

Low-Cost, Low-Administrative Burden Ways to Better Integrate Care for Medicare-Medicaid Enrollees

Individuals eligible for both Medicare and Medicaid (Medicare-Medicaid enrollees, also known as dual eligible beneficiaries) must navigate two separate systems of care in which the administrative and payment structures are frequently misaligned. By improving the coordination and integration of Medicare and Medicaid services, including medical care, long-term services and supports (LTSS), and behavioral health services, states can provide higher quality and less fragmented care at potentially lower costs. Some states are pursuing ambitious, large-scale demonstrations to better serve Medicare-Medicaid enrollees. But even outside large-scale reforms, there are steps that states can take that have relatively low costs and low administrative burdens.

This brief from the *Integrated Care Resource Center (ICRC)* discusses low-cost, low-administrative burden approaches in four categories: (1) stakeholder engagement; (2) training and education of providers; (3) information exchange; and (4) opportunities in capitated Medicaid managed care. States all have different environments and infrastructures, so what can be done at low cost and with little additional burden in some states will not be feasible in others. This brief is meant to stimulate ideas about concrete, actionable steps for states to better serve Medicare-Medicaid enrollees.

Stakeholder Engagement

Form Partnerships with Stakeholders

Forming partnerships with stakeholders is critical to integrating care for Medicare-Medicaid enrollees. Stakeholder input will help inform concrete initiatives that can improve care delivery. Taking time at the outset to gather input and develop strategies that meet stakeholder needs will better position the state for effective integration. Even if the state is not moving toward a large-scale integrated care initiative, identifying stakeholders' needs—no matter how big or small—is a valuable step to improving care for Medicare-Medicaid enrollees.

IN BRIEF: There are a number of low-cost, low-administrative-burden approaches that states can take to integrate care for Medicare-Medicaid enrollees (also known as dual eligibles). This brief from the Integrated Care Resource Center (ICRC) describes some of these approaches, including engaging stakeholders; training and education of providers; exchanging information among different types of providers; and enhancing existing Medicaid-only managed care programs that serve beneficiaries with complex needs.

Successful implementation of the strategies described in this brief will help states build support for and remove barriers to integration. This will better position states to implement the larger-scale changes that will be needed to fully integrate the care of Medicare-Medicaid enrollees.

Hosting numerous stakeholder meetings can be time consuming and costly, but a lower-cost, lower-burden approach is to form a stakeholder workgroup. A workgroup made up of advocates, state and local agency representatives, providers, and other stakeholders can provide direction and real-time feedback to the state regarding what does and does not work in existing programs. Workgroups should ideally meet at regular intervals and include representatives who can go back to their constituencies to relay meeting information and discuss solutions. The workgroup can also help the state understand what is feasible; identify administrative barriers to integration; and describe changes that will be needed for the state to move forward.

Engaging directly with beneficiaries is also very important, but stakeholder workgroups may not be the most effective way to obtain beneficiary feedback. Some beneficiaries may feel hesitant to advocate for their needs in the same room as professional advocates who may have different points of view. Also, transportation and resource issues may limit beneficiaries' ability to participate in workgroups. Instead, taking the time to visit

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beneficiaries to understand their thoughts on program options and including them as a sounding board to discuss program options may provide the state with more robust and accurate beneficiary perspective.

Training- and Education-Related Solutions

Strengthen Relationships between Primary Care Providers and Other Service and Support Providers

A significant source of fragmentation in Medicare-Medicaid enrollees' care stems from the lack of interaction between primary care providers (PCPs) and providers of LTSS and behavioral health services. PCPs, especially those who are reimbursed predominantly through Medicare, may not be familiar with a state's LTSS and behavioral health systems or with individual beneficiaries' care managers.

Strengthening ties between Medicare-Medicaid enrollees' PCPs and Medicaid resources can help a PCP provide the most appropriate care in the beneficiary's choice of care setting.

Knowing who on a beneficiary's team can assist in resolving a social, support, or behavioral health issue can help the physician.

At the most basic level, educating PCPs about the home- and community-based services (HCBS) and behavioral health systems will make them more familiar with referral resources that could improve the delivery of care and build an understanding of why an integrated program that serves Medicare-Medicaid enrollees is needed. To strengthen relationships between PCPs and HCBS and behavioral health providers, states can:

- **Analyze Medicare crossover claims data to identify and target PCPs who see high numbers of a state's Medicare-Medicaid enrollees.** A number of these providers may be within the same practice groups or health systems, so states can focus

education efforts to larger groups of PCPs.

- **Talk to practitioners about the Medicare-Medicaid beneficiaries for whom they provide care.** As a first step, find out what the challenges are in serving Medicare-Medicaid enrollees and offer help to resolve those issues. For example, providers may struggle with the no-show rate for appointments, medication adherence, etc. "Listening Sessions" with PCPs could be a way to gather their input.
- **Develop outreach strategies to connect PCPs with HCBS and behavioral health care managers and community resources to ensure that PCPs know who to contact if an LTSS or behavioral health need arises.** Such strategies can build on existing information exchange mechanisms, which may include: care conferences; transfer of care planning tools; or, where the capacity already exists, high-tech approaches such as web-based platforms that allow sharing of electronic assessment and care plan tools.
- **Assign one or two HCBS care managers to each provider practice serving large numbers of Medicare-Medicaid enrollees.** This will make it easier to develop meaningful collaboration between PCPs and the HCBS system. As a first step, ask HCBS recipients at their initial assessment where they receive primary care. Then, use this information to align HCBS care manager caseloads with primary care practices. Once the relationship is well-established, it will be more natural for communication to flow between HCBS care managers and the Medicare-Medicaid enrollees' PCPs to facilitate coordination of medical care and HCBS.
- **Provide PCPs with information on how to manage and where to refer**

beneficiaries with complex social issues. Individuals with mental illness or substance use disorder conditions, homelessness, or lack of informal supports may need referrals to additional social supports in the community such as local departments of social services, aging and disability resource centers, and community behavioral health centers. Addressing these needs may help PCPs to better manage beneficiaries' chronic medical conditions.

Expand Knowledge of LTSS and Behavioral Health Service Providers

Specialized providers play an important role in the care team for Medicare-Medicaid enrollees, but often these providers work in isolation and are not familiar with the other types of services that a Medicare-Medicaid enrollee receives. Helping LTSS and behavioral health providers become familiar with other types of services will help prevent the fragmentation that often exists in care for Medicare-Medicaid enrollees. To build this knowledge, states can:

- **Convene meetings of behavioral health and LTSS care managers to start a dialogue and expand the knowledge and resource base of both groups.** For example, behavioral health providers could educate LTSS care managers on referrals and low-cost behavioral health services such as those provided through Alcoholics Anonymous, Narcotics Anonymous, clubhouses, and peer supports. LTSS providers could educate behavioral health providers on community services such as congregate meals, Meals on Wheels, and Area Agency on Aging resources. Though not all of a care manager's case load will require such services, knowing whom to call and networking with care managers in another discipline will improve the care that Medicare-Medicaid enrollees receive.
- **Offer LTSS and behavioral health providers the opportunity to participate in learning collaboratives on chronic medical conditions.**

Leverage existing resources to help educate non-medical providers about the impact that chronic conditions have on individuals. By working with local associations and advocacy groups (e.g., American Heart Association, Cooperative Extension Agencies [obesity], American Diabetes Association) to conduct trainings at a low cost to the state, states can help strengthen non-medical providers' knowledge of how chronic conditions impact all aspects of an individual's care. For example, training could be provided for aides who prepare meals for beneficiaries with diabetes on the importance of a low-salt diet.

Helping long-term services and supports and behavioral health providers become familiar with other types of services used by Medicare-Medicaid enrollees will help prevent fragmentation of care.

Information-Related Methods

Improve the Flow of Information in Care Transitions

Many Medicare-Medicaid enrollees frequently transition between care settings: from hospitals to LTSS facilities, and into the community. Often, the care coordinator for one set of services (e.g., nursing facility or HCBS care manager) does not have access to information on a beneficiary's status while in a different care setting or, in the case of some HCBS care managers, is even dropped as a provider when a beneficiary remains in the hospital or nursing facility beyond a specified number of days. This results in slower and more complicated transitions. A low-cost, low-burden approach to integrating care is to improve the flow of information during care transitions for Medicare-Medicaid enrollees, to the extent permitted by privacy requirements. Information flow can be improved when states:

- **Require hospitals, nursing facilities, and providers in other care settings to share assessments of medical and social needs not only with the PCP, but also with the other providers on the care team such as a behavioral health or HCBS care manager.** This assessment should also include a current list of prescribed medications. The easiest way to introduce this practice is by adding language to Medicaid provider agreements requiring such

Access to real-time information is one of the most important tools states have for integrating the care of Medicare-Medicaid enrollees.

information to be provided in routine communication, e.g. with discharge paperwork. Over time, as electronic communication systems are built, these specifications can be added.

- **Build in incentives and/or penalties for discharging entities to encourage sharing of information needed to guide care transitions.** A relatively easy way to address this is by adding language to health plan contracts. For example, contract language could require that hospitals notify PCPs about emergency department visits. Contract provisions could also penalize nursing facilities for high levels of avoidable hospital readmissions.
- **Identify and remove any programmatic barriers to care management continuity that cause care managers to lose access to beneficiaries who have been admitted to institutional care.** This is the case in some states when, due to HCBS protocols, a waiver participant receives services in a facility for a duration that exceeds a specified number of days and care managers change as a result. In other states, Medicaid programs may divide responsibility for care management according to setting, limiting the ability of care managers to follow beneficiaries across care settings. Modifying these practices would improve the likelihood that facility-based care can be a stop on the continuum of care, not the final destination.

Obtain Real-Time Access to Information on Hospital and Emergency Room Use

One of the most important tools for integrating care for Medicare-Medicaid enrollees is access to real-time information on inpatient hospital and emergency room use. While states can generally obtain this information on Medicaid-only enrollees, they face substantial obstacles when the services are provided to Medicare-Medicaid enrollees, since Medicare is the primary payer for hospital care. States may be able to use their leverage as a Medicaid payer with

some hospitals to obtain information for Medicare-Medicaid enrollees, but this is likely to involve hospital-by-hospital discussions and negotiations.

States should explore partnering with a hospital or health system “champion” that is willing to provide expertise and staff to design information-sharing arrangements. States will benefit from having input and, ultimately, access to hospital data on at least a portion of their Medicare-Medicaid enrollees. Health systems will benefit from helping to shape the design and transfer of data and reducing readmission rates.

States obtaining real-time information on hospital admissions, discharges, pending discharges, and emergency room visits can share it with enrollees’ PCPs, nursing facility, HCBS, and behavioral health care managers during care transitions. This sharing of information is critical for facilitating continuity of care during a time when enrollees are likely to need extra support from their care providers.

Opportunities in States with Capitated Managed Care Programs

A number of states use health plans to manage and deliver services for Medicaid-only beneficiaries, including individuals whose complex care needs are similar to those of many Medicare-Medicaid enrollees. States can take steps to position themselves to include Medicare-Medicaid enrollees when the opportunity arises. Several of these steps involve strengthening the ties between health plans and the state’s LTSS and behavioral health systems. For example, states can:

- **Continue managed care enrollment for Medicaid-only beneficiaries receiving LTSS, or at least those in HCBS, in health plans for their primary and acute care services.** Some states disenroll Medicaid-only beneficiaries from managed care when they enroll in an HCBS waiver or nursing facility. Instead, for states considering building an integrated care program, allowing beneficiaries to

remain in managed care when they become eligible for LTSS can be a first step. States, however, may initially want to exclude Medicare-Medicaid enrollees from this effort (since their medical services are covered predominantly by Medicare). Even if LTSS are obtained through a fee-for-service carve out, this initial step gets the LTSS population used to managed care and gets health plans familiar with the unique needs of the LTSS population. It can be a useful starting point for those states considering a longer-term migration to capitated financing arrangements.

- **Require meaningful and ongoing contact between behavioral health care managers and health plan care managers.** A number of states provide behavioral health services outside of their health plan contracts through separate behavioral health organizations, fee-for-service, or other arrangements. Requiring health plan care managers to coordinate with behavioral health managers, when indicated and with appropriate permission, can improve health outcomes for beneficiaries. States could include this language in RFPs and contracts for physical health, behavioral health, and LTSS services. Specific examples of this kind of requirement would be for the behavioral health care manager to share information with the

health plan about how the enrollee is taking prescribed medications, or for the behavioral health and health plan care managers to share assessment and goal-setting information about enrollees they have in common.

Conclusion

States are acutely aware of the impact that better integration of care for Medicare-Medicaid enrollees can have on improved care delivery and cost effectiveness. However, many states are not yet in the position to fully integrate care and/or have limited resources to reach this goal.

The low-cost, low-burden strategies described in this brief can help set the stage for the more significant structural changes needed to fully integrate the care of Medicare-Medicaid enrollees. New contracting models, purchasing strategies, and information technology and quality measurement systems will ultimately be needed. By improving the current flow of information and strengthening the relationships between care providers, states can build support and remove barriers as they move toward fuller integration for Medicare-Medicaid enrollees.

Do you have other ideas for low-cost, low-administrative-burden ways for states to integrate care for Medicare-Medicaid enrollees? Email them to integratedcareresourcecenter@cms.hhs.gov.

The use of low-cost, low-burden integration strategies can help set the stage for the more significant structural changes needed to fully integrate the care of Medicare-Medicaid enrollees.