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Interdisciplinary Care Teams for Medicare-Medicaid Enrollees: Considerations for States

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IN BRIEF

Interdisciplinary care teams (ICTs) are an important component of integrated care programs for Medicare-Medicaid enrollees and typically consist of the enrollee, providers, other support professionals, and family members/caregivers. These ICTs work collaboratively to develop and implement care plans to meet individuals' medical, behavioral, long-term care, and social service needs. States developing or refining ICT requirements for integrated care programs may want to consider how prescriptive ICT requirements should be, how ICTs can better engage providers and hard-to-reach individuals, and how to measure ICT performance. This brief describes considerations for ICT development and oversight, and gives examples of strategies used by states integrating care for Medicare-Medicaid enrollees through various platforms.

States are pursuing opportunities to better integrate care for Medicare-Medicaid enrollees through various vehicles, including the Centers for Medicare & Medicaid Services' (CMS) capitated model financial alignment demonstrations, Medicare Advantage Dual-Eligible Special Needs Plans (D-SNPs), and Medicaid health homes. Across these different platforms, many states have placed responsibility for enrollees' care management on interdisciplinary care teams (ICTs). However, requirements for ICT composition, responsibilities, and operations vary by state program and may be refined over time.

As states develop ICT approaches, they should consider how ICTs can best engage both Medicare-Medicaid enrollees and their providers to ensure active participation in care plan development and implementation. However, this type of engagement may be challenging for enrollees who often have physical and behavioral health conditions, low levels of literacy, and language barriers and for providers who have many burdens on their time.

As part of The Commonwealth Fund and The SCAN Foundation-supported project, *Implementing New Systems of Integration for Dually Eligible Enrollees (INSIDE)*, representatives from eight states – **Idaho**, **Massachusetts**, **Minnesota**, **New Jersey**, **New York, Rhode Island**, **Virginia**, and **Washington** – were interested in exploring considerations around ICT requirements. This brief highlights ICT approaches in these states and their early lessons for implementing ICTs in integrated programs.

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State Requirements for ICTs

An ICT typically consists of an enrollee, providers (e.g., primary care physician, specialists, behavioral health provider), other professionals (e.g., pharmacists, physical therapists, dieticians, care manager)[1], and the enrollee's family members/caregivers who all work collaboratively to meet the enrollee's needs. The goals of ICTs are to manage care and services to avoid fragmentation, ensure access to appropriate and person-centered care, and provide a team approach to address clinical, social and behavioral needs. Common responsibilities of ICTs include:

- In-person or virtual meetings with the enrollee;
- Initial and ongoing assessment of the enrollee's health status and needs;
- Collaborative development, implementation, and review of care plans; and
- Facilitation and coordination of service delivery and the enrollee's transitions between institutions and the community.

These tasks may be led by a health plan care manager, another lead ICT team member, or multiple team members depending on state parameters for ICTs, enrollee input, and the individual care plan that is developed as part of the ICT process.

Across different integrated care platforms, ICTs are responsible for managing and coordinating enrollees' care. Medicare-Medicaid Plans (MMPs) participating in the financial alignment demonstrations must use ICTs to coordinate care.[2] D-SNPs are also required to have ICTs as part of their care coordination approach.[3] Medicaid health homes are required to integrate and coordinate services, but states have flexibility to determine eligible health home providers, which may be an individual provider, a team of health professionals, or an interdisciplinary health team.[4] In all these integration platforms, states may set requirements for the composition of ICTs, as well as the frequency and location of their meetings. The ICT requirements of seven INSIDE project states are described in Exhibit 1.

State Considerations for Designing and Managing ICTs

Representatives of seven states participating in CHCS' *INSIDE* project identified four main considerations for states in designing and managing ICTs:

1. How prescriptive should states make requirements for ICTs?

Some states give health plans and other integrated care providers broad flexibility in determining ICT composition, as well as the frequency and location of enrollee interactions with ICT members (see Exhibit 1). Other states opt for more prescriptive requirements to ensure that adequate expertise is included in the ICT and that communication with enrollees occurs at specified times. Prescriptive requirements may be useful for ICT oversight; however, flexibility is important for the delivery of person-centered care to individuals with complex needs. In addition, providers may desire flexibility in ICT requirements to meet the needs of various patient populations or realities of practice in different settings (e.g., community, office-based, facility) or locations (e.g., rural, urban).

Determining the right level of flexibility for ICT requirements is still a work in progress. Several states noted that modifying ICT requirements after states, plans, and providers have had the opportunity to assess what is and is not working improved ICT effectiveness. The most common areas for flexibility in ICT requirements are:

- **Leadership and roles.** Some of the states require primary care physicians (PCPs) to lead ICTs, but this requirement may be burdensome. Expanding care managers' roles to lead ICTs can reduce provider burden and may increase ICT effectiveness. In some of the states, such as Massachusetts, care managers are responsible for communicating with the enrollee. This approach allows ICTs to engage physicians at the right time and for the right purpose. In Massachusetts, registered nurses (RNs) or other licensed and/or certified clinical professionals lead ICTs as clinical care managers for enrollees with complex needs, and care coordinators lead ICTs for all other enrollees.

  In Idaho, care managers collaborate with a panel of various providers to tackle complex cases and support hard-to-reach individuals who have difficulties participating in comprehensive risk assessments.

- **Meeting location**. The seven states have allowed flexibility in the location of ICT meetings (in-person vs. virtual). Some of the states, such as Massachusetts, have promoted virtual ICT models, where providers and enrollees connect by phone. This approach makes it easier for providers and enrollees to communicate when they are geographically distant and takes into consideration providers' and enrollees' schedules and ability to get to specific meeting locations.

- **Meeting frequency**. The states have also set requirements for the frequency of ICT meetings. Virginia requires that ICTs meet monthly, but many other states are less prescriptive about meeting frequency. For example, in Massachusetts' financial alignment demonstration, ICTs are required to meet "periodically" as needed or directed by the enrollee. States such as Minnesota place a greater emphasis on the outcomes of care planning and coordination, and omit requirements for the frequency of ICT meetings.

New York Provides ICT Flexibilities

In New York's financial alignment demonstration, PCPs were initially required to attend in-person ICT meetings. This was burdensome to some providers and challenging to implement, so New York recently revised its ICT policies to allow PCPs to send designees to meetings and join by phone. The New York State Department of Health also worked with stakeholders to identify areas where ICT flexibility was needed for participants, plans, and other providers. As a result, the state amended its ICT approach so now:[5]

- Enrollees have the right to choose the composition of their ICT;
- Provider participation in ICTs is optional depending on member availability, items being discussed in the meeting, or enrollee preference;
- PCPs may sign off on completed care plans without attending ICT meetings;
- ICT members may meet at different times to develop the enrollee's care plan;
- ICT training is optional for providers;
- MMPs have increased authority to authorize medically necessary care plan services that are outside of the scope of practice of ICT members; and
- Procedures for information sharing and communication among ICT members are simpler and more flexible.

EXHIBIT 1: General ICT Contract Requirements in Select INSIDE Project States

State	Program Type	Team Lead/Members	Frequency of Meeting[a]	Location of Meeting[a]
Idaho	D-SNP	**Lead:** Care coordinator **Other Members:** Enrollee, enrollee's caregiver/supports, primary care physician (PCP), behavioral health (BH) clinician if appropriate, legal representative as needed, nurses, pharmacist, specialists, social workers, home- and community-based services (HCBS) providers, qualified peers, family members, advocates, state agency representatives, or others as requested by the enrollee. ICTs for individuals receiving services through 1915(c) developmental disabilities (DD) or 1915(i) waivers must include a DD plan developer/plan monitor/targeted service coordinator. A care specialist also works with the care coordinator and is always available via for phone for the enrollee and all ICT members.	Not prescribed	Not prescribed
Massachusetts	Capitated Model Financial Alignment Demonstration	**Lead:** PCP alongside care coordinator (or clinical care manager for enrollees with complex care needs), and BH clinician if appropriate. Clinical care managers must be licensed registered nurses (RN) or other individuals licensed and/or certified to provide clinical care management. **Other Members:** Long-term supports coordinator if indicated. Also may include, as appropriate and at the discretion of the enrollee: enrollee, registered nurse, specialist clinicians, social workers, community health workers, qualified peers, family members, informal caregivers, advocates, state agency representatives or other case managers, and any other individuals as requested by the enrollee.	Periodic	In-person and telephonic
Minnesota	D-SNP	**Lead:** Care manager (CM) or nurse practitioner (NP) **Other Members:** Enrollee and/or authorized family members, responsible parties/guardians, PCP, long-term services and supports (LTSS) providers, specialists, and others as appropriate and requested by the enrollee.	Not prescribed	Not prescribed

[a] Many states do not prescribe the frequency or location of meetings, which provides flexibility to health plans, providers, and enrollees to define these ICT parameters. State requirements are listed where prescribed.

State	Program Type	Team Lead/Members	Frequency of Meeting[a]	Location of Meeting[a]
New Jersey	D-SNP	**Lead:** PCP (unless enrollee requires someone other than PCP to be point-person for care) **Other Members:** Other PCP, specialist, and/or NP.	Not prescribed	Not prescribed
Rhode Island[b]	Capitated Model Financial Alignment Demonstration	**Lead:** CM **Other Members:** Enrollee, PCP, and may include, with the enrollee's consent family members and/or caregivers, specialists and other physicians, physician assistants, LTSS providers, nurses, pharmacists, BH specialists, social workers, and peer supports.	Not prescribed	Not prescribed
Virginia	Capitated Model Financial Alignment Demonstration	**Lead:** CM (or designee appointed by CM as necessary to cover in their absence) **Other Members:** Enrollee and/or authorized representative, PCP, BH clinician if appropriate, LTSS provider if indicated, pharmacist if indicated, and may include RN, specialist physicians, social workers, community health workers, qualified peers, family members, informal caregivers, advocates, state agency representatives, or targeted CMs, if applicable.	Monthly	In-person and virtual
Washington	Managed Fee-for-Service Model (Health Homes) Financial Alignment Demonstration	**Lead**: Health home care coordinator **Other Members:** Enrollee, primary care and specialist physicians, pharmacists, BH clinicians, LTSS providers, and family members and/or caregivers, and others as appropriate.	Not prescribed	Not prescribed

Source: Interviews with state officials and reviews of state contracts and memorandums of understanding (MOUs) with CMS.

[b] Rhode Island has not signed a three-way contract as of January 2016; requirements are based on the MOU and information provided by the state.

2. How can ICTs better engage providers?

Provider engagement is central to the success of ICTs, but requirements for provider leadership in meetings and care plan development may make providers reluctant to participate. Providers may also have numerous documentation and data reporting requirements that add to their burden. Determining the best approach to reimburse providers for their participation in ICTs, obtaining provider buy-in, and identifying approaches to ease provider burden are major challenges. Certain provider types, particularly PCPs, may be more reluctant to participate if states require PCPs to lead ICT meetings in-person and sign off on care plans without incentives to participate.

The seven states encourage provider buy-in by demonstrating the value of ICTs and offering incentives for participation:

- **Access to data.** The interviewed states found that access to accurate and timely data is extremely valuable to providers. Some states automatically send enrollee status updates and care plan changes to providers; however, states have had to consider the frequency and value of these updates so providers are not overwhelmed with information.
- **Streamlined data reporting.** Each of the states has streamlined data entry requirements and centralized electronic health records to reduce provider burden directly or by working with health plans. They have also modified provider documentation requirements for in-person meetings and care plans.
- **Financial incentives.** States interviewed are considering how to develop pay-for-performance metrics of ICT effectiveness and utilization, and provide financial incentives to providers who engage in ICTs. Minnesota, for example, encouraged plans to work with providers on outcome-based measures of their choosing.

Minnesota's Approach Promotes Provider Engagement and Shared Savings

For Minnesota's D-SNP-based Minnesota Senior Health Options (MSHO) program, the state uses a flexible ICT model. This gives providers such as Bluestone Physician Services, a mobile primary care clinic that provides both primary care and care coordination services, the ability to use different care models for specific high-risk populations and tailor quality outcome measures accordingly.

For example, Bluestone manages care through interchangeable, interdisciplinary care teams offering patients a personalized care team approach based on need and risk level. Physicians, advanced practice providers, and care coordinators (either registered nurses or social workers) are involved at varying degrees providing services to patients living in assisted living facilities and group homes, or living independently within the community. Some patients may need services heavily focused on care coordination while others may need more primary care-focused services. This flexibility in Minnesota's ICT approach allows Bluestone and other providers to engage providers for the right patient populations, and tailor care management approaches and quality measures to different care settings.

3. How can ICTs better engage hard-to-reach individuals?

Health plans and providers have experienced difficulties reaching and engaging some Medicare-Medicaid enrollees to complete health risk assessments (HRAs) -- required by capitated financial alignment demonstrations -- and to participate in care planning and ICT meetings. Individuals dually eligible for Medicare and Medicaid often have significant medical, behavioral health, and social service needs, as well as low levels of literacy and language barriers. These needs, along with homelessness or unstable housing, can make dually eligible individuals hard to reach by health plans and providers. Comprehensive collaboration with plans, providers, community organizations, and other stakeholders has been critical to successfully engage hard-to-reach enrollees who need help navigating the health and social support systems.

- **Community-based care management**. The seven states interviewed are interested in community-based care management strategies that build on existing relationships with community-based organizations and other providers. By working with community organizations to address social determinants of health (e.g., housing, food resources), especially for individuals with behavioral health conditions, states such as Washington have successfully engaged hard-to-reach enrollees and encouraged their participation in HRAs and ICT activities.
- **Provider training**. States often facilitate or participate in provider trainings. Most states mentioned that they provide some level of training for care managers or other providers that work with high-need and/or difficult-to-reach populations, even if health plans have primary responsibilities for working with these providers.

Washington's ICT Model Allows for Interdisciplinary Community Care Management and Multi-Pronged Outreach

In Washington's health home program, one provider, Sea Mar Community Health Centers, uses the flexibilities in the state's ICT model to create truly interdisciplinary teams. RN care managers are cross-trained in social determinants of health; integration specialists are cross-trained in chronic disease impact; and case managers are trained in case management, skill building, and support. Team members meet enrollees in their homes, as well as in other settings such as food banks, hospitals, homeless shelters, and supported living facilities. This team approach is person-centered, successfully engages difficult-to-reach enrollees, and provides a more comprehensive understanding of the challenges enrollees face.

4. How can states assess the value of ICTs?

For their financial alignment demonstrations, Massachusetts and South Carolina have included *process measures*, such as the timeliness of care plan development by ICTs and the percent of enrollees with a specific provider-type involved in the ICTs that assess activities carried out by providers. However, many states want to move beyond *process measures* to *outcomes measures* that assess the effect of ICT performance. The challenge in developing and selecting outcomes measures is that enrollees, providers, the state, measure developers, and other stakeholders may have different opinions about how to define ICT performance and value. States are interested in collaborating with measure developers and federal partners to advance work in this area. Importantly, enrollees may not fully understand the role of ICTs, so states are working to increase understanding of new care plan processes as an important precursor to assessing ICT

value from the enrollee perspective. States agree that the presence of ICTs and the sense of "having a village" of support is important for enrollee satisfaction and ICT oversight. The majority of states have anecdotal evidence of ICT success collected from health plans, providers, and enrollees, and they are increasingly using quality and oversight data to examine ICT performance:

- **Survey and audit data**. New Jersey used Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys and disenrollment surveys to measure enrollee experience with ICTs in its D-SNP programs. From these surveys, the state found that the ICT's care coordination role was less important to enrollees than whether they received the services they needed. Conducting care plan audits provided quantitative measures of ICT success and a tool to promote consistency in care management activities.
- **Patient tracers**. Rhode Island piloted a tracer methodology to identify potential risk areas, gaps and opportunities for improvement in care management. The patient tracer is a tracking system that allows staff to enter patient information and ensures that the patient's information is kept current. The information includes how long patients have been in each treatment area, which tests each patient has had or needs to have, etc. The tracer follows the enrollee from the point of contact to care management, and all through their ongoing care. The patient tracer helped the state to more closely assess the value of ICTs, providing a more in-depth understanding of how care management systems operated and were monitored.

Conclusion

States are working with health plans and providers to develop and refine ICT requirements to better address the complex care needs of Medicare-Medicaid enrollees. Effective care management through the use of ICTs is evolving over time through strong stakeholder collaboration. Acknowledging the need to balance prescriptiveness and flexibility in ICT requirements is particularly important to effectively engage providers and enrollees. Considerations for provider burden and the success of partnerships built in the community has led states, plans, and providers to re-evaluate care management and ICT efforts, particularly in financial alignment demonstrations and within D-SNPs. The strategies employed across states and key considerations outlined can inform state efforts in designing and refining care management approaches for integrated care programs.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy center dedicated to advancing innovations in health care delivery for low-income Americans. CHCS works with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. For more information, visit www.chcs.org.

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ENDNOTES

[1] This brief, with the exception of state-specific terms found in Exhibit 1, uses the term care manager to broadly encompass the different titles given to staff who perform both clinical and non-clinical care and service coordination and management functions. Other titles for this position include case manager, care coordinator, and service coordinator.

[2] The use of interdisciplinary care teams in the Financial Alignment Initiative is described in State Medicaid Director Letter (SMDL) 11-008. See: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Financial_Models_Supporting_Integrated_Care_SMD.pdf.

[3] MIPPA Section 164 amending 42 U.S.C. 1395w–28(f); MIPPA also required D-SNPs to have an interdisciplinary care management team.

[4] The use of interdisciplinary care teams in Medicaid health homes is described in SMDL 10-024. See: https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf.

[5] New York State Department of Health. *FIDA: New Flexibility Offered.* December 9, 2015. Available at: https://www.health.ny.gov/health_care/medicaid/redesign/fida/docs/2015-12-09_fida_reform_summary.pdf.