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Guiding Principles for Designing and Implementing Integrated Models for Individuals Dually Eligible for Medicare and Medicaid

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Justice in Aging presents guiding principles for developing and implementing integrated models for individuals dually eligible for Medicare and Medicaid. The principles underscore the fundamental values and goals that should inform the design of integrated models, including robust consumer protections, health equity, person-centered care, and vigorous oversight and accountability. The principles draw upon insights gained from years of engagement with the Financial Alignment Initiative and advocacy at the state and federal levels to enhance Dual Eligible Special Needs Plans (D-SNPs) and other integrated care offerings.

Integrated Models Safeguard Consumer Choice and Enable Informed and Unbiased Decision-Making

- People Dually Eligible are guaranteed the right to choose their coverage.
  - » To preserve choice within an integrated model, people must retain the right to determine how, where, and from whom they receive care, including the right to access Medicare through Original Medicare.
  - » Members are given the option to enroll in an integrated model rather than being automatically enrolled.
  - » Members can disenroll from a plan at any time with no lock-ins.
- Plan selection is simplified and enhanced.
  - » To facilitate meaningful comparisons across plans, plan benefits are standardized.
  - » The number of duplicative plans is reduced to encourage the prevalence of plans that foster higher levels of integration and coordination.
  - » All Medicare Advantage plans that serve duals must follow baseline integration standards, including enhanced reporting and care management requirements.
  - » Medicare Advantage plans with a membership of at least 50% people dually eligible should be required to follow heightened integration standards (i.e., D-SNP look-alikes are limited).
- People dually eligible receive clear, accurate materials that enable informed enrollment decisions.
  - » Assistive tools like Medicare Plan Finder, Medicaid handbooks, and up-to-date provider directories allow Medicare members and their advisors to meaningfully compare plans based on individual circumstances.
    - ▪ Consumer-facing tools contain information on plan integration level and aligned status.

        - Available materials enable people dually eligible and their advisors to conduct deep dives on services, provider networks, prescription drug formularies, and prior authorizations.
    - » People dually eligible receive materials from Medicare and Medicaid that do not conflict and work together.
    - » Materials reflect the health literacy, language and accessibility needs of individual recipients.

- People dually eligible have access to unbiased enrollment assistance.
    - » A fully funded SHIP network provides unbiased assistance with enrollment decisions to people dually eligible. Counselors should possess expertise in Medicare and Medicaid managed care benefits, enrollment, and eligibility processes.
    - » Enhanced oversight reduces deceptive marketing and communications and ensures accurate information about enrollment options.

Integrated Models Improve Access to Care and Member Experience Across the Diverse Dually Eligible Population

- Members can access their Medicare and Medicaid benefits without delay.
    - » Barriers to care access stemming from differing coverage criteria across Medicare and Medicaid are eliminated.
        - Where Medicare and Medicaid cover the same service, members should have access to the full extent of the service provided by each program.
        - Where programs employ differing criteria for the same service, the integrated model should rely on the least restrictive criteria.
        - Benefits are not delayed due to dual status (e.g., Medicaid does not delay coverage for DME waiting for Medicare denial; integration of supplemental benefits with Medicaid services).
        - Care coordination requirements direct plans to take explicit actions when coordinating overlapping benefits and carved-out benefits to ensure timely access to care (e.g., dental).
    - » Care and utilization management teams collaborate to ensure timely benefits approval and care management activities.
    - » Members have access to comprehensive provider networks, including medical, long-term services and supports, and other providers that reflect their health-related social needs. Providers should reflect the demographic characteristics of the dually eligible population (e.g., language, disability, accessibility, LGBTQ+).

- Members have access to quality, person-centered care coordination.
    - » Care is person-centered. The driving force behind model design and service delivery must be the holistic needs and goals of each member.
        - Care navigation empowers members to make informed decisions, facilitates access to holistic services that address members' health-related social needs, prioritizes community integration, and prevents avoidable health events.

» Care managers assist people in answering questions, navigating care challenges, and facilitating access to benefits and supports reflective of people's needs, goals, and quality of life objectives.

- Members know who their care manager is and how to contact them. Their primary care manager follows the member across care settings to support transitions in care.
- Care manager ratios enable individualized attention responsive to the unique needs of each member. These ratios account for the medical and psychosocial needs of members as well as their geographic location relative to the care manager.
- Among other requirements, care managers help people maintain their Medicaid eligibility; complete appeals and grievances; advocate for their needs and goals; connect to critical Medicare, Medicaid, and community-based services and supports; address common care coordination challenges stemming from lack of integration between Medicare and Medicaid, such as transportation and pharmacy coverage; and advance rebalancing efforts by working with members to determine community-based alternatives to institutionalized care.
- Care managers possess core competencies responsive to the needs of people dually eligible, such as knowledge of community integration, person-centered planning, culturally competent and trauma-informed care delivery practices, Medicaid home and community-based services (HCBS) and Medicare home health benefits, health-related social needs, dignity of risk, and health equity.
- Care managers are experienced and trained to work with people with physical disabilities, older adults, individuals with cognitive, intellectual, and developmental disabilities, and/or individuals with behavioral health needs.
- To the greatest extent possible, care managers reflect the demographic makeup of the dually eligible population within the plan's service area.

- **Integrated plans encompass services beyond those typically covered by Medicare and Medicaid.**
  - » Plan offerings enhance the adequacy of underlying services in Medicare and Medicaid.
  - » Supplemental benefits supplement, and not supplant, existing benefits. Targeted resources increase access to HCBS and dental, vision, and hearing benefits.

- **Integrated plans advance rebalancing efforts through nursing facility diversion and transition programs.**
  - » Care management staff receive robust training on HCBS and actively support transitions out of acute care settings into the community.
  - » HCBS offerings through supplemental benefits complement rather than duplicate existing coverage through Medicaid.

Integrated Models Provide Robust Consumer Protections

- **Integrated models simplify procedures so members experience a single system inclusive of the most comprehensive protections provided by both Medicare and Medicaid.**
  - » Integrated models preserve and incorporate all existing Medicare and Medicaid protections (e.g., federal and state non-discrimination protections, HCBS Access Rule). When a discrepancy exists between state and federal protections, the strongest standard is used.

- » Integrated models utilize unified appeals and grievance procedures.

- Members receive clear, timely, and accessible communications.
  - » All member materials and communications are integrated, giving the appearance of a single, unified plan from the member's perspective.
  - » Communications are developed so that members understand their benefits and consumer protections.
    - Plans are obligated to provide resources that are tailored to the language, health literacy, and accessibility needs of members.

- Integrated models utilize policy levers to minimize disruptions in care.
  - » Continuous eligibility for twelve months is required to prevent disenrollment due to administrative barriers, such as failing to return Medicaid forms, considering the relatively stable income and assets of people dually eligible.
  - » Continuity of care protections are required for a minimum of twelve months to enable members to retain access to out-of-network providers and non-formulary medications during transitions into integrated models.
  - » Deeming protections are required for six months to prevent plan disenrollment due to temporary loss of Medicaid eligibility.

- Members are protected from cost-sharing that exceeds what they would pay in Medicaid or Medicare fee-for-service for the same service.

- Members are protected from improper billing, with plans responsible for rectifying and reimbursing incorrect charges.

- Members have access to robust provider networks that reflect their unique needs.
  - » Network adequacy standards comprehensively address the language access, cultural competency, accessibility requirements, and intersectional needs related to recipients' identities, including age and disability.
  - » Network adequacy standards and oversight occur at the plan level.

- Members have access to independent support to navigate challenges associated with their care through fully funded ombuds services.
  - » Ombuds scope of work includes empowering members about their rights and working with plans to resolve care disruptions, including assisting with appeals and grievances. Additionally, ombuds must tackle systemic issues by identifying systemic challenges impacting people dually eligible and informing solutions based on ombuds intake and complaint data.

- Integrated models incorporate members in model design, implementation, and oversight processes.
  - » Integrated models establish and sustain Consumer Advisory groups that are supported with technical assistance, administrative and accessibility support, and consumer stipends to enable meaningful participation.
  - » Plans solicit member experience of care surveys to monitor service quality and adequacy.

- State Medicaid Agency Contracts (SMACs) are public and open for public comment.
  - Regulations for initial SMAC development and annual renewals require states to solicit meaningful public input from stakeholders through written and oral comment opportunities.
  - States must actively notify the public of these opportunities via electronic mailing lists, administrative records, and targeted stakeholder outreach. States should post model contracts on their websites.
  - At least 30 days before the commencement of plan procurement, states must solicit written comments on the model SMAC and host at least two public hearings to gather additional stakeholder input. States must then compile responses to public comments and explain how these responses were considered in developing their model SMACs.
- Standardized components of plan Models of Care (MOC) documents should be publicly displayed on the state's website to inform stakeholders about the plan's service delivery practices.

Integrated Models are Held Accountable through Robust Oversight

- State and Federal governments commit adequate resources and personnel to program oversight and management to enable thorough oversight commensurate with the model's scope.
- Plans collect and disaggregate demographic data to advance equity and monitor performance. Plans must establish benchmarks based on disaggregated data to address disparities in access, utilization, and care quality.
  - CMS and state evaluations hold plans accountable through regular benchmark reviews, audits of interpreter and accessibility processes, and analysis of complaint data related to discrimination.
  - States must collaborate with plans to ensure this data is publicly displayed, such as through an accessible dashboard, in a timely manner.
- Each integrated plan has its own contract to enable plan-specific performance measurement, star ratings, prior authorization metrics, and network adequacy standards.

Integrated Models Leverage Lessons Learned from Previous Integration Efforts

- Integrated models conduct rigorous systems and readiness testing to ensure functionality prior to launch.
- Policymakers account for state readiness to implement integrated models and establish protocols to effectively manage unforeseen disruptions.