Taxonomy of Long-Term Services and Supports Integration

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LONG-TERM
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Statement of Purpose:

The purpose of this document is to provide a framework for understanding the nature and extent of integration in programs that integrate LTSS with medical care and behavioral health. These programs are typically run by health plans, but could be managed by any organization that takes or shares financial risk for the cost of a person's care, for example Accountable Care Organizations.

This taxonomy is a standardized tool to assess where along a continuum a program lies with regard to specific components of integration. It is important to note that integration is not the goal in and of itself, but rather a means of improving care and decreasing the total cost of serving a high-cost, high-risk population. To this end, the taxonomy can be used to evaluate the importance of each component of integration for achieving quality and savings.

Context:

The degree to which a program is integrated along different components is influenced by the policy and regulatory framework in which they operate, the historical context in which the program evolved, and other conditions outside of the program's control. These factors along with the challenges of serving very high need populations create a very complex environment within which organizations must function in their efforts to integrate care. For some programs, these external factors constrain their ability to achieve greater integration in certain components. Despite these challenges, organizations have been successful in overcoming obstacles to achieve varied degrees of integration.

This Taxonomy references multiple dimensions of integration, albeit largely from an organizational standpoint. It is important to recognize that while organizations are undertaking these efforts to integrate care, they are also working to varying degrees to operate these programs in a manner that is consistent with the values of person-centered care. Although studying person-centeredness in care was not the focus of this work, efforts were made to recognize practices in the components of integration studied that are congruent with this approach.

Note: The terms "low integration" and "full integration" are not intended to imply any judgment or inherent value. Although the examples within the tables are theoretical, they reflect the progression of integration in each of the components described.

Components of Integration:

For each program, the following characteristics can be evaluated using the above continuum of integration:

I.	Care Management: Member Assessment and Care Planning
II.	Care Management: Organization and Operation of the Care Team
III.	Care Management: Communication
IV.	Care Management: Transitions
V.	Care Management: Risk Stratification and Targeting
VI.	Care Management: Person Centeredness
VII.	Scope of Integrated Services
VIII.	Primary Care and Provider Network Alignment
IX.	Administrative and Organizational Integration
X.	Financial Integration

I. Care Management: Member Assessment and Care Planning

Line of Inquiry

● What is the program's approach to member assessment and care planning?
● Are medical, LTSS, and behavioral needs included in a single comprehensive assessment and care plan?
● Do assessments and care plans include information about the social and functional context of the member?
● What is the program's approach to reassessments? How are changes made to the care plan as a person's circumstances change?

Criteria	Low Integration	Medium Integration	Full Integration
Member Assessment	Assessments are separate and specific to each service a member receives or episode of care. Assessment information is not shared, but is instead maintained separately by nursing facility, state agency or community service organizations.	Multiple assessments are done by providers corresponding to site and service-specific perspectives though efforts are made to share the information across involved caregivers to "compare notes" and share observations and findings. Reassessments are conducted in the same way and may not be unified in timing or scope.	A single, comprehensive in-home assessment begins the care planning process. Assessment information is shared widely, and the core assessment serves as the base for site- and service-specific assessments unique to different programs or organizations. Members are reassessed periodically in accordance with their acuity and as their circumstances change.
Care Planning	Care planning is service and setting specific. An individual may have multiple care plans—for acute care, for home-based or institutional care, for behavioral diagnoses—none shared or coordinated.	Members have separate care plans for medical and LTSS but efforts are made to closely coordinate the plans by the team of care managers. There is no formal way to share care plans electronically, or otherwise, so coordination depends on the efforts of the care providers to communicate	A single, comprehensive care plan is developed with the member and their family in collaboration with other members of the care team. This care plan serves as the basis for program authorization of specific services and supports. All members of the care team have access to view and make

		with other members of the care team and providers.	changes to the care plan. Providers can access the primary care manager and the care plan as needed 24/7, although not necessarily electronically (e.g., call center access could be adequate.)

Taxonomy of Long-Term Services and Supports Integration | April 2016

II. Care Management: Organization and Operation of the Care Team

<u>Line of Inquiry</u>

- Team Organization
  - Is there a team approach to care delivery? Who is on the care team? Are all relevant disciplines represented on the team? Do members of the team coordinate with one another?
  - Is there a core team? Does it include medical and non-medical members?
  - Do individuals have a single primary care manager or are there separate care managers for different aspects of their care? If there is more than one care manager, do they collaborate?
  - Is a member able to easily identify their care manager?
- PCP Role on the Team
  - Is the PCP or a representative of their practice a member of the core team? Is the PCP bought into the collaborative nature of the team or do they operate independently of team efforts? Does the PCP look to other team members for problem-solving and collaboration around patient care?
- Team Operation
  - How and under what circumstances does the care team convene? Are meetings in-person or virtual?
  - How is the care plan executed and evaluated? How does the program ensure that care delivery is congruent with the care plan?
  - Does the core care management team have the ability to influence medical care?
  - What is the 24/7 coverage protocol for care management?
- Performance Management
  - How is care manager performance assessed? What outcomes are care managers held accountable for?
  - What data does the plan look at to evaluate care coordination efforts?

Criteria	Low Integration	Medium Integration	Full Integration
Organization and Composition of the Care Team	One or more care managers may be involved with the member in conjunction with particular service(s) being provided but an organized team approach is not in place. The PCP's contact with care	A core team is identified as including the member (and/or family caregiver), PCP and care manager. The PCP's role on the team may be limited.	The structure of the interdisciplinary team is organized around the core team and augmented with the capacity to engage a range of other disciplines depending on the needs of the member. This same care team is engaged with the

	managers is very limited.		member across all domains of the member's care plan and care settings assuring clarity of access and accountability from the member's perspective. The care team focuses on the member's overall health and support system in their primary setting—home-based or institutional but is also involved in establishing plans in response to episodes of care that may result in transitions to short term settings as well. The PCP buys into the collaborative nature of the team's work.
Operation of the Care Team	PCP's interaction with care managers is limited to responding to medical events; PCP issues orders to justify payment for home based services; there is little or no coordination of LTSS with the medical care team.	The care manager often initiates discussion with the core team in response to events or episodic issues requiring problem solving. The core team operates most often in a virtual context.	In addition to episodic problem solving discussions, the team conducts regular team meetings where cases are reviewed to facilitate interdisciplinary engagement, modify care plans, plan care transitions, and schedule reassessments. Some members of the care team may meet in-person on a regular basis, while others may participate in a more virtual context and/or on an "as needed" basis.

III. Care Management: Communication

Line of Inquiry

- Who has access to the member's assessment information? Medical records? The LTSS care plan?
- How is the member's information shared? How well do these processes and systems work?
- Does the program / care team receive timely notification of adverse events, changes in condition, ER visits, hospital admissions, etc.?
- Do medical and other providers have timely access to the care manager who can share member information as needed? What is the process for emergent / as-needed communication between the primary care manager and providers?
- How does the organization use technology to facilitate communication with providers?
- Does the care team have the ability to observe what's going on in the home on a regular basis? Does the care manager connect well with the caregiver (family or paid) in the home? Does the caregiver share information on the member's status with the care manager?

Criteria	Low Integration	Medium Integration	Full Integration
Communication	Assessments, care plans, and medical records are not shared. Information (e.g., medication lists) may be shared via paper or PDF report but these are "static" documents. Care managers responsible for the coordination of LTSS services have little interaction with medical care providers beyond seeking PCP authorization for homebased services requiring M.D. approval. This is typically done by mail.	Care managers and caregivers may share reports on functional assessments, care plans, and care delivery with the medical team. The reported information may or may not be entered into the electronic medical record or the nursing facility or home care record for the patient or client. The information sharing occurs to help to facilitate care, but formal systems to incorporate shared communication likely do not exist. Care managers likely communicate	A core record is kept of the individual's care related assessments, care plans and progress. This information is shared across the care team and can be accessed and updated electronically by all members of the care team. This may serve as the base for more extensive records maintained separately by individual providers. Care managers communicate with medical care providers as a routine matter, utilizing whatever communication vehicles deemed most efficient and effective by the care teams. For practices with

		by phone or email with medical care providers on an as needed basis and seldom on an in-person basis.	high volume of members in the program, more regular in-person communication is likely to occur.
Health IT	All information systems are site- and organization-specific. Records may be electronic or a mix of electronic and paper records. Information sharing occurs through paper or PDF reports. There is no platform for sharing electronic records between organizations.	Records can be exchanged on request and shared versions can be accessed by other service providers; systematic inter-operability across providers does not exist.	The core care management team maintains a comprehensive individual record that can be referenced and populated by all care providers for that individual. Information in all individual organization systems can be exchanged with this lead system and comprehensive record.

IV. Care Management: Transitions

Line of Inquiry

- How does the program manage transitions between settings of care?
- Is data shared by and with the program to foster understanding of the member's pre- and post-acute status?
- When a member is hospitalized, when and how is the program brought in to participate in decision making?
- What are the responsibilities of the care manager across settings of care?

Criteria	Low Integration	Medium Integration	Full Integration
Managing Transitions	Care mangers involved in home and community based services do not have input to the direction of the in-patient discharge plan and setting; medical care providers make these decisions.	The program receives notification of a member's hospitalization and may be involved in authorizing post-acute care for the member when needed. The primary care manager is notified that a member is to receive short term post-acute care in a rehab or SNF setting and will follow the course of stay in that setting to assist the facility's discharge planning team in the preparation for a home discharge. Case conferencing with facility staff typically occurs virtually.	The team is actively engaged in discharge planning beginning shortly after hospital, acute rehab and SNF admission. The primary care manager assumes responsibility for arranging for any post-acute rehab or SNF care upon discharge from the hospital, monitoring to ensure appropriate level of care and is also responsible to facilitate necessary changes in the home care and service plan to enable members to return home when possible. Team may also be engaged in arranging for direct admission to a SNF from the community as a hospital diversionary strategy. Arrangements are made for appropriate training of the individual and caregivers in relation to new care plan components. Providers collaborate to ensure discharge readiness and a

			smooth transition between settings of care to enhance the likelihood of a successful transition and reduce readmissions.
Continuity of Care	In-patient providers have no data beyond member self- report to understand the individual's baseline status before admission. Post-hospital care continuity is limited to instructing the individual and family to make a follow up appointment with the PCP, and/or a discharge summary and transfer from being forwarded to a sub-acute provider. There is no care manager overseeing the member across care settings	The program helps to facilitate exchange of baseline information between in-patient care providers and the team so that the individual's baseline status and issues can inform clinical and discharge decision making. The team follows the member virtually across settings of care, ensuring appropriate utilization of services.	The program is integrally involved in decision making with medical care providers pertaining to transitions of care. The primary care manager facilitates the exchange of information with in-patient providers to inform clinical and discharge decision making. The care manager is responsible to the member and to the program for ensuring continuity of care across care settings. The PCP or another physician aligned with the practice may serve as the attending physician in the in-patient setting facilitating continuity of care. Designated members of the interdisciplinary team follow up with the member across care settings as needed. The team is focused on ensuring effective hand-offs of information and close monitoring across care settings to ensure stability.

Taxonomy of Long-Term Services and Supports Integration | April 2016

V. Care Management: Risk Stratification and Targeting

<u>Line of Inquiry</u>

- How does the program identify members who are at high-risk for high-cost events like hospital admissions or institutionalization?
- Does the program have a strategy for targeting more intensive care management and services to high-risk members?
- How do programs allocate care management resources and employ differentiated care management interventions commensurate with risk?

Criteria	Low Integration	Medium Integration	Full Integration
Risk Stratification and Targeting	The program may utilize tools to stratify their membership to identify members at high risk to differentiate care management strategies. This targeting activity impacts the approach that the program takes with the member, but does not extend to any care providers outside of the program	The program stratifies membership incorporating not only program data but also the clinical perspectives obtained from key care providers such as the primary care provider. Information about program activities targeted to particular members is shared with those providers.	The program stratifies membership incorporating both program data and clinical information obtained from providers and community service agencies involved in care delivery. Health risk assessment and predictive modeling tools incorporate data related to functional impairment and use of LTSS. Care planning for the member is informed by risk stratification activities and differentiated program intervention strategies are targeted to members accordingly. Intervention strategies titrate interdisciplinary team members' involvement, in-person visits, frequency of reassessments, etc, Full interdisciplinary care team involvement is greatest with those members at greatest risk.

VI. Member Engagement and Participation

<u>Line of Inquiry</u>

- Individual Goals and Preferences
  - What makes a care plan person-centered? How do you know whether the care that is provided is consistent with the person's goals and preferences and whether it is resulting in outcomes that are important to the person?
  - Does the care manager ask the individual about their goals and preferences? Do they organize the care plan around supporting those goals and preferences? How are LTSS customized to accommodate members' needs and preferences?
  - What is the program's approach to matching care setting to individual needs and preferences?
  - What strategies does the program use to engage members in their care and to promote self-management?
  - How does the program situate care within the context of the individual's daily life and life history?
  - Does the program offer members the option to have family members paid to provider personal care?
- Unpaid Caregivers
  - What is the program's approach to supporting and engaging family caregivers?
  - Does the program offer members the opportunity to self-direct services?
- Individual Outcomes
  - What individual and population outcomes does the plan assess? How do these outcomes relate to goals set in the care-planning process? Does the plan track outcomes that are not easily measured?
  - What are the consequences of the outcomes for members, providers, and the plan?
  - How is care manager performance assessed? What data does the plan look at to evaluate care coordination efforts?
  - Does the program measure its performance on person-centeredness? How?

Criteria	Low Integration	Medium Integration	Full Integration
Assessment and Care Planning	Members' goals and preferences may not be documented in the care plan and do not guide care. Care plans are organized around service-specific assessments and hours or clinical diagnoses. Family caregivers are not assessed for burden or provided with	Care managers have conversations with members about their goals and preferences and record these in the care plan. Care plans are congruent with member needs or goals, but the care team may be more focused on achieving clinical outcomes. The	Programs focus the assessment and care planning processes around member goals and preferences. Members can choose to self-direct their LTSS, including the option to pay a family member to provide care. Clinical goals are put in the context

	any special supports.	program uses member engagement more as a tool to improve self-management of care than a way of supporting members' personal choices.	of, and are subservient to, member needs or goals.
Care Delivery	The program does not keep member goals or preferences in mind during the care delivery process, whether captured in the assessment and care planning process or not.	The program does use member preference and goals in care delivery, but may give priority to clinical care.	Care delivery is situated in the context of the member as an individual, supporting their goals, and more focused on quality of life than the program's clinical outcomes.
Quality Measurement and Assessment	The program measures and reports medical process and outcome measures. The program does not track progress on member goals.	The program measures and reports medical process and outcome measures as well as LTSS process measures. The program also uses consumer satisfaction surveys to assess alignment with member goals.	In addition, the program is tracking progress on personal goals over time and uses goal attainment, consumer satisfaction, and quality of life measures. The plan has metrics and processes in place that track performance on person-centeredness for the population at an aggregate level over time.
Member Feedback	The program responds to member appeals, grievances and complaints as is required by regulators. No particular special attention is given to LTSS services.	The program reviews member appeals, grievances and complaints to assess opportunities for improvement. Plan has internal mechanisms to incorporate feedback into ongoing quality improvement and program development activities. Particular attention is paid to assessing how members are experiencing the provision of LTSS	The program proactively solicits member feedback both through direct inquiry (consumer forums/advisory meetings/other outreach activities) and through examination of appeals, grievances and complaints. Plan has internal mechanisms to incorporate feedback into ongoing quality improvement and program development activities.

		services on their overall healthcare experience.	Particular attention is paid to the interplay between LTSS and medical care services in meeting members' needs.

VII. Scope of Integrated Services

Line of Inquiry

- Indicate which of the following services are integrated by the program; indicate which of the following services are directly provided by the program:
  - Inpatient hospital care
  - Emergency room services
  - Primary care
  - Specialty outpatient care
  - Behavioral health
    - Do you have geriatric psychiatrists available to members?
  - Post-acute care
    - Do you use skilled nursing facilities as a substitute for hospitalizations (diversionary service)?
    - Sub-acute nursing facility, home and community-based medical services (e.g., home health, adult day health, etc.)?
  - Other LTSS including transportation (medical or non-medical), nutrition, respite care, home modification, personal care assistance, homemaker services, etc.
    - Transition of care services?
    - Do you integrate with housing? If so, how?
  - Which of these services do you consider to be essential to reducing utilization and integrating care (e.g., transportation)
  - Pharmacy benefits
    - Medication management
  - Hospice/end of life and palliative care

Criteria	Low Integration	Medium Integration	Full Integration
Scope of Services Integrated	Medical care, behavioral health and LTSS are provided and managed by different programs and organizations.	Program is responsible to manage medical care and one or more of the following: post-acute, behavioral health, and some LTSS, including services provided in a nursing facility or at home. Program may contract out for the management of certain services.	Program is responsible for integrating medical, post-acute care, behavioral health, pharmacy, transition of care, hospice/end of life/palliative care and LTSS including transportation and some alignment with housing. Program provides care management and may also directly provide some other services.

Taxonomy of Long-Term Services and Supports Integration l April 2016

VIII. Primary Care and Provider Network Alignment

<u>Line of Inquiry</u>

- Overall Network Strategy
  - Provider Contracting / Preferred Providers
    - How does the program ensure provider network adequacy and quality to meet members' medical and LTSS needs? Does the program have any special strategies for ensuring access to behavioral health services for members?
    - To what degree is a staff model used versus network providers? How are these "make/buy" decisions made? Criteria?
  - Financial Alignment
    - What is the nature of the financial relationships between the program and key providers?
    - Does the program share financial risk with any providers? How are payment methodologies used to enhance quality and cost-effectiveness of member care?
- Primary Care
  - How much influence does the program have in how PCPs operate?
  - What role does the PCP play in the care team? Does the PCP routinely engage (as needed) in care team decisions?
  - What is the PCP's involvement in oversight and decision-making for acute, post-acute, long-term, and non-medical social services? Is the PCP engaged in patients' transitions?
  - How are members assigned to PCPs? Does the program steer members to PCPs who specialize in caring for complex geriatric patients?
  - To what extent does the PCP's practice overlap with the population in the program? Is there enough volume to justify frequent collaboration? Does the program concentrate their membership with a smaller number of PCPs?
- Relationship with LTSS Providers
  - What is the relationship between the program and the LTSS provider networks? How much influence does the program have in how providers operate? Is the program able to strategically choose their network or must they contract with all traditional providers?
- Relationship with Behavioral Health Providers

  What is the relationship between the program and Behavioral Health provider networks? How much influence does the program have in how providers operate? Is the program able to strategically choose their network or must they contact with all traditional providers? What role do BH providers play in the care team?

- Relationship with Medical Providers
  - How are providers and provider teams organized to operationalize the integration of medical care, post-acute care, and LTSS?
  - What opportunities does the care team have to influence the direction of medical care? How is the core care team engaged for medical decisions, for example, during hospitalizations?
- Is the care manager informed of adverse events in advance of treatment decisions? How do providers recognize members of the program and know to connect to the care manager?
- Does the program measure and set standards for provider performance? Are any special tools used, for example, provider report cards?

Criteria	Low Integration	Medium Integration	Full Integration
Overall Network Strategy: Provider Contracting / Preferred Providers	The program contracts with a large number of medical, BH and LTSS providers, and as a result does not have a significant volume with any. The program does not operate a preferred provider network, and does not exercise a high degree of influence over providers. Minimal, if any, information sharing occurs between the program and providers to facilitate care coordination and management.	The program operates a preferred provider network, but insufficient volume, relationship and/or financial incentive exists so as to be effective in impacting behavior. The program shares information in an effort to influence provider performance, and has contractual processes in place to facilitate care coordination and management.	The program operates a preferred network of closely aligned providers, or may employ medical and LTSS providers directly. Payment arrangements and/or contractual processes support close coordination with primary care and/or other providers on member care. Deliberate strategies exist to promote utilization of a "preferred network" (which may be a part of a broader program contractual network) to build volume and relationships with select providers most aligned with program objectives and activities. Within its network, the program may enjoy an exclusive relationship with some highly aligned providers and/or share enough volume of members to enable

			providers to recognize the strengths and benefits of the business relationship. Actionable data is shared between the program and providers and among providers in an effort to inform clinical decision making. A single entity—likely the primary care manager—is designated as the communication hub for each member and the highly aligned provider or organization works in close collaboration with this care manager and the team as a whole as necessary.
Overall Network Strategy: Financial Alignment	The program contracts with medical and LTSS provider networks on a fee-for-service basis. The program contract does not incentivize or penalize provider performance related to achieving quality outcomes.	The program contracts with medical and LTSS provider networks on a fee-for-service basis. The program collects information on provider performance across quality, utilization and cost domains, and uses this data to offer financial incentives for high-quality care, for example in the form of bonus payments. The program may struggle to get provider participation in the financial incentives scheme.	The program may contract with some providers on a fee-for-service basis, but may sub-capitate certain provider groups, or have some other mechanism for sharing risk and savings. The program collects and shares data on a variety of quality, utilization and cost metrics, and benchmarks provider performance against appropriate benchmarks. This data is the basis for a financial incentive program in which many of the program's highly aligned providers actively participate.
Primary Care	The program contracts with	The program contracts with primary	The program influences PCP practice

Taxonomy of Long-Term Services and Supports Integration | April 2016

	primary care providers/practices on a fee-for-service basis. The program contract does not incentivize or penalize provider performance related to achieving quality outcomes. Program does not exercise a high degree of influence over PCP clinical care or practice operations. Minimal, if any, information sharing occurs between the program and providers to facilitate care coordination and management, does not have mechanisms for sharing data and communicating with PCPs regarding member care.	care providers/practices on a fee-for-service basis. The program collects information on primary care provider/practice performance across quality, utilization and cost domains. The program shares information in an effort to influence provider performance; however, insufficient volume, relationship and/or financial incentive exists so as to be effective in impacting behavior.	operations and primary care provider clinical care is closely integrated with the overall functioning of the care management team. The program has contractual relationships with the PCP/practice that aligns incentives and has established processes for communication and data-sharing between the PCP and the care manager and care team members. (See *Overall Network Strategy* descriptions above.)

IX. Administrative and Organizational Integration

<u>Line of Inquiry</u>

- Program Alignment
  - Does the organization's scope of managed care authority enable the integration of all dimensions of an individual's care? Do members have the choice to enroll in some but not all of the programs offered by the organization?
  - Does the organization have the ability to achieve programmatic alignment? Has the organization developed the necessary infrastructure to support integration of care delivery?
- Single Point of Accountability for Individual's Care
  - How do the organizational units involved in the continuum of a member's care interact and collaborate? (Units include care management teams, utilization management, prior authorization, provider relationships, etc.)
  - Does the care team serve as a single point of accountability for everything that happens to the member? Does the organization ever make decisions about member care without involving the care team? For example, are utilization management decisions made in the context of an individual's integrated care plan, or is it a separate activity conducted through standardized processes?
- Infrastructure
  - To what degree is the organization's infrastructure customized to meet the needs of the population being served across the spectrum of care?
- Culture
  - What is the program's history? Has the integrated program emerged from more of a clinical or health insurance background, or from a social services background?
  - Does the organization have a vision for providing integrated care? How does the organization's culture impact efforts to integrate? Does the program's governance structure affect the ability to integrate?
- Performance and Quality Management
  - What individual and population outcomes does the plan assess? How do these outcomes relate to person-centered processes and goals set in the care-planning process? Does the plan track outcomes that are not easily measured?
  - Are the program's quality metrics mostly clinical in nature, or do they capture the full experience of member care, including LTSS and quality of life outcomes?
  - What does the program report externally (e.g., to state authorities, for public report cards, etc.)?

Criteria	Low Integration	Medium Integration	Full Integration

Taxonomy of Long-Term Services and Supports Integration | April 2016

Program Alignment	Separate and distinct programs exist for members to receive their medical, behavioral and LTSS care and the organization may or may not operate all of these programs. Even when an organization does operate all of the relevant programs, because the regulatory environment does not promote the alignment of member enrollment in managed care programs, the organization is not able to structure its activities to achieve programmatic integration for members.	The organization operates separate and distinct programs and makes concerted efforts to align the programs. Regulatory agencies promote an individual's enrollment in separate programs all within the same organization so that program staff can work to integrate care across products. When members are enrolled in all of the relevant programs within one organization this allows some degree of integration to occur. Some elements of the organization's infrastructure may be designed to support integration across disparate programs.	The program was fully-integrated at establishment and individuals elect to participate in the fully integrated program. The organizational infrastructure is fully-customized to support integration.
Single Point of Accountability for Individual's Care	As members move across care settings, they are managed by different units within the organization. The units do not share information or coordinate on member care. Each unit's performance is based on their overall management of the setting for which they are responsible, but are not held accountable for individual member outcomes.	As members move across care settings, they are managed by different units within the organization (e.g., transitions of care team, inpatient management team), and accountability for the member resides with the unit managing care in that respective setting. Although each of the units shares information through the use of a common care management or member record platform, care is not fully coordinated with the primary care manager and	The primary care manager is always the single point of accountability for a member, regardless of the care setting. The care manager may rely on other members of the team for expertise in managing certain settings (e.g., the hospital), but the core primary care manager/team is fully accountable to the member and to the program for decisions pertaining to individual members. The care team works within a common structure under central management with consolidated

Taxonomy of Long-Term Services and Supports Integration | April 2016

		the core care team.	systems for management, claims processing, patient care records, and quality assurance and reporting.
Culture	The organization has added on this work to other functions of the organization and has made little change to date to recognize unique attributes of operating an integrated program.	A more integrated program's implementation has begun to surface issues within the organization and leadership and management have begun to undertake an examination of how the organization may need to evolve to address the unique challenges of providing integrated care to members.	The organization recognizes that it has entered into a very complex arena of health and social services work with its members, its provider network and its staff. The organization may adopt strategies to address the challenges inherent in this work to appropriately equip and support those involved in care. Examples of this may include: Person-Centered Care Training, Ethics Committees, Palliative Care Training, Community Forums for Member Feedback, etc.
Performance and Quality Management	The program collects and reports on quality metrics as required by state and federal contracts. Most metrics are medical in nature, and do not capture the quality of LTSS or progress on individual's personal goals and quality of life.	The program collects and reports on quality metrics as required by state and federal contracts. Most metrics are medical in nature, but the program is also measuring some aspects of member experience and LTSS quality. The program is leveraging this data to track performance on key outcomes.	The program collects quality metrics on the full experience of members—medical care, quality of LTSS, and person-centered outcomes like quality of life and goal attainment. Beyond reporting the results to external parties, the program also uses this data to ensure individuals receive the highest-quality care and to improve overall program performance on key outcomes.

Taxonomy of Long-Term Services and Supports Integration l April 2016

X. Financial Integration

Line of Inquiry

- To what degree is the organization at-risk for medical and LTSS costs?
- How does the extent and degree of capitation influence the organization and delivery of care?
- Is the capitation structured in a way that incentivizes certain settings of care more than others?
- What degree of cross-program fund flexibility exists? Can funds be commingled and used as the program sees fit?
- If the program holds any risk for any population, to what degree does the program hold complete risk for medical, LTSS, and behavioral care?

Criteria	Low Integration	Medium Integration	Full Integration
Financial Alignment	The insurer receives capitation for part of the care and may receive additional capitation for another part of care, but does not receive both for a substantial portion of the membership population.	The insurer receives capitation payments from Medicare and Medicaid and is able to, for a variety of reasons, obtain substantial overlapping enrollment.	The insurer receives capitation payments from both Medicare and Medicaid for all of the program enrollment for all of the services covered under both programs. The beneficiary can only elect the whole package.
Flexibility in Use of Funds	No flexibility in use of Medicare or Medicaid funds except to pay for services covered by the respective programs, or to offer health-related supplemental benefits.	No flexibility in use of Medicare funds except to pay for approved services offered as supplemental benefits; Flexibility to spend Medicaid funds on a limited set of non-covered services may be allowed.	Flexibility to spend Medicare and Medicaid funds interchangeably on covered and non-health-related non-covered services.
Reporting and Accountability	Units of service must be disaggregated and reported separately as either Medicare or Medicaid expenditures. (All authorities except PACE)		No separate accounting for use of funds. Program does not separately account for units of service. It accounts for overall expenditures and outcomes.

Taxonomy of Long-Term Services and Supports Integration | April 2016