

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

Health Plan of San Mateo

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

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

Background Information

Health Plan of San Mateo (HPSM) is a county-operated Medicaid plan in California that has been in operation since 1987. Nearly all Medicaid beneficiaries in San Mateo County receive their coverage through HPSM. The plan covers medical, LTSS, and some behavioral health. Behavioral health benefits for the severely mentally ill are carved out. For most Medicaid beneficiaries in the county, enrollment in the plan is mandatory for medical and LTSS coverage. Medicaid MLTSS is a recent development in California. Institutional LTSS was carved into HPSM's contract in 2010 and adult day health in 2012. Other community-based LTSS were only added in 2014 as part of California's Coordinated Care Initiative. The Coordinated Care Initiative is being implemented in seven counties (including San Mateo County), and consists of two components: (1) the launch of mandatory MLTSS for Medicaid beneficiaries, including dual eligibles, and (2) California's Duals Demonstration program—Cal MediConnect.¹

145,000 individuals are enrolled in HPSM.² Approximately 5,500 members receive LTSS in the community, and an additional 1,200 are institutionalized. In addition to providing Medicaid coverage, the plan has operated a D-SNP for dual eligible members since 2006, and began operating an MMP in

¹ Please refer to Appendix B for more information on Medicaid MLTSS programs in California.

² As of December 2015. Source: Communication with HPSM.

April 2014 as part of Cal MediConnect. Three-quarters of HPSM’s dually eligible members, about 10,000 beneficiaries, have their Medicare coverage with HPSM. Most of these members are in the MMP, and only those who are not eligible for MMP remain in the D-SNP. The other 25% of dual eligible members who do not have their primary medical coverage with HPSM are enrolled in Original Medicare, a D-SNP operated by Kaiser Permanente, or other Medicare Advantage plans. Regardless of primary payer, HPSM manages all complex members with a unified care coordination model. For this study, HPSM described their overall care model for all members with LTSS needs, across products.

As the sole Medicaid plan in the county, HPSM has long-standing relationships with many regional medical providers. The plan actively engages with the provider network, identifying barriers to high-quality, cost-effective care and using their leverage as a payer to encourage improvements. Since becoming responsible for institutional care in 2010, the plan also works with 10 of the 11 SNFs in the county. Plan leadership has also engaged in extensive outreach and relationship-building with the county and community organizations that provide LTSS and behavioral health. The plan meets regularly with all of these partners, and the ongoing stakeholder engagement has proven valuable to achieving improvements in member care. As HPSM has engaged with the LTSS system in their region, they have been able to identify problems and address them directly with the managers of those services.

Care Management and Provider Organization

HPSM has reorganized to become more integrated internally, and this is most clearly seen in the care management team. The plan has eliminated silos between LTSS and medical care teams, improved information sharing, and decreased duplication. This has required significant growth of and a shift in focus for the care management function. In the past, most care managers were nurses with hospital experience and focused on utilization and inpatient management. Today, HPSM care managers have much broader responsibilities for care coordination. Social workers and unlicensed care coordinators have been added to the team. HPSM has made a cultural shift in the approach to staffing. The plan now emphasizes competency in addressing members holistically, and has shifted to hiring individuals with backgrounds in psychosocial issues.

All HPSM care management staff share a home organizationally—the function is “line of business blind.” This means that all members are managed in the same system, and care management staff are overseen by the same leadership teams, irrespective of the member’s primary payer. Care managers have access to clinical support from HPSM’s medical directors, the Deputy CMO (a psychiatrist), clinical pharmacists, social workers, and nurses.

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

All HPSM members are eligible for care management. There are three tiers of risk: routine, moderate, and high-need. All members receiving LTSS are in routine care management, or more intensive care management if necessary. Members are identified for care management through HRAs, care coordination requests, data on transitions, and patterns of over- or underutilization. HRAs are administered upon enrollment and annually for dual eligible members in the MMP, D-SNP, and for Medicaid-only members who are seniors and persons with disabilities.⁵ For members at the lowest level of need, the plan provides telephonic outreach and coordination, primarily using unlicensed care coordination technicians. Members with a moderate level of need receive more intensive care management, including home visits, with a nurse or social worker taking the lead. Generally, about 500 members are in this intermediate level of care management at any time. This level of care is intended to be short-term and intensive, with members returning to routine telephonic management once their transitional needs are addressed. A small number of the most complex individuals are identified as high-need. These members are enrolled in a very intensive case management program, the Community Care Settings Pilot, described in more detail below.

California Duals Demonstration	
Program Name	Cal MediConnect
Initial Enrollment	April 2014
Covered Populations	Full-benefit dual eligibles in seven CCI counties
Population Carve-Outs	Individuals under age 21 ID/DD individuals Partial-benefit dual eligibles
Enrollment Approach	Passive with opt-out
Statewide Enrollment	125,257 ³
Opt-Out Rate	70% ⁴
Covered Benefits	Medical, LTSS, and some behavioral
Benefit Carve-Outs	Behavioral health benefits for the severely mentally ill

A care plan is developed for every member in care management. Care plans are organized around function and need, not diagnosis. This approach to care planning is based on the plan’s experience that high-risk members are not necessarily those suffering from serious chronic illnesses or multiple co-morbidities. Many of those individuals may be stable and managing their health well. In contrast, the highest-risk members are those who are not connected to the services and providers they need.

Plan staff implement care plans by leading the care team, working with the member and their PCP, and coordinating county and community LTSS providers. HPSM is not a provider organization, and instead sees the plan’s role as supporting the PCP-member relationship. Care management staff steer members towards providers with whom the plan has a strong relationship—like the Ron Robinson Senior Care Center—which facilitates information sharing and care coordination. HPSM has also created formalized relationships with LTSS providers, which helps the plan to quickly meet member needs and coordinate care. Essentially, the plan has vertically integrated with local LTSS providers, and in this way is able to influence care.

³ As of January 2016: <http://www.calduals.org/wp-content/uploads/2016/02/CMC-Enrollment-Dashboard-January-Final.pdf>

⁴ As of January 2016: <http://www.calduals.org/wp-content/uploads/2016/02/CMC-Enrollment-Dashboard-January-Final.pdf>

⁵ California’s Seniors and Persons with Disabilities (SPD) Medicaid category corresponds to what most states refer to as the “aged, blind, and disabled” population. Their coverage is often closely linked to eligibility for the federal SSI program.

Transitions

HPSM requires that hospitals notify the plan quickly of member admissions. Plan management has engaged with hospitals directly to reinforce the importance of timely notification, and in some cases has leveraged contract power to ensure hospital compliance with this request. Hospitalized members are managed by a dedicated inpatient review and care transitions team. This team follows members from admission through 30 days post-discharge, working closely with a unit focused on prior authorizations. The inpatient team provides concurrent inpatient review and discharge planning assistance during the inpatient stay, and then manages transitions using the Coleman model⁶ after discharge. If the member has ongoing care management needs beyond 30 days post-discharge, they are referred to the general care management team. If no ongoing needs are identified, the case is closed.

Community Care Settings Pilot

HPSM launched the Community Care Settings pilot in late 2014. This intensive transitional management program combines intensive care management with housing coordination services to move institutionalized members back in to community-based settings. The plan uses predictive analytics to target the intervention to a small set of members, and in the first year was able to move 53 members out of institutions. The pilot recovered its full start-up costs in the first year of operation through direct savings, and returns are expected to increase as the program further matures. The program is growing quickly, and in addition to 87 clients in the active caseload, there are about 100 individuals on the waiting list.⁷

Four groups of members are targeted for the pilot program. In order of priority, these are dual eligible institutionalized members, dual eligible members in rehabilitation facilities at risk of long-term institutionalization, Medicaid-only institutionalized members, and community-dwelling members at risk of institutionalization. Once members are enrolled in the program, they receive a comprehensive in-person assessment and six months to a year of intensive care management services—care managers typically follow only 15 to 20 individuals. Social workers serve as care managers for the program, with support from HPSM’s clinical staff as needed. Members also receive specialized housing coordination services to locate and secure appropriate, affordable housing in the community. HPSM contracts with Institute on Aging (IOA) for care management services and Brilliant Corners for housing coordination services. The program is overseen by the “Core Group,” which includes HPSM’s clinical leadership, representatives from county behavioral health and LTSS providers, and IOA’s care management staff. The Core Group meets frequently to review member’s cases and address barriers to care, with a special focus on challenges with county systems and providers.

Plan Incentives and Financial Results

For individuals receiving acute care and LTSS, HPSM receives capitated payments either from Medicare and Medicaid (for dual eligible members), or a single capitated payment from Medicaid (for Medicaid-

⁶ The Care Transitions Program (<http://www.caretransitions.org/>) was developed by Dr. Eric Coleman to improve care transitions by providing patients with tools and support that promote knowledge and self-management of their condition as they move from hospital to home, the Care Transitions intervention is composed of: 1) a patient-centered Personal Health Record that contains all essential care elements, 2) a structured Discharge Preparation Checklist, 3) a session with a Transitions Coach in the hospital prior to discharge, and 4) follow-up visits and phone calls from the Transitions Coach in SNF or in home.

⁷ Caseload data as of October 2015.

only members). Within this capitation, the plan is at risk for medical, LTSS, and some behavioral health. Behavioral health benefits for the severely mentally ill are carved out. A portion of the capitation is at risk contingent on the plan achieving quality metrics specified by CMS and the state. The plan does not share financial risk with providers.

For the Duals Demonstration, rates are set based on five individual categories that are aggregated to create a blended population rate: institutionalized individuals, members using adult day care, high-need members using HCBS, all other members using HCBS, and community well. This rate-setting methodology creates incentives for HPSM to transition members from institutions to HCBS. If the plan beats the expected rate for institutionalization, they can keep any savings until a new blended rate is set the following year. For Medicaid-only members, however, rates are experience-based. This means there are no financial incentives for moving these members into the community as the state captures all savings of any shift away from institutions.

HPSM is “mission-driven, not margin-driven,” and thus only needs to break even to be financially sustainable. Nevertheless, plan management believe their care model could be profitable in any market due to the value it generates system-wide. The benefits of the plan’s integration efforts extend beyond the healthcare system, and spill over into the region’s criminal justice system, human services, and emergency services, just to name a few. This value is significant enough that venture capital and private equity firms routinely approach the plan.

Utilization Management Strategy

HPSM’s utilization management strategy for members with LTSS needs is based on a clear theory of change for improving outcomes for this population. Plan leadership believes that coordinating care and connecting members to needed LTSS drives clinical outcomes and member satisfaction, and keeps members in the community. Those intermediate outcomes lead to financial results.

Moving members out of institutions is HPSM’s most significant utilization management tactic. Historically, the plan has had a higher rate of institutionalization than peers. This problem is compounded by a regional shortage of SNF beds and the lack of affordable housing in the Bay area. A year of care in a SNF costs \$150,000 while the plan can serve high-need members in the community for \$20,000 annually. The success of the Community Care Settings pilot in moving more than 50 members out of institutions has therefore generated more than \$6.5 million in annual cost avoidance for the plan.

Quality Metrics and Performance Management

California requires that Medicaid managed care plans participate in state quality programs, which focus on measures related to population health, including prenatal care, tobacco cessation, and diabetes management.⁸ More relevant to HPSM’s efforts on LTSS integration are the quality incentives in the Duals Demonstration. The federal government is withholding a portion of the capitation rate for plans participating in demonstrations across the country based on the achievement of certain quality metrics. In the first year, plans are being assessed based on completion of initial assessments within 90 days of enrollment, creation of a consumer advisory board, customer service surveys, timely submission of

⁸ The most recent state performance report for HPSM can be found here:

http://www.dhcs.ca.gov/dataandstats/reports/Documents/MMCD_Qual_Rpts/0914PlanSpecificPerfEvals/2013-2014PlanSpecPerfEvals/HPSM_CA2013-14_PerfEval_Report.pdf

encounter data, and timeliness of appointments and care.⁹ Beyond these federal requirements, California is collecting additional metrics as part of state-specific quality withhold program. Metrics for California Duals Demonstration plans are 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.¹⁰ HPSM is closely monitoring these demonstration metrics.

HPSM anchors their quality strategy on the Triple Aim: care outcomes, member experience, and cost outcomes. In addition to looking at three key performance indicators tied to the Triple Aim, the plan monitors a large number of measures that cascade under each of the three branches. Most of the measures the plan tracks are process measures. In addition to Duals Demonstration and Triple Aim measures, HPSM leadership monitor utilization rates, Medicare Star ratings, and HEDIS results.

Care manager performance is assessed largely with process measures. These measures include care plan completion timeliness, timely handling of care coordination requests, documentation appropriateness and timeliness, and member experience.

Person-centeredness has been a long-standing value at HPSM. Although the plan only recently became responsible for LTSS, the plan has always tried to provide a seamless experience for members. Historically, the plan has advocated for limiting carve-outs and worked to provide a holistic benefit package. Today, the plan uses the principles of human factor design to create processes that best meet member needs. Plan leadership seeks to organize the business around the member, which in some cases has required major deviations from standard health plan operations.

Key Integration Strategies and Outcomes

HPSM's integration strategy is predicated on a deeply-held cultural commitment to addressing the full person, with a special focus on LTSS, behavioral, and social needs. This is operationalized by limiting carve-outs and offering a benefit package that is as holistic as possible. HPSM also works to identify member needs proactively, and then to provide services based on member needs. Although this is a simple idea, it can be challenging to achieve in practice. Historically services were provided more on the basis of state program rules than on individual member needs. The plan's care model is facilitated by the fact that, unlike many other states, California does not specify the approach to member assessments and targeting in contracts with managed care plans. This has allowed HPSM the flexibility to iteratively develop and refine their approach to care management. Another key enabler of HPSM's integration strategy has been the investment in an electronic case management system. This platform allows the plan to do the risk stratification and care coordination at the core of the care model. The system was installed in 2014, laying the foundation for financial results, which the plan expects to achieve in 2016.

HPSM leadership recognizes that addressing the full person requires more than the coordination of Medicaid and Medicare benefits. Instead, it is necessary to coordinate all community resources an

⁹ See this CMS guidance for more detail: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidance060614.pdf>

¹⁰ See this CMS guidance for more detail: <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Downloads/DY1QualityWithholdGuidanceCA.pdf>

individual receives, to ensure that incentives are properly aligned. The plan’s status as an independent government organization serving San Mateo County has allowed them to take a leadership role in this coordination effort for the region. HPSM is accountable to the public and has been deeply embedded in the community for years, and as such has been able to act as an organizing entity for stakeholders and broker of relationships. The plan provided necessary leadership for an effort that was already consensus and commitment to within the regional social services and public health community. HPSM has been able to bring other entities—like hospitals and other providers—to the table through their role as a major payer. Personal relationships among staff who have moved between the different organizations have also facilitated the effort.

The result of HPSM’s leadership has been to create an “ecosystem of trust” among the various stakeholders. This is prerequisite to coordinating community resources and aligning incentives. Specifically, the relationships have allowed the plan to address barriers to care and achieve better results for members. The Community Care Settings pilot has been a key test of this process. The direct savings of the pilot have been substantial, averting more than \$6 million in nursing facility costs in the first year of implementation. HPSM believes that the pilot is also generating tremendous indirect value. Plan management have used the project to engage with providers on identifying system issues, testing solutions, and quickly systemizing solutions that prove effective. The true value of the pilot has been its effectiveness in changing the culture of the community around the plan, influencing county agencies and medical, LTSS, and behavioral health providers. As a result, HPSM is not only advancing integration within the plan, but is also promoting a culture of integration in the broader community.

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Long-Term Quality Alliance

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

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

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

