

# Findings from Arnold Ventures' Request For Information on the Dual-Eligible Experience

## Executive Summary

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Arnold Ventures (AV) seeks to address some of the most pressing policy challenges facing our country. Our work in health care is driven by a belief that our current system costs too much and falls short of adequately addressing people's health and health care needs. Our system is particularly dysfunctional for the 12 million low-income elderly and disabled individuals who are dual-eligible for Medicare and Medicaid. Dual-eligible individuals are more likely to have inpatient stays, visit emergency rooms, and rely on nursing homes than their Medicare-only counterparts.

Evidence suggests that the need to navigate two distinct and non-aligned coverage systems accounts for some of these disparate outcomes among people who are dual-eligible—particularly older adults and those with long-term care or substance use needs—and that integrating care delivery, financing, and administration has the potential to create the conditions for better care and better care experience. The focus of the AV Complex Care initiative is to fund research, technical assistance, and policy development that improve the systems that deliver care to this population, including by advancing integrated coverage.

While plans that integrate Medicare and Medicaid<sup>1</sup> exist today, few go far enough to provide a seamless experience for dual-eligible individuals or align financial incentives. Further, beneficiaries often do not enroll or stay enrolled in the models, reflecting myriad challenges associated with integrated enrollment including a confusing marketing environment, discouragement from providers, and in some cases, a disconnect between consumers' needs and their confidence in integrated plans' ability to meet those needs. The fragmentation and lack of sufficient information are particularly troublesome for dual-eligible individuals of color and those whose primary language is not English. To help inform policymakers who are responsible for the next generation of integrated models, and to ensure that these models promote a more equitable system, the AV Complex Care team is committed to promoting constructive consumer involvement in the development and advancement of integrated Medicare-Medicaid models for dual-eligible individuals.

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<sup>1</sup> For the purpose of simplicity, we use the word "plan" throughout this document to refer to all entities that provide health care coverage. However, we recognize that there are multiple models available to integrate care including provider-led and fee-for-service models, which are not typically referred to as health plans. The included recommendations apply broadly to all entities that provide coverage to dual eligible individuals.

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In line with this commitment, in summer 2021, we released a request for information (RFI) from stakeholders who work closely with the dual-eligible population to learn more about the on-the-ground experience of enrolling in and being enrolled in Medicare and Medicaid programs, with particular attention on integrated models. We received thoughtful and informative feedback from local and national advocacy organizations, thought leaders, integrated health plans and plan associations, and other organizations that represent dual-eligible consumers, which we summarize in the following report. As policymakers contemplate reforms, and we seek to support these efforts, we will consider the findings from this RFI and continue to learn directly from dual-eligible consumers.

Upon receiving and reviewing the RFI responses, we found that while each presented unique insights and recommendations, they coalesced around the principle that consumers be engaged early and often. We also heard a perspective that given that dual-eligible individuals enroll in a range of coverage options, including but not limited to integrated models, the recommendations included should apply to all such entities. Of course, considerations around how to implement this recommendation would be critical for ensuring an improved care experience for the dual-eligible population while still recognizing the benefits associated with and encouraging enrollment in integrated models. Notwithstanding these considerations, respondents indicated that across education and enrollment, care planning and management, and care model assessment and innovation, consumer understanding, consumer buy-in, and consumer input are all key to ensuring that plans meet the needs of the dual-eligible population.

The following report hones in on several themes associated with this overarching finding and outlines proposed recommendations for the federal government, state governments, and health plans to improve the experience of dual-eligible consumers.

These themes include:

- Consumers must receive adequate support to understand their coverage options.
- Enrolling in coverage must be made easier than it is today.
- Integrated plans must provide increased value to dual-eligible beneficiaries relative to alternative plans.
- Plans and providers must gain the trust of consumers.
- Plans must demonstrate their preparedness and ongoing capacity to effectively serve dual-eligible individuals.

The themes we discuss here are drawn from the RFI responses we received—they by no means encompass all consumer experiences, nor are they wholly representative of each respondent's opinion or the opinions of the AV Health Care team.

## **Consumers must receive adequate support to understand their coverage options.**

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Selecting a health care plan is a daunting task for anyone. Those eligible for Medicare, for example, have, in addition to traditional Medicare, an average of 39 Medicare Advantage plans to choose from,<sup>2</sup> each of which may include a unique set of provider networks, benefits, and cost-sharing requirements. Dual-eligible consumers have the added burden of navigating multiple separate systems for the different benefits they access through Medicare and Medicaid. While many mechanisms are currently in place to help consumers navigate enrollment options, very few include both Medicare and Medicaid information. Additionally, educational materials are not always accessible or particularly informative.

Regarding enrollment support, navigation programs are dominated by marketing and brokers who may have financial incentives to enroll dual-eligible individuals into non-integrated plans. While some neutral enrollment counseling programs do exist, for example, the State Health Insurance Assistance Programs (SHIPs), few specifically address the enrollment choices of dual-eligible individuals, and respondents expressed concern that the existing enrollment counseling programs lack the level of Medicare and Medicaid expertise necessary to support enrollment in integrated models.

Further, while consumers may not be wholly satisfied with their current coverage, the sheer number of options may preclude them from considering alternatives. Fewer than three in ten Medicare beneficiaries, for example, compare plans during open enrollment.<sup>3</sup> Additionally, consumers are often skeptical of transitioning to new plans for fear of losing covered benefits, medications, or relationships with their current providers or having additional cost-sharing responsibilities. Unfortunately, programs are not always equipped to educate consumers on how alternative plans fare relative to their current plan across all of these key issue areas.

Educational materials often also fall flat for consumers seeking to better understand their options. Such materials are often written in a language or format that is difficult for consumers to readily understand. Further, coverage models largely fail to distribute these documents to consumers' support systems, such as family, peers, community advocates, social workers, care coordinators, and providers, who often help with enrollment decisions. Achieving buy-in and support from providers is particularly important as perverse incentives may exist that encourage them to advise consumers to stay enrolled in their current plan. Evidence further suggests that outreach often misses key populations, including consumers residing in nursing facilities, consumers experiencing homelessness, and consumers who are frail or have significant functional limitations or cognitive impairments.

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<sup>2</sup> Kaiser Family Foundation. [Medicare Advantage 2022 Spotlight: First Look](#). November 2, 2021.

<sup>3</sup> Kaiser Family Foundation. [Seven in Ten Medicare Beneficiaries Did Not Compare Plans During Past Open Enrollment Period](#). October 13, 2021.

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**The following summarizes some of the solutions related to enrollment support programs and educational materials recommended by the respondents to improve clarity around coverage options for dual-eligible individuals:**

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#### **ENROLLMENT SUPPORT SYSTEM**

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- **Establish an enrollment counseling program tailored to dual-eligible consumers.**  
This program should be comprehensive and the counselors should understand the differences between integrated coverage options and non-integrated coverage options. This could be built on an existing program (e.g., SHIPs, Ombudsman offices) or could be achieved through a new program.
- **Train enrollment counselors on the issues that matter to consumers.**  
Ensure that enrollment counselors are adequately prepared to address key factors in consumers' enrollment decisions, including:
  - The benefits, medications, and providers that would be covered in the new plan compared to their existing plan
  - What cost-sharing requirements exist in the new plan compared to their existing plan
  - What (if any) increased alignments (i.e., one set of benefits, one ID card, etc.) are offered through the new plan compared to their existing plan
- **Address confusion created by plan-funded brokers.**  
Plan-funded brokers provide profit-motivated guidance to dual-eligible individuals that can undermine efforts to provide clear guidance on integrated coverage options.
- **Medicaid Managed Care Organizations (MCOs) should be responsible for assisting with educating their dual-eligible members about their Medicare options.**  
This requirement is especially relevant for those dual-eligible Medicaid MCO members who may enroll in an affiliated Dual-Eligible Special Needs Plan (D-SNP).

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#### **EDUCATIONAL MATERIALS**

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- **Improve marketing and educational materials.**  
Ensure comprehensibility, cultural appropriateness, and language accessibility, including by improving national-level standards and supporting states to improve state-specific resources for any plan that is permitted to enroll dual-eligible individuals. Efforts to improve educational materials should include community input to foster trust and buy-in. For example, both Medicare and Medicaid materials should:
  - Be written at or below a sixth-grade reading level
  - Rely on visuals, as relevant
  - Avoid the use of idioms
  - Be reviewed for cultural competency
  - Be professionally translated, including into braille
  - Be cognitively tested by consumers, especially those with health limitations or whose primary language is not English

- **Include provider directories.**

Provider directories help individuals identify plans that include providers with special experience, cultural competencies, and accessibility. Today, some but not all integrated models are required to provide such resources.

- **Improve marketing and educational material outreach strategies.**

- Conduct outreach not only to consumers themselves but to consumers' trusted information sources. Provider outreach is particularly important, as perverse incentives may exist that encourage this group to advise consumers to stay enrolled in their current plan.
- Conduct outreach in communities, including targeted outreach to populations that are difficult to reach or tend to be overlooked.
- Ensure that outreach is conducted using the preferred and most effective method(s) of communication (i.e., rely on phone or home-visits more than group presentations and use follow-up outreach efforts like mailed materials for extended review).

- **Decouple educational and marketing efforts.**

This recommendation is particularly important within Medicare Advantage because it is already largely addressed within the Medicaid program.

- Require plans to identify when their materials and enrollment services are part of a marketing campaign.
- Marry Medicare Advantage and integrated plans' marketing flexibilities to ensure that non-integrated plans do not have an increased ability to market to dual-eligible individuals relative to plans that integrate Medicare and Medicaid.
- Increase oversight to ensure that plans follow existing CMS marketing guidelines, including ensuring that plans do not telephonically market to prospective beneficiaries.

## **Enrolling in coverage must be made easier than it is today.**

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Beyond confusion around coverage offerings, dual-eligible individuals face barriers to enrolling in plans that best meet their needs, including integrated models. Today's eligibility determination and enrollment processes are neither aligned nor simple. Distinct Medicare and Medicaid enrollment periods and requirements lead to confusion among dual-eligible individuals and complicate efforts on behalf of enrollment counselors and families to present clear, holistic coverage options. Additionally, while enrolling once is confusing enough, dual-eligible individuals are more likely than their Medicare-only counterparts to go through the enrollment process more than once a year. This is because Medicaid is means- and, at times, needs-tested, and as dual-eligible individuals' means and needs fluctuate, they can lose their Medicaid coverage mid-year, requiring them to go through the enrollment process again once they have regained eligibility.

Another barrier to enrollment are Medicare Advantage plans that specifically target the dual-eligible population but provide no degree of integration with Medicaid. These so-called “Dual Eligible Special Needs Plan (D-SNP) look-alikes” further complicate the coverage option landscape and create confusion amongst people seeking to enroll.

**To improve and streamline enrollment in plans, including integrated plans, respondents proposed the following solutions:**

- **Ensure alignment in Medicare and Medicaid enrollment periods for dual-eligible consumers, specifically on the Medicaid side.**  
This will allow for streamlined enrollment into integrated models.
- **Instate 12-month continuous enrollment in Medicaid.**  
This will reduce the frequency with which dual-eligible individuals must navigate the eligibility and enrollment process.
- **Expand use of deeming policies.**  
These policies allow plans to “deem” beneficiaries eligible for Medicaid, regardless of their eligibility status for a certain period. Deeming can limit the frequency with which dual-eligible consumers are required to navigate the eligibility and enrollment process. Plans relying on deeming must adequately inform beneficiaries about the duration of the deeming period and the effective disenrollment date.
- **Allow the use of passive enrollment into integrated care with the option to opt out.**  
Passive enrollment can be used to encourage enrollment in integrated plans. To meaningfully preserve consumers’ right to select their health care coverage, all passive enrollment strategies must be coupled with education and the opportunity to opt out, as well as oversight of the integrated coverage option to ensure it can manage the influx of new members.
- **Limit the availability of non-integrated plans that target dual-eligible individuals.**  
The most common example of such plans is Dual Eligible Special Needs Plan (D-SNP)-look-alikes. Plans like these make it more difficult for dual-eligible individuals to enroll in plans that meaningfully integrate Medicare and Medicaid. While limits to such plans already exist, they must be made more effective.

**Integrated models must provide increased value to dual-eligible beneficiaries relative to alternatives.**

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All plans that enroll individuals who are dually eligible for Medicare and Medicaid should be held to high standards of performance and service offerings. However, by nature of their ability to meaningfully coordinate Medicare and Medicaid benefits, integrated models may stand to better serve dual-eligible individuals. Respondents indicated that promoting enrollment in integrated plans hinges on their ability to offer a unique

value to dual-eligible consumers. In particular, consumers are interested in plans that streamline their care experience, offer the services and benefits that they need or want, and cover specialized providers, including those with whom they have existing relationships.

While models that integrate Medicare and Medicaid must meet certain standards, they do not all meaningfully align the two programs. Rather than behaving as one coverage model with one set of benefits and administrative processes, some integrated plans simply coordinate the two programs while keeping them separate. Integrated plans also face barriers to ensuring continuity of services, benefits, and providers. Further, while some integrated plans are able to entice dual-eligible individuals with added services and benefits that consumers value, including those that address social determinants of health needs, others may lack the flexibility to do so.

**Respondents identified the following recommendations to increase the value associated with integrated models:**

- **The “integrated” plan determination should be meaningful.**  
The existing landscape of plans makes it difficult to understand the value of “integration.” Enrollment in an integrated model should mean that beneficiaries’ Medicaid and Medicare benefits can be accessed from one source and that there is person-level alignment of medical care and long-term services and supports. Allowing plans that do not meet this bar to be referred to as “integrated” contributes to confusion and devalues the term.
- **Plans should be responsible for “integration” of experience at the provider level.**  
Integration of benefits within one at-risk entity should translate into a seamless and well-coordinated patient experience. This includes ensuring that providers are educated about appropriate billing practices so as not to confuse or mis-bill beneficiaries.
- **Benefits should be tailored to the dual-eligible populations and plans should be given the flexibility to deliver person-centered care.**  
Integrated models should be able to offer the benefits and services that consumers value most, including benefits and services that address social determinants of health.
- **Guarantee continuity of care.**  
In the case where plans are unable to cover certain benefits or providers, plans must establish continuity of care transition provisions where, for a certain period, beneficiaries can continue to receive the medications or benefits they receive under their current plan or maintain a relationship with their current providers. Transition periods must be accompanied by adequate outreach and education to ensure that beneficiaries are both aware of any impending coverage losses and supported in finding alternative ways to meet their needs. Providers should also be educated to ensure that they do not turn away temporarily covered beneficiaries.

## Plans and providers must gain the trust of consumers.

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Some health plans, including some integrated plans, fail to create an environment of respect and trust where consumers are confident that those coordinating and delivering their care have their needs and interests in mind. Additionally, while managed care plans can provide important benefits for dual-eligible consumers, these plans have not always been rolled out in a way that has met consumers' needs. Respondents report that without a foundation of trust, consumers are unlikely to enroll and stay enrolled in their plan.

Plans may erode beneficiary trust in several ways. For example, they may fall short in establishing cultural competency or hiring diverse and culturally representative care workers. Dual-eligible individuals, and especially racial or ethnic minorities or people with behavioral health needs, often experience stigma when navigating health care systems. Lack of cultural competency and stigma make it difficult for consumers to feel that their needs are truly understood, that they are respected, or that the interests of the plan are aligned with their own. Respondents indicated that these issues run deeper than the plan—they are experienced at the provider level as well. Therefore, to root out distrust and maltreatment, the entity providing the coverage must be responsible not only for the culture and care perpetuated by their staff but for the culture and care perpetuated by the providers included within their network.

Beyond stigma, the dominant experience for dual-eligible consumers is that their coverage is not person-centered and does not respect their agency—consumers often feel care planning decisions are kept out of reach. This is especially true for consumers who typically make care decisions in concert with an advocate, such as a peer, family member, community group, social worker, or provider, as plans rarely involve these support networks in the care planning process. Moreover, in part due to high levels of staff turnover, dual-eligible individuals can be presented with a significant number of care coordinators, many of whom do not coordinate with one another. The outcome can be that a beneficiary is given agency within one piece of the care planning process, but their decisions may not be honored by another branch of their network.

### **The following outlines some steps that government and plans can take to build consumers' trust:**

- **Reduce stigma and bias across the health care system.**

Train providers, care coordinators, and staff on cultural competency and tactics to reduce stigma and bias, including around race, ethnicity, and mental or behavioral health diagnosis. To the extent possible, the plan should be held accountable for consumers' experience with stigma and bias across the spectrum of care they receive.

- **Use market power to improve provider performance.**

Plans should be expected to hold providers accountable for the culture they perpetuate and the care they provide. When necessary, plans should open competition to attract providers who better meet beneficiaries' needs.



- **Ensure cultural representation among staff.**

Hire care coordinators and other health staff from the local community and/or who are culturally representative of the population they are serving.

- **Ground the care planning process in beneficiaries' preferences.**

This necessitates including the beneficiary in all parts of the care planning process and ensuring that the care plan is reflective of the beneficiary's cultural preferences and natural supports.

- **Include consumers' trusted information sources and support systems in the care planning process.**

- **Increase alignment and communication across the care team.**

Minimize siloes between care coordinators and ensure that care teams are organized around beneficiary needs.

## **Plans must demonstrate their preparedness to serve dual-eligible individuals effectively.**

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While some plans, particularly certain integrated models, are subject to in-depth readiness reviews, which seek to demonstrate whether the entity at-risk for coverage is well-equipped to serve the dual-eligible population, not all plans that enroll dual-eligible individuals are held accountable to such standards. Additionally, respondents posited that readiness reviews do not adequately capture the requirements that ought to be imposed on plans that serve dual-eligible beneficiaries. Additional requirements and oversight are needed to ensure that every plan that enrolls dual-eligible individuals best meets their needs and preferences.

### **The following reflects respondents' recommendations to improve model requirements and accountability:**

- **Hold plans that serve dual-eligible individuals accountable for their care.**

- Improve training around model of care, care plan, and risk assessments.
- Hold staff accountable for the services they provide to dual-eligible beneficiaries.
- Require plans to employ professional translation services, as applicable, coupled with bilingual and culturally representative staff. Prohibit staff and providers from relying on family alone for translation.
- Require plans to include non-medical supports within the care planning team (e.g., recovery coach, certified peer specialist).

- **Expand the use and rigor of readiness reviews for integrated plans.**

- Require plans that enroll high numbers of dual-eligible individuals, including Dual Eligible Special Needs Plan (D-SNPs), to complete readiness reviews.
- Increase oversight of readiness reviews to ensure compliance.

- **Improve national core competencies for the assessment and care planning process.**  
Ensure that plans work with beneficiaries to develop a care plan and receive input and buy-in from beneficiaries before finalizing the care plan. Plan requirements should stipulate that assessments be conducted by trained staff, not third-party contractors.
- **Contract only with integrated plans that have a demonstrated track record of good care and compliance with requirements.**

## **Conclusion**

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The AV Complex Care team thanks the respondents to our RFI for their invaluable contributions to our work. The findings generated through this process will not only help inform our efforts to improve the experience of dual-eligible individuals, but help clarify areas where more research and support are needed. We look forward to continuing to learn from consumers and their advocates.