Opinion

Integrating Medicare and Medicaid: Successes to Date, Lessons Learned, and the Road Ahead

BRUCE A. CHERNOF

WHEN MEDICARE AND MEDICAID WERE SIGNED INTO LAW in the summer of 1965, the American health care landscape looked very different than today. The average life expectancy was 69, most of the top 10 causes of death were due to acute health events (eg, heart attack), and most people living with substantial functional impairment did so for only short periods of time before they died. Medicare was intended to pay for hospital and doctors' costs while Medicaid served as a safety net for low-income women of childbearing age and their children. The inclusion of nursing home care in Medicaid was basically an afterthought. Fast forward to 2019. Adults are living longer, causes of death are more likely associated with chronic health conditions (eg, diabetes), and the need for functional and community-based supports is vastly greater than was originally envisioned by Medicare's and Medicaid's framers.

Today Medicaid and personal out-of-pocket spending are the top payers for long-term services and supports in the United States. Private long-term care insurance has never held more than 8% of the market, and Medicare pays only for short-term, post-acute care.¹ However, the top 5% of Medicare utilizers represent 40% of Medicare spending—and roughly half of these individuals are also eligible for Medicaid.² The challenge is that these two programs have a long history of operating in their own silos and not coordinating their financing or benefits. Generally speaking, better models of care that deliver savings in one program often result in increased utilization and, hence, greater spending in the other.

While there are many examples of small-scale programs that have integrated care and financing for Medicare-Medicaid eligible individuals, implementation at large scale has been elusive, often limited by concerns that savings will not materialize. The Medicare-Medicaid Coordination Office with its Financial Alignment Demonstration was specifically

created to allow states to step forward and develop models that could substantially improve care for beneficiaries while delivering savings to states and the federal programs. We are now six years into this audacious set of pilots, which involve 12 states and nearly 440,000 people.³

Successes to Date

Given the complexity of implementing these pilots, findings are preliminary and lack significant cost and quality data, yet early federal and state evaluations show clear patterns of improvement in care delivery and beneficiary experience for those enrolled in specific Medicare-Medicaid Plans (MMPs). First, enrollees are satisfied. While transitions from fee-for-service to managed care can be challenging, enrollees in many demonstration states report high levels of satisfaction. In an independent evaluation in California, enrollees reported a higher level of satisfaction than those remaining in their original Medicare.⁴ Second, hospitalizations have decreased. Data from an independent federal evaluation show decreased hospitalizations in Ohio (20%) and Washington (5%).⁵ In California, enrollees reported a 20% decrease in hospitalizations.⁴ Lastly, long stays in nursing homes have decreased. The independent federal evaluation found that efforts to successfully return individuals to the community rather than house them in nursing homes increased as a result of the pilots.⁵

Lessons Learned

Important lessons have emerged from the demonstration that could help shape future implementation in other states. First, development and implementation take time. Standing up new integrated programs requires the cooperation of state officials, the Centers for Medicare and Medicaid Services (CMS), local health plans, and providers of many stripes. The roll-out of these programs can be more complicated than expected, and while moving expeditiously is important, time needs to be built into the implementation process to increase the likelihood of success. Minimizing disruptions with providers and resolving them promptly when they do occur are critical in the early phase to assure retention and success in the long term.

Second, development and implementation require people. As states recover from the fiscal crisis of the last decade, there has not been the usual hiring and development of new state leaders. Many states face human resource bandwidth challenges as senior staff begin to retire. Also, many states lack staff with a deep understanding of the Medicare program because it was previously not viewed as a state program. Third, stakeholder engagement is critical, generally the more the better. Integrating these two major programs for individuals who are, in fact, quite vulnerable sparks concerns that need to be heard and addressed. Advocacy organizations, and often providers as well, have concerns with how these programs will operate.

Fourth, standardization is fundamental. Care coordination that encompasses both medical and social needs is the key to better care at lower costs. Standardized tools to assess need and build care plans are the backbone of successful programs. Fifth, one should expect and plan for course corrections. Large-scale shifts in care delivery will nearly always have operational and logistical challenges. Patient and persistent leaders expect that problems will occur along the course and are able to solve problems quickly with all parties involved.

Finally, engaging directly with eligible beneficiaries improves program performance. Too often, state officials, CMS, and local advocates wrangle about language in communications to dually eligible beneficiaries. Often, by the time everyone's "required" language is included, communications look more like a jury summons than an opportunity to choose a better integrated approach to care. Communications should be developed to meet the needs of dual eligibles. Both beneficiaries in the program and those who opted out should be consulted about which language is working and which is not.

Looking Ahead

The Medicare-Medicaid demonstration represents the boldest effort since the creation of both programs to improve outcomes for those who are most vulnerable and have significant complex needs. While there have been important efforts in the past (which this demonstration builds on), either they have not been able to scale broadly (eg, PACE) or their integration methods were too modest and medically oriented (eg, Special Needs Plans [SNPs]).

It is clear from these and other similar trials that when thoughtfully integrated with the person in mind, these programs can deliver better care at lower costs.⁶ While the road to integration can seem circuitous and have unintended consequences that need to be addressed, it is important to acknowledge that the status quo—the stand-alone and siloed fee-for-service Medicare and Medicaid systems—is the most expensive, least person-centered choice. With the passage of the CHRONIC Care Act in 2018, CMS now has additional tools to improve access to community-based services in Medicare Advantage and to push SNPs to provide a far more integrated and responsive set of services.

As CMS expands and implements these new and developing opportunities, recommendations for success include (1) standardizing a functional and nonmedical needs assessment for all programs that serve older adults with complex needs (ie, MMPs, SNPs, PACE, accountable care organizations); (2) clarifying expectations around risk stratification and developing care coordination that encompasses the full range of a person's medical and nonmedical needs; (3) clarifying opportunities, incentives, and parameters for providing nonmedical services; (4) rapidly developing and deploying quality measures that make sense for this population and that drive value-based purchasing; and (5) aligning implementation and oversight of all programs serving dual-eligible individuals.

Transforming the health care system to improve the quality of life for older adults and their families and caregivers is critical. These new tools, along with the Financial Alignment Demonstration, lay the groundwork for scalable, more integrated care models.

References

1. ASPE. Long-term services and supports for older Americans: risks and financing. 2016; <https://aspe.hhs.gov/system/files/pdf/106211/ElderLTCrb-rev.pdf>. Accessed January 7, 2019.
2. Rodriguez S, Munevar D, Delaney C, Yang L, Tumlinson A. Effective management of high-risk Medicare populations. 2014; <http://avalere.com/news/avalere-issues-white-paper-on-the-management-of-high-risk-medicare-populati>. Accessed January 7, 2019.

3. Medicare Payment Advisory Commission. Report to the Congress: Medicare and the health care delivery system. 2018; http://www.medpac.gov/docs/default-source/reports/jun18_medpacreporttocongress_sec.pdf?sfvrsn=0. Accessed January 7, 2019.
4. Institute for Health and Aging, UC San Francisco. 2018 findings from the Cal MediConnect rapid cycle polling project. 2018; <https://www.thescanfoundation.org/evaluating-medicare-medicaid-integration>. Accessed October 31, 2018.
5. Centers for Medicare & Medicaid Services. Financial Alignment Initiative: evaluations. 2018; <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Evaluations.html>. Accessed January 7, 2019.
6. Center for Health Care Strategies. Snapshot of integrated care models to serve dually eligible individuals. 2015; <https://www.chcs.org/resource/snapshot-integrated-care-models-serve-dually-eligible-beneficiaries/>. Accessed January 7, 2019.

Address correspondence to: Bruce A. Chernof, MD, The SCAN Foundation, 3800 Kilroy Airport Way, Ste 400, Long Beach, CA 90806 (email: BChernof@thescanfoundation.org).