HEALTH MANAGEMENT ASSOCIATES

BRIEF #2

Medicare-Medicaid Integration: Reflecting on Progress to Date and Charting the Path to Making Integrated Programs Available to all Dually Eligible Individuals

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Medicare-Medicaid Integration:

and coordinated communication process.[66] Dual eligible subpopulations have distinct needs and preferences which contribute to enrollment and satisfaction with programs.
For example:

- Immigrant populations engage CBOs to supplement information received about integrated care programs. Despite accessing CBOs in California, immigrant populations experienced greater challenges accessing health care and information compared to US-born citizens. In California the experience of disempowerment was significant for L17(445.:

- ✓ Clearly inform providers about the integrated model's goals and benefits for individuals served, as well as supports for providers to avoid administrative challenges[81]
- ✓ Streamline and train providers on navigating program participant data and reporting and referral/authorization processes[82]
- ✓ Ensure adequate provider and MCO rates
- ✓ Encourage adoption of value-based payment arrangements that reward better outcomes
- ✓ Pay sufficient provider rates and make payment in a timely matter[83]
- ✓ Solicit ongoing provider engagement [84]

Care Coordination and Risk Stratification

A primary motivation for creation of integrated programs for dually eligible individuals is to be able to offer sophisticated systems of care coordination for members.[85] Care coordination is defined as the development of personalized needs assessments and person-centered care plans and interdisciplinary care teams who ensure that patients receive care consistent with their needs and defined care plans. The literature also defines person-centered care coordination to include a distinct focus on caregiver participation, transitions of care, and individuals' social determinants of health (SDOH). Risk stratification is defined as the assessment tools and analytics to identify levels and intensity of care coordination that should be provided. Such assessment tools and analytics target interventions toward individuals at high-risk for hospitalization, readmission and nursing home admission.[86]

The literature finds that consumer dissatisfaction in some capitated FAI programs resulted from lack of knowledge of who is their assigned care coordinator and confusion between roles of care coordinators and care managers.[87] An identified critical element of success is to ensure that individual consumers and their caregivers

capitated FAI prior to implementation of its program as it did not get an earlier design contract from CMS providing start-up grant funding. This caused program design planning to occur as it began enrollment into the program.[101] Other states faced challenges due to changes in state leadership commitment that caused delays and pauses in their program implementation. They also experienced instability in implementation and oversight due to state agency reorganization that reassigned needed staff that impacted program monitoring.[102,103] Table 6 provides critical elements of success for federal and state coordination.

Table 6. Adequate State Capacity from the Literature

FINDINGS
✓ Ensure adequate state supports and resources to reduce barriers in state capacity to support implementation of integrated programs[104]
✓ Seek additional resources and technical assistance from the federal government[105]
✓ Develop strong Medicare expertise within state agencies[106]

Performance and Outcome Measures Tailored to the Population

Standardized performance measures that are reflective of the population(s) served are critical to promote accountability and assess program success. [107] The literature cites a clear need for standardized measures of LTSS, and quality of life and outcome measures.

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Our review of publications and other publicly available information identified both barriers and successful features of integrated programs to date. It also highlighted gaps in data, limited engagement of diverse consumer stakeholders, lack of standardized metrics, and evaluation challenges that make it difficult to draw conclusive evidence on the full impact of programs or to identify one optimal model among existing programs. The gaps in the literature, along with mixed evidence on successful outcomes to date raise numerous questions that need to be addressed in order to move forward to extend availability of fully integrated program options. Future program design must be informed by engaging stakeholders, particularly dually eligible individuals and their caregivers, to address these pressing issues. Key questions in the future design, implementation and oversight of these programs include:

Primacy of Consumer Role

- How can integrated programs assure consumer priorities are central in the design, implementation, and ongoing monitoring and improvement of an enhanced integrated care model?
- How can high satisfaction levels among some participants be employed to increase overall enrollment?

Prioritization of Goals

- Given that evidence suggests one integration model will not likely improve all outcomes or meet the needs of all dually eligible subpopulations or stakeholders, how can policy makers, consumers and other stakeholders reach consensus on goals of integrated programs, and then focus program design accordingly? For example, what are the highest priorities among: reducing costs, program simplification (for consumers, providers, states) and reducing redundancies, lowering inappropriate service utilization, improving health outcomes, providing equal access for all dually eligible people regardless of where they live and their conditions, providing choice to consumers or to states, and improving quality of life? What metrics would best measure "success"?
- What are potential new designs that address current barriers, meet consumer needs, and promise to achieve high priority goals? For example, what changes are needed in payment, administration, or care delivery?
- Do goals vary across states? Is more than one integration framework needed?

Addressing State Diversity and Enhancing State Capacity

- How should integrated programs be tailored to the array of state characteristics including distinct delivery systems, populations, geography, availability of financing and resources, culture and other characteristics?
- How can state capacity be enhanced to make integrated programs sustainable and more widely available?

Federal and State Supports that Increase Participation

- What federal regulatory and policy changes are needed to attain an achievable and effective integrated program and delivery system?
- What federal supports - resources, incentives, guidance, regulations, metrics, oversight – would spark greater participation by states, providers, MCOs, and dually eligible people?
- How can CMS build on recent D-SNP requirements to strengthen and broaden approaches into a fully integrated model? Are D-SNPs an appropriate vehicle for integration or are there other models that CMS should pursue in addition to/in lieu of D-SNPs?
- How can CMS learn from capitated FAI program experience to create a fully integrated model, and are MMPs the appropriate vehicles?
- What is the optimal balance between prescriptive structuring/ensuring accountability and allowing/encouraging flexibility?
- If current integrated program options using health plans are kept, (i.e. enrollment in MMPs, MLTSS+D-SNP, FIDE SNPs) how can state and federal policy and actions support enrollment in them that helps dual eligible individuals enroll in the best option for them?

Upcoming meetings and interviews supported by Arnold Ventures will engage consumers and their caregivers or representatives, state and federal leaders, providers, and MCOs in grappling with these questions. They are intended to result in recommendations for designing effective integrated programs and ensuring that dually eligible individuals have access to programs appropriate to their needs.

[1] In this brief, when referencing the dually eligible population, we are referencing Medicare-Medicaid full benefit dual eligibles (FBDEs), those who qualify for full Medicaid benefits. Others who solely qualify for assistance with payment of Medicare premiums, and in some cases, Medicare cost sharing, are referred to as partial benefit dually eligible individuals and not the subject of this brief.

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