Integrated Care Resource Center

TECHNICAL ASSISTANCE BRIEF

OCTOBER 2015

Engaging Providers in Integrated Care Programs for Medicare-Medicaid Enrollees: Tips for States

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IN BRIEF: The success of integrated care programs such as financial alignment demonstrations and managed long-term services and supports programs depends on engaging a broad spectrum of providers. This brief offers tips to states on engaging physicians, hospitals, nursing facilities, and community-based service providers who serve Medicare-Medicaid enrollees in managed care systems. It provides examples of approaches employed by states that have launched integrated care programs.

Many states are pursuing integrated care programs, including financial alignment demonstrations, comprehensive contracts with Dual Eligible Special Needs Plans (D-SNPs), and Medicaid managed long-term services and supports (MLTSS) programs, to improve Medicare and Medicaid program alignment, service coordination, quality and cost-efficiency for Medicare-Medicaid enrollees. The success of these programs depends on engaging a broad spectrum of providers (e.g., physicians, hospitals, nursing facilities, and community-based service providers) to aid program design with their feedback and participate in health plan networks. In addition, since providers are a trusted source of information for their patients, it is crucial that they support the integrated care program and are willing to encourage their patients/clients to enroll.

Integrated care programs are often managed care arrangements, in which providers contract with health plans rather than enter into provider agreements directly with the state and/or the federal government. For many providers, especially Medicaid home- and community-based services providers, this is their first experience outside of the fee-for-service (FFS) environment. These providers not only need to understand how the integrated care program will operate and benefit their patients/clients, but also may need to learn how to work with health plans.

While health plans engage providers as they build and maintain their networks, provide training on billing and prior authorization processes, and share care coordination information, states also have a key role in provider engagement. This brief offers tips to states on engaging a broad range of providers who serve Medicare-Medicaid enrollees in managed care systems, and provides examples of approaches employed by states that have launched integrated care programs.

1. Develop and disseminate high-level program messages using multiple outlets.

States can use the goals and objectives that guided program design to develop a few high-level messages that will help providers, beneficiaries, and other stakeholders understand the benefits of the new integrated program. These messages can be shared through program names, slogans, and mission statements and disseminated via multiple outlets. Public meetings, provider forums, and print and social media campaigns can be used to reinforce high-level messages about program goals and benefits, while providing answers to provider and beneficiary questions. Other avenues for engagement include: (1) creating implementation and advisory councils with provider representation; (2) conducting regional provider meetings; (3) holding webinars or conference calls with different provider groups; and (4) maintaining electronic mailboxes to respond to provider questions. For example:

- **Virginia's** capitated financial alignment demonstration, Commonwealth Coordinated Care, uses the slogan *Medicare and Medicaid working together for you*, which emphasizes that it is a joint initiative, managed and supported by the state and the Centers for Medicare & Medicaid Services (CMS). Commonwealth Coordinated Care's mission statement and goals clearly identify the program benefits to providers as well as enrollees.[1] Virginia held multiple town hall meetings in all five Commonwealth Coordinated Care regions across the state and created a running list of provider frequently asked questions (FAQs).
- **Idaho's** Medicaid agency worked closely with the fully integrated dual eligible (FIDE) SNP participating in its Medicare Medicaid Coordinated Plan to co-brand and jointly publicize this integrated care program. The co-branding of materials and activities reassures stakeholders that the state is closely involved with program operations and reiterates the active role of providers in working closely with state staff to ensure program oversight and accountability. Idaho did a series of "road show" presentations for providers across the state with its one D-SNP, Blue Cross of Idaho, to build trust through in-person discussions. The state also works with Medicaid advisory committees, such as the Personal Assistance Oversight and Medical Oversight Committees, to provide program updates.
- **Florida** used a YouTube channel to share recorded provider trainings with question/answer sessions as it implemented its MLTSS program.

2. Emphasize that programs are joint federal-state, Medicare-Medicaid initiatives.

Some providers consider themselves to be "Medicare providers" and may be reluctant to work with states. These providers may be more receptive to engaging when it is clear that CMS is at the table, and the integrated care program is a joint Medicare-Medicaid initiative. States can partner with the Medicare-Medicaid Coordination Office and/or their CMS regional office to present information about integrated programs. An example of CMS-state collaboration is the development and posting of provider FAQs for the financial alignment demonstrations in Illinois, Michigan, New York, and Texas on CMS' Financial Alignment Initiative website.[2] States can also partner with CMS regional offices to communicate information about their programs to Medicare FFS providers. Virginia collaborated with the CMS Region 3 Office to place articles in its quarterly FFS provider newsletter about the Commonwealth Coordinated Care demonstration.

3. Engage with provider associations early on.

States can work with provider associations early in program design and throughout implementation to publicize program benefits to providers and enrollees and provide timely information about covered services, continuity of care, and other key provider issues. For example:

- **Ohio** worked with provider associations for more than a year prior to its Medicare-Medicaid financial alignment demonstration launch and gained support from the state medical association. Now, several provider associations that represent hospitals, Area Agencies on Aging, and home care workers, among others, are members of the MyCare Ohio Implementation Team, an advisory committee that provides feedback to the state on high-level implementation issues and program data.
- **New Jersey** worked with provider associations to obtain their input into program design and administration up to 18 months prior to launching its MLTSS program in 2014. This included inviting provider associations to participate in MLTSS Steering Committee meetings pre- and post-implementation. The state also participated in four pre-implementation stakeholder work groups: (1) Assuring Access; (2) Provider Transition; (3) Assessment to Appeals; and (4) Quality and Monitoring.

4. Tailor information to different provider types.

States can modify and personalize materials and information dissemination to target different provider types. The information needed for each type of provider will vary by the medical and social service needs of their patients, familiarity with Medicare and/or Medicaid, and experience working in a managed care environment. Large hospitals and nursing facilities are more likely to have the capital to invest in comprehensive data systems, more experience working with both Medicare and Medicaid health plans, and a diverse work force with wide-ranging skill sets than small home- and community-based service providers. Providers with less experience working with Medicare or Medicaid and fewer resources for staff training and data/information collection will benefit from receiving

information and training on specific program benefits and rules. Information and training can be targeted to the unique role and information needs of community-based, acute care, and inpatient providers to highlight the enhanced connections and functions in a coordinated system. States can hold in-person meetings, webinars, or conference calls for specific provider types, and can also produce provider-specific FAQ documents and/or create provider webpages. For example, Virginia holds weekly calls with health plan representatives and five different provider groups (adult day health providers; personal care and home health providers; nursing facilities; behavioral health providers; and hospitals and medical offices) to address specific provider questions and provide targeted program updates.

5. Create a mechanism to identify and clearly address common provider concerns.

New integrated care programs are likely to be accompanied by provider concerns. Providers need assurances that they will continue to be paid on time, their administrative burden will not increase, and their patients' services will not be disrupted when they enroll in the program. States can use provider association newsletters and provider trainings to explain key messages both pre- and post- implementation. It is especially helpful for states to create a well-designed, user-friendly, and regularly updated program website. California's dedicated website, www.CalDuals.org, is a comprehensive resource for both providers and beneficiaries. This website has a physician toolkit with information about submitting claims, contracting with participating health plans, and providing continuity of care. For example, the following pages: Dual Eligible Patient Insurance Status and Where Physicians Bill; How Physician Crossover Claims are Processed for Beneficiaries in Medi-Cal Managed Care Plans; and Continuity of Care Information have clear links to: (1) continuity of care requirements for physicians and other services; (2) processes for out-of-network referrals; and (3) information on contracting with Cal MediConnect plans.

Frequent provider concerns in managed integrated care programs include:

- **Billing processes and technical payment requirements.** States pursuing new programs should clearly describe any billing system changes, including anticipated new administrative efficiencies available to providers by submitting Medicare and Medicaid claims to one entity. States can underscore that health plans will be held to existing claims filing and timely payment requirements, and they can ensure that all payment requirements are updated and made publicly available. States can also highlight any provider payment rate protections such as Medicaid FFS rate floors that may be in place for a specified transition period (e.g., the first year or so of the program). Schedules for hands-on provider billing training, conducted either by plans or jointly with states, can be included on the state's website and in emails from the state. States may also highlight opportunities for providers to negotiate new payment structures with plans (i.e., providers may have flexibility to negotiate beyond current payment methodology requirements).
- **Potential differences in provider and benefit requirements across plans or in the new program overall.** States may allow health plans in integrated care programs some flexibility related to prior authorization processes and other benefit coverage policies outside of federal and state coverage requirements. Clearly explaining prior authorization submission and timeliness requirements and other provider-specific issues such as provider appeals processes can mitigate providers' administrative burden. States could consider developing simple summaries of how administrative and other processes differ across plans. Other providers may have specific concerns about benefit changes. For example, in several states, home health agencies were concerned that Medicare FFS certification standards would be different for participation in integrated Medicare-Medicaid plan networks. CMS and states clarified that these agencies must continue to be certified by CMS and operate according to Medicare Conditions of Participation.[3]
- **Continuity of care provisions.** It is important to provide information about continuity of care requirements to both in- and out-of-network providers. In particular, out-of-network providers need to know when they can continue to receive payment for services during the continuity of care period and how to submit claims for payment to health plans. Clear information and streamlined processes may create more favorable opinions of the new integrated care program and increase the likelihood that providers will encourage their patients to participate. All financial alignment demonstrations have continuity of care requirements that allow beneficiaries to continue seeing existing out-of-network providers for a specified period of time following enrollment, usually 90 to 180 days. Likewise, New Jersey has no limit on continuity of care for its MLTSS program. In New Jersey, health plans must meet continuity of care

requirements until an assessment is completed and a new plan of care is in place for newly enrolled members. The timeframe for completion of face-to-face assessments and care plans is 90 days for high-risk members and 180 days for all other enrollees.

6. Be transparent about challenges and successes, and build in avenues for ongoing feedback.

Sharing information about program challenges and successes helps providers respond to questions from their patients and make informed choices about contracting with program health plans. Providers may also be more receptive to hearing about program successes if they feel the state and health plans are being open about addressing challenges. Massachusetts presents balanced information about program successes as well as areas for improvement on its One Care website. For example, the state released results from a survey that found providers believed One Care expanded access to services for younger people with disabilities, a critical program goal.[4] On the other hand, the survey also showed that stakeholders thought the state needed to improve provider contracting, billing, and communication with One Care Plans. Massachusetts also issues monthly reports on One Care enrollment activity, including total number of enrollees by plan and county, and total opt-out numbers.[5]

Equally important for states is to collect plan and provider insight about on-the-ground program operations. In-person meetings or conference calls with state staff and health plans give providers the opportunity to discuss issues, ask questions, and share stories. Many states also operate advisory councils or other stakeholder groups that include providers, such as Massachusetts' One Care Implementation Council. Florida developed a simple form for MLTSS providers to submit questions for feedback. At the launch of the MLTSS program, state staff met daily to review and respond to these questions. States can also solicit provider feedback, stories, and updates through social media, while monitoring social media trends that might indicate where additional outreach and education may be needed.

7. Encourage collaboration among health plans in training and documentation.

States can require health plans to provide joint provider trainings on billing and prior authorization procedures. In Virginia, the state required all health plans participating in Commonwealth Coordinated Care to provide joint trainings on billing to reduce the number of trainings providers needed to attend and to clearly identify similarities and differences between plans to reduce provider confusion. States can also require plans to contribute to a single reference document that all plans then use for billing and authorization procedures. A few months prior to launch of its capitated financial alignment demonstration, Healthy Connections Prime, South Carolina staff and participating health plans partnered to host regional provider forums in locations throughout the state to address the impact of the demonstration on the system generally, as well as on specific types of providers. Encouraging this type of collaboration may be easier for states with fewer participating health plans, but may yield a bigger payoff for providers in states with more plans.

Conclusion

By proactively engaging providers, states can help to build broad-based support for integrated care programs such as the financial alignment demonstrations and MLTSS programs. Providers can offer valuable input on the design, implementation, and ongoing operation of integrated systems of care for Medicare and Medicaid enrollees.

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ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services to help states improve the quality and cost-effectiveness of care for Medicare-Medicaid enrollees. The state technical assistance activities provided within the ***Integrated Care Resource Center*** are coordinated by Mathematica Policy Research and the Center for Health Care Strategies. For more information, visit **www.integratedcareresourcecenter.com.**

Endnotes

[1] Virginia Department of Medical Assistance Services. “Integrated Care for Medicare-Medicaid Enrollees.” http://www.dmas.virginia.gov/content_pgs/altc-enrl.aspx.
[2] Centers for Medicare & Medicaid Services, Medicare-Medicaid Coordination Office. “Financial Alignment Initiative.” http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.html.
[3] For CMS’ Conditions for Participation to be certified as a Medicare and/or Medicaid home health provider see: Centers for Medicare & Medicaid Services. “Home Health Providers.” Available at: http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/HHAs.html.
[4] Massachusetts Executive Office of Health and Human Services. “One Care Implementation Council – One Care Provider Feedback Survey Results.” September 2014. Available at: http://www.mass.gov/eohhs/docs/eohhs/healthcare-reform/prev-meetings/2014/140912-feedback-survey-results-draft.pdf.
[5] Massachusetts Executive Office of Health and Human Services. “One Care Enrollment Reports.” Available at: http://www.mass.gov/eohhs/consumer/insurance/one-care/one-care-enrollment-reports.html.