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) individuals[2] 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.

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ESSENTIAL ELEMENTS AND POLICY RECOMMENDATIONS	

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 individual Inte

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

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

5.

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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	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

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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.

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-

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Element 8: Payment models to incentivize consumer quality of life	
	Review and approve ICP VBP plans. Make all ICP VBP plans transparent to stakeholders by publishing plans to the state's Medicaid website.
ICP	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

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

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

Requirements for ICPs should include

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[xv] Managed Fee-for-Service (MFFS) Model, Centers for Medicare & Medicaid Services, https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-