CHCS Center for Health Care Strategies, Inc.

From the Beneficiary Perspective: Core Elements to Guide Integrated Care for Dual Eligibles

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Arguably no beneficiary population experiences a more disjointed, complicated, and inefficient delivery system than adults who are dually eligible for Medicare and Medicaid. From a state's perspective, there has been little incentive to improve care delivery for this population, since Medicare is the primary payer of services. From the federal government's perspective, until recently the Medicare and Medicaid programs were administered in separate silos of CMS and these programs have historically been viewed as distinct and separate programs.

From the beneficiary perspective, however, these programs are one and the same. They provide health insurance and to beneficiaries it does not matter who pays first or which program covers what services. Beneficiaries are concerned with whether they can receive the services they need -- when they need them, from the providers they like, and in the setting of their choice.

Under the leadership of Don Berwick, the Centers for Medicare & Medicaid Services (CMS) has mapped out a new focus for improving the American health care system aimed at achieving three overarching goals:

- Improving care by focusing on safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity.
- Improving health by addressing root causes of poor health, e.g., poor nutrition, physical inactivity, and substance abuse.
- Reducing per-capita costs.

Through the Patient Protection and Affordable Care Act (ACA), states and federal government are poised to make headway in meeting these *Triple Aim* targets for duals. Early innovator states have laid the groundwork upon which interested states can build their programs. Through the support of The Commonwealth Fund, the Center for Health Care Strategies (CHCS) worked with seven states (Colorado, Maryland, Massachusetts, Michigan, Pennsylvania, Texas, and Vermont) in the *Transforming Care for Dual Eligibles*

IN BRIEF

This technical assistance brief was developed to help Medicaid stakeholders and others committed to improving care for dual eligibles design more responsive integrated care models. It draws from the experiences of seven innovator states that participated in the *Transforming Care for Dual Eligibles*, a national initiative that worked with states to develop integrated care programs. The brief:

- Details nine core program design elements that are critical for achieving high-quality, patient-centered, and cost-effective care for dual eligibles; and
- Details how these core elements look from the beneficiary perspective through the experiences of two actual beneficiaries.

States interested in additional information and resources to guide integrated care approaches, should reference the *Integrating Care for Dual Eligibles: An Online Toolkit* at **www.chcs.org**.

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initiative to assist in developing integrated care programs. In its work with these and other states across the country, CHCS identified nine core elements that are essential for effective integrated care programs for dual eligible beneficiaries.

This technical assistance brief details these nine program design elements and illustrates the important impact that they have on the lives of Mrs. F and Mr. M, two dual eligible beneficiaries whose stories came to us from care managers in integrated programs in two states.[1]

Core Elements of Integrated Care Programs

1. Comprehensive assessment to determine needs;
2. Personalized (person-centered) plan of care;
3. Multidisciplinary care team;
4. Family caregiver involvement;
5. Comprehensive provider network;
6. Strong home- and community-based options;
7. Adequate consumer protections;
8. Robust data-sharing and communications system; and
9. Financial incentives aligned with integrated, quality care.

As detailed below, both Mrs. F and Mr. M[2] have multiple chronic physical and behavioral health needs and also face socioeconomic obstacles that hamper their ability to get the health care they need. While their individual stories may be unique, their need for comprehensive, integrated care that addresses their full array of unique complex needs is universal among the dual eligible population.

Meet Two Dual Eligible Beneficiaries

Mr. M is a 75-year-old non-English speaking Somali male who lives alone in a federally subsidized apartment. His daughter and grandchildren live several hours away and are not involved in his care. He does not have any other Somali supports and his other family members still live in Somalia. Due to his health problems including tuberculosis, a bulging vertebral disk, an unsteady gait, and severe post-traumatic stress disorder (PTSD), he is isolated in his apartment and has neither the energy nor the ability to engage in the community without assistance. Mr. M has been enrolled in his states' integrated care program for the past year.

Mrs. F is a 68-year-old female who is strong willed and independent. She has multiple medical problems including a below-the-knee amputation, peripheral vascular disease, coronary artery disease, hypertension, depression, anxiety, a history of alcohol abuse, and memory loss. Mrs. F spent a year in a nursing home following a difficult rehabilitation period after her amputation. She recently transitioned back to the community. Mrs. F enrolled in her states' integrated care program the month before she successfully transitioned back to the community.

[1] These beneficiary stories are based on two actual individuals enrolled in integrated care programs for dual eligibles, but the names and identifying information have been changed.

Core Elements for Effective Integrated Care

Following are core elements essential for effective integrated care approaches for dual eligibles and a glimpse at how these core program design elements can be implemented at the beneficiary level to improve care delivery.

ELEMENT 1: Comprehensive Assessment to Determine Needs

Many states now use a standardized assessment tool to determine beneficiary long-term supports and services (LTSS) requirements. Clearly identifying health and psychosocial needs is an essential first step toward improving care. Most individuals' needs however, do not fall neatly into one service category and often the most pressing need can fluctuate among medical, LTSS, behavioral health, and social requirements.

> *Mr. M's integrated assessment identified his need for pain management and LTSS such as gait-training, durable medical equipment, and environmental modifications to prevent falls. It also identified his need for significant support in managing his PTSD and for social supports due to the lack of community members able to speak Somali. Using a standardized assessment tool to evaluate all aspects of an individual's health and living situation can help ensure that the resulting plan of care is designed to support the individual's entire scope of needs.*

ELEMENT 2: Personalized (Person-Centered) Plan of Care

Care managers do their best to manage large caseloads and the often significant needs of the individuals they support. Due to the constraints of time or limited tools, care managers sometimes do not put the individual's unique strengths, challenges, and goals at the center of the plan of care.

> *Mrs. F is fiercely independent. After residing in a nursing facility for over a year, she wanted to leave for a more independent setting. After one month of working with her integrated health plan's care manager, the care manager identified Mrs. F's independence as a key strength. The care coordinator supported Mrs. F's efforts to identify an apartment on her own that she wanted to live in and supported Mrs. F in arranging her services for discharge. The care coordinator not only helped to arrange services for Mrs. F, but she also helped her regain the confidence that she needed to live independently in the community again.*

ELEMENT 3: Multidisciplinary Care Teams That Put the Beneficiary at the Center

Dual eligible beneficiaries often need services and supports from a wide range of providers. An individual's needs shift over time and what is a pressing need one month may not be a priority the next month. Integrated care programs with strong multidisciplinary care teams, facilitated by the care coordinator, can support the often-changing needs of beneficiaries.

> *For Mr. M, his struggle with PTSD is his primary issue, so a behavioral health provider must be part of his care team. However, Mr. M also needs assistance with medication management, pain management, and activities of daily living, as well as significant social supports since he does not speak English and often feels isolated from the community. Mr. M benefits from his care team made up of a range of providers including his care coordinator and behavioral health provider, but also a physician, social worker, nurse, and personal care provider. Mr. M's care team also includes a community-based educator who is familiar with Somali culture to ensure that his care plan is culturally-appropriate. Facilitating communication among these providers significantly improves the quality of care that Mr. M receives.*

ELEMENT 4: Involvement of the Family Caregiver

The importance of the family or community caregiver's role cannot be underestimated. Indeed, Medicaid home- and community-based services programs are often reluctant to support a beneficiary in a home-based setting without adequate family or community supports and a back-up plan for when hired providers are unavailable due to an emergency or inclement weather. While the beneficiary's goals and needs are at the center of the plan of care, the family or community caregiver's skills, abilities, and comfort with involvement must also be factored into plan development.

> *Mrs. F's only son was initially not supportive of her move from the nursing facility to the community. The two had been estranged and he was reluctant to aid in caring for his mother. The integrated plan's care coordinator worked with the son to define roles and boundaries for his involvement with his mother's care. The son's role in Mrs. F's life continues to be limited; however, he assisted her with her move and helped her settle into her apartment. Even this amount of time-limited support was extremely beneficial to Mrs. F.*

ELEMENT 5: Comprehensive Provider Networks, including a Strong Primary Care Base

Adequate provider networks are a hallmark of a successful integrated care program. Inclusion of a strong primary care base provides the central point from which all other medical services can be arranged.

> *When Mrs. F moved back to the community, she needed a wide range of medical providers to continue her physical rehabilitation and provide skilled nursing care for the wound from her amputation. By working with the primary care physician, the integrated care plan's care coordinator set up visits from RNs, occupational therapists, and physical therapists, and arranged for durable medical equipment. These medical services and supports enable Mrs. F to live safely in the community again. Not long after Mrs. F's transition to the community, the care coordinator noticed that Mrs. F's wound looked infected and she immediately scheduled an appointment with an orthopedist. Mrs. F required further surgery, but thanks to the strong provider network and in-person visits from the care coordinator, the infection cleared and Mrs. F recovered. Early detection of problems enabled Mrs. F to avoid further complications that would have invariably resulted from an untreated and serious infection.*

ELEMENT 6: Strong Home- and Community-Based Service Options, including Personal Care Services

Comprehensive home- and community-based services enable individuals to live safely in the setting of their choice and engage in the community to the greatest extent possible. Such services are also a cost-effective way to help people maintain their independence, potentially prevent a decline in health status, and avoid nursing home stays. They also help prevent more costly medical services. Most strong integrated care programs allow individuals to self-direct their personal care services. This enables individuals to hire the personal care attendant of their choice, such as a neighbor or in some states, a family member.

> *Mr. M struggles with severe PTSD. He is hampered by an overwhelming fear that limits his ability to go out alone in the community and causes him to hear voices, have hallucinations, and have difficulty sleeping. Mr. M also has a history of falling at night due to confusion and an unsteady gait resulting from war wounds sustained in Somalia. Before Mr. M enrolled in his state's integrated care program, his normal remedy for confusion during the night was to call 911 and obtain costly emergency services. Upon enrolling in the integrated care program, Mr. M's care manager had a Lifeline system set up in his apartment. Now when Mr. M wakes up frightened or confused, he uses his Lifeline system. The Lifeline contractor contacts a Somali-speaking support person or his personal care attendant to come assist him. The care coordinator ensures that the Lifeline referral information is kept up to date.*

ELEMENT 7: Adequate Consumer Protections

One of the biggest concerns that advocates and individuals often have about integrated care programs is whether there will be adequate protections for enrollees. These protections include an appropriate, easy-to-navigate, and responsive grievance and appeals process; marketing protections and guidelines to keep individuals from being pressured into certain plans; and a strong and respected voice in decisions about care and support services.

> *Fortunately neither Mrs. F nor Mr. M has had to access the grievance and appeals process for their health plan – but if they ever need it, both Medicare and Medicaid require that plans allow individuals to appeal to both sides of the program at the same time. Mrs. F lives in a state where the community health and human services offices provide counseling to individuals regarding their health plan selection. The state designed this enrollment process so beneficiaries would not be confronted with high-pressure sales representatives. Most importantly, both Mrs. F and Mr. M benefit from care coordinators who listen to their needs and regularly update their plans of care. Attentive care coordinators can help solve problems early so that issues do not escalate to the point of a complaint.*

ELEMENT 8: Robust Data-Sharing and Communications System

Successful integrated care programs have robust communication systems and readily share data across providers. Effective programs utilize care coordinators and frequently employ other staff members who monitor this data and determine what information should be shared with which providers. Without a strong communication system, it is easy for providers to lose track of beneficiaries and for costly tests to be repeated because the results are not accessible. Ideally, patient information systems are web-based, linked to providers' electronic health records, and accessible by enrollees.

> *Mr. M benefits from his health plans' strong focus on cross-provider communications. His care manager ensures that his needs are being met by working closely with his personal care attendant. She communicates regularly with his primary care physician and mental health provider so that they are aware of the assistance he is receiving and to ensure the appropriateness of the ongoing personal care attendant hours. The care manager speaks directly with the primary care physician and mental health provider to ensure that they have a clear understanding of Mr. M's needs, any current medical complaints, and the possible need for additional services.*

ELEMENT 9: Aligned Financial Incentives

Having a single entity accountable for the broad spectrum of services required by dual eligibles is the most straightforward way of ensuring that financial incentives are properly aligned. Thus, integrated health plans are incentivized to make upfront investments to ensure the safety of an individual's home and to pay for other LTSS such as personal care attendants, so that events such as painful and costly falls and trips to the emergency room are avoided.

> *Mrs. F receives regular visits from a care coordinator and a nurse. Although these regular visits require a financial outlay by the plan, the care coordinator and nurse successfully improved Mrs. F's wound care regimen, helped her avoid a repeat infection, and supported her in living independently in an apartment for close to three years. Also, because the monthly reimbursement rate changes with utilization history of the beneficiary, once Mrs. F had avoided nursing facility care for over a year, the integrated health plan changed her rate cell. The state now pays a lower monthly capitation rate for Mrs. F. The state benefits from paying a lower rate and the health plan benefits from decreased utilization of expensive facility care. Most importantly, Mrs. F benefits from the high quality of care that she receives.*

Conclusion

Integrated care programs provide dual eligible beneficiaries with the right services, at the right time, in the setting of their choice. They can also thoroughly take into account the individual's strengths and the goals that he or she wants to achieve. A robust care coordination process, aligned financial incentives, strong consumer protections, and an active data sharing process are critical elements in a program that seeks to improve care for the dually eligible population. Individuals who reside in states with strong integrated care programs greatly benefit from coordinated care. Integrated care systems provide the array of services needed to optimally serve this high-need and often vulnerable population. Mrs. F and Mr. M continue to face new challenges, but through the support of their care coordinators and their entire care teams they still reside independently and continue to make strides toward living happier and healthier lives.

Transforming Care for Dual Eligibles – Resources at www.chcs.org

Under *Transforming Care for Dual Eligibles*, the Center for Health Care Strategies (CHCS) is working with seven states -- **Colorado, Maryland, Massachusetts, Michigan, Pennsylvania, Texas,** and **Vermont** -- to develop and implement innovative strategies for integrating care. This national initiative, made possible by The Commonwealth Fund, is seeking to develop a range of integrated delivery models for dual eligibles that can be implemented by other states across the country. Participating states are receiving in-depth technical assistance covering program design, care models, financing mechanisms and contracting strategies and CHCS is also facilitating linkages with the Centers for Medicare & Medicaid Services to identify new avenues for Medicare-Medicaid integration.

To learn about CHCS' *Transforming Care for Dual Eligibles* initiative or to download related resources, including policy briefs, hands-on tools, and templates to help guide state integration efforts, access *Integrating Care for Dual Eligibles: An Online Toolkit* at **www.chcs.org**.

About the Center for Health Care Strategies

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care. CHCS works with state and federal agencies, health plans, and providers to develop innovative programs that better serve Medicaid beneficiaries with complex and high-cost health care needs.