

BRIEF #3

Medicare-Medicaid Integration:
Essential Program Elements for Integrated
Care Programs for Dually Eligible
Individuals

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This issue brief is part of a multi-phased research initiative to increase enrollment in integrated care programs (ICPs)¹ that meet dually eligible individuals' needs and preferences.

- *Phase 1, ICP Enrollment.* Consistent with other research, we found only 1 in 10 full benefit dually eligible (FBDE) individuals² is enrolled in an ICP. See [Issue Brief #1](#) for more information on Phase 1.
- *Phase 2, ICP Successes and Barriers.* To better understand the factors influencing ICP enrollment, our next phase of research summarized the features for success and the barriers encountered by ICPs. See [Issue Brief #2](#) for more information on Phase 2.
- *Phase 3, ICP Essential Elements.* To encourage ICP enrollment and retention, our third phase of research identified the essential elements of ICPs centered around, informed by, and made available to dually eligible individuals.

Informed by stakeholder interviews, this brief identifies 10 essential elements for establishing and simplifying ICP programs dually eligible individuals want to enroll in. It provides recommendations for federal and state policy changes and resource supports needed to build these elements into ICPs regardless of program model.

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¹ For this brief, ICPs are defined as financing and care delivery organizing entities or programs that coordinate and integrate Medicare and Medicaid-covered services and supports for dually eligible individuals.

² When using the term dually eligible individuals in this brief, we are referencing Medicare-Medicaid full benefit dually eligible individuals (FBDEs), those who qualify for full Medicaid benefits. Others who solely qualify for assistance with payment of Medicare premiums, and in some cases, Medicare cost sharing, are referred to as partial benefit dually eligible individuals and are not the subject of this brief.

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EXECUTIVE SUMMARY

Federal and state policy makers have long been working to expand enrollment in integrated care programs (ICPs). However, approximately only 1 in 10 dually eligible individuals is enrolled.^{i,ii} For this brief, ICPs are defined as financing and care delivery organizing entities or programs that coordinate and integrate Medicare and Medicaid-covered services and supports for dually eligible individuals. This definition includes the Centers for Medicare & Medicaid Services (CMS) Financial Alignment Initiative (FAI) capitated model, which includes participating Medicare and Medicaid Plans (MMPs), and managed fee-for-service model; the Program of All-Inclusive Care for the Elderly (PACE); Medicare Advantage (MA) Fully Integrated Dual Eligible Special Needs Plans (FIDE SNPs); Medicaid Managed Long-Term Service and Supports Program (MLTSS) managed care organizations and aligned MA dual eligible special needs plans (D-SNPs); and state-specific programs that may be proposed to CMS. [See Table 2 ICP Models.](#)

ICPs are a promising model to provide services and supports to dually eligible individuals and to enable them to achieve higher quality of life and preferred outcomes – to live independently and engage in their communities. To date, enrollment has been concentrated in the CMS FAI capitated model and, most recently, in MLTSS with aligned D-SNPs (MLTSS+D-SNPs). As of January 2019, approximately 388,000 individuals were enrolled in capitated FAI models and approximately 386,000 individuals were enrolled in aligned MLTSS+D-SNP models.ⁱⁱⁱ

To increase ICP enrollment and expand availability, policy makers need to partner with consumers to inform program design and address limited state capacity. Consumers need programs tailored to their diverse needs and preferences, and a system that is easy to navigate. ICP development efforts also need to account for state capacity constraints, as well as variation in geography, and overall state landscape to achieve these goals.

ICPs should be designed in partnership with dually eligible individuals. All are very low-income and the majority experience some combination of multiple chronic conditions, mental illness and/or substance use disorder, cognitive and physical disabilities, and social needs.^{iv} They are also diverse in race, ethnicity, age, gender, sexual orientation, health status, disability type, and other characteristics. Of note, Black, Indigenous, and people of color (BIPOC) and Latinx people comprise a greater share of the dually eligible population than Medicare-only individuals. The population's composition magnifies the imperative to address health equity.^v

States have a large role to play in standing up and overseeing ICPs; however, many lack the necessary capacity and infrastructure, limiting ICP growth. ICPs require strong Medicaid agency leadership and dedicated staff with policy and financial expertise in Medicare and Medicaid. They also need information technology infrastructures and analytic and oversight capacity. States must balance their wish to allocate resources and funding to develop and implement successful ICPs against budgetary pressures. To address state capacity, many prominent policy experts and the Congressional advisory commission Medicaid and CHIP Payment and Access Commission (MACPAC) recommend the federal government consider providing states with additional support and incentives to undertake this important yet complex and time-consuming work.^{vi} Federal support for the states could be provided in the form of

start-up grants to states to stand up ICPs or funding supports for Medicare and Medicare-Medicaid integration expert staff at state Medicaid agencies.

Informed by stakeholder interviews, HMA identified 10 essential elements for establishing and simplifying ICPs programs in which dually eligible individuals want to enroll and stay enrolled. These elements should be considered an interconnected set of baseline requirements for all ICPs regardless of model. Incorporating some but not all applicable elements will perpetuate the confusing, complicated, and fragmented systems of care and supports most dually eligible individuals must navigate and the delivery system limitations that persist. The 10 elements are organized into three categories: eligibility and enrollment; delivery of care and supports; and critical consumer access. For each element, we propose policy recommendations at the federal and state government and ICP levels.

Table 1. Ten Essential Elements for ICPs and Policy Recommendations

ESSENTIAL ELEMENTS AND POLICY RECOMMENDATIONS	
CATEGORY 1: ELEMENTS FOR ELIGIBILITY AND ENROLLMENT INTO ICPs	
1	Simplified Medicare and Medicaid eligibility processes and paperwork
Federal	<ul style="list-style-type: none"> ✓ Create a library of simplified, easy to read, culturally responsive and disability and linguistically-accessible Medicaid eligibility forms available through a state self-service portal.
State	<ul style="list-style-type: none"> ✓ Conduct targeted outreach to Medicaid enrollees three months prior to turning age 65 to support individuals with Medicaid eligibility redeterminations and coordinate with Medicare eligibility processes. ✓ Send ICPs serving individuals under age 65 “turning 65” reports to identify enrollees turning 65 every six months.
ICP	<ul style="list-style-type: none"> ✓ Conduct targeted outreach to individuals in the turning 65 report to provide support for maintaining eligibility.
2	Comprehensive and expert consumer choice counseling and/or enrollment assistance
Federal	<ul style="list-style-type: none"> ✓ Develop standardized base training for State Health Insurance Programs (SHIPs) which simplify explanations of ICP options for consumers and empowers choice. ✓ Establish a national dually eligible individual help line and online resource center to answer questions about available ICP programs.
State	<ul style="list-style-type: none"> ✓ Augment the federal base training program with state specific ICP enrollment options to train SHIPs and other state selected entities providing choice counseling and enrollment assistance.
CATEGORY 2: ELEMENTS FOR DELIVERY OF CARE AND SUPPORTS IN ICPs	
3	Diverse consumer input to inform tailored delivery systems and integrated programs
Federal	<ul style="list-style-type: none"> ✓ Provide support to state Medicaid programs to establish a permanent consumer-led implementation council to provide consumers (and family members and guardians) with an active role in designing, implementing, overseeing, and refining ICPs. Consumers should reflect the diverse dually eligible population. Other participating stakeholders would include providers, community-based organizations (CBOs) and ICP entities. ✓ Develop a consumer-informed toolkit for developing, operationalizing, and measuring the effectiveness of consumer-led implementation councils.

ESSENTIAL ELEMENTS AND POLICY RECOMMENDATIONS	
	<ul style="list-style-type: none"> ✓ Provide resources to convene effective consumer-led implementation councils. ✓ Collaborate with state Medicaid programs to identify best practices for using program funding to compensate consumers for sharing expertise to inform ICPs.
State	<ul style="list-style-type: none"> ✓ Using the federal toolkit, create consumer-led implementation councils for ICPs. ✓ Provide on-the-ground assistance for planning and convening consumer-led implementation council meetings.
ICP	<ul style="list-style-type: none"> ✓ Participate in the consumer-led implementation council and provide the council with supporting information and data as needed. ✓ Convene consumer advisory councils and provide training to consumers to ensure meaningful participation, applicable to some but not all ICPs.
4	Robust data infrastructure to tailor and adapt program approaches and drive health equity
Federal	<ul style="list-style-type: none"> ✓ Publish annual state-specific chart packs on dually eligible individuals that share information on eligibility, service use, and costs, based on combined Medicare-Medicaid data files.
State	<ul style="list-style-type: none"> ✓ Establish a data infrastructure with the capacity to support data collection and sharing, analytics and evaluation, including health disparity measurements.
ICP	<ul style="list-style-type: none"> ✓ Collect a specified list of data including race and ethnicity and social assessment data at the ICP level, supported by data collection systems that incorporate data from CBOs.
5	Coordinated efforts to maximize capabilities to address unmet social needs
Federal	<ul style="list-style-type: none"> ✓ Define a federal minimum data set for social risk factor collection by ICPs through use of ICD-10-CM Z codes and individual needs assessments.
State	<ul style="list-style-type: none"> ✓ Identify social risk factors beyond the federal minimum data set for ICPs to assess and incorporate into person-centered care plans. ✓ Develop social risk adjustment models using social risk factors to advance payment accuracy and quality as a complement and/or enhancement to the federal approach.
ICP	<ul style="list-style-type: none"> ✓ Collect and submit social risk factor data to comply with federal and state data set requirements. ✓ Use individual assessment information to make appropriate referrals for services, and document service provision and outcomes. ✓ Partner with CBOs to identify and facilitate addressing unmet social needs.
6	Single process for assessments and plans of care, and one care team for each consumer
Federal	<ul style="list-style-type: none"> ✓ Document and share successful ICP approaches for developing and overseeing single processes for assessment and plans of care, and one interdisciplinary care team.
State	<ul style="list-style-type: none"> ✓ Extend existing ICP requirements to all ICPs that one ICP care coordinator conduct assessments and create a single person-centered care plan with the individual. ✓ Extend existing ICP requirement to all ICPs that ICPs have a single interdisciplinary care team for all Medicare and Medicaid services and supports which includes the consumer's self-identified key HCBS provider. ✓ Review and approve ICP training programs for care coordinators on the diverse characteristics, needs, and preferences of dually eligible individuals and subpopulations, and on operationalizing the independent living philosophy and recovery principles.^{vii}
ICP	<ul style="list-style-type: none"> ✓ Submit training program curriculum for care coordinators to the state for approval.

ESSENTIAL ELEMENTS AND POLICY RECOMMENDATIONS	
	<ul style="list-style-type: none"> ✓ Have one care coordinator conduct assessments and create a single person-centered care plan covering all Medicare and Medicaid services and supports for enrollees. ✓ Have a single interdisciplinary care team, which may include peer support workers and disability advocates, as desired by individuals.
7	Meaningful and transparent quality measurement to empower consumers and stakeholders
Federal	<ul style="list-style-type: none"> ✓ Develop a set of ICP quality indicators in partnership with consumers to build upon the current Medicare and state-specific Medicaid measurement sets.
State	<ul style="list-style-type: none"> ✓ Incorporate state ICP quality indicators developed in partnership with the consumer-led implementation council. ✓ Develop ICP quality indicator reporting templates in partnership with the consumer-led implementation council.
ICP	<ul style="list-style-type: none"> ✓ Collect and report federal and state quality indicators to the state using reporting templates.
8	Payment models to incentivize consumer quality of life improvements
Federal	<ul style="list-style-type: none"> ✓ In partnership with a national consumer and provider expert panel, develop a community first ICP VBP toolkit to improve consumer quality of life and outcomes, as well as advance ICP essential elements.
State	<ul style="list-style-type: none"> ✓ Develop, in partnership with the consumer-led implementation council, ICP VBP plan requirements to improve consumer quality of life and to advance ICP essential elements. ✓ Review and approve ICP VBP plans. ✓ Make all ICP VBP plans transparent to stakeholders by publishing plans to the state’s Medicaid website.
ICP	<ul style="list-style-type: none"> ✓ Develop and submit ICP VBP plan to the consumer-led implementation council for review and then to the state for approval.
CATEGORY 3: ELEMENTS TO SUPPORT CRITICAL CONSUMER ACCESS IN ICPs	
9	Adequate, engaged, and diverse workforce to support consumer needs and preferences
Federal	<ul style="list-style-type: none"> ✓ Provide technical assistance to states and ICPs, through CMS and the Administration for Community Living (ACL), to improve workforce recruitment and retention by establishing clearer role definitions, best practices, and guidelines for determining sufficient living wages, and developing a meaningful career ladder. ✓ Develop base training for ICP medical and non-medical providers on the diverse characteristics, needs, and preferences of dually eligible individuals and subpopulations, and on independent living and recovery principles.
State	<ul style="list-style-type: none"> ✓ Add state-specific training requirements to federal base training as identified in partnership with the consumer-led implementation council. ✓ Define qualified family caregivers to whom ICPs must provide supports, education, coaching, respite and, in some instances, compensation for services provided.
ICP	<ul style="list-style-type: none"> ✓ Conduct specialized recruitment for a diverse workforce with experience with dually eligible subpopulations, including peer support workers and people with lived experience of disability. ✓ Train providers, including health, behavioral health, and LTSS direct care workers, using the base training created by CMS and any state-specific additional training elements.

ESSENTIAL ELEMENTS AND POLICY RECOMMENDATIONS	
10	Access to needed services in rural areas
Federal	<ul style="list-style-type: none"> ✓ Provide support to state Medicaid agencies for consumer-run implementation council workgroups made up of diverse stakeholders to address access issues in rural areas. ✓ Review and modify regulatory requirements impeding access in rural areas for the Medicare program and Medicaid program.
State	<ul style="list-style-type: none"> ✓ Review and approve ICP innovation plans to expand access to services and supports in rural areas. ✓ Review and modify regulatory requirements impeding access in rural areas for the Medicaid program.
ICP	<ul style="list-style-type: none"> ✓ Work with the state to collaboratively close gaps in access to care and services in rural areas. ✓ Develop and submit innovation plans incorporating asset-based provider networks to expand rural access.

INTRODUCTION

Dually eligible individuals are diverse in race, ethnicity, age, gender, health, and disability type, and other characteristics. All dually eligible individuals are very low-income and the majority experience some combination of multiple chronic conditions, behavioral health needs, cognitive and physical disabilities, and social needs including unstable housing, lack of access to transportation, food insecurity, employment instability, exposure to community and interpersonal violence, and social isolation and loneliness.^{viii} Accordingly, dually eligible individuals are more likely to report that they are in poor health than Medicare-only individuals.^{ix} In 2017, the average annual total spend for Medicaid, Medicare, and other coverage for dually eligible individuals was approximately double the spend for Medicare-only individuals, at \$30,510 compared to \$15,630.^x

Most dually eligible individuals must navigate two programs that are almost entirely siloed, operating under different policies and processes. Health disparities inherent in the current health care system compound these barriers. Black, Indigenous, and people of color (BIPOC) and Latinx people comprise a greater share of the dually eligible population than among Medicare-only individuals magnifying the need to ground new programs in health equity, designed around an intersectional understanding of health disparities.^{xi} During the COVID-19 pandemic, dually eligible individuals have been disproportionately affected with poorer health outcomes such as higher mortality rates and hospitalization rates approximately 2.6 times higher than Medicare-only individuals.^{xii}

The federal government through CMS has encouraged states to better coordinate and integrate Medicare and Medicaid. Federal and state policy makers are working to significantly expand enrollment in integrated care programs (ICPs). ***For this paper, ICPs are defined as financing and care delivery organizing entities or programs that coordinate and integrate Medicare and Medicaid-covered services and supports for dually eligible individuals. See Table 2 below.***

Table 2. ICP Models

ICP Models		
#	Program Type	Definition
1	Financial Alignment Initiative (FAI)	Two CMS demonstration models with states to better align the financing of Medicare and Medicaid and integrate primary, acute, behavioral health and LTSS for dually eligible individuals. ^{xiii} The two FAI models are described below.
	Capitated model	A state, CMS and a health plan, referred to as a Medicare-Medicaid Plan (MMP), enter into a three-way contract, and the plan receives a prospective blended payment to provide comprehensive, coordinated care. ^{xiv}
	Managed Fee-for-Service Programs (MFFS) model	A state and CMS enter into an agreement through which the state is eligible to benefit from savings resulting from initiatives that improve quality and reduce costs for Medicare and Medicaid. ^{xv}
2	Program of All-Inclusive Care for the Elderly (PACE)	An integrated program of medical and social services directed by a Medicare program provider and managed by an interdisciplinary team of healthcare professionals for certain frail, community-dwelling individuals who are eligible for

ICP Models		
#	Program Type	Definition
		institutional levels of care. ^{xvi} PACE providers receive monthly Medicare and Medicaid capitation payments for each enrolled dually eligible individual. ^{xvii}
3	Medicare Advantage (MA) Fully Integrated Dually Eligible Special Needs Plans (FIDE SNPs)	MA Dually Eligible Special Needs Plans (D-SNPS) with FIDE SNP designation that provide Medicare and Medicaid benefits by a single health plan entity, consistent with state policy.
4	Medicaid Managed Long-Term Service and Supports Program (MLTSS) managed care organizations and aligned D-SNPs (MLTSS+D-SNP)	MLTSS managed care organizations are required by the state to operate a companion D-SNP with dual integration requirements contained in the state Medicaid agency contract (SMAC). This program operates as an ICP when enrollees are enrolled in aligned MLTSS managed care organizations and D-SNPs.
5	State-specific programs	States may propose unique ICPs to CMS for approval.

Federal and state policy makers have long been working to expand enrollment in ICPs; however, approximately only 1 in 10 dually eligible individuals is enrolled.^{xviii} ICPs are a promising model to provide services and supports to dually eligible individuals and to enable them to achieve higher quality of life and preferred outcomes – to live independently and engage in their communities. To date, access and enrollment has been concentrated in the CMS FAI capitated model and, most recently, in aligned MLTSS managed care organizations and D-SNPs (MLTSS+D-SNPs). As of January 2019, approximately 388,000 individuals were enrolled in capitated FAI models and approximately 386,000 individuals had aligned enrollment in MLTSS+D-SNP models.^{xix}

To expand ICP availability and increase enrollment, policymakers need to work in partnership with consumers to inform program design and address limited state capacity. Consumers need programs tailored to their diverse needs and preferences, and a system that is easy to navigate. ICP development efforts also need to account for constraints in state capacity and variations in geography, and overall state landscapes to achieve these goals.

While state and CMS partnerships have advanced the creation of these ICPs, states have a large role to play in standing up and overseeing ICPs. Many lack the necessary capacity and infrastructure, limiting ICP growth. ICPs require strong Medicaid agency leadership and dedicated staff with policy and financial expertise in Medicare and Medicaid. They also need information technology infrastructures and analytic and oversight capacity. States must balance their wish to allocate resources and funding to develop and implement successful ICPs against budgetary pressures. To address state capacity, many prominent policy experts and the Congressional advisory commission Medicaid and CHIP Payment and Access Commission (MACPAC) recommend the federal government consider providing states with additional support and incentives to undertake this important yet complex and time-consuming work.^{xx} This could be provided in the form of federal start-up grants to states to stand up ICPs or federal funding supports for Medicare and Medicare-Medicaid integration expert staff at state Medicaid agencies.

Medicare-Medicaid Integration Project

Health Management Associates (HMA), with support from Arnold Ventures, designed a multi-phase research initiative to identify policy solutions to ensure that dually eligible individuals receive seamless, individualized care through ICPs that meet their needs and preferences and encourage enrollment.

- **Phase 1, ICP Enrollment.** In the first phase of research we analyzed the availability of ICPs in states. We also analyzed the growth and differences in enrollment in integrated programs across the country. Consistent with other research, we found only 1 in 10 dually eligible individuals is enrolled in an ICP.^{xxi} We also found that much enrollment is concentrated in dual demonstration programs authorized under the CMS FAI capitated model, which operates in a limited number of states, and some programs experience high rates of individuals opting out. This led to questions why, when ICPs are available, consumers elect not to enroll or disenroll after receiving care and services from these programs. See [Issue Brief #1](#) for more information on Phase 1.
- **Phase 2, ICP Successes and Barriers.** To better understand the factors contributing to limited ICP enrollment, our next phase of research summarized the features for success and the barriers encountered by ICPs based on a review of literature and available public information. In this work we identified key questions requiring answers to better inform ICPs on how to meet the needs of the dually eligible population.^{xxii} See [Issue Brief #2](#) for more information on Phase 2.
- **Phase 3, ICP Essential Elements.** Our research path led us to a third phase in which we identified the essential elements of ICPs centered around, informed by, and made available to dually eligible individuals and encourage ICP enrollment and retention.

This third issue brief summarizes the perspectives of a range of stakeholders interviewed on how ICPs can best serve the needs of dually eligible individuals regardless of the structure of the program model – whether care and supports are delivered through private managed care plans or another delivery model. Stakeholders included consumers, consumer advocates, providers, community-based organizations (CBOs), a highly integrated health plan, and state policymakers. We interviewed stakeholders from states that offer highly integrated ICPs to low or nascent states on dual integration policy. This range of states also provided perspectives unique to both urban and rural areas. Our four target states included:

- *Michigan*, which offers a highly integrated product through the financial alignment initiative, aka “dual demonstration,” using MMPs
- *Pennsylvania*, which has a Medicaid managed long-term services and supports program (MLTSS) requiring participating MCOs to also operate a companion D-SNPs
- *Oklahoma* and *Louisiana*, which do not currently have ICPs operating in the state, other than a limited number of Program of All-Inclusive Care for the Elderly (PACE) programs

Based on stakeholder interviews, this brief identifies 10 essential elements and policy recommendations for ICPs. The elements are organized into the following three categories:

- Eligibility and enrollment into ICPs

- Delivery of care and supports in ICPs
- Critical consumer access in ICPs

Many, if not all elements have been the focus of previous and ongoing state and federal efforts to improve health and social service delivery to dually eligible individuals and those eligible for only Medicaid with similar needs and preferences. *These 10 essential elements need to work in tandem and move forward simultaneously to achieve meaningful expansions in integrated care for dually eligible individuals. The policy recommendations presented in this paper further identify actions that can be taken at the federal, state, and local ICP levels to advance these 10 essential elements. We recognize implementation may require additional investments to achieve their long-term attainment. States will need additional support from the federal government to address state capacity to design and implement ICPs with these elements.*

METHODOLOGY

HMA conducted interviews with dually eligible individuals, dually eligible consumer advocates, CBOs, provider associations, state regulators, and health plans to better understand and define the critical components of a successful ICP that is informed by, centered around, and supportive of dually eligible individuals. We paid particular attention to the experiences of individuals with disabilities and racial and ethnic minority populations. We identified and selected interviewees based on their lived and learned experiences and knowledge of the dually eligible population, and to represent a diverse array of perspectives. HMA conducted a total of 19 individual or group interviews representing 6 stakeholder groups. In total, we interviewed 39 people. A complete list of interviewees can be found in [Appendix A – Stakeholder Interviewees](#).

HMA developed and used semi-structured interview guides to elicit interviewee perspectives on the elements that contribute to a successful ICP and ensure that ICP options meet the needs and preferences of the population. HMA structured the interviews according to eight overarching questions:

1. **Program goals.** What are the highest priorities and goals for programs or approaches to integrating care for dually eligible individuals/consumers/patients?
2. **Key components.** How well do current programs meet dually eligible individuals' needs? What are the essential elements integrated programs must have?
3. **Opportunities to better engage and serve the population.** How can ICP programs meet the needs of all dually eligible individuals and their unique characteristics?
4. **Consumer input, education, and awareness.** How can integrated programs provide consumers, their families, and advocates with a “seat at the table” to best inform and shape the design, development, implementation, and ongoing refinement of ICPs? How should consumer outreach and education efforts be structured to ensure that consumers with diverse health and social needs and backgrounds have the support to make informed choices regarding their coverage and care?

5. **Providers' ability to provide tailored services and supports.** To what extent do integrated care options (or lack thereof) help or hinder providers' ability to care for dually eligible individuals? How can providers be supported to provide care and service delivery that accounts for the unique social, cultural, or linguistic needs of the individuals you serve?
6. **Additional state or federal supports.** How can states be supported and prompted to move forward with integrating care with federal partners?
7. **Financial implications of integrated care.** What are the financial implications of integrated care for providers, and state and federal governments?
8. **Future policy changes needed.** How can state and federal policy be changed overall to better serve people with complex needs?

Interviewees were selected to represent a full range of individual experiences across different types of states – from stakeholder experience in highly integrated states, moderately integrated states, and low or minimally integrated states. In all, HMA interviewed stakeholders in four states, which ranged from more mature ICP efforts to low to nascent efforts to develop ICPs. HMA also sought to ensure that stakeholders represented input from those in states diverse in population demographics and urban and rural geographies. State selection criteria included:

- Level of integration efforts to develop ICPs (nascent or low/medium/high)
- Geographic representation (census area and rural/urban/frontier)
- Number of dually eligible individuals (national ranking)
- Racial, ethnic, and cultural diversity of residents

Based upon state selection criteria and other factors including status of COVID-19 pandemic prevalence in states, we chose to interview stakeholders in Louisiana, Michigan, Oklahoma, and Pennsylvania. ([See Appendix B – State Selection with Criteria](#))

HMA obtained input on this brief from 14 external expert reviewers with distinct vantage points on advancing integrated care for dually eligible individuals. They included perspectives of consumers and their families and caregivers, state and federal governments, providers, and community-based organizations (CBOs).

Limitations

HMA experienced limited availability of some potential interviewees due to the priority of addressing the COVID-19 pandemic, particularly among state officials. The lack of availability was exacerbated by the resulting economic downturn and states' need to focus on budget shortfalls.

While interviews occurred with stakeholders from only four states, we believe information gathered resonates for the country at large, based on the state selection criteria used.

HMA intentionally included two states – Oklahoma and Louisiana – with low to nascent activity on dual integration, knowing that stakeholders in those states may not be as familiar with dual integration and integrated care, and therefore, less likely to engage in the HMA interview process. Across these two

states we conducted a total of 4 interviews which involved 12 individuals, including Medicaid officials from both Oklahoma and Louisiana.

FINDINGS - ELEMENTS NEEDED FOR A SYSTEM THAT IS INFORMED BY, CENTERED AROUND, AND SUPPORTIVE OF DUALY ELIGIBLE INDIVIDUALS

The overarching theme from interviews with stakeholders is that ICPs and related processes must be consumer oriented and simple for them to navigate. Dually eligible individuals need clear, understandable information related to the programs available to them. ICPs must be informed by and tailored to the diverse characteristics and preferences of dually eligible subpopulations. All ICPs require a single, unified care coordination system that captures social needs as well as clinical needs. These themes are woven throughout the ICP essential elements.

The 10 essential elements are baseline requirements for establishing ICP programs in which individuals will want to enroll because they meet their needs. These elements are interconnected. Incorporating some but not all applicable elements will perpetuate the confusing, complicated, and fragmented systems of care and supports most dually eligible individuals must navigate, and as shared by stakeholders interviewed, the delivery system limitations that persist. The 10 essential elements fall into the following categories:

Eligibility and enrollment into ICPs

- ✓ **Element 1.** Simplified Medicare and Medicaid eligibility processes and paperwork
- ✓ **Element 2.** Comprehensive and expert consumer choice counseling and/or enrollment assistance

Delivery of care and supports in ICPs

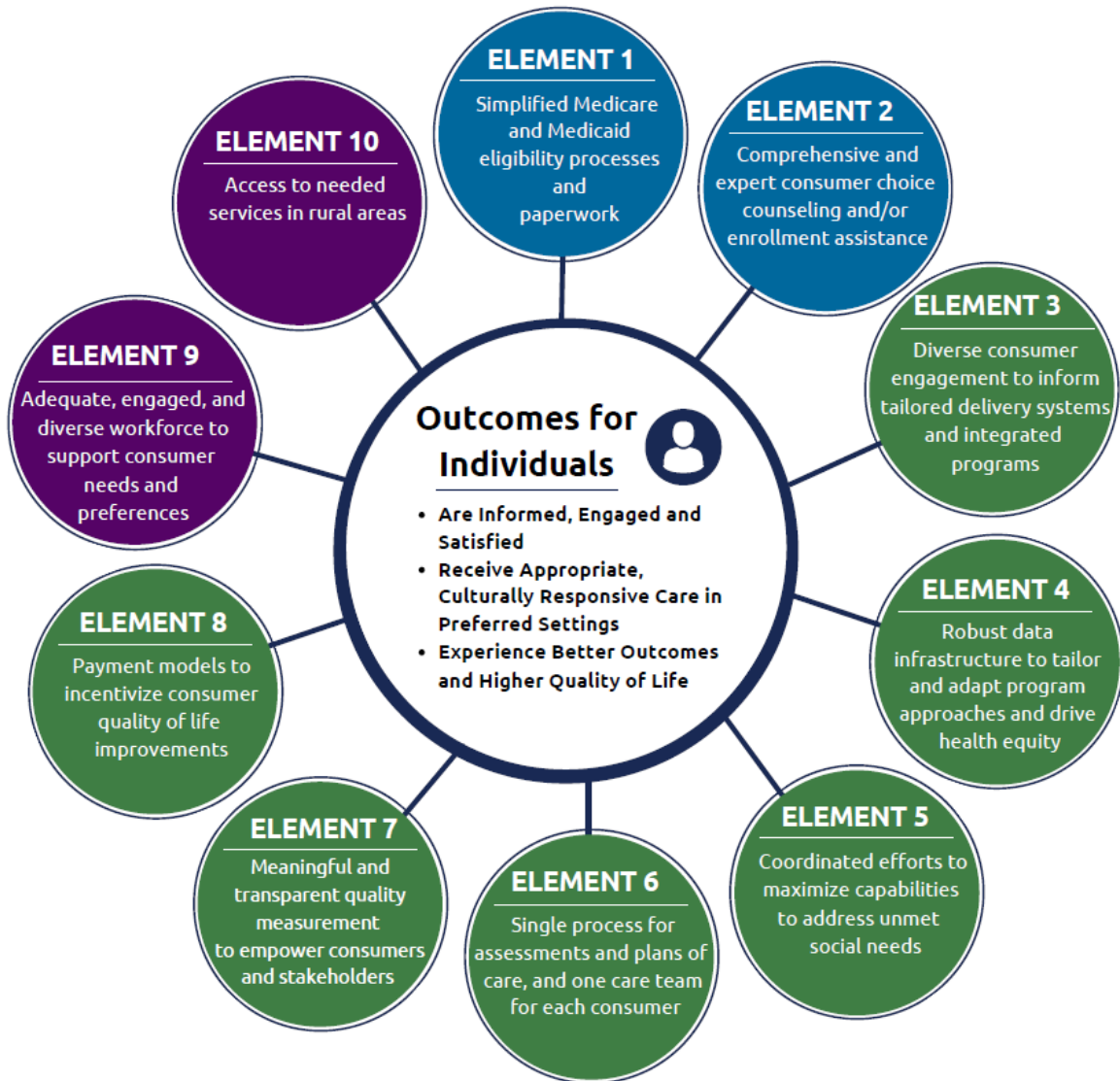
- ✓ **Element 3.** Diverse consumer engagement to inform tailored delivery systems and integrated programs
- ✓ **Element 4.** Robust data infrastructure to tailor and adapt program approaches and drive health equity
- ✓ **Element 5.** Coordinated efforts to maximize capabilities to address unmet social needs
- ✓ **Element 6.** Single process for assessments and plans of care, and one care team for each consumer
- ✓ **Element 7.** Meaningful and transparent quality measurement to empower consumers and stakeholders
- ✓ **Element 8.** Payment models to incentivize consumer quality of life improvements

Critical consumer access in ICPs

- ✓ **Element 9.** Adequate, engaged, and diverse workforce to support consumer needs and preferences
- ✓ **Element 10.** Access to needed services in rural areas

Figure 1 below shows the constellation of elements interviewees consistently stated are needed in ICPs. It depicts the relationship between each element and the direct relationship between each element and outcomes for the individual.

Figure 1. ICP essential elements informed by and built around dually eligible individuals



Ten Essential Elements for ICPs

Eligibility and enrollment into ICPs

✓ *Element 1: Simplified Medicare and Medicaid eligibility processes and paperwork*

Interviewees underscored that dually eligible individuals' confusion in accessing health care and supports through the two programs starts with the application and eligibility processes for Medicare and Medicaid. They must navigate two separate, complicated eligibility processes.

Most interviewees, particularly consumers and consumer advocates, shared there is a need to simplify and align the Medicare and Medicaid enrollment processes through effective no wrong door approaches that connect consumers to the right entities for processing eligibility. Required forms are dense and contain language that is difficult for individuals to understand. Documents should use clear, plain language and simplify information. One interviewee noted that Michigan Medicaid's revised forms for publicly financed programs "made all the difference" in making it easier to complete the process; a change in wording and improved layout with boxes to check and larger font made the process much less stressful. ([Link to Michigan Medicaid and Other Public Assistance Application Form](#))

Consumers shared that they lose and regain dual eligibility status due to process delays and difficulty navigating Medicaid eligibility requirements at critical times: 1) when they turn age 65 and must meet different Medicaid eligibility requirements than those for people under 65; 2) when they apply for Medicaid home and community-based waiver programs that require meeting functional level of care criteria in addition to financial eligibility requirements; and 3) during Medicaid redeterminations. Interviewees most frequently cited difficulty with eligibility determinations when turning age 65. They shared that losing dual eligibility status results in confusion, affects enrollment options, and disrupts care.

Element 1 Recommendation

Administration of eligibility processes under current authorities for Medicare and Medicaid should be simplified and clarified for people navigating the two distinct systems and support stability in enrollment. Individuals should have easy access to publicly available information that walks them through the steps and required paperwork for the Medicare and Medicaid eligibility processes that is as streamlined as feasible. Federal officials should compile examples of forms that are clear and contain digestible amounts of information. Individuals should receive targeted outreach and support prior to turning 65 when Medicaid eligibility is determined using criteria different from eligibility criteria for people under age 65. Further, federal and state governments could consider a deeming period of Medicaid eligibility for individuals during pending eligibility applications and redeterminations affecting dual eligibility status.³

³ For example, in California, deeming "allows a beneficiary who has lost full-scope Medi-Cal eligibility to remain in a Cal MediConnect plan for a certain period of time before being disenrolled from the plan. In other words, a beneficiary is *deemed eligible* for purposes of Cal MediConnect enrollment. Essentially, deeming provides a grace period for maintaining Cal MediConnect eligibility." "Two Cal MediConnect Eligibility Protections: Deeming and Aid-Paid-Pending," Justice in Aging, Fact Sheet, <http://www.dualdemoadvocacy.org/wp-content/uploads/2017/04/Updated-Cal-MediConnect-Deeming-042017.pdf>

Element 1: Simplified Medicare and Medicaid eligibility processes and paperwork	
Federal	✓ Create a library of simplified, easy to read, culturally responsive and disability and linguistically-accessible Medicaid eligibility forms available through a state self-service portal.
State	<ul style="list-style-type: none"> ✓ Conduct targeted outreach to Medicaid enrollees three months prior to turning age 65 to support individuals with Medicaid eligibility redeterminations and coordinate with Medicare eligibility processes. ✓ Send ICPs serving individuals under age 65 “turning 65” reports to identify enrollees turning 65 every six months.
ICP	✓ Conduct targeted outreach to individuals included in the turning 65 report to provide support for maintaining eligibility.

✓ *Element 2: Comprehensive and expert consumer choice counseling and/or enrollment assistance*

As individuals navigate eligibility processes, they are often simultaneously evaluating coverage and enrollment options. All stakeholder groups interviewed shared that the current choice process is a source of confusion and frustration and that existing educational channels and resources for dually eligible individuals do not adequately empower them to make well-informed and meaningful decisions. Many interviewees relayed that they receive varying levels of availability, objectivity, and sophistication among people providing supports and, in some cases, they receive inaccurate information. These interviewees also noted that existing resources do not provide information that is most important for consumers, such as whether they would have access to their existing providers and the settings in which they are eligible to receive certain services.

One state agency official confirmed that many dually eligible individuals are not aware of or do not have access to “robust” options counseling where they reside. One consumer shared the lack of information about the availability of a Medicaid home and community-based waiver program that could have provided supports to enable their spouse to remain at home and prevent nursing facility placement. Another consumer shared that they received inadequate information about their enrollment options, which did not include their ability to enroll in a fully integrated health plan option available to them – a FIDE SNP. Previously, they had been enrolled with that health plan’s Medicaid health plan option.

Dually eligible individuals may receive in-person and telephonic support from State Health Insurance Assistance Programs (SHIPs)⁴ administered through local Area Agencies on Aging (AAAs),⁵ and Aging and

⁴ SHIPs are state programs that receive funding from the federal government to provide free local health coverage counseling to people with Medicare. Glossary, Healthcare.gov, <https://www.healthcare.gov/glossary/state-health-insurance-assistance-program/>

⁵ AAAs are public or private nonprofit agencies designated by a state to address the needs and concerns of older persons at the regional and local levels. Area Agencies on Aging, Administration for Community Living, <https://acl.gov/programs/aging-and-disability-networks/area-agencies-aging#:~:text=An%20Area%20Agency%20on%20Aging,the%20regional%20and%20local%20levels.>

Disability Resource Centers (ADRCs).⁶ Some interviewees attributed variation in quality of enrollment assistance to limited federal and state resources to administer SHIP programs and a lack of standardized training to ensure volunteers are well-informed about all coverage options available to dually eligible individuals.

Dually eligible individuals also receive information from Medicare agents and brokers, Medicaid enrollment brokers, and health plans. Several interviewees stated that dually eligible individuals are “inundated” with information from television advertisements and materials from health plans, making it difficult for them to process the information and compare one enrollment option with another.

Element 2 Recommendation

The Administration for Community Living (ACL) should work with CMS, including the Medicare-Medicaid Coordination Office (MMCO), to develop a standardized base training for SHIPs. This base training could help ensure a minimum level of accuracy, consistency and accountability in eligibility assistance and enrollment education for dually eligible individuals. It could also ensure that options counselors are familiar with all available ICP options and other programs that support an individual’s goals for independent living, recovery and community engagement. States, and local AAAs and ADRCs could build upon the national base training to ensure that SHIP counselors are well educated on the specific eligibility requirements and ICP enrollment options within their states.

States can augment their choice counseling and enrollment infrastructure by training CBOs including Independent Living Centers (ILCs) and providers about Medicare and Medicaid eligibility and ICP enrollment options.

In addition to more comprehensive and expert in-person and telephonic enrollment support services, individuals may also benefit from tailored and targeted informational resources to support their independent navigation, such as a consumer accessible website.

Element 2: Comprehensive and expert consumer choice counseling and/or enrollment assistance	
Federal	<ul style="list-style-type: none"> ✓ Develop standardized base training for State Health Insurance Programs (SHIPs) which simplify explanations of ICP options for consumers and empowers choice. ✓ Establish a national dually eligible individual help line and online resource center to answer questions about available ICP programs.
State	<ul style="list-style-type: none"> ✓ Augment the federal base training program with state specific ICP enrollment options to train SHIPs and other state-selected entities selected to provide choice counseling and enrollment assistance.

⁶ ADRCs serve as single points of entry into the LTSS system for older adults, people with disabilities, caregivers, and veterans and families. Aging & Disability Resource Centers, National Association of Area Agencies on Aging, <https://www.n4a.org/adrcs#:~:text=Aging%20and%20Disability%20Resource%20Centers,%E2%80%9Cno%20wrong%20door%E2%80%9D%20systems>

Delivery of care and supports tailored to consumers in ICP models

✓ *Element 3: Diverse consumer engagement to inform tailored delivery systems and integrated programs*

Stakeholders shared broad consensus for ICP design and oversight tailored to and informed by meaningful engagement with the diverse dually eligible populations representing the communities served. They noted the varying needs and preferences among consumers given the range of chronic conditions and disability types such as cognitive, hearing, mobility and vision, and diversity of characteristics including age, race, ethnicity, gender, and lesbian, gay, bisexual, transgender, questioning, queer, intersex, asexual (LGBTQUIA).

Interviewees offered the following approaches for engaging consumers: 1) States and federal partners should conduct robust, proactive outreach to engage all subpopulations to ensure that all are able to inform ICP policy and design; 2) People and entities with whom diverse individuals have relationships could help to let people know that there is a “seat at the table” for consumers to shape ICP policy and program development; and 3) ICPs could use incentives to compensate consumers for sharing their lived experience.

Non-medical providers such as home and community-based services (HCBS) providers and CBOs interviewed expressed they are necessary participants in the design of ICPs that meet the needs and preferences of diverse dually eligible individuals. However, they noted that they are often overlooked at the policy level. They see their role as supporting consumers to receive care in community settings, often in individual’s homes.

Consumer advocates, consumers, and CBOs identified a need for accessible information and communications tailored to the diverse needs across subpopulations. They shared content and format must be tailored to account for differences in age, language preferences, and disability type. For example, interviewees suggested requiring use of differing formats to engage and share information with younger individuals and older adults – electronic means of communication via social media may work for younger individuals, while a non-electronic means of communication may work better for older adults.

Consumers, consumer advocates, and providers underscored there must be meaningful consideration of consumer recommendations and requests during development, implementation, and oversight of ICPs. This includes building trusted partnerships with consumers and other stakeholders through formal and informal communication and reporting back actions taken in response to input.

Element 3 Recommendation

Meaningful consumer engagement should include informed and active consumer participation and transparent reporting of actions taken on consumer recommendations. Understanding the key questions, concerns and needs shaping the decision-making process for dually eligible individuals has the potential to significantly increase their enrollment in ICPs. This should be required at the ICP program and entity levels.

At the ICP program level, state and federal policymakers should partner with diverse consumers and their families to shape ICP policy and program design around their needs and preferences. Policymakers should establish formal councils for consumers to lead, design, develop, monitor, and oversee the implementation of ICP programs and policy, in collaboration with state policymakers, providers, and health plans, as applicable. To ensure diverse participation, state and federal partners should engage individuals and organizations who have relationships with distinct dually eligible subpopulations to help recruit consumer participants.

At the ICP entity level, as required for MMPs, all ICPs should be required to convene a diverse consumer advisory council with meaningful consumer engagement.

Element 3: Diverse consumer engagement to inform tailored delivery systems and integrated programs	
Federal	<ul style="list-style-type: none"> ✓ Provide support to state Medicaid programs to establish a permanent consumer-led implementation council to provide consumers (and family members and guardians) with an active role in designing, implementing, overseeing, and refining ICPs.⁷ Consumers should reflect the diverse dually eligible population. Other participating stakeholders should include providers, CBOs and ICP entities. ✓ Develop a consumer-informed toolkit for developing, operationalizing, and measuring the effectiveness of consumer-led implementation councils. ✓ Provide resources to convene effective consumer-led implementation councils. ✓ Collaborate with state Medicaid programs to identify best practices for using program funding to compensate consumers for sharing expertise to inform ICPs.
State	<ul style="list-style-type: none"> ✓ Using the federal toolkit, create consumer-led implementation councils for ICPs. ✓ Provide on-the-ground assistance for planning and convening consumer-led implementation council meetings.
ICP	<ul style="list-style-type: none"> ✓ Participate in the consumer-led implementation council and provide the council with supporting information and data as needed. ✓ Convene consumer advisory councils and provide training to consumers to ensure meaningful participation, applicable to some but not all ICPs.

⁷ In 2013, Massachusetts developed the One Care Implementation Council to give consumers an active role in the implementation of Massachusetts' Financial Alignment Initiative. The program is called One Care. The Council is supported by the Executive Office of Health and Human Services (EOHHS) and has been replicated in a number of other states participating in the Financial Alignment Initiative. The Council's impact is a notable example of effectively engaging consumers and their advocates in policy and program change. The Implementation Council, formed through a Request for Response process, elected a chair who is a One Care enrollee (but also can be a family member) who then worked with co-chair(s) to develop agendas, facilitate meetings and oversee work plans and reporting activities. See blog <https://www.communitycatalyst.org/blog/what-the-massachusetts-one-care-implementation-council-teaches-us#.YHNn3sPsauU>. Full report available at <https://www.communitycatalyst.org/blog/what-the-massachusetts-one-care-implementation-council-teaches-us#.YHNn3sPsauU>

✓ *Element 4: Robust data infrastructure to tailor and adapt program approaches and drive health equity*

Stakeholders want a robust data infrastructure with the capacity to help ICPs evolve responsively around dually eligible individuals' needs and preferences. All stakeholders interviewed – states, plans, providers, CBOs, and most importantly, consumers – need data to answer questions and make decisions. It was noted that a strong data infrastructure could help ICPs and providers develop a population profile to inform the provider network, stratify populations by race and ethnicity, and create value-based payment models to improve outcomes. Data can help consumers to compare ICPs, which may contribute to raising quality and performance of all ICPs.

Interviewees underscored the need for access to comprehensive, complete, and actionable data on the diverse dually eligible population. They noted this includes Medicare and Medicaid data. Stakeholders shared there is a lack of basic types of data to develop a “full view” of consumers. Others noted lack of data means it is “not possible to conduct an accurate analysis of the population.”

Providers cited three primary gaps in the data precluding their ability to comprehensively analyze the population and their individual needs: 1) Race and ethnicity data to advance health equity; 2) Behavioral health data including substance use data to tailor program approaches to the needs of consumers with mental illness and substance use disorders; and 3) Real-time Medicare data and Medicaid data to put appropriate services and supports in place when individual health and social circumstances change. Interviewees further underscored that these data gaps lead to lack of information necessary for creating, refining, and evaluating program approaches as well as for reporting outcomes, all of which are critical to driving quality of life improvements for consumers.

Consumers also shared their frustration over the lack of easy access to transparent and meaningful metrics to make comparisons across ICPs and enrollment options across entities participating in ICPs. Consumers want states and ICP entities to provide access to more meaningful quality indicators to support consumer choice and to drive improvements based on consumer needs.

Element 4 Recommendation

States and federal partners should support a strong data infrastructure with the capacity to collect, use, and analyze comprehensive data on dually eligible individuals to support tailored program approaches for individual subpopulations and underserved populations. The federal government can support states in accessing and building a comprehensive view of their dually eligible populations encompassing data on demographics, including race and ethnicity, disability type, service use and costs, based upon Medicare-Medicaid combined data sets. This view would help states examine the population on an intersectional basis to address health disparities.

The states should develop a strong data infrastructure capturing eligibility and enrollment, claims and non-claims data, data from social assessments and functional assessments, and consumer surveys. It could extend to data across human services, social services, and education. The data infrastructure

capabilities could also provide the ICP and providers with access to information on a real-time basis, allowing them to respond to dually eligible individuals' immediate needs requiring timely responses.⁸

Over time, the data collection process and infrastructure could capture consumer experiences and outcomes needed to improve ICP design and consumer uptake. The data can also help point to gaps in the delivery system that can be remedied through creative services design and/or service expansions, either by the ICPs or by the state.

Element 4: Robust data infrastructure to tailor and adapt program approaches and drive health equity	
Federal	✓ Publish annual state-specific chart packs on dually eligible individuals that share information on eligibility, service use, and costs, based on combined Medicare-Medicaid data files.
State	✓ Establish a data infrastructure with the capacity to support data collection and sharing, analytics and evaluation, including health disparity measurements. ⁹
ICP	✓ Collect a specified list of data including race and ethnicity and social assessment data at the ICP level, supported by data collection systems that incorporate data from CBOs.

✓ *Element 5: Coordinated efforts to maximize capabilities to address unmet social needs*

Nearly all interviewees indicated the need to better address dually eligible individuals' unmet social needs. Many also offered that consumers' social needs may be as critical and/or immediate than clinical services provided under Medicare and Medicaid. Interviewees indicated that these unmet needs can adversely affect clinical outcomes and quality of life.

Stakeholders shared that Medicare and Medicaid providers and others do not adequately capture social needs. They shared this is due to either shortcomings of the existing tools and/or limited use of the tools available. As a result, these consumer needs often remain unmet. One CBO interviewee pointed out

⁸ The CMS Interoperability and Patient Access Rule should have a positive effect on data availability to enable whole-person care. The Interoperability Rule is designed to give people enrolled in Medicare or Medicaid better access to their data, facilitate their use of software applications to manage their own healthcare data from multiple payers and providers, and request that their data be transmitted securely from one place to another when they change health plans. Access to mental health and substance use disorder data will require additional consent policies and data use agreements. Other providers may need technical assistance and training to understand how to comply with them. For more information on the Final Rule:

<https://www.cms.gov/outreach-and-education/outreach/npcnational-provider-calls-and-events/2020-12-09-interoperability>; and, <https://www.federalregister.gov/documents/2020/05/01/2020-05050/medicare-and-medicaid-programs-patient-protection-and-affordable-care-act-interoperability-and>

⁹ In the creation of this strong infrastructure, state Medicaid programs could consider how to leverage all federal and state supports including the CMS State Data Resource Center data sharing agreement, the state Medicaid agency contract (SMAC) requirement, and the CMS Interoperability and Patient Access Final Rule, and any other CMS and state programmatic changes to advance these goals. The U.S. Congress and CMS have introduced and implemented many changes to improve data access and uses. The 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program, from the Office of the National Coordinator of Health Information and Technology (ONC) requires health IT vendors to make patient data downloadable using the same common data sharing standard. See:

<https://www.federalregister.gov/documents/2020/05/01/2020-07419/21st-century-cures-act-interoperability-information-blocking-and-the-onc-health-it-certification>

providers can use ICD-10-CM Z codes but do so inconsistently because there is no payment for use of the code. This CBO specifically highlighted instances of providers not identifying housing status - leading to the development of inappropriate discharge plans to the community without appropriate supports.

Several CBOs and Centers for Independent Living (CILs) indicated that ICP partnerships with local CBOs are essential to addressing the social needs of dually eligible individuals. They further noted that CBOs bring a unique understanding of local communities and how to engage individuals to ensure they receive appropriate social supports. Another interviewee shared ICPs could engage other CBOs such as ADRCs to provide social supports.

Element 5 Recommendation

CMS should partner with stakeholders to define a minimum data set of social factors such as unstable housing, lack of access to transportation, food insecurity, employment instability, and social isolation and loneliness.^{10,xxiii} States could expand this minimum data set to include additional social risk factors. Data collection for identifying service needs could be accomplished through a combination of ICD-10-CM Z code submission and needs assessments. ICPs and CBOs should use the data collected to ensure services and supports are identified and facilitated.

CMS should also require states and ICPs to incorporate social risk information from an individual's needs assessment and person-centered care plan into a data infrastructure. Dependent upon individual preferences, the ICP could share the data with an individual's providers. Data may be used to risk adjust ICP payments.

CMS and states could also use the minimum data set to examine: 1) level of reporting by ICPs through ICD-10-CM Z code submission and needs assessments; 2) variations in prevalence of social risk factors across population groups, ICPs, and geographic regions; and 3) the association between social risk factors and outcomes, dependent upon the feasibility to integrate the minimum data set with outcome data.

Element 5: Coordinated efforts to maximize capabilities to address unmet social needs	
Federal	<ul style="list-style-type: none"> ✓ Define a federal minimum data set for social risk factor collection by ICPs through use of ICD-10-CM Z codes and individual needs assessments to inform person-centered care delivery and to advance payment accuracy and quality.
State	<ul style="list-style-type: none"> ✓ Identify social risk factors beyond the federal minimum data set for ICPs to assess and incorporate into person-centered care plans. ✓ Develop social risk adjustment models using social risk factors to advance payment accuracy and quality as a complement and/or enhancement to the federal approach.

¹⁰ CMS could review data collected through The Accountable Health Communities Health-Related Social Needs Screening Tool. The Accountable Health Communities Health-Related Social Needs Screening Tool, Centers for Medicare & Medicaid, <https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf>

Element 5: Coordinated efforts to maximize capabilities to address unmet social needs	
ICP	<ul style="list-style-type: none"> ✓ Collect and submit social risk factor data to comply with federal and state data set requirements. ✓ Use individual assessment information to make appropriate referrals for services, and document service provision and outcomes. ✓ Partner with CBOs to identify and facilitate addressing unmet social needs.

✓ *Element 6: Single process for assessments and plans of care, and one care team for each consumer*

There was consensus among stakeholders interviewed that ICP enrollees should be assigned a single care coordinator. All interviewees identified that there must be less duplication across Medicare and Medicaid for dually eligible individuals in care coordination functions. Most stakeholders interviewed underscored that the assessment and care planning process is the core component to identifying and addressing individuals' needs.

Consumers, consumer advocates, and other stakeholders highlighted the critical importance of the approach used by the person who both performs the initial needs assessment and supports the development of the person-centered care plan. Individuals administering the needs assessment must relate to and build a trusting relationship with the person they are supporting, with respect for their culture and ethnicity, living situation, and other personal characteristics and preferences. When assessment questions are asked "as is" without knowing and considering the situation of the individual, they can be perceived as offensive and degrading. CBOs emphasized the need to train professionals in motivational interviewing techniques for asking probing questions. They also shared that if people are not comfortable with who is serving them or do not understand the services available to them, they will be more likely to disenroll from ICPs.

Stakeholders in states without MMPs shared that ICP design should address the existing separation of Medicare and Medicaid care teams. Stakeholders in those states supported a blended team approach to best serve dually eligible individuals – one that brings together Medicare and Medicaid providers inclusive of nonmedical professionals, such as direct care HCBS providers.

CBOs highlighted the value of using the approach employed by the social work profession in care coordination. They shared social workers are trained to comprehensively address individuals' situations holistically, including life circumstances. They urged adopting this approach to bridge disconnects between medical and non-medical care across Medicare and Medicaid.

Element 6 Recommendation

ICP requirements should specify one care coordinator, and a single person-centered care plan across Medicare and Medicaid for each dually eligible individual as reflected in the design of the FAI capitated model and PACE. The care coordinator should serve as the point person with whom the consumer connects for help understanding service and support options, bridging the clinical and social aspects of their care and supports needs, and making decisions to inform their person-centered care plan. As

required of MMPs and PACE, they should have a single interdisciplinary care team for all their Medicare and Medicaid services and supports.

Current D-SNP requirements support the unique needs of each enrollee through quality, care management and care coordination processes. Every person enrolled in a D-SNP receives a health risk assessment which informs their individualized person-centered care plan and is supported by their care coordinator and interdisciplinary care team.^{xxiv} States can use the state Medicaid agency contract (SMAC) with D-SNPs to extend this requirement across aligned MLTSS and D-SNPs.

Care coordinator requirements should include training on the diverse characteristics, needs, and preferences of dually eligible individuals. The care coordinator would ideally be from and reflect the racial, ethnic, and linguistic composition of the individual's community.

Element 6: Single process for assessments and plans of care, and one care team for each consumer	
Federal	<ul style="list-style-type: none"> ✓ Document and share successful ICP approaches for developing and overseeing single processes for assessment and plans of care, and one interdisciplinary care team.
State	<ul style="list-style-type: none"> ✓ Extend existing ICP requirements to all ICPs that one ICP care coordinator conduct assessments and create a single person-centered care plan with the individual. ✓ Extend requirement to all ICPs that ICPs have a single interdisciplinary care team for all Medicare and Medicaid services and supports which includes the consumer's self-identified key HCBS provider, as relevant. ✓ Review and approve ICP training programs for care coordinators on the diverse characteristics, needs, and preferences of dually eligible individuals and subpopulations, and on operationalizing the independent living philosophy and recovery principles.^{xxv}
ICP	<ul style="list-style-type: none"> ✓ Submit training program curriculum for care coordinators to the state for approval. ✓ Have one care coordinator conduct assessments and create a single person-centered care plan covering all Medicare and Medicaid services and supports for enrollees. ✓ Have a single interdisciplinary care team, which may include peer support workers and disability advocates, as desired by individuals.

✓ *Element 7: Meaningful and transparent quality indicators to empower consumers and stakeholders*

Several interviewees underscored the need for quality measurement and key performance indicators to reflect the needs and goals of the population served. Consumer advocates indicated consistency in quality measurement and reporting would better enable dually eligible individuals to compare the available options. They shared transparent and meaningful data should be an integral part of the information individuals receive to enable informed enrollment choices.

One health plan representative emphasized the need for timely assessments of quality directly from their enrollees. In order to understand how their enrollees perceive the quality of care they receive, the health plan administers an annual consumer satisfaction survey which provides an opportunity for consumer feedback and recommendations based on their experiences with the services they have

received over the course of the year. This survey is in addition to the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. The health plan uses this feedback to inform refinements to the programs and services it offers to their enrollees.

Element 7 Recommendation

CMS and states should continue efforts to develop and refine measurement sets for the Medicare and Medicaid programs that can provide for comparisons of outcomes and the quality of care delivered under programs serving dually eligible individuals. Federal efforts include several quality initiatives that are currently underway in partnership with the National Quality Forum (NQF), the ACL, and other stakeholder organizations. They are aimed at identifying and/or developing meaningful quality measures to assess the care delivered to the dually eligible population and aligning quality measurement and reporting across Medicare and Medicaid.

To support informed enrollment choices, CMS in alignment with states should require ICPs to report on a core set of quality indicators reflecting consumer experience and outcomes. The indicators should reflect what consumers value - including independent living, recovery, preference to live in the community, wellness and prevention, and quality of life. They could include ICP disenrollment rates, reported consumer satisfaction with their person-centered care plans, the proportion of individuals residing in the community that meet an institutional level of care, and consumer reported healthy days. Indicators could be stratified by race, ethnicity, gender, and other characteristics including disability type. This will require the consistent collection of data. Meaningful and transparent quality indicators may both improve quality and increase integrated program uptake.

Consumers could access this information from their enrollment support entities to make choices to determine which coverage option best meets their circumstances and preferences. This information should be required to be submitted by ICPs in standardized formats.

Element 7: Meaningful and transparent quality measurement to empower consumers and stakeholders	
Federal	✓ Develop a set of ICP quality indicators in partnership with consumers to build upon the current Medicare and state-specific Medicaid measurement sets.
State	<ul style="list-style-type: none"> ✓ Incorporate state ICP quality indicators developed in partnership with the consumer-led implementation council. ✓ Develop ICP quality indicator reporting templates in partnership with the consumer-led implementation council.
ICP	✓ Collect and report federal and state quality indicators to the state using reporting templates.

✓ *Element 8: Payment models to incentivize consumer quality of life improvements*

Many interviewees underscored the important role that payment models and incentives should play in standing up successful ICPs and improving consumer quality of life. Many providers stated preference for using value-based payment (VBP) models with links to meaningful outcomes over the continued use

of status quo fee-for-service (FFS) payment arrangements with no links to outcomes. CBOs expressed they wanted VBP models to support desired outcomes including living in the community with HCBS – to further “rebalancing,” community engagement, achieving wellness goals, prevention of functional impairment, care plan engagement, and consumer self-care activities.

CILs and CBOs noted that VBP models should be structured to align with ICP goals for a community-based, person-centered, and tailored care delivery system focused on consumer quality of life. An external expert reviewer added that VBP models must be used to promote the greatest opportunity for quality of life, based on choice, control, and meaningful engagement in community settings such as faith-based settings, school and work.

Interviewees also noted VBP models should be more broadly used to address structural, systemic, or geographical barriers to achieving wellness and health equity such as those found in underserved and under-resourced communities, where many dually eligible individuals reside. Interviewees suggested ICPs could use payment models to address provider shortages in rural communities and to close significant health disparities in urban areas. As one CBO representative suggested, ICPs could pay higher rates to providers willing to serve individuals in areas historically under-resourced.

Interviewees also called for a range of other innovative payment arrangements such as expanded federal and state authorities for ICPs to implement consumer rewards to motivate greater focus and engagement on their health and wellness.^{xxvi} Both a CBO representative and a state official interviewed suggested incentivizing consumers with rewards such as gift cards to encourage use of behavioral health evidence-based practices such as self-care applications, and to learn more about their care needs. For example, ICPs could use consumer incentives to encourage individuals to improve medication adherence.

Element 8 Recommendation

State and federal partners should require ICP entities to use payment models to incentivize providers and reward consumers to advance the ICP essential elements and to improve consumer quality of life. They can be targeted to promote community living, health equity, wellness goals, and community engagement, as well as prevent secondary disability.

ICP payment models should be developed in partnership with consumers and providers. The federal government should develop a VBP toolkit for ICPs, and states could support ICPs in designing and implementing proposed VBP strategies. Further, states and federal partners could give ICPs flexibility to implement innovative payment models exceeding basic VBP models.

Element 8: Payment models to incentivize consumer quality of life	
Federal	✓ In partnership with a national consumer and provider expert panel, develop a community first ICP VBP toolkit to improve consumer quality of life and outcomes, as well as advance ICP essential elements.
State	✓ Develop, in partnership with the consumer-led implementation council, ICP VBP plan requirements to improve consumer quality of life and to advance ICP essential elements.

Element 8: Payment models to incentivize consumer quality of life	
	<ul style="list-style-type: none"> ✓ Review and approve ICP VBP plans. ✓ Make all ICP VBP plans transparent to stakeholders by publishing plans to the state's Medicaid website.
ICP	<ul style="list-style-type: none"> ✓ Develop and submit ICP VBP plan to the consumer-led implementation council for review and then to the state for approval.

Critical consumer access in ICPs

✓ *Element 9: Adequate, engaged, and diverse workforce to support consumer needs and preferences*

Providers, consumer advocates, and state officials interviewed stated that a reliable, engaged and adequate nonmedical HCBS direct care workforce is the foundation of supporting individuals with diverse and complex needs. Almost all interviewees cited the critical need to address the longstanding shortage of HCBS direct care workers who enable many dually eligible individuals to live independently in the community.¹¹ They highlighted that strategies should reflect their value and the importance of what they do to support consumer ability to live in the community by: 1) providing them sufficient pay; 2) clarifying and simplifying titles, job descriptions, and scope of practice of the direct care workforce; 3) including them in interdisciplinary care teams; and, 4) developing a meaningful career ladder.

Interviewees also shared the need for supporting the important role of family caregivers acting as direct caregivers. They noted providing resources and supports helps achieve consumer preferences for their caregivers and expands the ability to address critical workforce issues including availability and access.

Almost all interviewees shared that the composition of the overall workforce serving dually eligible individuals must include skilled individuals with experience supporting the populations they are serving. Further, this must apply to medical and non-medical providers including health, behavioral health, LTSS direct care workers, and care coordinators. Providers and CBOs suggested that organizations overseeing providers or directly providing services to the population hire a diverse workforce within all levels of the organization.

Element 9 Recommendation

CMS, with ACL, should provide technical assistance for improved workforce recruitment and retention by establishing simplified and clear role definitions, best practices and guidelines for determining sufficient living wages, and developing a meaningful career ladder that reflects direct care workers' integral role in supporting dually eligible individuals. This should include recognizing and supporting

¹¹ Direct care workers provide personal care and other services that support an individual's activities of daily living (ADLs), such as bathing and dressing, and instrumental activities of daily living (IADLs), such as meal preparation and managing finances and transportation. These activities are not only critical to their daily living routines, but to their ability to be a part of their local communities. When the workforce is inadequate, individuals who rely upon assistance with ADLs and IADLs may experience falls, inadequate nutrition, and decline in health status. They may be unable to attain life goals and preferences to remain living in the community.

family caregivers by providing support, education, coaching, respite and, in some instances, compensation for services provided.

Requirements for ICPs should include provision of training to medical and non-medical providers on the diverse needs of dually eligible individuals and documentation of completed training of all providers including direct care workers. ICPs should conduct specialized recruitment for providers with experience with dually eligible subpopulations, including peer support workers and people with lived experience of disability.

Element 9: Adequate, engaged, and diverse workforce to support consumer needs and preferences	
Federal	<ul style="list-style-type: none"> ✓ Provide technical assistance to states and ICPs, through CMS and ACL, to improve workforce recruitment and retention by establishing clearer role definitions, best practices, and guidelines for determining sufficient living wages, and developing a meaningful career ladder. ✓ Develop base training for ICP medical and non-medical providers on the diverse characteristics, needs, and preferences of dually eligible individuals and subpopulations, and on independent living and recovery principles.
State	<ul style="list-style-type: none"> ✓ Add state-specific training requirements to federal base training as identified in partnership with the consumer-led implementation council. ✓ Define qualified family caregivers to whom ICPs must provide supports, education, coaching, respite and, in some instances, compensation for services provided.
ICP	<ul style="list-style-type: none"> ✓ Conduct specialized recruitment for a diverse workforce with experience with dually eligible subpopulations, including peer support workers and people with lived experience of disability. ✓ Train providers, including health, behavioral health, and LTSS direct care workers, using the base training created by CMS and any state-specific additional training elements.

✓ *Element 10: Access to needed services in rural areas*

Stakeholders interviewed want to find ways to improve access to needed services for dually eligible individuals in rural areas. Provider and consumer interviewees conveyed that many dually eligible individuals residing in rural geographies face uncertain access to health care and social services. They lack or have limited access to many types of providers such as mental health services and oral health providers. They underscored limited transportation as a major challenge to receiving needed health care services in rural communities.

One interviewee in Oklahoma underscored that a lack of consideration for rural challenges can have a profound impact on the dually eligible population, because they are disproportionately represented in

rural areas. This interviewee pointed out that Oklahoma is geographically 80 percent rural. The state has “hospital deserts, food deserts, and transportation concerns.”¹²

Interviewees also described care disruptions in rural areas can lead to a reliance on higher levels of care, even when unnecessary. One consumer, living in a rural community, described that after she lost access to her local doctor, she had to rely on the emergency room for routine care.

Another dually eligible individual relayed that rural access barriers adversely impact community supports in addition to health care service delivery. This consumer with lived experience of serious mental illness residing in a rural area described that their friend “lost a big part of her support system” when their community clubhouse closed. The interviewee linked the closure directly to the state’s changes in regulations for community clubhouses under Medicaid behavioral health services. They shared that when states make regulations for providers and entities like clubhouses, they do not take into account the implications for providers in rural communities who may find it challenging to meet regulatory requirements.

Several providers suggested that ICPs could be required to map community assets to leverage existing resources. They noted that ICPs often overlook the value of CBOs which are embedded in and know local communities to help build network capacity in rural areas. They specifically mentioned AAAs. Another interviewee stated that there should be shared responsibility for ensuring adequate provider networks in rural areas.

A state Medicaid official shared that many rural residents lack access to broadband, without which rural community residents are not able to access telehealth. Telehealth has become a crucial tool for providing care to rural consumers. It can provide access to remote patient monitoring, medication management, care coordination services, and a range of therapies. It has also been used to expand access to provide mental health services and medication assisted treatment (MAT).¹³ One interviewee urged states to leverage avenues such as Cooperative Extension Services to make WiFi available to eligible consumers.

Element 10 Recommendation

ICPs should address the characteristics and limitations of rural geographies. Federal and state governments should require ICPs to partner with rural communities to assess and understand the need

¹² Nationally, of individuals living in rural areas, a lower proportion of white individuals were dually eligible (12.5 percent) compared to other racial and ethnic groups: African American (33.3 percent), Hispanic (55.4 percent), American Indian/Alaska Native (33.6 percent), and other non-white individuals (33.4 percent). Kevin J. Bennett, Ashley S. Robertson, & Janice C. Probst, “Characteristics, Utilization Patterns, and Expenditures of Rural Dually eligible Medicare Beneficiaries,” South Carolina Rural Health Center, November 2014, https://sc.edu/study/colleges_schools/public_health/research/research_centers/sc_rural_health_research_center/documents/133characteristicsutilizationpatterns2014.pdf

¹³ Telemedicine should be able to help mitigate shortages in health professionals. The lack of technology infrastructure, particularly broadband internet, is a significant limitation to expanding the use of telemedicine. “Left Out: Barriers to Health Equity for Rural and Underserved Communities,” Report of the Committee on Ways and Means Majority U.S. House of Representatives, July 2020, https://waysandmeans.house.gov/sites/democrats.waysandmeans.house.gov/files/documents/WMD%20Health%20Equity%20Report_07.2020_FINAL.pdf

to develop tailored approaches for rural residents. ICP rural community partnerships should leverage the opportunities and strengths of rural geographies to improve access to providers, a direct care workforce, and services.

In partnership with state Medicaid programs, ICPs should play a lead role in expanding rural access to needed services for dually eligible individuals by leveraging the assets of the community, including contracting with AAAs, and expanding the use of telehealth. ICPs should explore the use of community-health workers, which are also referred to as community health representatives (CHRs) in tribal communities, to expand the rural workforce.^{xxvii} There are many efforts underway at the federal and state levels to expand access to telehealth^{xxviii} which could increase access to services and supports for dually eligible populations residing in rural communities.

Federal and state administrators could build flexibility in ICP regulatory requirements for the Medicare and Medicaid programs to address market shortages for covered services and supports in rural communities. A process could be established for requesting exceptions to ICP provider network requirements. This could take the form of an application to the federal and state governments, as applicable. Applications could require ICP documentation of rural market constraints affecting access to services and supports. States could also consider strategies on the Medicaid side alone to expand access in rural communities, including prospective payment approaches providing fixed income support to providers, and network requirement modifications.¹⁴

Element 10: Access to needed services in rural areas	
Federal	<ul style="list-style-type: none"> ✓ Provide support to state Medicaid agencies for consumer-run implementation council workgroups made up of diverse stakeholders to address access issues in rural areas. ✓ Review and modify regulatory requirements impeding ICP access in rural areas for the Medicare program and Medicaid program.
State	<ul style="list-style-type: none"> ✓ Review and approve ICP innovation plans to expand access to services and supports in rural areas. ✓ Review and modify regulatory requirements impeding access in rural areas for the Medicaid program.
ICP	<ul style="list-style-type: none"> ✓ Work with the state to collaboratively close gaps in access to care and services in rural areas. ✓ Develop and submit innovation plans incorporating asset-based provider networks to expand rural access.

¹⁴ Jane Hyatt Thorpe and Katherine Hayes, "Selected Provisions from Integrated Care RFPs and Contracts: Care Coordination, Integrated Care Resource Center," July 2013, http://www.chcs.org/media/ICRC_Care_Coordination_FINAL_7_29_13.pdf

LOOKING FORWARD

HMA has identified 10 essential elements to increase access to ICPs tailored to address the diversity of dually eligible individuals' needs and to support their desire and right to live independently in the community. The federal government and states have worked together to advance ICPs. However, we need to accelerate progress. States need resources and support to develop and improve ICPs that consumers want to enroll in and stay enrolled in. Looking forward, we hope the state and federal governments, in partnership with consumers, ICPs and community stakeholders, continue to work together to achieve and evolve beyond these 10 elements to improve quality of life and advance health equity for dually eligible individuals.

Appendix A – Stakeholder Interviewees			
<i>Name, Title, Email</i>	<i>Interviewee Category</i>	<i>Organization</i>	<i>Interview Date</i>
Michigan			
Sandy Bell sandyotto1@gmail.com	Consumer	N/A	01/22/2021
Jennifer Leigh jennleigh35@yahoo.com	Consumer	N/A	02/02/2021
Ron Taylor, <i>President and CEO</i> taylorr@daaa1a.org Wanda Boyman, <i>Finance Director</i> bowmanw@daaa1a.org Tyruse Walls, <i>Senior Manager</i> WallsT@daaa1a.org	Resource Center	Detroit Area Agency on Aging	02/01/2021
Linda Little, <i>CEO</i> llittle@nso-mi.org Avani Sheth, <i>CMO</i> asheth@nso-mi.org	Community Based Organization	Neighborhood Service Organization	11/02/2020
Patricia Anderson, <i>Executive VP of Reimbursement</i> patanderson@hcam.org Melissa Samuel, <i>President/CEO</i> MelissaSamuel@Hcam.org	Provider Association	Health Care Association of Michigan	11/18/2020
Brad Casemore, <i>CEO</i> Brad.casemore@swmbh.org Sarah A. Ameter, <i>Customer Service Manager</i> Sarah.Ameter@SWMBH.org Sarah Green, <i>Senior Integrated Healthcare Specialists</i> Sarah.Greem@swmbh.org Mila Todd, <i>Chief Compliance and Privacy Officer and Director of Network Management</i> Mila.Todd@swmbh.org	Provider (Prepaid Inpatient Health Plan - PIHP)	South West Michigan Behavioral Health	11/20/2020
Phillip Bergquist, <i>MPCA - Health Center Operations Officer</i> pbergquist@mpca.net Anne Scott, <i>MPCA -Director of Health Center Support</i> ascott@mpca.net Russ Kolski, <i>Michigan Community Health Network - Executive Director</i> rkolski@mi-chn.com	Rural Health Center	Michigan Primary Care Association, Michigan Community Health Network	12/14/2020
Pennsylvania			
Minta Livengood livengoodminta@gmail.com	Consumer	N/A	11/10/2020
Rochelle Jackson msrljackson@gmail.com	Consumer	N/A	10/13/2020
Pam Auer, <i>Director of Advocacy and Community Engagement</i> pauer@cilcp.org	Resource Center and Consumer Advocate	The CIL Disability Resource Center	10/02/2020
Rebecca May-Cole, <i>Executive Director</i> rmaycole@p4a.org	Resource Center	Pennsylvania Association of	12/10/2020

		Area Agencies on Aging	
Misty Dion, <i>President</i> mdion@cilncp.org Michael Grier, <i>Executive Director</i> mike.grier@thepecil.org	Community Based Organization	Pennsylvania Centers for Independent Living	11/05/2020
Terri Henning, <i>CEO</i> thenning@pahomecare.org	Provider Association	Pennsylvania Home Care Association	10/27/2020
John Lovelace, <i>President of UPMC for You, and President of Government Programs and Individual Advantage Products</i> LovelaceJG@UPMC.EDU April Golenor, <i>Chief Medicare Officer</i> golenora@upmc.edu Brendan Harris, <i>Vice President Community HealthChoices</i> harrisb6@upmc.edu	Health Plan (Medicare Advantage Fully Integrated Dual Eligible Special Need Plan – FIDE SNP)	UPMC	02/24/2021
Kevin Hancock Recent former Pennsylvania Department of Human Services Deputy Secretary for the Office of Long-term Living December 2017 – June 2020 khancock@healthmanagement.com	State		03/02/2021
Oklahoma			
William (Bill) Whited, <i>State Long-Term Care Ombudsman</i> William.Whited@okdhs.org	State	Oklahoma Department of Human Services	12/22/2020
Sean Voskuhl, <i>AARP OK State Director</i> swvoskuhl@aarp.org Chad Mullen, <i>Associate State Director- Advocacy</i> chmullen@aarp.org	Consumer Advocate	AARP	01/05/2021
David Ward, <i>Manager, LTSS</i> David.Ward@okhca.org	State	Oklahoma Health Care Authority	03/12/2021
Louisiana			
Tara Leblanc, <i>Interim Medicaid Executive Director</i> tara.leblanc@la.gov Michael Boutte, <i>Medicaid Deputy Director</i> Michael.Boutte@la.gov Laurie Jewell, <i>Medicaid Program Manager</i> LAURIE.JEWELL@LA.GOV Robin Wagner, <i>Deputy Assistant Secretary</i> Robin.Wagner@LA.GOV	State	Louisiana Department of Health	02/09/2021

Appendix B - State Selection Criteria	
State	Relevant Characteristics for Selection
Michigan	<ul style="list-style-type: none"> • Highly integrated on development of ICPs (capitated FAI program) • Midwestern state • 39 percent of state “noncore” • Urban Detroit with Black or African American people comprising almost 80 percent of the population • Ranked number 8 in the U.S. for number of dually eligible individuals
Pennsylvania	<ul style="list-style-type: none"> • Medium to high on development of ICPs <ul style="list-style-type: none"> ➢ Medicaid managed long-term services and supports program (MLTSS) requiring that participating Medicaid health plans operate D-SNPs ➢ FIDE SNP • Northeastern state • State with the greatest number of PACE programs (LIFE) in the country • Ranked number 5 in the U.S. for number of dually eligible individuals
Oklahoma	<ul style="list-style-type: none"> • Low to nascent state on development of ICPs <ul style="list-style-type: none"> ➢ Expressed interest in but did not pursue managed fee-for-service FAI • Southwestern state • No MLTSS program • 53 percent of state “noncore” • State composition includes 35 percent nonwhite, large Native American population, and sizeable Latinx population
Louisiana	<ul style="list-style-type: none"> • Nascent state on development of ICP • Southern state • No MLTSS program • State composition includes 41 percent nonwhite

Sources: (1) Noncore, based on the Centers for Disease Control and Prevention for the urban-rural classification of noncore; (2) Race/ethnicity, based on data from the Henry J. Kaiser Family Foundation; (3) FBDEs, based on the Centers for Medicare and Medicaid Services (CMS), Medicare-Medicaid Coordination Office (MMCO) data, <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics>

Notes

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- ⁱⁱ “Chapter 6: Improving Integration for Dually Eligible Beneficiaries: Strategies for State Contracts with Dual Eligible Special Needs Plans,” Report to Congress on Medicaid and CHIP, Medicaid and CHIP Payment and Access Commission, June 2021, <https://www.macpac.gov/wp-content/uploads/2021/06/June-2021-Report-to-Congress-on-Medicaid-and-CHIP.pdf>
- ⁱⁱⁱ “Medicare and Medicaid – Alignment of Managed Care Plans for Dual-Eligible Beneficiaries,” United States Government Accountability Office (GAO) Report to Congressional Committees, March 2020, <https://www.gao.gov/assets/gao-20-319.pdf>
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- ^v Ellen Breslin, Dennis Heaphy, Tony Dreyfus, Anissa Lambertino, Jeff Schiff, “Advancing Health Justice Using Medicaid Data: Key Lessons from Minnesota for the Nation,” AcademyHealth, January 2021, https://academyhealth.org/sites/default/files/publication/%5Bfield_date%3Acustom%3AY%5D-%5Bfield_date%3Acustom%3Am%5D/advancinghealthjusticeusingmedicaiddata_jan2021_0.pdf
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- ^{ix} “A Data Book: Health Care Spending and the Medicare Program,” Section 4, Dual-Eligible Beneficiaries, Medicare Payment Advisory Commission, July 2020, http://medpac.gov/docs/default-source/data-book/july2020_databook_sec4_sec.pdf?sfvrsn=0
- ^x “A Data Book: Health Care Spending and the Medicare Program,” Section 4, Dual-Eligible Beneficiaries, Medicare Payment Advisory Commission, July 2020, http://medpac.gov/docs/default-source/data-book/july2020_databook_sec4_sec.pdf?sfvrsn=0
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- ^{xvii} Medicare enrollees who are not eligible for Medicaid pay monthly premiums equal to the Medicaid capitation amount, but no deductibles, coinsurance, or any other type of Medicare or Medicaid cost-sharing. Programs of All-Inclusive Care for the Elderly Benefits, Centers for Medicare & Medicaid Services, <https://www.medicare.gov/medicaid/long-term-services-supports/pace/programs-all-inclusive-care-elderly-benefits/index.html>
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