/bpci-models2-4-yr2evalrpt.pdf; www.postacutecarenetwork.com
19 http://tandem365.com/

TANDEM365 delivers non-traditional services that are not typically reimbursed by insurance plans. These include:

- Meals.
- Transportation.
- Telehealth.
- Personal emergency response systems.
- Personal care.
- Navigators who attend doctor visits or meet an older adult in the ED, when necessary.
- Round-the-clock rapid-response support from an emergency medical services team.

Commercial payers have acknowledged TANDEM365's three primary values: lower cost, satisfied members and improved outcomes. One payer, PriorityHealth, initially helped pilot the program among plan members whose health care spending exceeded $25,000 per year. PriorityHealth paid $625 per month for every member participating in TANDEM365.

The initial pilot showed these results for the program's high-touch, in-home services:

- Inpatient hospital stays reduced by 38%.
- ED visits reduced by 52%.
- Overall total cost of care lowered by 35%.[20]

Following the successful pilot, PriorityHealth penned a three-year contract to continue its partnership with TANDEM365 through a new, risk-sharing arrangement. TANDEM365 has also been asked to pilot its program with Blue Care Network of Michigan.

SASH

The Supports and Services at Home (SASH) program was created by LeadingAge member Cathedral Square Corporation in collaboration with multiple health and aging services provider organizations. Launched in 2011, SASH is an affordable, housing-based care coordination program that serves as an extender to community health teams (CHT) supporting Vermont's statewide medical home model.

Teams composed of housing-based care coordinators and wellness nurses work with dedicated representatives of community-based service agencies (Area Agencies on Aging, Visiting Nurse Associations, and mental health agencies) to support participating residents in one or more affordable housing communities. The teams may also serve Medicare recipients living in the communities surrounding the housing properties.

SASH teams:

- Conduct comprehensive assessments of residents to identify any health- and wellness-related needs.
- Help those residents access and arrange services to address identified needs.
- Provide onsite wellness and prevention programs.
- Coordinate with the CHTs to assist individuals who have complex needs, and monitor those individuals in the community.
- Work with local hospitals to help support and monitor transitions home after a hospital stay.

20 http://tandem365.com/wp-content/uploads/2014/01/T365-PlanteMoran-Report.pdf

Initially, the SASH care coordinator and wellness nurse were primarily supported through Medicare's Multi-Payer Advanced Primary Care Practice demonstration.[21] The care coordinator/wellness nurse team currently continues to receive Medicare support through the states Vermont All-Payer ACO Model.

Across Vermont, approximately 5,000 individuals living in more than 100 housing properties and in the surrounding communities are participating in the SASH program. An ongoing evaluation has found that SASH is slowing the growth of total annual Medicare expenditures for participants in early-launching housing properties by an estimated $1,227 per beneficiary per year, compared to non-participating individuals.

The SASH program is another example of how integrated service models are most successful when they start with the needs of individuals where they live, and connect and surround those individuals with needed services through an accountable group of providers.

Interim Steps

LeadingAge strongly maintains that true reform of Medicare and Medicaid, and the broad development of integrated services, requires a single program and a single funding source that combines existing Medicare and Medicaid dollars so older adults can access a full range of services to address their medical, health-related, social and LTSS needs.

We understand that such an approach is a long-term goal. Therefore, we recommend a menu of interim steps that policy makers could take to support a move toward integration, and incentivize providers to adopt a more holistic approach.

Building a Foundation for Holistic Service Delivery

- *Take a broader look at needs:* Expand the existing Medicare wellness visit benefit to include a comprehensive assessment that evaluates an older adult's need for services and supports to foster independence and manage health and wellness. The American Geriatrics Society supports this concept.
- *Expand the list of reimbursable services:* Permit Medicare and Medicaid reimbursement for any services that optimize the health or function of an older adult as long as he or she is part of an integrated service model, has received a comprehensive risk assessment, and has a corresponding care and service plan.

Facilitating Coordination Among Providers

- *Foster health information sharing:* Reexamine the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to identify actual barriers to health information sharing among health and service providers. Once these barriers to integration are identified, seek appropriate legislative or regulatory changes, and educate providers about the types of sharing that HIPAA allows.
- *Align expectations of providers across the continuum:* Include performance measures for primary care physicians and hospitalists in the Merit-based Incentive Payment System track of the Quality Payment Program to encourage and assess their coordination with LTSS and post-acute care providers.

21 Several care coordinators are also funded wholly or partially as service coordinators through the U.S. Department of Housing & Urban Development. The program also receives support from Medicaid, other state agencies and foundations.

Expanding the Pool of Providers Who Can Lead Integrated Models

If we are serious about transforming service delivery and lowering cost, we must pursue models that originate in the community and engage with individuals before a hospitalization occurs. Achieving this goal requires the participation of a variety of providers.

- *Medicare:* Reimburse LTSS or community-based organizations responsible for coordinating care for Medicare beneficiaries or individuals who are dually eligible for Medicare and Medicaid. To facilitate reimbursement, Medicare should also develop a corresponding code, similar to the Medicare Chronic Care Management Current Procedural Terminology code available to physicians.
- *Demonstration programs:* Amend existing ACO and other CMMI demonstration language to:
    - Expand the definition of providers that can lead these integrated service models. Include LTSS, post-acute, and other community-based organizations and providers in this definition.
    - Allow these providers to apply for the Advanced Investment Model ACO so they can obtain an "advance" on their projected shared savings. Providers can use that advance to make the upfront infrastructure investments needed to pursue such integrated service models.
- *LTSS providers:* CMMI should launch a demonstration to test a voluntary, national, fully-integrated service model like the one described in this paper. The model, led by post-acute and/or LTSS providers, would allow Medicare funds to be pooled with Medicaid and/or private funds. It would also leverage technologies that have been demonstrated to effectively22 support integrated service models in addressing older adults' needs.
- *Medicare Advantage:* Broaden the definition of "provider" so senior living and assisted living providers could develop and deliver provider-sponsored Medicare Advantage plans. In addition, consider revising Medicare Advantage plan requirements, including reserve requirements, for provider-sponsored plans so they are similar to the requirements governing PACE programs.

Removing Limitations on Service Delivery

- *Eliminate minimum hospital stay requirements for obtaining needed care or services:* Waive the three-day inpatient hospital stay requirement for all integrated service models when a comprehensive care or service plan is in place and a care coordinator or service facilitator is involved. Eliminate the observation status under Medicare fee-for-service for the purposes of determining nursing home eligibility for post-acute care. This is already permitted under Medicare Advantage plans and some alternative payment models.

Creating a Flexible Framework

- *Build on other models:* Create and test a regulatory framework for the new integrated services model that builds on PACE and FIDE SNP. At a minimum, the framework should require a community-based hub of providers to conduct a comprehensive risk assessment, develop an aging service plan, coordinate services through a single service facilitator, and consolidate and integrate funding for older hub participants. Provider payment options might look like those available under the Next Generation ACO model.

22 http://www.leadingage.org/sites/default/files/2013_CAST_Telehealth_and_Remote_Patient_Monitoring_%28RPM%29_Case_Studies_0.pdf; and http://www.leadingage.org/white-papers/telehealth-and-remote-patient-monitoring-long-term-and-post-acute-care-primer-and

- *Deliver services in the right place:* Eliminate the requirement that service provision be limited to a certain site of service or source of payment. Instead, allow for service provision to be governed by provider scope of practice and qualifications so services can be provided in homes, congregate housing communities, assisted living communities, or another location, as long as that care can be provided safely. This change would help address workforce shortage issues, ensure that older adults receive timely access to care where and when they need it, and potentially reduce unnecessary ED visits and health care utilization.
- *Allow consumer choice:* Permit older adults to choose the group of providers that receives and utilizes all available public and private funding to provide them with cross-continuum coordination of services. This "integrator" could be a health plan, ACO, integrated service hub, medical home or health care home. The integrator would only be chosen by a third party if an individual did not make a selection.

Conclusion

For more than 50 years, LeadingAge has sought to ensure that every older person has the right and the opportunity to develop his or her full human potential, regardless of age. Today, LeadingAge steps forward to be part of crafting a new vision of health for all Americans as we age. We envision an integrated service model that:

- Provides coordinated, seamless and affordable access to services and supports addressing an older adult's need to achieve wellness and maintain independence.
- Rewards collaboration, communication and coordination across sites of service and service providers.
- Seeks to deliver high-quality, cost-effective outcomes for older adults.
- Embraces the critical role that families and unpaid caregivers play.
- Offers dignity to all of us as we age.
- Recognizes the essential role of organizations whose primary purpose is to serve older adults.

LeadingAge believes, and the experience of our members suggests, that services and supports for older adults and those living with chronic conditions are more cost-effective and produce better outcomes for the individual when they are integrated, coordinated and person-centered, and when they address the social determinants of health, rather than merely reacting to symptoms.[23]

Creating an integrated service system to address an older adult's needs requires that discussions about services and supports begin with the person, not the hospital. It involves engaging with the person to assess and identify his or her health, social service and financial needs. It engages the older person and his or her family in determining what can be done to help the person optimize quality of life, meet personal goals, and prevent undesirable situations like falls, dangerous drug interactions or hospitalizations.

LeadingAge and its members stand ready to work with policy makers to advance policies that allow older adults, their families and their providers to meet these goals.

Being successful in this endeavor means nothing less than creating a society in which all older adults can age with dignity while enjoying the health and quality of life we all want and deserve.

23 http://www.npaonline.org/policy-advocacy/state-policy/research; http://tandem365.com/wp-content/uploads/2014/01/T365-PlanteMoran-Report.pdf; http://postacutecarenetwork.com/resources/bundled-payments/; https://innovation.cms.gov/Files/reports/bpci-models2-4-yr2evalrpt.pdf;