

Vision for an Integrated System
MAY 2017

As health plans, we have been successful in helping individuals with functional needs and their families attain their goals through obtaining and managing the assistance they need. Our programs contribute to societal objectives of rebalancing, integrating beneficiaries in the community, and managing the cost of Medicaid long-term services and supports (LTSS) for states.

As we strive to achieve these objectives, we aim to improve on our success through opportunities to engage in fully-integrated approaches. Broad integration that enables plans to provide services and hold financial risk across medical and non-medical sectors can achieve better outcomes for beneficiaries and for state governments. Fully-integrated approaches that streamline and coordinate care for persons with disabilities and older adults covered under Medicaid, or under Medicare plus Medicaid (“dual eligibles”) are more accountable to beneficiaries and states for quality and outcomes while improving access to care for beneficiaries, managing cost for states, and achieving greater sustainability.

As we look to the future, we believe a common framework should emerge for all arrangements through which organizations take broad capitated risk (e.g., for medical and non-medical services) – a framework that would allow for a variety of modalities¹ to fit the unique needs of individual beneficiaries in different circumstances.

A common framework should apply to all plans that integrate and hold financial risk for medical, behavioral health, LTSS and other non-medical services and supports. Payment to plans that serve dually eligible individuals should combine all applicable federal and state Medicare and Medicaid funds through a single payment determination and administration process. Payment rates must be actuarially sound and payment methodologies must be transparent. Furthermore, payment must account for the full range of needs of the population and be sufficient to cover services. The mechanism should provide for pooling and sharing of overall savings between the state, federal government and the plan.

The common framework should incorporate financial performance measures that create accountability to government payers for managing costs, and for achieving state and federal payer goals of rebalancing, reducing institutionalization, readmissions to hospital and institutional settings, and reducing avoidable episodes of care.

¹ Modalities would include current varieties: Program for All-Inclusive Care for the Elderly (PACE), Medicare-Medicaid Plans (MMPs), Fully-Integrated Dual Eligible Special Needs Plans (FIDE-SNPs), Dual Special Needs Plans (D-SNPs), Medicaid Managed LTSS (MLTSS) plans, Accountable Care Organizations (ACOs) and Medicare Advantage (MA) plans that take risk for LTSS, and other possible varieties of plan.

The common framework should additionally provide for accountability to government payers and to members and their families through performance measures that speak to progress toward consumer satisfaction and quality of life, and societal goals of reduction of health disparities, impact on social determinants of health, and rebalancing among settings and effective community integration.

Since integrated plans hold financial risk across the care continuum and are accountable to their members and to state and federal governments for their performance and the outcomes they achieve, they should have broad benefit flexibility to provide services that best meet the unique and varied individual needs of their members “In Lieu of Services” that may be specified in statute or regulation.

All eligible Medicaid beneficiaries should be afforded the benefits that come with full integration of LTSS and Medicare. States should have the option of creating a requirement for eligible individuals to be in a Medicare product that is fully integrated - whether it is a health plan product (e.g., MMP, DSNP, MA), PACE, ACO or some other new modality. The individuals to be enrolled should have the choice of modality and, of course, choice within the modality.

The standard for care coordination and the resulting care and service plans should be consistent across Medicare and Medicaid programs. The Person-Centered service planning process should be the gold standard. Plans should be compelled to provide information and tools that support participants to select self-direction and access services in their homes and communities, the most integrated settings they desire, and to play as active a role as they choose in health and service-related decisions, making arrangements, and coordinating care and services.

This vision of fully-integrated plans serving all eligible beneficiaries who need or will need LTSS and complex care can be achieved through an expansion of existing models available on a small scale today that could serve a much larger population, and through comprehensive reform of the statutory and regulatory structure that now governs the separate state and federal financing mechanism that fund the various silos of care across the care continuum.