Analysis of Care Coordination Requirements in Integrated Care Models

Medicaid and CHIP Payment and Access Commission

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Overview

- Integrated care models for dually eligible beneficiaries
- Care coordination
- Results of research conducted by Health Management Associates (HMA)
- Questions for further discussion
Integrated Care Models

• Aim to improve care for beneficiaries and reduce costs
• States may pursue one or more of the following:
  – Financial Alignment Initiative
  – Managed long-term services and supports (MLTSS) programs aligned with Medicare Advantage dual eligible special needs plans (D-SNPs)
  – Fully integrated dual eligible special needs plans (FIDE-SNPs)
  – Program of All-Inclusive Care for the Elderly (PACE)
  – Managed fee for service
Care Coordination

• Given that many dually eligible beneficiaries have complex medical needs, care management is an important part of integrated care models
  – Managing care transitions
  – Coordinating Medicare and Medicaid benefits
  – Reducing poor outcomes such as avoidable hospitalization
  – Connecting beneficiaries to services to address social determinants of health (SDOH)
State Standards for Integrated Care Models

• States include standards for care coordination in contracts with managed care organizations (MCOs)
• Past research has examined care coordination standards in FAI, FIDE-SNP, and MLTSS contracts
• Given that states’ focus on aligning D-SNPs with MLTSS programs is more recent, there is less information on those contracts
Purpose and Methodology

• To understand care coordination requirements for models operated by MCOs
  – FAI demonstrations
  – MLTSS aligned with D-SNPs
  – FIDE-SNPs

• Activities:
  – Catalog contract requirements
  – Summarize stakeholder experiences
  – Highlight emerging state practices for and challenges to care coordination
  – Identify differences and similarities across integrated models
## Contracts Reviewed

<table>
<thead>
<tr>
<th>Integrated care model</th>
<th>State contracts reviewed</th>
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<tbody>
<tr>
<td>Financial Alignment Initiative (FAI)</td>
<td>California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, Tennessee, Texas, and Virginia</td>
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<tr>
<td>Managed long-term services and supports (MLTSS) aligned with dual eligible special needs plans (D-SNPs)</td>
<td>Arizona, Florida, Hawaii, Tennessee, Texas, and Virginia</td>
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<tr>
<td>Fully integrated dual eligible special needs plans (FIDE-SNPs)</td>
<td>Arizona, California, Florida, Idaho, Massachusetts, Minnesota, New Jersey, New York, Tennessee, and Wisconsin</td>
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**Notes:** New York has two capitated FAI demonstrations. Separate MLTSS and D-SNP contracts were reviewed for Arizona, Florida, Tennessee, Texas, and Virginia, for a total of 11 contracts for that model. Hawaii’s contract combined both MLTSS and D-SNP provisions.
Contract Elements Reviewed

- Qualifications and training of care coordinators
- Care coordinator caseload ratios
- Involvement of caregivers
- Use of subcontractors and functions
- Health risk assessments (HRAs)
- Individualized care plans
- Interdisciplinary care teams
- SDOH
- Management of care transitions
- Data and information systems
- Stakeholder engagement
Key Findings from Contract Review

- Some states have more detailed contract coordination requirements in both D-SNP and MLTSS contracts
- Most contracts require care coordinator involvement in care transitions
- Contracts often include requirements for information technology, data sharing, and reporting
- Contracts do not typically specify requirements for care coordinator training
Key Findings from Contract Review, Continued

- Most HRAs in MLTSS+D-SNP programs are not specifically tailored to dually eligible beneficiaries
- A number of FIDE-SNP contracts require using an integrated Medicare and Medicaid HRA
- Many contracts refer to the inclusion of family and other caregivers
- Contracts vary in their specificity regarding how to incorporate SDOH in care planning
Stakeholder Interviews

- Centers for Medicare & Medicaid Services
- Medicaid officials from two states (Tennessee and Virginia)
- Three health plan associations, with total participation of seven plans
- Two medical directors from integrated managed care organizations
- Two consumer advocacy organizations
- Two representatives from home and community-based services (HCBS) provider organizations
Key Themes from Stakeholder Interviews

- Importance of locating and engaging beneficiaries
- Focus on management of care transitions in all integrated care models
- Plans prefer more flexibility in contract standards
- Technology solutions have potential to support care coordination in real time
- Incorporation of SDOH in care planning is evolving
Key Themes from Stakeholder Interviews: Challenges

- Difficulty engaging primary care providers
- Challenges coordinating across MLTSS and D-SNPs
- Strained nursing facility and care coordinator relationships
- Concern among consumer advocates about level of collaboration
- HCBS providers feel underutilized
Questions for Further Consideration

• What is the right balance between contract prescriptiveness and giving plans flexibility to innovate?
• How will care coordination practices continue to evolve?
• How can we overcome challenges in assessing care coordination approaches?