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Integrated Care Programs Serving Dually Eligible Beneficiaries – Health Plan Standards, Challenges and Evolving Approaches

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Overview

- [ ] **REPORT OBJECTIVES AND METHODOLOGY**

- [ ] **REPORT FINDINGS - CARE COORDINATION REQUIREMENTS AND PRACTICES AMONG INTEGRATED OR ALIGNED HEALTH PLANS**

- [ ] **CARE COORDINATION SUMMARY - EMERGING AREAS OF FOCUS**

REPORT OBJECTIVES AND METHODOLOGY

REPORT

Care Coordination in Integrated Care Programs Serving Dually Eligible Beneficiaries – Health Plan Standards, Challenges and Evolving Approaches

REPORT TO THE MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION, Health Management Associates, Sarah Barth, Sharon-Silow Carroll, Esther Reagan, Mary Russell, Taylor Simmons, March 2019

+ **Report prepared by HMA under contract to the Medicaid and CHIP Payment and Access Commission (MACPAC) to better understand health plan care coordination standards, practices and trends across integrated managed care models for dually eligible beneficiaries**

  + **Medicaid Managed Long-Term Supports programs with requirements for integration with Medicare Advantage Dual Eligible Special Needs Plans (MLTSS+D-SNPs)**

  + **D-SNPs with designation as Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs)**

  + **Capitated Financial Alignment Initiative (FAI) Demonstration Medicare-Medicaid Plans (MMPs)**

Note: The findings, statements and views expressed in the report are those of the authors and do not necessarily reflect those of MACPAC

REPORT OBJECTIVES

+ **Detail specific state and federal managed care contract requirements related to care coordination under each of the three models**

+ **Summarize state, health plan, provider, and health plan member experiences implementing, monitoring, or receiving care coordination services**

+ **Highlight effective care coordination practices and challenges for ensuring effective care coordination**

+ **Identify differences and similarities in health care coordination practices across the three integrated managed care models**

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Four methods to achieve study's objectives

+ **Comprehensive literature review**

+ **Review of 32 contracts with health plans involving the three integrated managed care program models in place as of August 2018**

+ **12 individual and group stakeholder interviews with 30 individuals including:**

    + **1 federal office at CMS**

    + **3 state Medicaid officials from two states (Tennessee and Virginia)**

    + **19 health plans executives from 7 health plans and 3 health plan associations**

    + **2 medical directors from 2 integrated health plans**

    + **3 consumer advocates from 2 consumer advocacy organizations**

    + **2 representatives from 2 HCBS organizations**

+ **Synthesis of findings**

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CARE COORDINATION TERMINOLOGY

+ **There is not one single term universally used to refer to care coordination**

+ Some states have multiple systems or programs (e.g. case management and care coordination) with distinctions that one system or activity is more clinically oriented focusing on an episode of care and other systems focusing on ongoing, whole person needs

+ **For research purposes, the term care coordination is used in the paper as a general term that refers to:**

    + Coordinating and managing care and services across the continuum of primary, acute, behavioral health, long-term services and supports (LTSS) and social services for dually eligible individuals

+ **Care coordination standards** are intended to ensure health plans assess members' needs, create person-centered care plans, and establish communication channels to share information across providers, individuals served, types and levels of services, and sites of care

CARE COORDINATION FOR INTEGRATED MEDICARE-MEDICAID MANAGED CARE MODELS

COMPONENTS OF CARE COORDINATION

Health Needs Assessment	Person-Centered Care Plan	Interdisciplinary Care Team
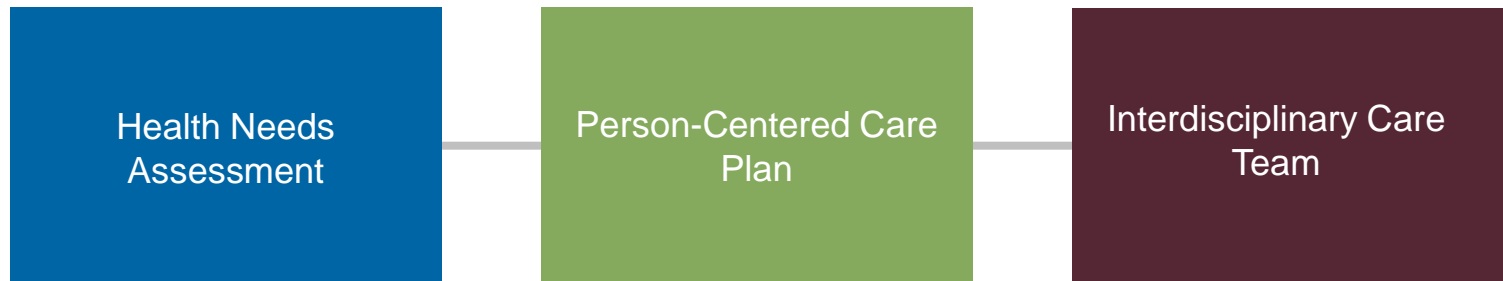
+ **Key components to provide integrated, whole person care for individuals with complex needs - LTSS and dually eligible for Medicare and Medicaid**

    + **Multiple health care, behavioral health, LTSS and social service needs**

    + **Social determinants of health (SDOH) – housing insecurity and homelessness, food insecurity, inadequate access to transportation, poverty, low health literacy and more that can affect access to care and outcomes**

REPORT FINDINGS

Health Management Associates

KEY FINDINGS – CONTRACT REVIEWS

+ **Contract variation** is most pronounced across states and not necessarily models – states with more experience with managed care tended to have more detailed care coordination contract provisions

  + Tennessee and Virginia have extensive experience with managed care and had the most detailed care coordination requirements in MLTSS+D-SNP contracts

+ **The degree of contract prescriptiveness** on care coordination requirements has implications for both setting minimum standards and facilitating innovation – many interviewees shared state and federal expectations regarding minimum standards need to be clear

  + Tennessee's MLTSS+D-SNP care coordination requirements are among the most prescriptive related to care coordination. At first, the plans saw them as burdensome but longer-term TennCare plans appreciated knowing the state's high expectations

  + Overall, contracts did not contain specific requirements around care coordinator training - Interviews shed light that it afforded health plans and states more flexibility in approach to training and focus on specific topics (care coordination for individuals with Alzheimer's – California; Palliative care – South Carolina)

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KEY FINDINGS – CONTRACT REVIEWS

+ <u>Requirements for data sharing, notification and discharge planning for individuals'</u> <u>transition between acute and non-acute settings exist across all three models</u>

  + *Tennessee MLTSS+D-SNP examples*: MLTSS plans must receive and process standardized electronic Daily Inpatient Admissions, Census and Discharge Reports from each D-SNP in region served; MLTSS plans must ensure all D-SNP notifications are timely and appropriately triaged; D-SNPs must provide notification within 2 business days of receipt of upcoming/current inpatient admissions (hospital and SNF) including observation days and ER visits

  + *Virginia MLTSS+D-SNP examples*: Each MLTSS plan must have at least 1 dedicated <u>regional</u> <u>transition care coordinator</u> in each region without a caseload, other than individuals in transition, to assist with care transitions and must work with D-SNP care coordinators upon approval by the member; <u>MLTSS plan must coordinate with member's D-SNP or MA plan</u> <u>regarding Medicaid services that may be needed</u>; D-SNPs must provide Medicaid plan with notifications within 48 hours of becoming aware of hospital admissions, ER visits and NF admissions

  + *Rhode Island MMP examples*: Transitional care management and support during transitions must be available 24 hours a day, 7 days a week; conduct onsite visits at the facility with the Lead Care manager and/or care coordinator; modify ICP as needed within 5 days of discharge; Convene ICT meetings as needed

  + *Idaho FIDE example*: Specifically references coordination of <u>services needed to avoid</u> <u>readmissions</u>

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KEY FINDINGS – CONTRACT REVIEWS

+ <u>Some states stand out in specification of data collection and information technology systems required to support care coordination and related reporting requirements</u>

TENNESSEE

+ MLTSS systems must:
  + Support coordination of Medicaid and Medicare services in integrated way
  + Support of coordination of D-SNP discharge planning between care settings
  + Accept D-SNP Daily Inpatient Admissions, Census and Discharge Report
  + Maintain daily report to determine appropriate and timely discharge planning

VIRGINIA

+ D-SNP submission of all information requested on a "D-SNP Dashboard" each month for the following 6 areas:
  + Enrollment
  + Enrollment demographics
  + HRAs and Plans of Care
  + Coordination with Medicaid plan
  + Grievances and appeals
  + Staffing

MASSACHUSETTS

+ MMPs must have a single, centralized enrollee record containing medical, function, social status including involvement with community agencies and contacts with family members and caregivers

KEY FINDINGS – CONTRACT REVIEWS

+ <u>Many contracts specify SDOH-related services (e.g. supporting housing, transportation, employment) as part of the care coordination process</u>

  + MLTSS+D-SNP

    + Florida requires care coordinators <u>be trained on</u> local resources for housing, education and employment

    + Arizona requires care coordinators to <u>facilitate access</u> to non-covered services available in the community and provide them with information about local resources that <u>may help transition them to greater self-sufficiency in areas of housing, education and employment</u>

    + Virginia includes very specific language that health plan care coordination must identify SDOH and member access to <u>education, housing services, job training, food security, transportation needs, and resources that support member connection to social supports</u>

  + FIDE SNP

    + Wisconsin requires that <u>social service coordinators are part of the interdisciplinary care team</u> and are responsible for conducting assessments – HRA is to include <u>exploration</u> of member's housing and finances, and preferences for education and vocational activities, including supported employment

  + Capitated FAIs

    + Must include SDOH as <u>required domains of the HRA</u>

KEY FINDINGS – INTERVIEWS

+ **Care coordination is dependent upon being able to locate and effectively engage members**

  + Health plans often receive contact information that is outdated, inaccurate or missing requiring plans to expend resources on finding and engaging individuals

+ **Health plan representatives relay person-centered care planning requirements for care coordination have been interpreted differently by states and health plans – compliance is difficult to measure**

  + Tennessee is working with health plans to ensure health plan understanding of person-centered care coordination requirements through:

    + Health plan readiness reviews

    + Peer training working with all TennCare plans in partnership with the Tennessee Council of Developmental Disabilities (health plan members are trained to teach peers on how to better lead and guide their own person-centered planning process and care plans)

+ **Variation exists across MLTSS and D-SNP plans on the importance they place on care coordination and care coordination across Medicaid and Medicare plans**

  + Interviewees shared that it often reflects the plan leadership perspective

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KEY FINDINGS – INTERVIEWS

+ <u>Health plan care coordinator training differs across health plans but generally consists of initial foundational care coordinator training on benefits and services followed by more targeted training specific to dually eligible individuals' characteristics and needs</u>

  + One health plan includes scenario-based learning

  + Another health plan provides ad hoc training as circumstances arise and includes providing updates on state and federal requirements

  + Virginia conducts 2 bi-weekly telephonic training sessions with MLTSS health plan care coordinators (Tuesday Q&A; Thursday structured calls focusing on specific conditions, populations or processes)

    + Care coordinators do not have to disclose who they are when they ask questions during sessions

+ <u>Stakeholders noted there are opportunities to improve care coordinator training through involvement and collaboration with individuals with disabilities</u>

  + Person-centered care planning should be designed to directly solicit their goals and preferences

KEY FINDINGS – INTERVIEWS

+ **There is value in conducting HRAs in-person for subpopulations with complex needs**

  + Conducting in-home assessment via a home visit may be more important than the assessment tool used for these individuals

  + It was noted that not all individuals need in-person assessments and that it is expensive

+ **Engaging primary care providers (PCP) in care coordination activities is challenging**

  + Small PCP panels make it difficult for health plans to incentivize PCPs to engage with health plans

  + PCPs have limited time with all that they have to do with paperwork and reporting

  + Health plan input is technology is not always the solution – PCPs may see a provider portal as just one more thing they have to sign into

+ **HCBS providers report staff have not been connected to health plan care coordination activities even though they are in the member's/consumer's homes, have trusting relationships with them and provide additional eyes on the member**

  + There have been a few small pilots to promote communication between health plans and HCBS staff that have shown value in identifying individuals needing interventions

  + There are untapped opportunities for collaboration and information sharing

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KEY FINDINGS – INTERVIEWS

+ <u>Most stakeholders agree health plans are learning more about the importance of addressing SDOH and incorporating SDOH into the care coordination process.</u>

  + One health plan interviewed has a <u>robust line of SDOH questions in its HRA –</u> SDOH needs are automatically populated in the care plan and generates referrals to resources

  + One health plan interviewed has its <u>own transportation fleet</u> which makes access to transportation much quicker for its members

  + States vary in the degree they work with health plans to <u>communicate across state agencies responsible for certain SDOH and community-base organizations</u> (e.g. across Medicaid and Aging agencies, Departments of Health)

  + A consumer advocate relayed the capitated FAI demonstrations have brought both behavioral health and SDOH to health plans' attention, but that <u>care coordinators need more training on available resources, including contracted services and non-contracted services such as Meals on Wheels</u>

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KEY FINDINGS – INTERVIEWS – HEALTH PLAN CHALLENGES AND SOLUTIONS

+ **Difficulty engaging primary care providers in care coordination activities**

    + Send the care plan to the PCP through a variety of means – health plan provider portal, fax, telephone

    + Send a case manager to offices of providers with larger health plan member panels once a week to discuss all members served by that office to reduce the time burden on the provider

    + Build in pay-for-performance or value-based purchasing to pay PCPs for extra time spent on care coordination

    + Provide information to PCPs that are most important to them (e.g., member pharmacy utilization, change in patient condition)

+ **Tense relationships between nursing facilities and care coordinators**

    + Place a health plan care coordinators in institutional settings to improve relationships and be a resource for them and the individuals they serve

+ **Use of technology to support person-centered care coordination**

    + One health plan is building capacity of its electronic care management system to translate person-centered care plan into a member-facing document

+ **Assessment burden for individuals across Medicare and Medicaid**

    + Health plan(s) are undertaking efforts to create a single HRA for MLTSS and D-SNP products

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CARE COORDINATION SUMMARY - EMERGING AREAS OF FOCUS

+ Next steps and emerging areas of focus for care coordination

  + Increasing face-to-face care coordination for individuals with more complex needs

  + Incorporating social service needs into health risk assessments

  + Further defining and measuring person-centered care planning

  + Working with members to engage in their health and wellness

  + Advancing family and caregiver involvement

  + Integrating electronic medical records and sharing data

  + Enhancing care coordinator training so that it is ongoing and focused on specific topics important to dually eligible individuals

  + Integrating health risk assessments

  + Assessing and addressing social risk factors or SDOH

+ On the horizon – developing measures that reflect care coordination outcomes related to improving health status and quality of life

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Monitoring Outcomes: Themes from Evaluations of Integrated Care Models

Medicaid and CHIP Payment and Access Commission

Kirstin Blom

Purpose

- Evidence is limited on the effects of integrated care so MACPAC set out to collect available research on integrated care models and summarize key findings

- Work can inform federal and state policymakers as they consider launching new models or refining existing ones

- MACPAC contracted with the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota to compile an inventory of peer-reviewed evaluations and gray literature

Evaluation Inventory

- Compiles 51 evaluations for selected models in spreadsheet format

- Summarizes key findings from each evaluation

- Available to download from our website: https://www.macpac.gov/publication/inventory-of-evaluations-of-integrated-care-programs-for-dually-eligible-beneficiaries/

- Companion issue brief highlights key findings and identifies gaps in the research. It is available here: https://www.macpac.gov/publication/evaluations-of-integrated-care-models-for-dually-eligible-beneficiaries-key-findings-and-research-gaps/

Models Evaluated

- Financial Alignment Initiative (FAI) – 24 evaluations

- Program of All-Inclusive Care for the Elderly (PACE) – 12 evaluations

- Dual eligible special needs plans (D-SNPs) – 9 evaluations

- Other – 6 evaluations

Findings Across Models

- Evaluations generally found a decrease in hospitalizations and readmissions

- For other services (including emergency department use, nursing facility use, and beneficiary experience), results varied across evaluations

- Several evaluations estimated effects on Medicare spending; most did not estimate effects on Medicaid due to lack of data

Financial Alignment Initiative

- Key findings from 24 evaluations:
  - Evidence of decreased emergency department use and hospitalizations, with mixed effects on other services
  - Beneficiaries reported varying experiences with care coordinators
  - Some analyses estimated savings to Medicare but did not include effects on Medicaid spending due to lack of data

Program of All-Inclusive Care for the Elderly

- Key findings from 12 evaluations:
  - PACE was associated with a reduced risk of hospitalization and higher use of preventive care, but findings on nursing facility use varied
  - Mixed findings on the effect of PACE on Medicaid and Medicare spending

Dual Eligible Special Needs Plans

- Key findings from 9 evaluations:
  - Care coordination had mixed effects on health outcomes
  - Evidence of reductions in hospitalizations, hospital readmissions, and nursing facility admissions
  - D-SNPs were associated with a decrease in Medicare spending per person; however the evaluations did not include effects on Medicaid spending

Limitations on Available Research

- Difficult to draw definitive conclusions about the effectiveness of models because:
  - relatively few evaluations exist for each model
  - findings may reflect differences in evaluation methodology, populations included, or comparison groups which must be taken into account when interpreting results
  - evaluations are not yet available for all FAI states
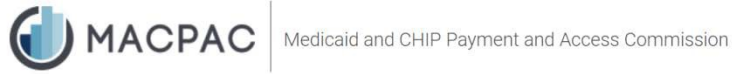 - research is limited on D-SNPs aligned with managed long-term services and supports programs

Gaps in Research

- More research is needed on integrated care models, particularly on:
  - outcomes for subpopulations, such as those under age 65, age 65 and older, and individuals with certain chronic conditions
  - the effects of integrated care models on Medicaid spending, particularly for the FAI and D-SNP models
  - how state design decisions affect outcomes
  - comparing the effectiveness of different models

Questions?

- Kirstin Blom – Principal Analyst
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- Kristal Vardaman – Principal Analyst
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Monitoring Outcomes: Themes from Evaluations of Integrated Care Models

Medicaid and CHIP Payment and Access Commission

Kirstin Blom

The Complex Art of Making It Simple

Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries

Erin Weir Lakhmani, MSW, LSW

NASUAD HCBS Conference

August 27, 2019

Note: The findings, statements and views expressed in this presentation are those of the study authors and do not necessarily reflect those of MACPAC.

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Overview

- **Background and Context for the MACPAC Study**

- **Methodology**

- **Key Findings**

- **Conclusion and Key Policy Questions**

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Enrollment Policy – FAI Demonstrations

- **Only full-benefit dually eligible beneficiaries (FBDEs) are eligible to enroll**
  - States may further limit the eligible population (for example, to only FBDEs who are over age 65, under age 65, residing in certain counties, receiving (or not receiving) certain long-term services and supports (LTSS), etc.). See Appendix B in our report appendices for more information: https://www.macpac.gov/publication/appendices-factors-affecting-enrollment-in-integrated-care-demonstrations-for-dually-eligible-beneficiaries/

- **Enrollment is voluntary; beneficiaries can enroll, disenroll, or change plans at any time**
  - While the standard Medicare special enrollment period (SEP) for dually eligible beneficiaries became quarterly starting 1/1/2019, all demonstration states have chosen to waive that change and continue to allow continuous enrollment in their FAI demonstrations in 2019.

- **Capitated Model Passive Enrollment**
  - States are allowed to use passive enrollment to automatically assign beneficiaries to an MMP, but must allow beneficiaries the option to opt out.

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Motivation for the Study

- **Total enrollment in the FAI has been lower than anticipated**
  - In 2017, on average, 29 percent of eligible individuals were enrolled in the demonstration

- **Wide variation in the share of eligible beneficiaries enrolled in FAI demonstrations**
  - From 4 percent in New York to more than 67 percent in Ohio

- **Wide variation in enrollment in participating Medicare-Medicaid Plans (MMPs) in most states. For example:**
  - CA: 5,600 to >25,000
  - TX: 2,100 to 14,400

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Research Questions

- **Which states and MMPs have been the most effective in enrolling eligible beneficiaries and increasing participation rates over time?**

- **Which state policies and strategies have been most (and least) effective in increasing participation rates among eligible enrollees?**

- **Are certain MMP strategies or characteristics associated with higher enrollment levels and enrollment growth?**

Approach, Data and Methods

- **Interview themes and results from three quantitative analyses:**
  - Semi-structured interviews with:
    - State officials in all 10 demonstration states
    - Executives and managers from 15 MMPs with higher levels of enrollment relative to other MMPs
  - Enrollment and participation rate trends over the course of each state's demonstration period, using CMS and state data
  - Temporal analysis: proximity of state enrollment policies to notable changes in enrollment
  - Patterns between beneficiary participation rates and state policies and MMP characteristics

- **Classified the influence of program elements on participation rates and enrollment as:**
  - **Primary,** if they emerged from both quantitative and qualitative analyses or were identified by at least 15 of 25 interview respondents
  - **Secondary,** if identified by 5 to 14 interview respondents

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Participation Rates by State, 2014-2018

FAI-Eligible Beneficiary Participation Rates in State FAI Demonstrations, 2014-2018

Legend: ■ 2014 ■ 2015 ■ 2016 ■ 2017 ■ 2018
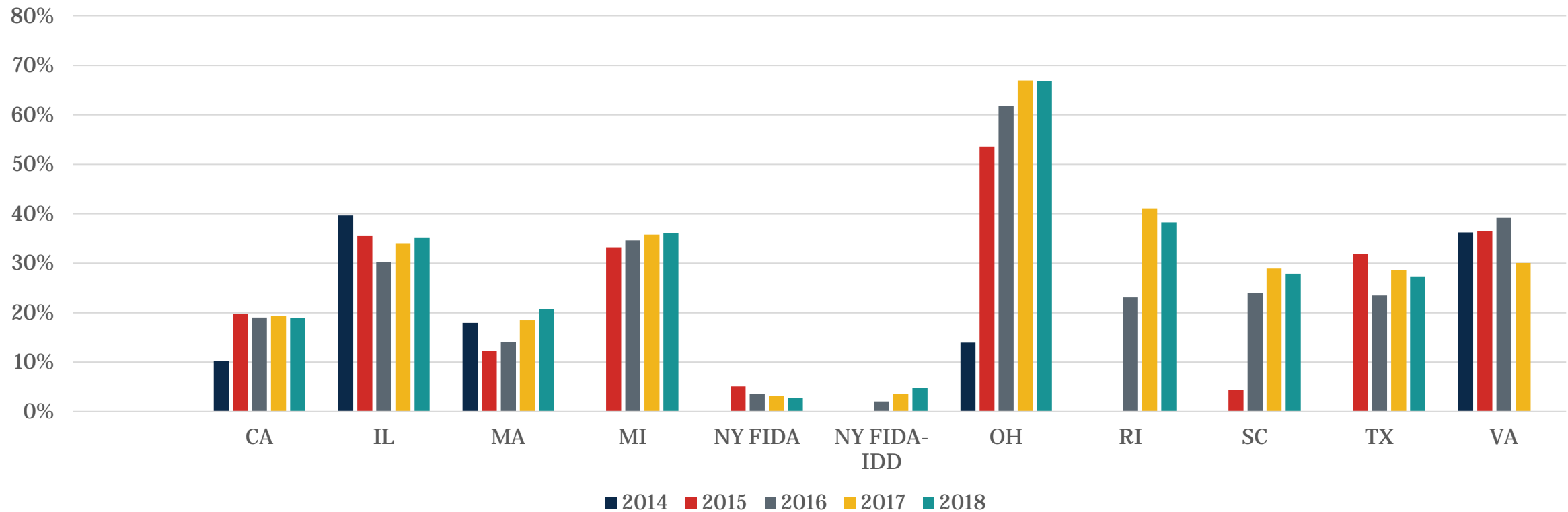
- **Ohio, Rhode Island, Virginia,** and **Michigan:** generally at or above the 75th percentile
- **Illinois, South Carolina**, and **Texas**: generally near the median
- **California, New York**, and **Massachusetts**: generally at or below the 25th percentile

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Major Factors Associated with Enrollment

Higher Enrollment	Lower Enrollment
Primary	
• Passive enrollment • Alignment of FAI demonstration and managed long term services and supports (MLTSS) program features • Positive beneficiary relationships with care coordinators through early "welcome" calls and face-to-face visits	• Insufficient engagement and support of long-term services and supports (LTSS) providers
Secondary	
• Medicaid "deeming" policies, when allowed by the state • Collaboration with established, trusted community-based organizations • Strong provider networks • Emphasis on certain outreach messages	• Beneficiaries' ability to enroll in, disenroll from, or change MMPs at any time • Influence from primary care providers, specialists, and hospitals (in some states) • Systems and data exchange issues (in some states) • Complexity of content in beneficiary enrollment notices
State use of an independent, third-party enrollment broker: viewed by state officials as increasing enrollment, but by MMPs as decreasing enrollment	

A note about competing products: While not found to be a primary or secondary factor, our report also discusses the role of competing products and financial incentives in influencing beneficiary enrollment decisions.

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Passive Enrollment

- **Passively enrolling beneficiaries into integrated MMPs is associated with higher enrollment**
  - <u>How</u> passive is done also matters: how often, with which beneficiaries, and use of staggered waves to control the number of beneficiaries enrolled at any one time

Example:
Texas MMP enrollment timeline
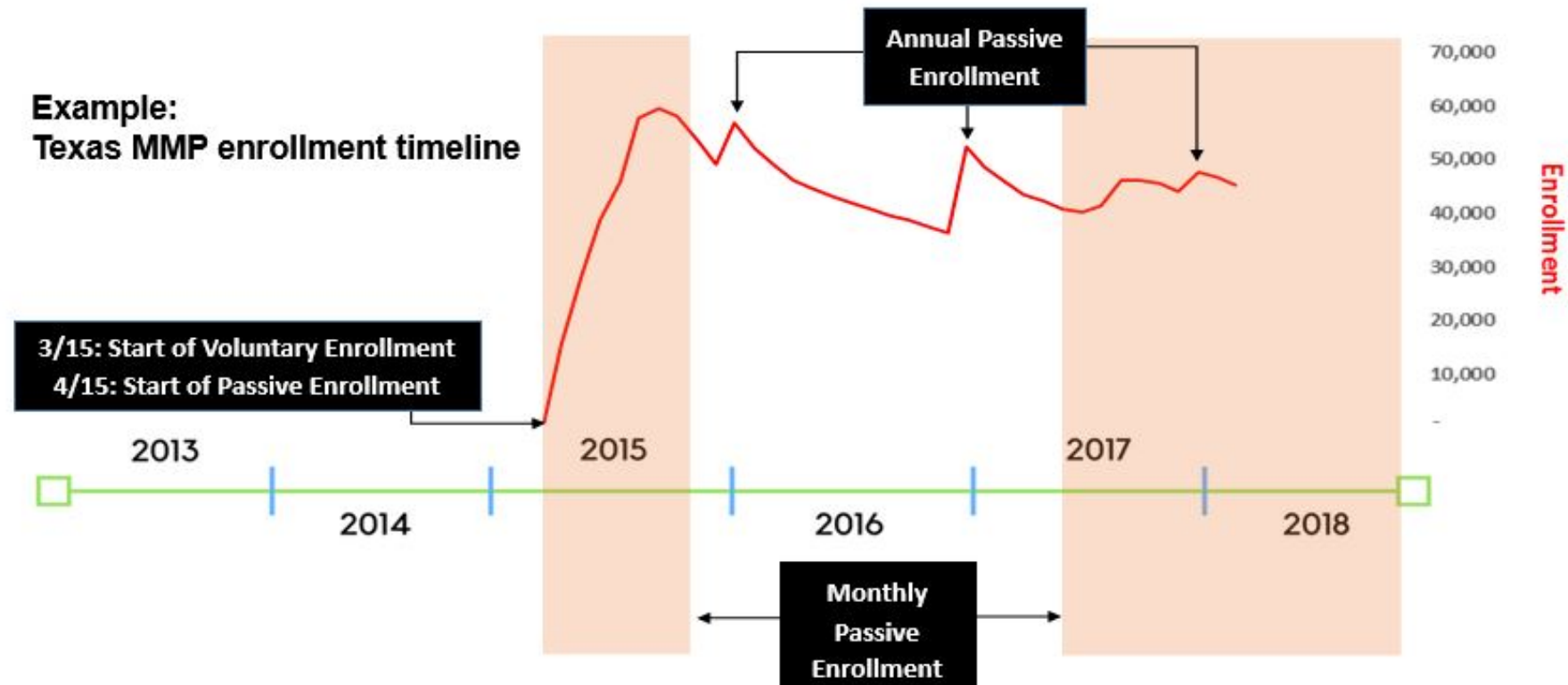
Program Design Alignment (MLTSS and FAI Demonstration)

Aligning key design features of state MLTSS programs and FAI demonstrations makes it easier to conduct targeted outreach

- Ohio, which has the highest participation rate, has complete alignment
- Rhode Island also aligned many program features and had the second highest rate participation rate in 2017 and 2018

	OH	CA	IL	MA	MI	NY	RI	TX
Same program name for Demonstration and MLTSS?	✔	✗	✗	✗	✗	✗	O d	✗
Rolled out Demonstration and MLTSS simultaneously?	✔ a	✔ b	✗	✗	✗	✗	✗	✗
Eligible populations are identical?	✔	O	✔	✗	O	O	O	O
Participating counties identical for both programs?	✔	✔	O c	O	O	O	✔	O
Same health plans offer MMP and MLTSS plans in each Demonstration county?	✔	O	O c	O	✗	O	✔	✔ e

✔ = Elements completely aligned

O = Elements overlap, but not completely aligned

✗ = Elements completely different

For detailed footnotes, see page 15 of our full study report, available at https://www.macpac.gov/publication/the-complex-art-of-making-it-simple-factors-affecting-enrollment-in-integrated-care-demonstrations-for-dually-eligible-beneficiaries/.

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Other Primary Factors Associated with Enrollment

- **Contact between MMP care coordinators and beneficiaries prior to enrollment and face-to-face visits with new members as soon as possible**
  - Builds trust and gives MMPs a chance to explain—and show—the benefits of care coordination

- **MMP engagement with LTSS providers and community-based organizations**
  - Tensions between MMPs and LTSS providers, including nursing facilities and home and community-based service (HCBS) providers, was the most frequently cited factor inhibiting enrollment
    - MMPs' lack of experience contracting with LTSS providers and LTSS providers' lack of experience contracting with managed care
  - MMPs who made concerted efforts to engage LTSS providers prior to and after demonstration launch said that those efforts helped to foster greater collaboration (though work still to be done in this area)

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Conclusion

Dually eligible beneficiaries are more likely to enroll, and remain enrolled, in integrated MMPs when:

- They are passively enrolled
- Benefits of integrated care are tangibly and quickly demonstrated
- Integrated care plans are cast as a preferred option among many that are available

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Key Policy Questions *(some related to FAI demonstrations and others to integrated care initiatives more broadly)*

- Should MMPs be allowed to use **default enrollment** (when Medicaid beneficiaries enrolled in a Medicaid plan operated by the same company first become dually eligible for Medicare) in certain circumstances?

- Should dually eligible beneficiaries enrolled in MMPs be allowed to **change their Medicare plan at any time**?

- Could CMS further **simplify beneficiary MMP enrollment notices**?

- To what extent can states **align MLTSS and integrated care program features**?

- What would be the effect on enrollment of states adopting Medicaid eligibility **deeming policies**?

- How can states ensure that **provider networks are adequate** in integrated care programs?

- What is the state's role in **encouraging enrollment** into fully integrated plans?

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For more information

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The Complex Art of Making It Simple: Factors Affecting Enrollment in Integrated Care Demonstrations for Dually Eligible Beneficiaries

https://www.macpac.gov/publication/the-complex-art-of-making-it-simple-factors-affecting-enrollment-in-integrated-care-demonstrations-for-dually-eligible-beneficiaries/

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