

## **Inland Empire Health Plan**

Jennifer Windh  
September 2016

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

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

### **Background Information**

Inland Empire Health Plan (IEHP) is a public health plan serving Riverside and San Bernardino counties in Southern California. IEHP began operations in 1996, and today covers about 90 percent of the Medicaid beneficiaries in the two counties.<sup>1</sup> There is one other Medicaid plan in the region (operated by Molina) that covers the other 10 percent of the beneficiaries. IEHP covers medical, LTSS, and some behavioral care. Behavioral care for the severely mentally ill is carved out to the counties. Enrollment in a managed care plan is mandatory in order to receive other Medicaid medical and LTSS benefits. LTSS was carved into the benefit package fairly recently. Community-Based Adult Services (CBAS)—California’s adult day health center program—was carved into managed care in 2012. Institutional long-term care and home and community-based services (HCBS) provided through California’s In-Home Supportive Services (IHSS) and Multipurpose Senior Services Program (MSSP) were carved in at the launch of the Coordinated Care Initiative (CCI) in 2014. CCI includes both the state’s duals demonstration and managed LTSS (MLTSS) for Medicaid-only beneficiaries.

There are 1.16 million Medicaid beneficiaries enrolled in IEHP plans. Approximately 1.14 million of these members are enrolled in IEHP’s Medicaid Managed Care plan, approximately 80,000 (7 percent) of whom are seniors and persons with disabilities (SPD)—the Medicaid population most likely to need

---

<sup>1</sup> As of May 2016. Source: Author correspondence with plan.

Medicaid MLTSS in California	
<b>Program Name</b>	MLTSS
<b>Year Established</b>	2014
<b>Covered Populations</b>	Medicaid beneficiaries age 21 and older in seven CCI counties
<b>Population Carve-Outs</b>	Individuals younger than 21 PACE and AIDS Healthcare Foundation Enrollees Residents of ICF/DD facilities
<b>Enrollment Approach</b>	Mandatory
<b>Statewide Enrollment</b>	Not available
<b>Covered Benefits</b>	Medical, LTSS, and some behavioral care
<b>Benefit Carve-Outs</b>	Behavioral health benefits for the severely mentally ill
<b>Dual Eligible Population</b>	Not available

LTSS. IEHP also operates a Medicare-Medicaid Plan (MMP) in the duals demonstration—CalMediConnect.<sup>2</sup> There are 21,375<sup>3</sup> members enrolled in IEHP’s MMP. IEHP used to operate a Dual Eligible Special Needs Plan (D-SNP) for dual eligible members, but closed this product after transitioning almost all members into the MMP.

Although IEHP is financially responsible and at risk for all LTSS, the plan does not have operational control over all services. CBAS and institutional long-term care facilities are fee-for-service providers in IEHP’s network, and are managed by the plan. However, although the plan has financial responsibility for IHSS and MSSP benefits, these programs are operated independently by county agencies. That means that IEHP does not have a direct relationship with the IHSS and MSSP providers serving members, and does not control the kind or amount of services members receive from these programs.

### Care Management Approach

The bulk of IEHP’s internal medical care management staff are focused on medical issues: for example, complex case management for short-term clinical issues, inpatient review, and transition management. This is partly because historically most of the plan’s members were low-income families with children with primarily short-term, clinical care management needs. The carve-in of all SPD beneficiaries in 2011 and the relatively recent carve-in of LTSS to the plan’s benefit package has spurred an evolution in the plan’s approach to managing medically complex members with multiple chronic illnesses and LTSS needs. The care management team consists of nurses and care coordinators, who work together to organize the care for the members.

California Duals Demonstration	
<b>Program Name</b>	Cal MediConnect
<b>Initial Enrollment</b>	April 2014
<b>Covered Populations</b>	Full-benefit dual eligibles in seven CCI counties
<b>Population Carve-Outs</b>	Individuals younger than 21 ID/DD individuals Partial-benefit dual eligibles
<b>Enrollment Approach</b>	Initially passive with opt-out, but now voluntary
<b>Statewide Enrollment</b>	120,971 <sup>4</sup>
<b>Opt-Out Rate</b>	71% <sup>5</sup>
<b>Covered Benefits</b>	Medical, LTSS, and some behavioral
<b>Benefit Carve-Outs</b>	Behavioral care for the severely mentally ill

<sup>2</sup> As of May 2016. Source: Author correspondence with plan.

<sup>3</sup> As of May 2016: <http://www.calduals.org/wp-content/uploads/2016/05/CMC-Enrollment-Dashboard-May-Final.pdf>

<sup>4</sup> As of May 2016: <http://www.calduals.org/wp-content/uploads/2016/05/CMC-Enrollment-Dashboard-May-Final.pdf>

<sup>5</sup> Ibid.

The plan attempts to complete a Health Risk Assessment (HRA) for every member of the MMP and for SPD members in the Medicaid Managed Care product—the two populations most likely to need LTSS.<sup>6</sup> IEHP successfully completes HRAs for about half of the group they contact. HRAs are conducted telephonically by a vendor who asks about the member’s medical, behavioral, and LTSS needs. The final question of the HRA asks the member about their three most pressing issues. The vendor sends completed HRAs to IEHP. An IEHP care manager reviews the results with the member and develops a care plan based around the three outstanding issues identified by the member. The care plan addresses chronic medical conditions, activities of daily living, behavioral health issues, social issues, and other barriers to care such as transportation difficulties. Care managers touch base with members periodically to check that progress is being made on the existing goals and add new items the member wants to work on. Once all issues have been resolved and there are no more actionable items on the care plan, the case is closed, but this is rare because of the complexity and high level of need among the population that IEHP serves.

Medicaid LTSS Benefits in California				
Program Name	Statewide Enrollment	IEHP Enrollment <sup>7</sup>	Description	Relationship to Managed Care
<b>Long-Term Care (LTC)</b>	71,000 <sup>8</sup>	2,400	Medicaid coverage for institutional long-term care in nursing facilities, intermediate care facilities, and other institutions after Medicare benefits and/or private resources have been exhausted	Carved into Medicaid Managed Care in 2014; facilities operate as network providers to plans
<b>In-Home Supportive Services (IHSS)</b>	467,000 <sup>9</sup>	29,474	In-home personal care services provided as an alternative to nursing homes and other institutional care	Managed care organizations (MCOs) gained financial responsibility in 2014, but program is administered by an independent county agency
<b>Community-Based Adult Services (CBAS)</b>	34,270 <sup>10</sup>	742	Nursing, therapies, mental health, personal care, meals, and other services provided at an adult day health center	Carved into Medicaid Managed Care in 2012; CBAS centers operate as network providers to plans

<sup>6</sup> Many aspects of the care model are structured by state and federal regulation. For example, plans participating in the duals demonstration are required to complete an HRA for every member.

<sup>7</sup> As of August 2016. Source: Correspondence with plan.

<sup>8</sup> As of 2014. Public Policy Institute of California, “Nursing Homes in California.” Available at: [http://www.ppic.org/main/publication\\_show.asp?i=1168](http://www.ppic.org/main/publication_show.asp?i=1168)

<sup>9</sup> Public Policy Institute of California, “California’s In-Home Support Program.” Available at: [http://www.ppic.org/main/publication\\_show.asp?i=1169](http://www.ppic.org/main/publication_show.asp?i=1169)

<sup>10</sup> As of March 2016. California Department of Aging, “CBAS Dashboard: Center Overview.” Available at: [http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/CBAS\\_Dashboard/Center\\_Overview/](http://www.aging.ca.gov/ProgramsProviders/ADHC-CBAS/CBAS_Dashboard/Center_Overview/)

<b>Multipurpose Senior Services Program (MSSP)</b>	9,440 <sup>11</sup>	343	Care management and supportive services (including personal care, meals, transportation, and other services) to maintain older adults who are nursing home certifiable in the community	MCOs gained financial responsibility in 2014, but program is administered by an independent county agency
<b>Other HCBS Waivers: Assisted Living Waiver (ALW), Nursing Facility / Acute Hospital Waiver (NF/AH), and In-Home Options Waiver (IHO)</b>	4,194 <sup>12</sup>	Data not available.	Federal 1915(c) waivers that provide HCBS to specific sub-populations at risk of institutionalization and with capped enrollment	Individuals enrolled in these waivers are excluded from the MMP

For members who receive LTSS, further assessment and care planning is delegated to the entity responsible for delivering the service: CBAS, MSSP, or IHSS. Care managers employed by CBAS and MSSP complete member assessments and care plans, and then share these with the plan via a secure site. The assessments are then shared among internal departments via MedHOK—IEHP’s electronic case management system. For IHSS, there is no care planning or ongoing care management. IHSS assessments are used to determine the number of hours and tasks for which the member can receive assistance. IHSS does not share assessments with IEHP, but does let the plan know how many hours and tasks have been approved for the member.

IEHP has developed several units within the plan’s care management function that have specialized expertise, including units focused on behavioral health and disabilities. The behavioral health unit is staffed by licensed clinical social workers who serve as a resource to other IEHP staff and manage members with behavioral issues. These social workers evaluate members and connect them directly with network providers. The disability unit conducts outreach to members, identifies and connects members to community resources, and participates in the Inland Empire Disabilities Collaborative (described below). A specialized LTSS unit within the care management unit acts as a liaison to county agencies (IHSS, MSSP) and is an expert on local providers and resources. The LTSS team works closely with others across the care management department to ensure members are referred to appropriate services, and then works with providers and county agencies to get services in place as quickly as possible. IEHP is working to further expand their care management capabilities by adding social workers who can deal with social determinants of health like homelessness and housing issues. In addition to these specialized care management functions, the plan contracts with two specialty care management vendors—Charter and Landmark Health—to provide intensive management and home-based care to the highest risk members. (Charter and Landmark are discussed in further detail in the sections below.)

<sup>11</sup> CalDuals.org (2013) “CCI: Cal MediConnect: Policy for Cal MediConnect: Care Plan Option services.” Available at: <http://www.calduals.org/wp-content/uploads/2013/06/Demo-CPO-services-Paper-6.3.13.pdf>

<sup>12</sup> Ibid.

In IEHP's care model, each care manager manages the resources for which they are responsible, and works with the other specialized units and other teams as needed for the member. Thus, a single member may interact with several different care managers. The different team members work together to determine who is the primary contact for the member, and all team members document their interactions with the member in the MedHok electronic record. The various team members collaborate and share information, and work diligently to provide an organized experience for the member. IEHP's care managers attempt to find synergies and reduce duplication of services.

Interdisciplinary team (IDT) meetings are a formal tool to coordinate across different care management teams. IEHP hosts regular IDT meetings to discuss members with substantial challenges. Care managers identify members they would like to discuss with the team at each meeting. Participants include the medical director; all care managers or other team members working with the individuals being discussed (including CBAS and MSSP care managers); representatives from the behavioral health, transitions, and disabilities teams; the managers of IEHP's care management team; a plan pharmacist and nutritionist; member and provider services representatives; and representatives of any provider group taking risk for the member. Charter and Landmark also host regular IDT meetings which are attended by the IEHP care management team.

#### *Specialty Home Health and Transitional Care Vendor: Charter Healthcare Group*

IEHP began working with Charter in February 2015. Charter originally operated as a home health and hospice company serving Riverside and San Bernardino counties, with a staff of nurses on-call 24/7 to visit patients at home. Building from the organization's success in keeping hospice patients out of the hospital, Charter developed a transitional care service in partnership with a local independent practice association (IPA). Today, the company offers transitional care services to several clients, including IEHP.

IEHP members who have had three hospitalizations or more in the last 30 days are referred to Charter for short-term, intensive, home-based transitional care management. Upon admission to the program, Charter sends a nurse to visit the member at home, assess the member, and begin to connect the member with medical providers and services. Charter stratifies their caseload into four risk tiers, with the highest risk members receiving four home visits a week and the lowest risk members receiving a home visit every other week. Charter nurses work on behavior modification by educating the member about appropriate use of the ER, with an intense focus on hospital diversions. Instead of going to the ER, members are encouraged to call Charter. Within an hour of the call, Charter can dispatch a team to deliver needed medical care in the member's home. Patients in the program are connected to a primary care physician (PCP) and care manager, who assume responsibility for managing the member after discharge. There is a weekly IDT meeting between Charter and IEHP care management staff to discuss admits, discharges, and challenging cases. Charter also provides home visits to IEHP members who are not in the transitional care program if an IEHP care manager determines there is an urgent need for in-home care to prevent a hospitalization.

Charter maintains an average caseload of about 300 IEHP members, with an average length of stay in the program of 60 days. Charter does not have a risk-sharing arrangement with IEHP; instead, they are

paid a case rate for serving members. Charter's intervention averages 50 hospital diversions a week for their IEHP caseload, and an internal study showed a 60 percent decrease in hospital admissions and length of stay in the six months following the intervention. IEHP leadership have observed a marked decrease in acute bed days since they began working with Charter.

#### *Specialty Care Management and Home-Based Care Vendor: Landmark Health*

Landmark began managing IEHP members in February 2016. Landmark provides ongoing, intensive care management plus home-based care to IEHP's members with the most complex care needs. IEHP has a risk-sharing arrangement with Landmark—Landmark is paid based on the savings they achieve for the population they manage through decreased ER and hospital use. IEHP pays a portion of the savings to Landmark, and reinvests the remaining surplus in strengthening the overall program and improving member care.

Several criteria determine which IEHP members are eligible for Landmark's intervention. The member must see a PCP who has a direct contract with IEHP—that is, they cannot be part of an IPA to which the plan has delegated care management. The member must reside in the geographic area served by Landmark's home-based care teams. Finally, the member must have five or more chronic conditions from a list of 14 that Landmark has specified. Landmark identifies eligible members using claims data. The program does not currently accept patients based on referrals.

About 7,000 IEHP members have been identified as eligible for Landmark, and the program has engaged 560 members so far. Once a member is identified, Landmark contacts members and their PCPs via mail and phone. Once Landmark has connected with the member, a family nurse practitioner (FNP) visits them at home to conduct a comprehensive assessment. The FNP sends the completed assessment to a registered nurse (RN) care manager, who establishes a telephonic relationship with the member. The FNP and RN work together to develop a care plan, consulting other Landmark team members (e.g., psychiatrist, social worker) as needed. The care manager connects the member with LTSS and other resources on the basis of their comprehensive assessment. Members are also routinely screened for behavioral health issues, and connected to appropriate providers as needed. Landmark stratifies their caseload into four acuity levels. Members at the highest level of acuity are visited at home weekly or even daily, while those at the lowest level are monitored telephonically with a home visit every three months.

Landmark uses a variety of strategies to bring the member under management. Care managers educate members about appropriate use of the ER, encouraging them to call Landmark instead. Landmark has 24/7 in-home response capabilities to support the member at home in lieu of an ER visit.

Landmark uses a team approach to caring for members, with a physician in the lead. The FNP and RN care manager serve as the core provider dyad, and are supplemented as needed by psychiatrist, psychiatric NPs, and social workers. Landmark holds a weekly IDT meeting with IEHP to discuss the most challenging cases.

It is too early in the intervention to evaluate Landmark’s impact on participants’ medical costs, but the program has succeeded in getting 45 percent of participants to call Landmark before going to the ER, indicating that they may be preventing a substantial number of potentially high-cost hospital visits.

### **Relationships with Providers**

IEHP’s medical provider network is somewhat unique due to the strong presence of IPAs in Southern California. About 60 percent of IEHP’s members are in a delegated model in which an IPA assumes responsibility for care management and shares risk with the plan for costs and outcomes. In general, IPAs’ care management capabilities are focused on medical issues like disease management and transitions of care. Accordingly, IEHP’s risk sharing arrangements with IPAs cover medical care—including inpatient risk and post-acute care—but IEHP retains the risk for behavioral health and LTSS services. For members with LTSS needs, IEHP expects IPAs to identify patients who would benefit from LTSS and refer them back to the plan to coordinate Medicaid LTSS benefits. IEHP has done extensive training with IPAs on the benefits available to members, which members are eligible for these benefits, and the value of LTSS coordination to the IPA in terms of avoided medical utilization. Over the past few years, this training has had an impact, and many physicians now appreciate having access to these tools.

As mentioned above, although IEHP is financially responsible and at risk for all LTSS, the plan does not have operational control over IHSS and MSSP benefits, which are administered by county agencies. Unlike with CBAS or institutional LTSS providers, IEHP does not have a direct relationship with the IHSS and MSSP providers serving members. However, the plan has strong, collaborative relationships with the county agencies. For example, MSSP care managers participate in IEHP’s IDT meetings. These relationships reduce the administrative burden of coordinating services and enable the plan to provide a seamless experience for the member. IEHP also has deep relationships with local safety net providers and other community resources, which allows them to address member needs outside of the covered benefit package.

### **Financial Integration**

#### *Financial Alignment*

There are two populations for which IEHP is financially aligned—that is, they are at full risk for all of their medical, LTSS, and behavioral care. These two populations are (1) dual eligible individuals enrolled in the MMP, and (2) Medicaid-only beneficiaries enrolled in the Medicaid Managed Care product.<sup>13</sup> However, there is a significant population for which IEHP is not aligned: dual eligible individuals enrolled in the Medicaid Managed Care product. There are 43,000 dual eligible IEHP members who are enrolled with the plan for Medicaid coverage but receive Medicare coverage elsewhere, either as fee-for-service coverage or through an unrelated Medicare Advantage plan. Many of these members opted-out of the MMP. IEHP faces substantial challenges in coordinating care for

---

<sup>13</sup> There is one exception to full alignment for Medicaid-only beneficiaries in the Medicaid Managed Care product: behavioral health benefits for individuals with serious mental illness are carved out and managed by the county.

non-aligned dual eligible members, because the plan does not have information about their medical utilization or relationships with their medical providers.

For members for which IEHP is at risk for all medical, LTSS, and behavioral care, the plan has a clear financial incentive to invest in care management and LTSS and social services when they can avert costly medical utilization like hospitalization. These incentives are one driver of IEHP's recent decision to invest in relationships with Charter and Landmark. Although expensive, these interventions are less costly than the hospital care they are designed to prevent.

The plan reports that the rate structure for LTSS in California creates minimal financial incentives for plans to move institutionalized members back to the community. There appears to be a population that would be appropriate for repatriation, and some facilities have asked IEHP to help them repatriate custodial members in order to free up beds for post-acute Medicare patients. Some members who live in facilities could be safely supported in the community, but lack access to adequate housing. However, in both the MMP and Medicaid Managed Care products, Medicaid rates for LTSS do not encourage repatriation. There are four rate categories for LTSS: institutional, community with a high level of services, community with a low level of services, and community with no services. These are not averaged into a single global rate for all members. Instead, if a member moves out of a nursing home and into the community, their rate is adjusted downward accordingly, meaning that the plan has not been able to capture any savings. IEHP pursues the best plan of care for each individual, but has not been able to receive any financial benefit in cases of repatriation.

The state's rate structure for non-institutional LTSS also limits IEHP's financial incentives to manage the total cost of LTSS service plans. The way the state structures payment for MSSP and IHSS diminishes the value to IEHP of closely reviewing service plans for inefficiencies. The state has also limited the plan's ability to manage the total package of LTSS members receive by requiring IEHP to delegate operational responsibility for these programs to county agencies.

#### *Comprehensive Benefits and Flexibility in Use of Funds*

IEHP covers a comprehensive benefit package and has considerable flexibility in how they use funds to support members with LTSS needs in both the MMP and the Medicaid Managed Care products. In the MMP, IEHP offers the full array of Medicaid and Medicare covered benefits; vision, dental, and transportation as "value-added benefits"; and can cover additional services as "Care Plan Option" (CPO) benefits. Examples of services paid for as CPO include home modifications and hours of personal care beyond what has been authorized for the member. CPO benefits are not separately reimbursed by the state, but the plan is authorized to provide them out of the capitation they receive.

IEHP has similar flexibility in the Medicaid Managed Care product, and can use administrative funds to meet member needs outside of covered benefits. For example, the plan has bought beds, appliances, and done home modifications in order to support members in the community.

Plan leadership emphasized that the effort to proactively coordinate resources is often more impactful than providing the funds to cover additional services. IEHP has helped to meet many members' needs

by helping them navigate the system and connecting them to resources that are already available in the community. For example, the plan sponsors and actively participates in the Inland Empire Disabilities Collaborative, a local non-profit organization consisting of over 200 agencies that provide services or advocate on behalf of people with disabilities. This relationship deepens IEHP's knowledge of services available to their members outside the plan.

### **Quality Metrics and Performance Management**

As part of the duals demonstration, IEHP is required to participate in a quality incentives program. The federal government withholds a portion of plans' capitation rate based on the achievement of certain quality metrics. In the first year, plans were assessed on a range of process measures, including completion of initial assessments within 90 days of enrollment, creation of a consumer advisory board, customer service surveys, timely submission of encounter data, and timeliness of appointments and care.<sup>14</sup> California collects additional metrics as part of a state-specific quality withhold program, including documentation of care goals, coordination with behavioral health providers, individualized mental health care plans, member contact with care coordinator, physical access compliance, and additional encounter data specifications.<sup>15</sup> The Field Research Corporation is also conducting regular polls to understand the experience of Californians enrolling in and opting out of the duals demonstration.<sup>16</sup>

IEHP leadership keeps track of standard plan performance metrics, including HEDIS and CAHPS, as well as the measures required as part of the duals demonstration. Beyond these measures, the plan is not assessing outcomes as part of a systematic performance management strategy. One of the barriers to doing so is the absence of appropriate measure for people receiving LTSS that would work across the heterogeneous population IEHP serves. The care management department does assess some measures of performance, primarily process measures that indicate the efficiency and timeliness of their services as well as the degree of integration within the unit. For example, IEHP tracks the number of referrals to the LTSS team from the medical case management team. The plan is working to develop additional measures of care management performance.

IEHP also holds providers accountable for quality metrics. The plan's contract with Landmark has specific quality metrics with built-in incentives that include HEDIS quality measures, member satisfaction, and some process measures. IEHP also has substantial financial incentives as part of pay-for-performance contracts with medical providers. Most of the measures are clinical and not specific to LTSS. Additionally, the plan passes on the quality withhold measures for the duals demonstration to Medicare IPAs.

---

<sup>14</sup> See this CMS guidance for more detail: <https://www.cms.gov/Medicare-MedicaidCoordination/Medicare-and-MedicaidCoordination/Medicare-Medicaid-CoordinationOffice/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidance060614.pdf>

<sup>15</sup> For IEHP's most recent state performance results, see Appendix Q of this report: [http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD\\_Qual\\_Rpts/TechRpt/CA2014-15\\_EQR\\_Tech\\_Rpt.pdf](http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/TechRpt/CA2014-15_EQR_Tech_Rpt.pdf)

<sup>16</sup> The results of this polling can be found on The SCAN Foundation's website: <http://www.thescanfoundation.org/evaluating-medicare-medicaid-integration>

As a not-for-profit, IEHP focuses more on providing the right care to the member than on financial goals. The plan uses a person-centered approach to help members navigate a relatively siloed system of financing and delivery of care, in particular for certain LTSS programs and for dual eligible members who take Medicare coverage with a different plan. IEHP has found that this commitment to coordinating resources at the member level has been successful and faced minimal barriers.

### **Key Integration Strategies and Outcomes**

IEHP has adopted a different strategy to LTSS integration than many other organizations that are financially aligned for medical and LTSS coverage. Partly as a result of state policy, IEHP delegates elements of care management for certain populations and programs. The plan works to coordinate the various entities involved in care management, decreasing duplication, and ensuring that the member has access to necessary services. A key element of this strategy is developing specialized expertise in the care management department. IEHP has dedicated staff experts on LTSS, local disability resources, and behavioral health. The plan is also able to extend their care management approach through the use of partners. IEHP's experience with delegating care management to IPAs, CBAS, and MSSP likely informed their ability to partner with Charter and Landmark to provide intensive care management to high-risk members.

Charter and Landmark have been able to quickly deliver value to IEHP, successfully decreasing acute bed days and rehospitalizations within six months of beginning operations. The plan expects to see further improvements as the relationship matures and more patients are introduced to the program. This suggests that plans may be able to partner with vendors to quickly implement advanced care management strategies. This may be a particularly appropriate strategy for plans that serve a diverse population of who the majority are relatively low risk. For organizations that do not specialize in managing complex, high-risk populations, it may make sense to delegate responsibility for these members to a specialty care management partner.

IEHP leadership also stressed the value of local knowledge and relationships in providing integrated care to members. All health care is local, and this is even more the case for LTSS and community providers of social services. IEHP relies on strong relationships with county agencies and local organizations to support members with LTSS needs in the community and address the social determinants of health.

IEHP is not yet able to demonstrate a financial return on LTSS integration in terms of overall decreased medical utilization, but has confidence in the strategy they are pursuing through partnerships with Landmark and Charter. The financial alignment of medical and LTSS coverage for a high-need population through California's duals demonstration has been a key factor enabling IEHP to invest in these new care management initiatives.

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

### **Long-Term Quality Alliance**

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

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

### **Acknowledgements**

Supported by a grant from The SCAN Foundation - advancing a coordinated and easily navigated system of high-quality services for older adults that preserve dignity and independence. For more information, visit [www.TheSCANFoundation.org](http://www.TheSCANFoundation.org).

### **Contact**

Long-Term Quality Alliance  
(202) 452-9217  
[info@ltqa.org](mailto:info@ltqa.org)  
[www.ltqa.org](http://www.ltqa.org)

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

