Strategies to Achieve Beneficiary-Centeredness in Medicare-Medicaid Integration

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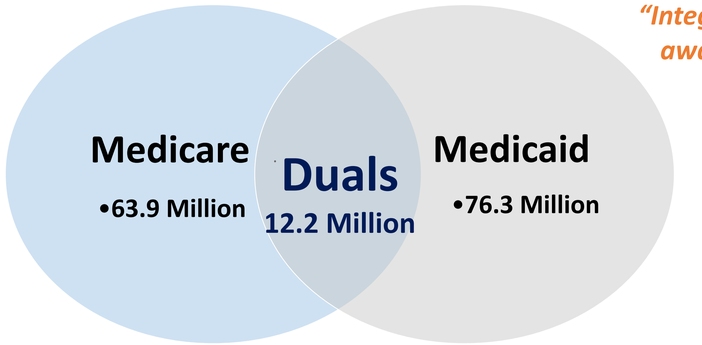
Introduction



- Beneficiaries dually eligible for Medicare and Medicaid often experience fragmented care, poor health, and high utilization due to suboptimal coordination and alignment between the two programs.
- As states across the U.S., including North Carolina, strive to advance Medicare-Medicaid integration, we sought to identify strategies to achieve beneficiary-centered care through and within these models.

Methods

- Employed a 2-phased approach:
  - **Phase 1:** Targeted review of peer-reviewed and grey literature.
  - **Phase 2**: Interviews (n=20) and focus groups (n=4) with a range of stakeholders involved in Medicare-Medicaid integration nationally and in North Carolina.

Overview of Interview Sample (n=X)	
National Stakeholders	
National Experts	2 Interviews (n=2)
State Medicaid Officials	3 Interviews (n=8)
North Carolina Stakeholders	
DHHS Officials	5 Interviews (n=10)
Consumer Groups	4 Interviews (n=4)
Providers	2 Interviews (n=4), 2 focus groups (n=8)
Insurance Plans	4 Interviews (n=10)
Area Agencies on Aging	2 Focus Groups (n=16)

- Literature review and interviews covered a range of topic domains:

- Conducted content and thematic analyses to identify and assess key themes and strategies across domains.

Findings

"Integration is a continuum…the aim is to get further on the continuum so that beneficiaries aren't aware of two programs….but rather one experience that meets their needs and preferences…."

Engage and Empower the Beneficiary

- Establish beneficiary councils to guide state leaders.
- Tailor outreach materials to account for different levels of health literacy, languages, cultures; highlight benefits of integration.
- Offer opportunities for self-direction, Money Follows the Person, and continuity of care allowances.
- Embed robust beneficiary protections.

Provide Whole-Person Care

Care must holistically address physical, behavioral, and social needs. Three key priorities include:

1. Extend services that address SDOH.
2. Provide robust and integrated behavioral health (e.g., primary-behavioral care integration).
3. Widen access to home- and community-based services (HCBS) (e.g., grants for home adjustments, care transition planning).

Align Integration Strategies with Broader State Value-Based Care Reforms

- Leverage Medicaid managed care infrastructure and public and private initiatives to shift from FFS to value-based, person-centered care.
- Capitalize on political will and stakeholder buy-in to situate duals integration with broader efforts to improve health, health equity, and value, rather than silo effort.

Incorporate Beneficiary-Centered Outcomes in Performance Measurement

- Incorporate health status, quality of life, quality of care, beneficiary and caregiver experience and satisfaction, access to whole-person care, and health equity metrics into measurement strategy.
- Monitor real-time successes and gaps to assess impacts and refine integration approach.

Assemble a Simplified and Seamless Continuum of Care

- Match beneficiaries with dedicated care navigator or manager.
- Engage interdisciplinary workforce, including community-based organizations.
- Build adequate provider network; educate providers on benefits, coordination resources, shared decision-making.
- Extend internet, telehealth, and remote monitoring services.
- Provide caregiver supports.

Implications

A multi-component, multi-level approach is needed to create a holistic ecosystem of integrated care centered on the beneficiary.

At the **System Level**, states should commit to a culture of beneficiary-centered care and one that prioritizes a whole-person approach and equity, while investing in and/or leveraging broader payment and delivery reforms and infrastructure supports (e.g., data, workforce) that advance integration and overall better health, health care, and value for their communities.

At the **Process Level**, states should create a model of care that engages and empowers beneficiaries and caregivers; integrates services across various domains of care (e.g., physical, behavioral, social); coordinates care according to diverse beneficiary circumstances and values; supports providers and access to their services; and affords preference-driven transitions across different settings of care, including home and the community.

At the **Outcomes Level**, states should measure outcomes that matter to beneficiaries in evaluating success and that will advance equity of health and health care for dual-eligible beneficiaries.

States at any stage of integration can utilize these findings to a) assess readiness to pursue an integrated care model for dual-eligible beneficiaries, 2) identify gaps in existing approaches and infrastructure, and/or 3) refine and evaluate current strategies.

Acknowledgements and Contacts

Support for this work was provided by Arnold Ventures. The findings presented here do not necessarily reflect the views of Arnold Ventures. The authors would like to thank the interviewees for their time and for sharing their expertise, insights, and recommendations.

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