Goals and Principles
Integrated Care for Individuals with Dual Eligibility
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Growing attention to the challenges of meeting the needs of Americans with the most complex conditions has brought renewed interest in the role that integrated care can play. The potential for integration today resides largely in managed health care plans that hold broad financial risk for their members' care.

This paper reflects the shared thinking of policy experts in our leading national health plan associations: America's Health Insurance Plans (AHIP), the SNP Alliance, the National MLTSS Health Plan Association, and the National PACE Association.

The paper is offered as a foundation for building a broad consensus among consumers, providers, and payers on a national strategy for advancing integration toward a goal of improving quality of life and outcomes for those with the most complex care needs.

Individuals who have dual eligibility for both Medicare and Medicaid receive their health care coverage through two separate and uncoordinated programs – one federal and the other state-run. Services and supports for those individuals are often fragmented, with separate systems for physical health, behavioral health, and long-term services and supports (LTSS) that are unaligned and poorly coordinated. The result is a patchwork of care, often constrained by conflicting rules, which are inflexible and unresponsive to individual needs, redundant in some cases, while leaving significant care gaps in other areas, and often generating avoidable and expensive medical and/or institutional care.

Integration starts with addressing the holistic needs of the individual. It requires the alignment of comprehensive payments, policy, regulation, enrollment and service delivery across the full spectrum of services and supports for physical, behavioral, and functional needs through a single entity responsible and accountable for coordination of services. It includes sharing of information across settings, providers, and payers in a manner that supports the individual's choices and wellbeing.

Integrated care has the potential to achieve better outcomes for dual-eligible beneficiaries than the more prevalent bifurcated system of health coverage and should be made more widely available. The purpose of this document is to describe the characteristics of a well-functioning integrated care approach. The goals and

principles illustrate a shared vision of the experience integrated entities aspire to create for their members.

There are existing examples that are currently integrating care for this population, including but not limited to PACE, FIDE-SNPs, MMPs.

Goals of Integrated Care

- Better outcomes experienced by beneficiaries, which may include improved health, independence, quality of life, experience of care and beneficiary satisfaction.
- Greater ability for individuals with disabilities and/or functional or cognitive limitations to live with dignity in the most-integrated setting of their choice that meets their support needs.
- Increased ease of access and coordination of benefits and care delivery for individuals whose needs span multiple domains (behavioral health, physical health, LTSS, and social determinants of health (SDOH)) and/or whose service requirements span multiple programs.
- More effective and efficient care delivery, with services provided in an appropriate balance of home, community, and institutional settings, commensurate with the person's needs.
- Aligned incentives (including payment, regulatory oversight and delivery models) for payers, providers, states and the individual.

Principle 1: Integrated Care is Holistic and Person- and Family-Centered.

The integrated entity:

a. Earns trust of individuals and their chosen support person(s) through truly person-centered planning that engages the individual and respects individual goals and preferences.
b. Takes into account and supports the goals and preferences of the individual.
c. Provides useful information regarding choice of health plan, self-direction and provider-based service option to allow individuals and their chosen support person(s) to make informed decisions based on both cost and quality outcomes that align with their goals and preferences.
d. Engages individuals and their chosen support person(s) in choices of services and service providers.
e. Respects the individual's decisions as to what level of risk they choose to accept and incorporates that into a care plan

Operational considerations:

- To be person- and family-centered, an integrated care system enables informed choice by:
  a. providing beneficiaries and their families the information needed to make informed decisions aligned with their goals and care needs; and
  b. supporting consumer information and education, so beneficiaries and their chosen support person(s) understand the anticipated outcomes/results.
  c. Prioritizing person-centered choices.

Principle 2: Integrated Care is Seamless for the Individual.

An integrated approach should appear as and be experienced by the individual as a single entity covering the range of physical health, behavioral health, and LTSS to which the person is entitled. It should be accessible, understandable and easy to navigate.

An integrated entity:

a. operates as a single entity that is responsible and accountable for all covered services.
b. coordinates care across the full spectrum of services and supports to which the person is entitled – covers and coordinates medical, behavioral, and long-term services and supports.
c. coordinates through or with a cross-disciplinary care team.

Operational Considerations:

- Integration results in a seamless experience of care for the individual by providing:
  - single entry point (for enrollment),
  - single point of contact (for all interaction with the plan); and
  - lead care manager with responsibility for the individual and authority to manage care across all sectors.

- Integrated plans are considerate of the broad range of needs of the individual and leverage available community resources to improve expereiences for beneficiaries.

- The cross-disciplinary team:
  - can meet in person or virtually, supported by appropriate technology.
  - aligns the individual's primary care provider (PCP), lead care manager, and principal chosen support person(s) consistent with an individual's wishes.

- involves specialty care providers and LTSS providers as appropriate and approved by the individual.
- Utilizes comprehenive individualized assessments and person-centered care plans as the basis for care coordination and delivery.

- There are integrated information systems to:
  - enable all members of a care team to access and share critical, real--time information on an individual's condition, status, goals and preferences, which may be done through techonology.
  - combine or share important assessment, clinical, care plan, and service delivery information spanning medical, behavioral health, LTSS, and social dimensions of care.
  - maintain two-way connectivity of the individual and their chosen support person(s)in the home with members of the individual's care team to ensure the timely sharing of *critical* information, including information on changes in condition and significant transitions in care, support in-home care procedures, and coordinate care.

Principle 3: Integrated Care is Efficient and Sustainable.

Integrated approaches align incentives through comprehensive payment structures to promote efficient and improved resource use across the continuum of care.

An integrated entity:

a. has the flexibility to provide non-traditional Medicare/Medicaid benefits and manage care in a person-centered way to optimize individual's care outcomes.
b. strives to maximize value in the use public resources by making the most efficient use of resources to manage care that improve health and quality of life outcomes, or maintains and supports functional needs of individuals, while attaining desired outcomes for the individual.
c. improves care for individuals with complex care needs by improving home- and community-based services and supports and reducing avoidable medical events requiring institutional placement, including emergency room visits, hospitalizations and nursing home admissions.
d. Shares savings from reduced health care expenditures with states and the federal government to ensure continued alignment of incentives.

<u>Operational Considerations:</u>

- Integrated entities have the incentive to support the individual in the most integrated setting desired by and possible for the individual; and the ability to adequately support any needed transition from more restrictive settings to the community.
- Integrated entities have resources available regardless of geography.

Principle 4: Integrated Care is Accountable and Measurable.

An integrated entity:

a. Is accountable to individual members, states, and the general public for
    - outcomes of importance to the individual,
    - cost effective use of state and federal resources.
b. Achieves outcomes that are better than what individuals receive outside of integrated care measured on a regular basis, by a consistent set of outcome-based quality measures across all integrated entities.
c. Generates data that allows for measurement of quality and costperformance and outcomes that can support consumer decision making, government monitoring and comparison to non-integrated device options.

<u>Operational Considerations:</u>

- Meaningful, pertinent quality measures that are relevant to the population served must be developed
    - Measurement should clearly allow payers and consumers to see and measure value and performance and allow transparency.
    - Measure sets should include a standard core set of outcomes-based measures for dual eligible integrated entities that are reported on a regular basis across states and across integrated entities.
    - Measure sets should balance the measurement needs of states, plans and members and should minimize administrative burdens on plans beneficiaries, and providers.