

Medicare-Medicaid Integration

Problem: A significant share of health care spending is driven by a relatively small group of people with significant needs. This is particularly true for a subset of the population that are simultaneously enrolled in Medicare and Medicaid, the “dual-eligible” population. The federal government spends an outsized share of their Medicare and Medicaid budgets caring for this population, yet these people are more likely to live in nursing homes, be hospitalized, and visit emergency rooms.

Solution: Congress and the administration should build upon models that integrate Medicare and Medicaid and support states with establishing these models to achieve better outcomes for people who are dually eligible.

1

Improve Integrated Models.

Any integrated models should be comprehensive in terms of benefits, align financial incentives, and ensure the Medicare and Medicaid programs feel like one integrated delivery system to people who enroll. People and their needs should be at the heart of an integrated model—a care coordinator is needed within the model to help develop and maintain a care plan.

2

Support Education and Enrollment.

The landscape of coverage choices available to people who are dually eligible should not be overwhelming as is often the case today. Investments should be made into education. The enrollment process should be streamlined to ensure people know about and can easily enroll in the best coverage option for them.

3

Incentivize better care and lower spending.

Too often care is delivered in last resort, expensive settings, like nursing homes. Integrated models can shift this dynamic and keep people in the community, which has the potential to improve an enrollee's experience and reduce spending.

INTEGRATE MEDICARE AND MEDICAID

Ensure that every dually eligible person has access to a meaningfully integrated coverage option.

Integrated models should be a coverage option made available to all people who are dually eligible no matter where they live. States are primarily responsible for implementing these models today, and therefore should be required to implement an integrated model that is comprehensive in terms of benefits, aligns financial incentives, and ensures the Medicare and Medicaid programs feel like one to people who enroll in the model.

Leverage existing vehicles to integrate.

Almost every state has at least one D-SNP operating which can serve as a vehicle to integrate Medicare and Medicaid. Given this, states should be permitted to use the D-SNP as the integrated model so long as it meets the new definition of an integrated model.

Limit benefit carve-outs.

State long-term services and supports and behavioral health benefits are often “carved out” and delivered separately from other Medicaid benefits for the dual-eligible population. Integrated models should provide the dual-eligible population with whole person care by ensuring that they do not have to go through multiple, uncoordinated programs to access the services they need.

Align financial incentives.

Medicare and Medicaid payments that finance care for people who are dually eligible are often established separately from each other, which can lead to higher spending. Instead, payments should be set jointly, and the programs should separately pay the integrated model for their respective portion for each enrollee. Incentives, penalties, and financial transparency measures like medical loss ratio requirements then should be applied to the total payment amount. Lastly, the total payment amount should be budget neutral and, at a minimum, in parity with any other coverage option the integrated model must compete with for enrollees, like Medicare Advantage, to ensure that the integrated model can be competitive.

SUPPORT ENROLLMENT INTO INTEGRATED COVERAGE

Provide enrollment education.

Resources should be available to assist people who are dual-eligible with making decisions about their coverage, including easily accessible places online where people can understand their coverage options and neutral guides (i.e., someone who does not represent a managed care plan) to discuss their options. These materials need to be available in an accessible and culturally informed manner.

Implement automatic enrollment.

The default coverage option for people dually eligible should be an integrated model aligned with their existing provider relationships. However, people must be able to opt out of the integrated model and select fee-for-service coverage at a minimum and be adequately informed of the automatic enrollment such that remaining enrolled in the integrated model reflects a choice.

Limit detractors of enrollment.

People who are dually eligible face an overwhelming amount of coverage choices. The number of integrated models available to a person that is dually eligible should be limited. States should also eliminate all plans that are specifically targeted to people who are dually eligible if they are not operating an integrated model. For example, D-SNPs and Medicaid managed care should not be permitted to serve the full-benefit dual-eligible population absent providing a truly integrated delivery system. Lastly, non-integrated coverage options, like general Medicare Advantage plans, should be limited in their ability to provide coverage to people who are dual-eligible or, at a minimum, there should be no financial incentive to enroll this population, as is the case today.

INCENTIVIZE BETTER CARE AND LOWER SPENDING**Provide robust care coordination.**

People who enroll in the integrated model should have a risk assessment completed and a care coordinator assigned. The care coordinator should advocate for people assigned to them and help with the creation and maintenance of a care plan and goals approved by the enrollee. The advocate needs to support the enrollee in meeting the goals established in the care plan and needs to aid at important points of transition, for example post-hospitalization.

Ensure financial, quality, and data transparency and accuracy.

Integrated models should be required to provide information about the services provided to their enrollees, the providers in their networks, and their use of the dollars they receive. States should be required to examine outcomes associated with each individual integrated model alongside how their integrated model program is serving the dually eligible population overall.

Create a path for complaints.

People who are dually eligible need somewhere to turn if they experience challenges accessing coverage or care. Each state should have an ombudsman program that can provide support that spans Medicare, Medicaid, and integrated models for people who are dual-eligible. Complaints gathered from the ombudsman program should be monitored for trends and program improvement opportunities.

Establish effective oversight alongside stakeholders.

States should be required to implement an advisory board that is reflective of their dual-eligible population and other stakeholders, as relevant, to provide input on the design of the state's approach to Medicare and Medicaid coordination, and then ongoing monitoring of such approach.

Incentivize community-based care.

A goal of the program should be to keep as many people living in the community as possible, consistent with their wishes. Incentives to encourage this goal should be built into the budget neutral payment amount, measurement, and benefit design flexibility.

Address disparities.

Black and Hispanic enrollees are disproportionately represented in the dual-eligible population. Payment and measurement must address racial and ethnic disparities in access, experience, and outcomes and encourage providers and any at-risk entities to make progress towards addressing those gaps.