REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-N-21

Subject: Integrating Care for Individuals Dually Eligible for Medicare and Medicaid

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Referred to: Reference Committee A

Council on Medical Service Report 5-Nov-20, Medicaid Reform, addressed the Medicaid program generally without specifically addressing coverage and payment for care of individuals dually eligible for Medicare and Medicaid. Delivery of care and financing reform for the dual eligible population was the topic of Council on Medical Service Report 5-A-13, when several state demonstrations designed to better integrate care were just getting started. Evidence from a variety of integrated models tested over the intervening years is now available to inform new American Medical Association (AMA) policy on integrated benefits for this predominantly low-income, medically complex population. Although many dually eligible individuals live with some combination of chronic conditions, mental illness, substance use disorder, and cognitive and/or physical disabilities, this is an extremely heterogeneous group. Because they tend to be high-need, high-cost enrollees, state and federal policymakers continuously search for ways to increase care quality while saving Medicare and Medicaid dollars. For example, recent policy discussions have focused on how to enroll more dually eligible individuals into integrated plans, especially Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs).

The incidence of long COVID-19, considered a disabling condition under the Americans with Disabilities Act when it substantially limits major life activities, may increase the number of dually eligible enrollees—a group already disproportionately impacted by the pandemic—and highlight the need for improved health outcomes. Integrated care refers to delivery system and financing approaches that coordinate and integrate covered services and supports for dually eligible individuals. In theory, integrated plans should have a high potential for reducing costs and improving care; in reality, achieving integration has been difficult due in part to the complex and diverse needs among dually eligible people and the involvement of siloed government health programs that were not designed to work together. This report, initiated by the Council, provides an overview of existing integrated models, summarizes relevant AMA policy, and recommends new AMA policy outlining criteria essential to successful integrated care.

BACKGROUND

The number of individuals dually eligible for Medicare and Medicaid has risen steadily in recent years to almost 12.3 million people.[1] In comparison to Medicare-only enrollees, dually eligible patients have more complex and chronic health needs and are more likely to experience inequities in social determinants of health that contribute to chronic disease.[2] Nearly half of dually eligible enrollees are people of color; dually eligible individuals are also more likely to be female, have functional and activities of daily living limitations, and report being in poorer health.[3] According to preliminary Medicare COVID-19 data from the Centers for Medicare & Medicaid Services (CMS), dually eligible individuals were more than twice as likely to be infected with COVID-19, and more than three times as likely to be hospitalized by the virus, than Medicare-only

patients.[4] Sixty-one percent of dually eligible individuals are age 65 and over, and 40 percent utilize Medicaid long-term services and supports (LTSS) ranging from nursing home care to home and community-based supports.[5] Over 40 percent have at least one mental health diagnosis, and just over half become dually eligible for Medicare-Medicaid because of disability.[6]

Although dually eligible individuals often face barriers to accessing primary and preventive care, this population utilizes more covered services,[7] including services in emergency departments.[8] Accordingly, dually eligible patients are disproportionately more costly to Medicare and Medicaid than traditional enrollees.[9] Although dually eligible individuals make up 20 percent of Medicare enrollees and 15 percent of Medicaid enrollees, they account for 34 percent of Medicare spending and 32 percent of Medicaid spending.[10]

Because Medicare and Medicaid are complex programs, each with distinct goals and coverage and payment rules, care for dually eligible individuals can be fragmented, poorly coordinated and difficult for patients to navigate. Cost-shifting persists across Medicare and Medicaid, and one program may be less likely to implement policy or program changes that result in savings to the other. Many stakeholders have noted that the disconnect between Medicare and Medicaid complicates care coordination and increases inefficiencies as well as administrative burdens among patients, physicians, and other providers.[11] Suboptimal care coordination may in turn compromise patient care and increase program spending.

Medicare benefits for this population include primary care, preventive care, inpatient and outpatient acute care, post-acute skilled nursing (SNF) care, and prescription drug coverage. Medicare is the primary payer while Medicaid may cover a range of services not covered by Medicare, including—depending on the state—LTSS, some behavioral health benefits, and transportation. Medicaid coverage varies by state and between partial-benefit and full-benefit dually eligible enrollees, with full-benefit enrollees—who make up over 70 percent of the dual eligible population—eligible for all services that are covered by Medicaid in their state. Partial-benefit enrollees receive Medicaid assistance with Medicare premiums and, in some cases, Medicare cost-sharing, but are not eligible for other Medicaid benefits. State and federal efforts to integrate benefits focus predominantly on full-benefit dual eligible enrollees.

INTEGRATED CARE MODELS

Many stakeholders have maintained that managed care plans offering both Medicare and Medicaid services would improve quality and reduce spending for dually eligible individuals, and several integrated models were developed over the last decade. Early integrated care plans in Massachusetts, Minnesota, and Wisconsin were identified as promising in that they reduced enrollee use of hospital services and, importantly, redirected some LTSS use from nursing facilities to home and community-based care.[12] The most prominent integrated care plans include models tested through CMS demonstrations, D-SNPs, and the Program of All-Inclusive Care for the Elderly (PACE).

Financial Alignment Initiative: CMS has long cited financial misalignment between Medicare and Medicaid as a barrier to coordinating care for dually eligible enrollees, and it tests models with states using waivers. Financial Alignment Initiative (FAI) demonstrations are designed to better align financing and integrate primary, acute, behavioral health and LTSS for Medicare-Medicaid enrollees. FAI, which began in 2013, offers options to states for integrating care, including a capitated model that establishes Medicare-Medicaid Plans (MMP), a managed fee-for-service model, and a state option to create an alternative model. Nine of the 11 states that currently participate have chosen the capitated MMP model, in which CMS, a state, and a health plan enter a

contract under which CMS and the state pay each health plan a prospective capitated monthly payment. States are permitted under the FAI to increase participation in MMPs using passive enrollment, which automatically enrolls dually eligible individuals in an MMP with the ability to opt out. Enrollment in MMPs has been lower than expected, although participation rates vary across participating states. Notably, a significant number of dually eligible people who have been passively enrolled in an MMP have subsequently opted out. Although evaluations have shown this model to be associated with decreased emergency department use and hospitalizations, other impacts—for example, on Medicare spending and savings—have been mixed and varied across participating states.[13]

Under FAI's managed fee-for-service (FFS) model, care is provided through FFS with assigned care coordinators to help enrollees obtain needed care. The state of Washington is implementing the FFS model and has experienced good enrollment numbers. Washington uses Medicaid health homes with a care coordinator and multidisciplinary team serving dually eligible enrollees. Evaluations of this model have shown decreased inpatient and SNF admissions and long-stay nursing facility use as well as major reductions in Medicare spending (which the state was able to share).

Dual-Eligible Special Needs Plans: D-SNPs were introduced in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and made permanent under the Bipartisan Budget Act of 2018. D-SNPs are available in 44 states and are required to contract with the Medicaid agency in each state in which they operate. "MIPPA" contracts, named for the Medicare Improvements for Patients and Providers Act under which they are authorized, are used by states to increase the level of integration. For example, states can use MIPPA contracts to require D-SNPs to align with managed LTSS (where such managed programs are available) so that dually eligible individuals are able to access Medicare and Medicaid services (including LTSS) through the same entity. States can similarly require D-SNP contractors to ensure coordination of behavioral health and/or other Medicaid services, and to share Medicare data with the state.

Predominant D-SNP integrated models fall into two categories: those that require aligned Medicaid managed LTSS; and fully integrated D-SNPs, which provide Medicare and Medicaid benefits, consistent with state policy. Research has found D-SNPs to be associated with reduced hospitalizations and readmissions; however, results have been mixed with regard to emergency department use and LTSS services.[14] There has been some evidence of decreased Medicare spending among D-SNPs, and many stakeholders find D-SNPs promising because they are widely available and have enrolled over three million dually eligible people.[15]

PACE: PACE provides comprehensive, interdisciplinary medical and social services to certain frail people over age 55, enabling them to remain at home instead of in a nursing home. PACE is the most integrated model but only serves about one percent of dually eligible individuals across 31 states. The program has been associated with reduced inpatient hospital use but the impact on nursing facility use and Medicaid spending has been mixed.

Only about one in ten dually eligible individuals is enrolled in integrated care models despite considerable work over the years. Although D-SNPs have enrolled over three million people, PACE and FAI—both highly integrated—have enrolled 55,000 and 395,000 enrollees, respectively.[16] Most dually eligible enrollees (more than 70 percent) are in fee-for-service plans and, among those with Medicare Advantage plans, one quarter are in non-integrated plans.[17] Low enrollment numbers have been attributed to the lack of program availability in some areas and high rates of disenrollment from certain programs.[18] Resource constraints and competing priorities in states may also limit the availability of integrated programs.

ELEMENTS OF SUCCESSFUL INTEGRATED CARE MODELS

At least 43 combinations of Medicare and Medicaid coverage are available nationwide, giving many dually eligible enrollees several plan options from which to choose.[19] D-SNP, MMP and PACE are targeted towards dually eligible individuals; additionally, some qualify for institutional special needs (I-SNP) plans, which are MA plans limited to patients with institutional-level care needs. While the literature has highlighted data challenges, including the lack of available Medicaid data, individuals enrolled in integrated programs have reported satisfaction with reduced cost-sharing and improved access to medical, behavioral health and other services.[20]

Each of the integrated models has different strengths and limitations in terms of level of integration, availability across states, enrollee experience, capacity to scale, and cost savings. A literature review of integrated models by Health Management Associates highlighted the following factors that contribute to improved programming for dually eligible individuals:

- Individual consumer engagement in program design, communications, implementation and ongoing program oversight;
- Provider engagement and robust networks;
- Care coordination and risk stratification;
- Strong state and federal government collaboration;
- Adequate state capacity; and
- Performance and outcome measures tailored to the population.[21]

Stakeholder interviews with patients, physicians, advocates, health plans, and state officials informed a second Health Management Associates brief that identified essential program elements needed for plans to successfully support dually eligible individuals. As stated in the report, the ten essential elements are:

1. Simplified Medicare and Medicaid eligibility processes and paperwork;
2. Comprehensive and expert consumer choice counseling and/or enrollment assistance;
3. Diverse consumer engagement to inform tailored delivery systems and integrated programs;
4. Robust data infrastructure to tailor and adapt program approaches and drive health equity;
5. Coordinated efforts to maximize capabilities to address unmet social needs;
6. Single process for assessments and plans of care, and one care team for each consumer;
7. Meaningful and transparent quality measurement to empower consumers and stakeholders;
8. Payment models to incentivize consumer quality of life improvements;
9. Adequate, engaged, and diverse workforce to support consumer needs; and
10. Access to needed services in rural areas.[22]

Of note, states are at various junctures of integrating care for dually eligible individuals. Some states, including Arizona, Idaho, and Tennessee, have made greater use of MIPPA authority and are providing fully integrated care. On the other hand, no integrated care options are available in North Dakota and Wyoming.[23] States may also employ multiple strategies to integrate care, as Ohio does by implementing both PACE and FAI.

Viable enhancements to integrated care plans are regularly discussed by the Medicaid and CHIP Payment and Access Commission and the Medicare Payment Advisory Commission. At least one proposal, from the Dual Eligible Coalition and Leavitt Partners, envisions consolidation of care

under a new program—Title 22—that combines Medicare, Medicaid, and state funding into a fully integrated program specifically for dually eligible individuals.[24]

RELEVANT AMA POLICY

Policy H-290.967, established by Council Report 5-A-13, includes the following principles on the delivery of care and financing reform for Medicare and Medicaid dually eligible patients: (1) various approaches to integrated delivery of care should be promoted under demonstrations; (2) customized benefits and services from health plans are necessary according to each beneficiary's specific medical needs; (3) care coordination demonstrations should not interfere with established patient-physician relationships; delivery and payment reform for dually eligible beneficiaries should involve practicing physicians and take into consideration the diverse patient population and local area resources; (4) states with approved financial alignment demonstration models should provide education and counseling to beneficiaries on options for receiving Medicare and Medicaid benefits; (5) conflicting payment rules between the Medicare and Medicaid programs should be eliminated; (6) Medicare and Medicaid benefit plans and the delivery of benefits should be coordinated; and (7) care plans for beneficiaries should be streamlined among all clinicians and social service agencies.

Addressing Medicare-Medicaid dual eligible demonstration programs, Policy D-290.980 advocates that established patient-provider relationships and current treatment plans will not be disrupted; dually eligible individuals should not be automatically enrolled without their approval or consent; any savings from coordination of care to dually eligible individuals should arise from better health outcomes and efficiencies gained; and demonstrations should not be employed as a policy lever to reduce provider payment rates. Policy H-290.984 strongly opposes mandatory enrollment of Medicare and/or Medicaid patients in managed care plans. Similarly, Policy D-290.978 calls on CMS to require states to develop processes to facilitate opting out of managed care programs by dual-eligible individuals. Policies D-290.998 and H-290.978 advocate that states pay Medicare deductibles and cost-sharing for dual-eligible patients.

The AMA advocates for the same policies for Medicaid managed care that are advocated for private managed care plans, as well as criteria for federal and state oversight of Medicaid managed care plans that are delineated in Policy H-290.985. Network adequacy elements for public and private health plans are outlined in Policy H-285.908. Policy H-285.973 (1) advocates that all managed care plans be required to provide appropriate access, when geographically available, to representatives of all medical and surgical specialties and subspecialties; and (2) advocates that health plans not restrict appropriate referrals to medical and surgical subspecialists, including those specialties that are age group specific.

Policy H-280.945 supports (1) incentivizing states to expand the availability of and access to home and community-based services; and (2) better integration of health and social services and supports, including the PACE program. Policy H-165.822 (1) encourages new and continued partnerships to address non-medical, yet critical health needs and the underlying social determinants of health; (2) supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs; and (3) encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health. Policy H-180.944 states that "health equity," defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

DISCUSSION

Because dually eligible individuals are typically medically complex and in need of a wide range of services and supports, they are among the highest need and highest cost enrollees within Medicare and Medicaid.[25] Integrated care plans are promising models for providing care that addresses the medical, behavioral, long-term care and social needs of this diverse patient population. In its review of the literature, the Council found that new models as well as enhancements to existing models have the potential to improve care quality and life quality for dually eligible people, but that success often depends on state capacity and resources available to implement integrated care. Managing the costs of care for dually eligible people is particularly challenging because nearly half of enrollees require LTSS, including those who receive institutional-level care. The Council highlights its recent work on LTSS, including Council on Medical Service Report 5-A-18, Financing LTSS, which established AMA policy (Policy H-280.945) supportive of incentivizing states to expand the availability of and access to home and community-based services. Council on Medical Service Report 4, presented at this meeting, recommends new AMA supporting streamlined funding for home and community-based services.

The Council supports ongoing study and refinement by CMS and states and hopes that increased collaboration and learning will help expand best practices. Accordingly, in lieu of supporting any specific model, the Council recommends support for integrated care that aligns with AMA policy and meets additional criteria that are critical to ensuring an integrated model's success.

The Council further recommends reaffirmation of Policy H-290.967, which establishes principles on care delivery and financing reform for dually eligible patients; Policy D-290.978, which calls on CMS to require all states to develop processes to facilitate opting out of managed care programs by dual eligible individuals; and Policy H-165.822 on health plan initiatives addressing social determinants of health. Finally, the Council recommends reaffirmation of Policy H-180.944, which defines health equity as optimal health for all and promotes equity in care. In comparison to Medicare enrollees, a greater share of dual eligible individuals are people of color, women, and people with disabilities. Advances in health equity and reducing disparities in health and health access must be considered by integrated care models if they are to improve care quality, life quality, and health outcomes over the long term.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) support integrated care for individuals dually eligible for Medicare and Medicaid that aligns with AMA policy and meets the following criteria:

    a. Care is grounded in the diversity of dually eligible enrollees and services are tailored to individuals' needs and preferences.
    b. Coverage of medical, behavioral health, and long-term services and supports is aligned.
    c. Medicare and Medicaid eligibility and enrollment processes are simplified, with enrollment assistance made available as needed.
    d. Enrollee choice of plan and physician is honored, allowing existing patient-physician relationships to be maintained.
    e. Services are easy to navigate and access, including in rural areas.

f. Care coordination is prioritized, with quality case management available as appropriate.
g. Barriers to access, including inadequate networks of physicians and other providers and prior authorizations, are minimized.
h. Administrative burdens on patients, physicians and other providers are minimized.
i. Educational materials are easy to read and emphasize that the ability and power to opt in or out of integrated care resides solely with the patient.
j. Physician participation in Medicare or Medicaid is not mandated nor are eligible physicians denied participation. (New HOD Policy)

2. That our AMA reaffirm Policy H-290.967, which establishes principles on the delivery of care and financing reform for Medicare and Medicaid dually eligible patients. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-290.978, which calls on the Centers for Medicare & Medicaid Services to require all states to develop processes to facilitate opting out of managed care programs by dual eligible individuals. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-165.822, which encourages new and continued partnerships to address non-medical health needs and the underlying social determinants of health; supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs; and encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-180.944, which states that health equity, defined as optimal health for all, is a goal toward which our AMA will work by advocating for health services, research and data collection; promoting equity in care; increasing health workforce diversity; influencing social determinants of health; and voicing and modeling commitment to health equity. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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