Mathematica
Progress Together

Advancing Integrated Care for Dually Eligible Individuals: Factors Influencing State D-SNP Contracting Decisions

July 20, 2021

Erin Weir Lakhmani, Danielle Chelminsky, Alena Tourtellotte, Alyssa Bosold, Debra Lipson, and James Verdier

The research underlying this report was completed with support from the Medicaid and CHIP Payment and Access Commission (MACPAC). The findings, statements, and views expressed are those of the authors and do not necessarily represent those of MACPAC.

This page has been left blank for double-sided copying.

Acknowledgments

This study was supported by the Medicaid and CHIP Payment Access Commission (MACPAC), a non-partisan legislative branch agency that provides policy and data analysis to government bodies issues affecting Medicaid and CHIP. We express special thanks to Kirstin Blom, Ashley Semanskee, and Kristal Vardaman at MACPAC for their support and guidance. The authors also appreciate the contributions of Mathematica staff to the production of this issue brief—Brigitte Tran (graphic design), Donna Verdier (editing), and Sharon Clark (formatting and production assistance). We are also indebted to the state Medicaid agency staff, health plan executives, and other stakeholders we interviewed for taking time to participate in interviews and share their candid views about states' adoption of and experience with D-SNP contracting strategies. We are inspired by their dedication to improving integrated care options for dually eligible individuals.

This page has been left blank for double-sided copying.

Contents

Glossary vi

Executive Summary xi

I. Introduction 1

II. Data and Methods 5

III. Findings 9

A. Factors influencing state adoption of D-SNP contracting strategies 9

1. Current D-SNP operations 9

2. Medicaid managed care programs for dually eligible individuals 9

3. Other factors 10

B. Barriers to D-SNP contracting in rural areas 12

1. Member recruitment and payment rates 12

2. Network adequacy 13

C. Benefits and challenges of adopting 11 specific D-SNP contracting strategies 14

1. Contracting strategies applicable to all states 15

2. Contracting strategies applicable to states that enroll dually eligible individuals and individuals becoming dually eligible into managed care plans for coverage of Medicaid benefits 25

D. Additional D-SNP contracting strategies 33

IV. Conclusions 37

References 41

Appendix A Organizations Interviewed and State Characteristics A-1

Appendix B Detailed Explanations of the 11 State D-SNP Contracting Strategies Examined in Study B-1

Appendix C D-SNP Contracting Decision Matrix, Revised to Include Additional Strategies Suggested by Interviewees C-1

Appendix D Potential Use of D-SNP Contracting Strategies in Hypothetical State Scenarios D-1

Appendix E State Characteristics and Integrated Care Models E-1

Tables

II.1 State D-SNP contracting strategies that promote Medicare-Medicaid integration 7

A.1 Organizations interviewed, by state A-3

A.2 Characteristics of states interviewed A-3

B.1 State D-SNP contracting strategies that promote Medicare-Medicaid integration B-3

E.1 State characteristics and use of integrated care models to serve dually eligible individuals E-6

Figures

I.1 D-SNP enrollment, 2006–2020 1

II.1 Continuum of integration in state D-SNP contracts 5

III.1 Determining which D-SNP contracting strategies may be used in specific states 10

III.2 Examples of state SMAC requirements to enhance or integrate D-SNP care coordination 23

Glossary

The definitions in this table are designed to inform readers about how certain terms are used within this report. These definitions may differ from those used in other documents or for other purposes.

Table G.1. Glossary of key terms

Term	Definition
Affiliated plans	Affiliated plans are Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) and Medicaid managed care plans that are owned by the same parent company, operate in the same geographic areas, and enroll dually eligible individuals.
Aligned enrollment	When dually eligible individuals' enrollment is aligned, they receive their Medicare and Medicaid benefits through a single parent company. Aligned enrollment occurs (1) when a dually eligible individual is enrolled in a Dual Eligible Special Needs Plan (D-SNP) for both Medicare and Medicaid benefits or (2) when a dually eligible individual is enrolled in a D-SNP and an affiliated Medicaid managed care plan offered by the same parent company in the same geographic area.
Care coordination	Care coordination is a process by which a beneficiary's care needs are assessed and services to address those needs are arranged and coordinated across providers and payers. Care coordinators work closely with the beneficiary as well as the beneficiary's family (when approved by the beneficiary), care team, and other service providers to facilitate (1) access to services and supports and (2) effective communication among the entities involved in the beneficiary's care.
Default enrollment	Default enrollment is a process by which a Dual Eligible Special Needs Plan (D-SNP) may automatically enroll members of its affiliated Medicaid managed care plan into the D-SNP when those members become eligible for Medicare (unless the members choose otherwise through a required opt out process), with approval from the Centers for Medicare & Medicaid Services and the state Medicaid agency. Default enrollment is only permissible in circumstances in which the member will continue to receive Medicaid benefits through the parent company after becoming eligible for Medicare. The only default enrollment effective date possible is the date an individual is initially eligible for Medicare Advantage (that is, has Medicare Parts A and B for the first time). Default enrollment requirements and processes are described at 42 CFR 422.66(c)(2).
Direct contracting	Direct contracting (sometimes called direct capitation) occurs when a state pays a capitated rate to a Dual Eligible Special Needs Plan (D-SNP) to cover Medicaid benefits for the D-SNP's enrollees. D-SNP coverage of Medicaid benefits can range from only coverage of Medicare cost sharing to coverage of all Medicaid benefits, including behavioral health and long-term services and supports.
Dual Eligible Special Needs Plans (D-SNPs)	Dual Eligible Special Needs Plans (D-SNPs) are Medicare Advantage plans that only enroll and serve dually eligible individuals. All D-SNPs cover Medicare Parts A, B, and D benefits. To operate in a state, a D-SNP must hold a contract with the state Medicaid agency that includes certain elements (see 42 CFR 107(c-d) for minimum contract elements). D-SNPs must also design and implement a Model of Care that provides for care management and other services for the specific dually eligible populations they serve. Some states contract with D-SNPs to cover and pay for partially or fully integrated Medicare and Medicaid benefits. All D-SNPs must at least coordinate Medicare and Medicaid benefits for their enrollees.

Term	Definition
Dually eligible individuals	Dually eligible individuals are eligible for both Medicare and Medicaid. To be considered dually eligible, individuals must be (1) eligible for Medicare Part A or Part B and (2) receiving full Medicaid benefits or Medicare Savings Program assistance, which subsidizes all or some Medicare premiums and cost sharing. Dually eligible individuals may be designated as full-benefit or partial-benefit dually eligible individuals, depending upon the Medicare Savings Program they qualify for and whether they qualify for full Medicaid benefits in their state.[1]
Exclusively aligned enrollment	Exclusively aligned enrollment occurs when a state's contract with the Dual Eligible Special Needs Plan (D-SNP) limits its enrollment to only full-benefit dually eligible individuals who receive Medicaid benefits from the D-SNP or an affiliated Medicaid managed care plan offered by the D-SNP's parent company.
Full-benefit dually eligible individuals (FBDE individuals)	Full-benefit dually eligible (FBDE) individuals are eligible for Medicare and categorically eligible for full (comprehensive) Medicaid benefits in the state where they live. FBDE individuals include those who have Qualified Medicare Beneficiary (QMB) benefits and full Medicaid benefits (known as QMB+), those who have Specified Low-Income Medicare Beneficiary (SLMB) benefits and full Medicaid benefits (known as SLMB+), and those who have full Medicaid benefits but no Medicare Savings Program benefits (known as Other FBDEs).[2]
Fully Integrated D-SNP (FIDE SNP)	Fully Integrated D-SNPs (FIDE SNPs) provide dually eligible individuals access to Medicare and Medicaid benefits under a single legal entity that holds both a Medicare Advantage contract with the Centers for Medicare & Medicaid Services (CMS) and a Medicaid managed care contract with the state Medicaid agency. FIDE SNPs have capitated contracts with the state Medicaid agency in each state where they operate to provide coverage of specified primary care, acute care, behavioral health, and long-term services and supports (LTSS). FIDE SNPs must provide coverage of nursing facility services for a period of at least 180 days during the plan year. CMS allows carve-outs of behavioral health services and limited carve-outs of LTSS, consistent with state policy. FIDE SNPs also coordinate the delivery of Medicare and Medicaid services using aligned care management methods and specialty care networks for high-risk beneficiaries. They employ policies and procedures approved by CMS and the state to coordinate or integrate beneficiary communications, enrollment, grievances and appeals, and quality improvement.
Highly Integrated D-SNP (HIDE SNP)	Highly Integrated D-SNPs (HIDE SNPs) provide coverage consistent with state policy for long-term services and supports, behavioral health services, or both under a capitated contract that meets one of the following arrangements: (1) the capitated contract is between the Medicare Advantage organization and the Medicaid agency or (2) the capitated contract is between the Medicare Advantage organization's parent organization (or an affiliated plan) and the Medicaid agency.
Integrated care systems	In integrated care systems, Medicare and Medicaid program administrative requirements, financing, benefits, and care delivery are coordinated. Both sets of benefits may be covered through a single entity or coordinating entities, such as through health plans, medical systems, and providers.

[1] For information about full- and partial-benefit dually eligible categories, see the CMS document entitled "Dually Eligible Individuals—Categories" at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf.

[2] Ibid.

Term	Definition
Medicaid auto-assignment	Medicaid auto-assignment takes place when a state enrolls beneficiaries into a Medicaid managed care plan automatically after they have been offered a choice of plan options but have not actively chosen a plan themselves. When automatically assigning beneficiaries to Medicaid managed care, states often use algorithms that consider the beneficiary's current provider and plan relationships.
Partial-benefit dually eligible individuals	Partial-benefit dually eligible individuals are enrolled in Medicare Part A or B and Medicare Savings Program benefits, which subsidize all or some Medicare premiums and cost sharing, but they do not receive full (comprehensive) Medicaid benefits. They are known as QMB Only, SLMB Only, QI, or QDWI beneficiaries, based on the Medicare Savings Program they are enrolled in: (1) the Qualified Medicare Beneficiary (QMB) Program; (2) the Specified Low-Income Medicare Beneficiary (SLMB) program; (3) the Qualified Individual (QI) Program; and (4) the Qualified Disabled Working Individual (QDWI) Program.[3]
Passive enrollment	Passive enrollment is a process through which beneficiaries are automatically enrolled in health plans but have the option to opt out or choose a different plan. Rules for passive enrollment of beneficiaries into Medicaid managed care plans are described at 42 CFR 438.54. In several states' Financial Alignment Initiative demonstrations, dually eligible individuals may be passively enrolled in a Medicare-Medicaid Plan (MMP) and have the opportunity to opt out at any time if they prefer another plan or coverage arrangement. States may also passively enroll dually eligible individuals into Dual Eligible Special Needs Plans (D-SNPs) in certain circumstances. See 42 CFR 422.60(g) for details.
Unaligned enrollment	Unaligned enrollment occurs when a dually eligible individual is enrolled in a Dual Eligible Special Needs Plan operated by one parent company but receives Medicaid benefits through (1) a Medicaid managed care plan offered by a different parent company or (2) a fee-for-service Medicaid program.

Source: Integrated Care Resource Center (2021).

[3] Ibid.

This page has been left blank for double-sided copying.

Executive Summary

To improve health outcomes for dually eligible individuals and reduce costs for Medicare and Medicaid, the Centers for Medicare & Medicaid Services (CMS) has worked with states and health plans to integrate services covered under both programs for this population through three major models: (1) Programs of All-Inclusive Care for the Elderly (PACE), (2) demonstrations under the Financial Alignment Initiative (FAI), and (3) contracts with Dual Eligible Special Needs Plans (D-SNPs) (Medicaid and CHIP Payment and Access Commission [MACPAC] 2020a).

D-SNPs are a type of Medicare Advantage plan that enroll—and are specifically designed to serve—only dually eligible individuals. All D-SNPs cover Medicare benefits and must at least coordinate Medicaid benefits. Since 2013, all D-SNPs must also have contracts with the Medicaid agencies in their states of operation, and those contracts must include at least the minimally required elements described at 42 CFR 422.107. In addition, states can leverage their contracting authority to go beyond these requirements and advance more extensive integration of Medicare and Medicaid benefits. In 2020, 42 states, the District of Columbia, and Puerto Rico had contracts with D-SNPs (CMS 2020). However, relatively few states have used D-SNP contracting strategies to achieve partial or full integration of Medicare and Medicaid benefits.

To identify ways in which states can maximize their D-SNP contracting authority to promote integration of benefits as well as enrollment in integrated plans, MACPAC contracted with Mathematica to conduct a qualitative research study with the following goals: (1) identifying the advantages and disadvantages of various contracting strategies, (2) understanding the factors that promote or inhibit state adoption of those strategies, and (3) informing MACPAC deliberations about further steps that could increase the availability of and enrollment in integrated models.

Study methods

Mathematica conducted 16 semi-structured interviews with 42 representatives from four states and the District of Columbia (D.C.); five health plans; two beneficiary advocacy organizations; and four other key stakeholders, including the CMS Medicare-Medicaid Coordination Office (see Appendix A for the full list of organizations). The four selected states and D.C. all contract with D-SNPs but have different degrees of integration. In addition, they vary in their use of Medicaid managed care to serve dually eligible individuals, their proportion of older adults residing in rural areas, and their proportion of dually eligible individuals enrolled in D-SNPs. (Figure II.1 lists the states interviewed and shows where they fall on a continuum of integration.)

Interviewees discussed states' adoption of and experience with 11 specific contracting strategies (listed in Table ES.1), which were divided into two sets: (1) those that all states can implement and (2) those that are relevant only to states that operate Medicaid managed care programs that enroll dually eligible individuals or individuals becoming dually eligible. We chose these 11 contracting strategies for review based on their use by several states to advance integration of Medicare and Medicaid benefits as well as their interest to MACPAC.

Because these 11 strategies do not constitute an exhaustive list of contracting strategies that states may use to advance integration, we asked interviewees about other strategies that states use or could use to support integration. In addition to asking about the use of each strategy, we asked interviewees about

factors that support or prevent state adoption of each strategy, their advantages and disadvantages, and special challenges to D-SNP contracting in rural and frontier areas.

Table ES.1. State contracting strategies that promote integration of Medicare and Medicaid benefits and/or enrollment in integrated D-SNPs

Where strategy is applicable	Contracting strategy
All states	Limit D-SNP enrollment to full-benefit dually eligible individuals
	Contract directly with D-SNPs to cover Medicaid benefits
	Require D-SNPs to operate with exclusively aligned enrollment
	Require D-SNPs to use enhanced care coordination methods and/or meet Medicaid care coordination requirements
	Require D-SNPs to send data or reports to the state for oversight purposes
	Review Medicaid information in certain D-SNP marketing and enrollee materials
States with Medicaid managed care programs for dually eligible individuals or individuals becoming dually eligible	Contract only with D-SNPs that offer affiliated Medicaid plans (and/or vice versa)
	Require complete service area alignment between D-SNPs and affiliated Medicaid plans
	Coordinate Medicaid procurement cycles with Medicare timelines
	Use Medicaid enrollment algorithms to automatically assign D-SNP enrollees to affiliated Medicaid managed care plans
	Allow (or require) D-SNPs to use default enrollment

Source: Mathematica analysis of state D-SNP contracting strategies.

Key findings

Several themes emerged from our interviews regarding the benefits and challenges of each D-SNP contracting strategy. In some cases, interviewees also suggested potential federal or state actions that could help address the challenges identified.

1. Factors influencing state adoption of D-SNP contracting strategies

States' existing D-SNP and Medicaid managed care programs and policies and their dually eligible populations' geographic and demographic characteristics influence state decisions regarding the adoption of particular D-SNP contracting strategies. The following are examples:

- States already contracting with D-SNPs can leverage existing D-SNP contracts to require coverage of Medicaid benefits through either the D-SNP or an affiliated Medicaid plan (Medicaid managed care plans that are owned by the same parent company as the D-SNP). States that do not currently contract with D-SNPs may have more flexibility to adopt a range of integration strategies in new contracts, while other states would have to modify existing contracts and arrangements.
- States with existing Medicaid managed care programs for dually eligible individuals, or those planning to implement one, can selectively contract with D-SNPs and Medicaid plans to promote integration, while those without Medicaid managed care can require D-SNPs to cover Medicaid benefits.

- State policies that carve out dually eligible populations or certain benefits from Medicaid managed care can hinder use of D-SNP or Medicaid managed care contracts to integrate benefits.
- States that already operate other integrated care initiatives (Financial Alignment Initiative demonstrations, in particular) may be less inclined to use D-SNP contracts to integrate benefits if the two initiatives could compete with each other for enrollment.
- States with a large number of dually eligible individuals residing in rural or frontier areas may face D-SNP contracting barriers. States with small populations of full-benefit dually eligible (FBDE) individuals or large numbers of partial-benefit dually eligible individuals may have difficulty limiting D-SNP enrollment to FBDE individuals.

To implement most of the contracting strategies discussed in this report, states need to invest substantial time and resources. In addition, limited Medicaid agency budgets and staff resources can impede their adoption. State contracting decisions may also be influenced by federal policies and priorities regarding integrated care and stakeholder support or opposition to certain D-SNP contracting strategies.

2. Barriers to D-SNP contracting in rural areas

States face several challenges to contracting with D-SNPs in rural or frontier areas. Small, dually eligible populations and relatively low Medicare Advantage payments to plans can limit D-SNP interest in serving these areas. In addition, D-SNPs sometimes face difficulty meeting CMS network adequacy requirements in rural areas because of insufficient numbers and types of providers. Interviewees suggested several policy changes that could help address these challenges: (1) states could launch Medicaid managed care programs to help health plans develop provider networks and a membership base in rural areas; (2) CMS could develop a Medicare waiver authority for D-SNPs that cannot meet its network adequacy requirements in certain areas but must operate statewide to meet states' selective contracting requirements; (3) states could use their D-SNP contracting authority to contract exclusively with county-owned health plans in rural counties (in states with such plans); (4) states could work with plans to increase the use of telehealth in rural areas; and (5) states and CMS could use network adequacy requirements developed for FAI demonstrations with D-SNPs.

3. Benefits and challenges of adopting 11 specific D-SNP contracting strategies

Contracting strategies applicable to all states

- **Limiting D-SNP enrollment to FBDE individuals.** This would be one of the simplest strategies to implement in most states. In addition, it would enable uniform delivery of care coordination and information about enrollee benefits to all enrollees within a D-SNP. However, in states with a small FBDE population or a large number of partial-benefit dually eligible individuals enrolled in D-SNPs, limiting enrollment to FBDE individuals could make it difficult for D-SNPs to enroll enough members to sustain operations and could cause disruption in coverage for the partial-benefit dually eligible individuals already enrolled. As an alternative, states could require D-SNPs to enroll partial-benefit dually eligible individuals in plan benefit packages (PBPs) that are separate from PBPs for FBDE individuals, which could also facilitate uniform delivery of care coordination and information within each PBP.
- **Contracting directly with D-SNPs to cover Medicaid benefits.** This strategy could be particularly useful in states that do not enroll dually eligible individuals in Medicaid managed care because it provides an opportunity to integrate Medicare and Medicaid benefits for D-SNP enrollees without

having to enroll dually eligible individuals into a full-fledged Medicaid managed care program. Challenges to using this strategy include (1) D-SNPs' lack of experience with long-term services and supports (LTSS) provider contracting and delivery of services to address social determinants of health and (2) beneficiary and provider confusion when D-SNPs are paid to cover a subset of Medicaid benefits and other benefits are excluded (that is, carved out). Interviewees suggested that states should minimize Medicaid benefit carve-outs when using this strategy to promote greater integration and minimize confusion.

- **Requiring D-SNPs to operate with exclusively aligned enrollment.** Exclusively aligned enrollment occurs when a state's contract with the Dual Eligible Special Needs Plan (D-SNP) limits its enrollment to only FBDE individuals who receive Medicaid benefits from the D-SNP or an affiliated Medicaid managed care plan offered by the D-SNP's parent company. This strategy would achieve the greatest degree of benefit integration. However, it could result in fewer dually eligible individuals enrolled in D-SNPs and would require significant state infrastructure and investment.
- **Including care coordination and data sharing requirements in D-SNP contracts.** State-specific care coordination and data sharing requirements can promote better coordination of benefits for D-SNP members and enhance states' awareness of Medicare service utilization and disparities within their dually eligible population. However, monitoring plan compliance with such requirements can be challenging. In addition, state requirements that D-SNPs share data or reports with the state for oversight purposes are useful only if states can (and do) use the data submitted. Two interviewees also noted that timely state sharing of Medicaid eligibility and enrollment data with D-SNPs facilitates better care coordination.
- **Reviewing Medicaid information in D-SNP marketing materials and enrollee notices.** The health plan interviewees often expressed concern about lengthy, duplicative, and sometimes contradictory state and CMS review processes. However, they were open to the idea of state provision of template language on Medicaid benefits for D-SNPs to include in their marketing materials and enrollee notices, such as summaries of the benefits covered by the plan and notices describing enrollee appeal and grievance rights and processes. Other interviewees, particularly beneficiary advocates, expressed support for state reviews of Medicaid information in D-SNP materials. The advocates noted that it would be easier to share feedback on such materials with the state rather than with multiple D-SNPs. One health plan representative suggested that the states, along with CMS, could develop a single set of rules and review processes for integrated D-SNP materials, like the processes established for the FAI demonstrations.

Strategies applicable to states with Medicaid managed care programs for dually eligible individuals

- **Using selective contracting.** This strategy facilitates aligned enrollment—that is, when a dually eligible individual is enrolled in a D-SNP and a Medicaid managed care plan through the same parent organization, which increases the potential for better integration of Medicare and Medicaid benefits. However, Medicaid procurement decisions can dissolve aligned enrollment for individuals in D-SNPs and affiliated Medicaid managed care plans (managed care plans offered through the same parent companies as the D-SNPs) if the Medicaid plan loses a reprocurement bid. In addition, in states that use selective contracting, plans that do not win Medicaid managed care contracts may aggressively market regular, non-D-SNP Medicare Advantage plans to dually eligible individuals, ultimately steering them away from integrated plans. To address this issue, one interviewee suggested that CMS could consider restricting the types of Medicare Advantage plans available to dually eligible individuals in areas with integrated plans.

- **Requiring completely aligned service areas.** States that implement selective contracting can also require affiliated D-SNPs and Medicaid managed care plans to operate in the same geographic service areas, a strategy that further promotes integration and creates a framework for exclusively aligned enrollment. Obstacles to D-SNP contracting in rural areas may make this strategy impractical in certain states, however.
- **Coordinating Medicaid procurement timelines with Medicare timelines.** Variation between Medicare's timelines for launching and maintaining D-SNPs and state Medicaid managed procurement cycles can present challenges for states interested in implementing selective contracting. However, interviewees agreed that trying to fully coordinate these processes would not be worthwhile, given the amount of state investment required and the unpredictability of Medicaid procurement decisions and health plan protests. Instead, one interviewee thought coordinating Medicaid managed care enrollment periods with Medicare enrollment periods might be more effective in boosting beneficiary enrollment in affiliated plans. One health plan reported that one state allowed it to implement a D-SNP within one year of its Medicaid managed care award in lieu of coordinating the procurement timelines.
- **Automatically assigning D-SNP enrollees to affiliated Medicaid plans or allowing (or requiring) D-SNPs to use default enrollment.** Both of these strategies can help increase the number of dually eligible individuals enrolled in integrated plans. However, some interviewees stressed the importance of communicating with beneficiaries to ensure they understand the consequences of automatic assignment and retain the ability to select different coverage arrangements if they choose. In addition, some states lack the advanced information technology (IT) capabilities needed to implement these strategies. One interviewee suggested that CMS could encourage or incentivize states to use default enrollment. Others would like CMS to allow states to use waiver authority to implement "passive" enrollment into integrated D-SNPs, like what is now allowed in FAI demonstrations.[4]

4. Additional contracting strategies suggested by interviewees

In addition to the 11 D-SNP contracting strategies specifically examined in this study, interviewees suggested three additional contracting strategies to further Medicare-Medicaid integration:

- **Partnering with D-SNPs to develop D-SNP supplemental benefit packages** that complement the Medicaid benefits available to FBDE individuals, expand the package of benefits available to D-SNP enrollees, and reduce costs for states.
- **Incorporating Medicaid quality improvement priorities into contracts with D-SNPs that cover Medicaid benefits** (through the D-SNP or an affiliated Medicaid plan) to further advance states' quality improvement strategies for dually eligible individuals.
- **Developing automatic crossover payment processes** with D-SNPs and Medicaid managed care plans that have at least some unaligned enrollees, to simplify provider billing and payment of Medicare cost sharing to providers who serve the dually eligible individuals enrolled in these plans.

[4] While interviewees recommended this, it is not clear whether implementing this kind of enrollment into D-SNPs would actually be possible under Medicare or Medicaid waiver authority.

Conclusions

We found several key considerations for states as they leverage D-SNP contracting strategies to advance integration of Medicare and Medicaid benefits and promote enrollment in integrated plans:

- **State context matters.** Whereas some D-SNP contracting strategies could be used by any state, others are applicable only to states that enroll dually eligible individuals in Medicaid managed care. In addition, it may be easier for states new to D-SNP contracting to implement a fully integrated program from the beginning; however, states with existing contracts may have a greater risk of disrupting continuity of care for current enrollees and encountering resistance from plans if they use selective contracting or limit D-SNP enrollment to FBDE individuals. For example, states new to contracting with D-SNPs could use direct contracting and exclusively aligned enrollment to create a fully integrated model from the outset. In states with existing D-SNP contracts, on the other hand, implementation of these strategies could disrupt coverage arrangements for current D-SNP enrollees and potentially lead to D-SNP disenrollment. For information about which contracting strategies may be most feasible in different state contexts, see Appendix D.
- **Resources and long-term commitment matter.** States need to invest significant financial and staffing resources to advance integrated care initiatives, but many states do not yet have the Medicare policy expertise to navigate complexities in D-SNP contracting. Leadership buy-in and staff champions often play a critical role in advancing D-SNP contracting strategies, so turnover in key staff or leadership positions can interrupt or derail state progress toward integrated care.
- **D-SNP contracting strategies often involve trade-offs between the level of integration and the number of individuals enrolled.** Some contract requirements that increase integration of Medicare and Medicaid benefits may decrease the share of dually eligible individuals enrolled in D-SNPs (at least in the short term). For example, restricting D-SNP enrollment to FBDE individuals allows the plan to better integrate care and member materials, but it could lead to substantially fewer enrollees if partial-benefit dually eligible individuals cannot enroll or are disenrolled from D-SNPs because of that restriction. Conversely, allowing partial-benefit dually eligible individuals to enroll in D-SNPs may mean that a greater share of dually eligible individuals enroll in D-SNPs, but those D-SNPs will be less integrated as a result (see Chapter III.C for details).
- **Some D-SNP contracting strategies may have unintended consequences that may not be easy (or possible) to resolve.** Several interviewees noted that selective contracting may lead to some aligned D-SNP enrollees becoming unaligned or being forced to change their D-SNP or Medicaid plan when an organization loses a Medicaid reprocurement bid.
- **D-SNP contracting in rural areas is challenging.** Small dually eligible populations and CMS network adequacy requirements create obstacles to statewide D-SNP contracting in states with a large share of dually eligible beneficiaries who live in rural or frontier regions. Some state and CMS policy changes might address these barriers.
- **Federal requirements and CMS priorities for integrated care influence state decisions to adopt D-SNP contracting strategies.** Federal laws and regulations, along with federal support for state initiatives, can accelerate states' use of D-SNPs as a platform for integrating care for dually eligible individuals.
- **Stakeholder engagement is critical to successful integrated care initiatives.** Health plans, providers, and beneficiary advocacy organizations often influence enrollment into integrated (or nonintegrated) health plans. If states do not successfully engage these stakeholders and gain their

support when implementing D-SNP contracting strategies to promote integration, the stakeholders may use their influence to steer potential enrollees away from integrated care.

Integrating care for dually eligible beneficiaries is a complex endeavor that varies substantially by state. By taking into account the factors that influence state decisions and understanding which D-SNP contracting options are best suited to each state, federal and state policymakers can advance integration through those D-SNP contracting strategies that are most feasible and likely to succeed.

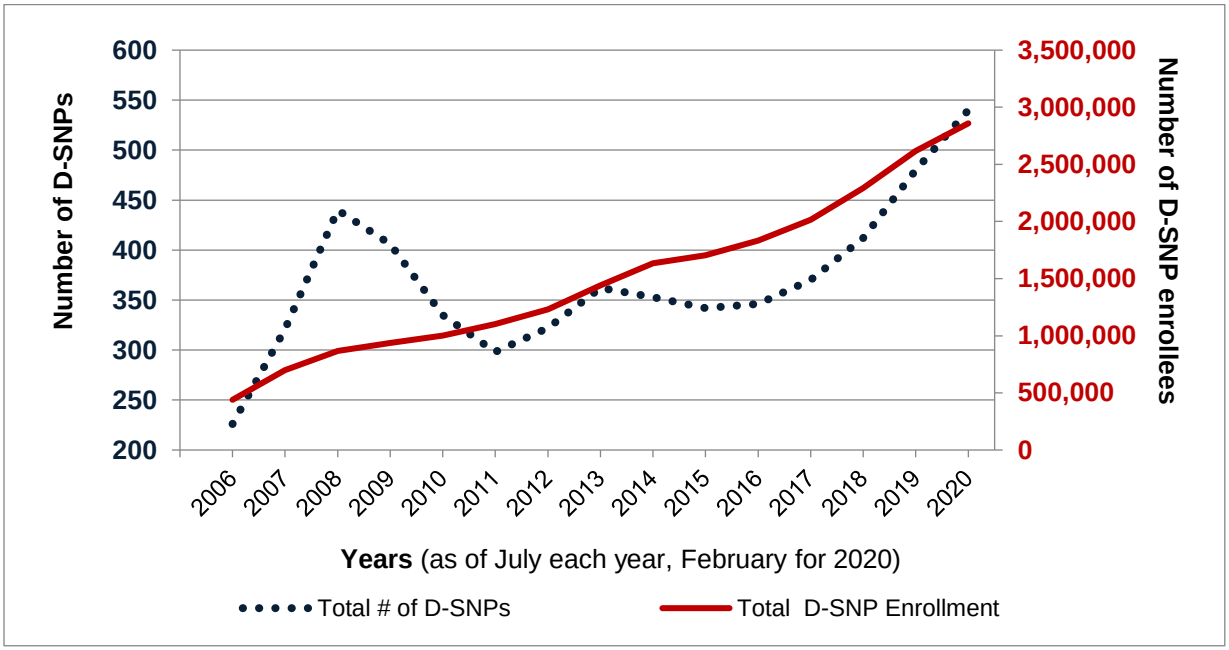
This page has been left blank for double-sided copying.

I. Introduction

Dually eligible individuals, who are covered by both Medicare and Medicaid, account for disproportionate shares of spending in both programs and have a higher prevalence of chronic health conditions, functional limitations, and social risk factors than those who qualify only for Medicare (Centers for Medicare & Medicaid Services [CMS] 2019; Medicare Payment Advisory Commission [MedPAC] and Medicaid and CHIP Payment and Access Commission [MACPAC] 2018). Because Medicare and Medicaid are separate programs, dually eligible individuals face obstacles in navigating the two systems. Likewise, health care providers, states, and health plans face challenges as well as competing payment incentives in delivering and coordinating care for this vulnerable population. The COVID-19 public health emergency has only exacerbated these challenges (Ennslin Janoski et al. 2020) and intensified the need for greater integration of Medicare and Medicaid financing, administration, and benefits.

CMS has worked with states to design and implement integrated care initiatives that will improve health outcomes for dually eligible individuals and reduce costs for Medicare and Medicaid. However, these integrated care models vary in their degrees of integration. Although evaluations have generally shown a decrease in hospitalizations and readmissions among integrated plan enrollees when compared with those not enrolled in such plans, the findings have been mixed (MACPAC 2019). In addition, while enrollment in integrated care initiatives increased sixfold from 2006 to 2019 (from 161,777 to more than 1 million beneficiaries), fewer than 10 percent of all dually eligible individuals nationwide were enrolled in an integrated plan in 2019 (CMS 2019). During this period, growth in Programs of All-Inclusive Care for the Elderly (PACE) and Financial Alignment Initiative (FAI) demonstrations was limited while enrollment in Dual Eligible Special Needs Plans (D-SNPs) increased steadily (see Figure I.1).

Figure I.1. D-SNP enrollment, 2006–2020



Source: CMS Special Needs Plan (SNP) Comprehensive Reports. Available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.html.

D-SNPs are a type of Medicare Advantage plan first authorized by federal law in 2003 to exclusively serve dually eligible individuals. Since 2013, they have been required to hold a contract with the Medicaid agency in each state of operation. Those contracts must meet certain minimum requirements (Integrated Care Resource Center [ICRC] 2020a). The Bipartisan Budget Act of 2018 (BBA) (P.L. 115-123) permanently authorized D-SNPs and required them to take certain steps to promote greater integration of the services covered by Medicare and Medicaid (Talamas et al. 2020).[5]

Although the required minimum elements (see Box I.1) for state Medicaid agency contracts (SMACs)[6] ensure at least some coordination between the D-SNP and the state Medicaid agency (or other relevant Medicaid entities), those requirements do not result in fully integrated Medicare and Medicaid coverage (MedPAC 2019). However, states can use their contracting authority to impose additional requirements and achieve greater integration. For example, states can limit D-SNP enrollment to full-benefit dually eligible (FBDE) individuals, who qualify for all Medicaid benefits in addition to coverage of Medicare cost sharing and thus have a greater need for coordination across Medicare and Medicaid. In addition, states can opt to contract only with D-SNPs that also operate Medicaid managed care plans (referred to as selective contracting in this report). Alternatively, states can pay D-SNPs a fixed per capita amount to cover the costs of providing Medicaid benefits, a strategy referred to as direct contracting in this report. Direct contracting can be a particularly useful option in states that do not already use Medicaid managed care to serve dually eligible individuals because it facilitates coverage of Medicare and Medicaid benefits through a single plan without requiring the state to launch or change Medicaid managed care programs. In a direct contracting model, only the dually eligible individuals who choose to enroll in a D-SNP would have their Medicaid benefits covered by the D-SNP; all other dually eligible individuals would continue to receive state Medicaid benefits on a fee-for-service basis (or through whatever model serves as the default form of coverage for the dually eligible population in that state).

Although 42 states, the District of Columbia, and Puerto Rico had contracts with D-SNPs in 2020 (CMS 2020), relatively few states[7] had adopted the D-SNP contracting strategies that result in the most integrated care models, likely at least in part because of several challenges:

[5] The CMS Medicare Advantage and Prescription Drug final rule for 2020 and 2021, CMS-4185-F, published at 84 FR 15680, codified requirements mandated by the Bipartisan Budget Act of 2018 to increase integration of Medicare and Medicaid benefits for D-SNP enrollees. Per this rule, all D-SNPs must at least "coordinate" Medicaid benefits. Any D-SNP that does not qualify as a fully integrated D-SNP (FIDE SNP) or a highly integrated D-SNP (HIDE SNP)—by covering Medicaid behavioral health benefits or long-term services and supports, or both—must notify the state or its designee of hospital and skilled nursing facility admissions for high-risk FBDE enrollees. In addition, SMACs with FIDE SNPs and HIDE SNPs that operate with exclusively aligned enrollment must require that those plans use newly integrated plan-level appeal and grievance procedures.

[6] SMACs are sometimes referred to as MIPPA contracts because a provision in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required D-SNPs to contract with states.

[7] As of 2020, Arizona, Hawaii, Idaho, Massachusetts, Minnesota, New Jersey, and Virginia have used selective contracting, direct contracting, and/or restriction of enrollment to FBDE beneficiaries within D-SNPs to promote aligned enrollment (and in the cases of Idaho, Massachusetts, Minnesota, and New Jersey, to achieve "exclusively aligned enrollment" in which D-SNP enrollment is restricted to only enrollees who will receive both Medicare and Medicaid benefits through the plan). In addition to Idaho (which directly contracts with D-SNPs for coverage of substantially all Medicaid benefits for D-SNP enrollees), Alabama and Florida also use direct contracting methods to make per capita payments to D-SNPs for select Medicaid benefits—Florida for non-LTSS Medicaid services and Alabama for Medicare cost sharing. (Mathematica internal data)

- Many states lack the resources, capacity, or knowledge of federal Medicare Advantage requirements to design and manage complex D-SNP contracting and oversight activities and mesh them with their Medicaid programs ((U.S. Government Accountability Office [GAO] 2020).
- Variation between Medicaid and Medicare Advantage procurement cycles and network adequacy requirements can complicate the process of selective contracting (Archibald et al. 2019; MACPAC 2020b; Milligan 2020).
- Restricting D-SNP enrollment to FBDE individuals can increase integration for those enrollees but decrease the total number of dually eligible individuals who are eligible to enroll in D-SNPs (MedPAC 2019).

Box I.1. Minimum elements for SMACs

D-SNPs are required to document eight minimum elements in their contracts with states:

1. **Coordinating the delivery of Medicare and Medicaid benefits and services.** A description of how D-SNPs will coordinate delivery of Medicaid benefits internally, with the state, or with other plans to deliver Medicaid-covered services.
2. **Categories of dually eligible beneficiaries who are eligible to enroll in the D-SNP.** An outline of which dually eligible beneficiaries can enroll in the D-SNP.
3. **Medicaid benefits covered by the D-SNP.** A list of all Medicaid benefits offered by the D-SNP, by a Medicaid managed care organization operated by the D-SNP's parent organization, or by another entity owned and controlled by its parent organization.
4. **Cost sharing protections.** An acknowledgment that D-SNPs will not impose cost sharing on dually eligible beneficiaries above and beyond the limits outlined in the Medicaid state plan.
5. **State identification and sharing of information on Medicaid provider participation.** A description of the process the state will use to share a list of Medicaid providers with the D-SNP for inclusion in the D-SNP provider directory.
6. **D-SNP verification of enrollee eligibility for Medicare and Medicaid.** A description of the process the state will use to provide the D-SNP with information on beneficiary eligibility for Medicaid so that the D-SNP can verify both Medicare and Medicaid eligibility prior to enrolling a beneficiary into the D-SNP.
7. **D-SNP service area.** A list of the geographic areas where the D-SNP will market and enroll beneficiaries.
8. **Contract period.** An outline of the contract period of performance, which must be at least from January 1 to December 31 of the year following the contract's due date.

Further description of these minimum requirements, as well as additional contract requirements that apply in special circumstances (for D-SNPs that do not qualify as Fully Integrated D-SNPs [FIDE SNPs] or Highly Integrated D-SNPs [HIDE SNPs], for D-SNPs seeking FIDE SNP or HIDE SNP designations, and for integrated plans implementing integrated appeals and grievance processes), can be found in ICRC's technical assistance tool, Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans (ICRC 2020a).

In its June 2020 report to Congress, MACPAC noted that "increasing both the availability of integrated care and the number of people enrolled in integrated models is a path to better care for individuals and more effective and efficient coordination between Medicaid and Medicare" (MACPAC 2020b, p. 33). MACPAC recommended that Congress provide federal funds to enhance the states' capacity to

implement these models (MACPAC 2020b). Given the increased number of D-SNPs across states and the rising shares of dually eligible enrollees in D-SNPs in recent years, states can use their contracting authority to improve integration of Medicare and Medicaid and increase the proportion of dually eligible enrollees in integrated plans.

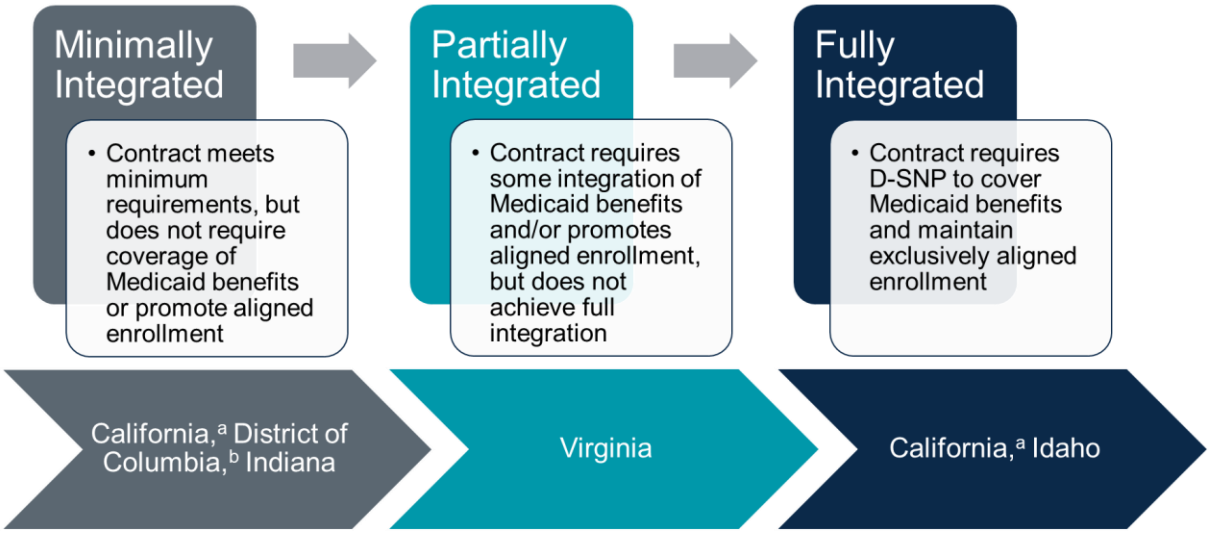
To support further development of integrated care initiatives involving D-SNPs, MACPAC contracted with Mathematica to examine opportunities existing under current law for states to maximize their D-SNP contracting authority to integrate Medicare and Medicaid benefits and promote enrollment in integrated plans. The study's purpose was to identify the advantages and disadvantages of various contracting strategies, understand the factors that promote or inhibit state adoption of those strategies, and inform MACPAC deliberations about further steps that could increase the availability of and enrollment in integrated D-SNP models.

We begin by summarizing the data and methods used to conduct the study (Chapter II). We then present a detailed summary of our findings (Chapter III), including (1) factors that promote or hinder state adoption of D-SNP contracting strategies, (2) challenges that hinder D-SNP contracting in rural and frontier areas, (3) the benefits and challenges of 11 specific contracting strategies to further integration in D-SNPs, (4) contextual factors that support state use of each strategy, and (5) additional strategies suggested by our interviewees. We conclude by highlighting the overarching themes from our interviews (Chapter IV).

II. Data and Methods

We conducted 16 interviews between October 1 and November 15, 2020, with a diverse set of respondents who represented four states, the District of Columbia (D.C.), a variety of health plans, beneficiary advocacy organizations, CMS, and other key stakeholders (Appendix Table A.1). We carefully selected the four states and D.C. to ensure representation of a variety of D-SNP integration levels. Specifically, we included at least one state with D-SNP contracts that fell into multiple categories along a continuum of integration (Figure II.1).

Figure II.1. Continuum of integration in state D-SNP contracts



Source: Mathematica analysis of state contracts with D-SNPs

[a] In 2021, California has D-SNP contracts that fall into both the fully integrated and the minimally integrated categories. As the state works to implement its proposed CalAIM initiative, it plans to use more integrated contracting strategies with D-SNPs in 2023.

[b] Although the District of Columbia's 2021 D-SNP contracts fall into the minimally integrated category, it plans to implement fully integrated D-SNP contracts in the future.

In addition to selecting states and D.C. based on their current placement across the spectrum of D-SNP integration, we also made sure that they represented a variety of other relevant contextual factors, such as (1) the presence of a state Medicaid managed care program that serves dually eligible individuals; (2) the extent to which parent companies offer both D-SNPs and Medicaid managed care plans for dually eligible individuals in the state (that is, affiliated plans); (3) the share of the state's age 65 and older population that resides in rural areas; and (4) the share of dually eligible individuals currently enrolled in D-SNPs (Appendix Table A.2).

For each state, we interviewed staff from the state Medicaid agency and from at least one health plan that currently operates a D-SNP in the state. Several of the health plans operate in multiple states, which enabled their staff to discuss their experiences with implementing a variety of state D-SNP contracting strategies. We also identified key stakeholders who could speak about their experiences in one or more of our selected states, including beneficiary advocates and subject matter experts with previous experience

working at state Medicaid agencies. Each interview examined states' adoption of and respondents' experience with the 11 specific contracting strategies, focusing on factors supporting or preventing state adoption as well as each strategy's benefits and perceived challenges or disadvantages.

The 11 contracting strategies are briefly described in Table II.1. They are divided into two groups: (1) those applicable to all states and (2) those applicable only to states that cover Medicaid benefits for dually eligible individuals through Medicaid managed care programs. Figure III.1 in Chapter III includes a decision tree designed to help states identify the strategies available in their particular context. More detailed explanations of each contracting strategy can be found in Appendix B.

Prior to our interviews, we collected information from state interviewees on state adoption of the 11 strategies. We used that information to tailor the focus of each interview to discuss the benefits and challenges for states, plans, and beneficiaries associated with particular strategies, as well as factors influencing state adoption (or lack of adoption) of each strategy. We also asked interviewees to discuss trade-offs in implementing certain strategies and whether certain strategies led to greater integration of Medicare and Medicaid benefits or increased enrollment in integrated D-SNPs. In addition, we specifically asked interviewees to discuss any challenges faced in contracting with D-SNPs to cover rural or frontier areas.

A member of the study team was assigned to take detailed notes for each interview and review the notes for accuracy afterward using interview recordings. We then used a combination of inductive and deductive qualitative coding techniques to identify themes across interviews. Two team members reviewed and coded each set of interview notes to ensure reliability and consistency. The complete results of the qualitative analysis were also reviewed for accuracy, clarity, and interpretation by the project director, the project's quality assurance reviewer, and a senior advisor.

Table II.1. State D-SNP contracting strategies that promote Medicare-Medicaid integration

Contracting strategy	Brief definition or explanation	State examples[a]
Strategies applicable to all states		
1. Limit D-SNP enrollment to full-benefit dually eligible individuals	To ensure that D-SNPs can offer uniform benefits, cost sharing, and care coordination to all D-SNP enrollees and present benefit information simply and clearly in enrollee materials, states can limit D-SNP enrollment to individuals who qualify for full Medicaid benefits in the state or full-benefit dually eligible (FBDE) individuals. Alternatively, states can require D-SNPs to use separate Medicare Advantage Plan Benefit Packages (PBPs)[b] to enroll full- and partial-benefit dually eligible individuals.	AZ, HI, ID, MA, MN, NJ *(PA and VA require separate PBPs)*
2. Contract with D-SNPs to cover Medicaid benefits (direct contracting)	States can contract directly with D-SNPs to cover a range of Medicaid benefits, from simple coverage of Medicare cost sharing (a practice implemented in Alabama) to coverage of Medicaid wraparound benefits (Florida) to a full package of Medicaid benefits, including behavioral health and long-term services and supports (Idaho).	AL, FL, ID
3. Require D-SNPs to operate with exclusively aligned enrollment	Exclusively aligned enrollment occurs when a state limits enrollment in a D-SNP to FBDE individuals who receive their Medicaid benefits from the D-SNP or an affiliated Medicaid managed care plan offered by the same parent company as the D-SNP. This maximizes coordination because only one organization is responsible for Medicare and Medicaid benefits.	ID, MA, MN, NJ, NY
4. Require D-SNPs to use specific or enhanced care coordination methods	States can incorporate a variety of requirements into their D-SNP SMACs to enhance the amount or degree of care coordination provided to D-SNP enrollees and facilitate greater integration of Medicare and Medicaid benefits. See Chapter III.C for specific examples of care coordination requirements that states can incorporate into their SMACs.	ID, MA, MN, NJ, TN, VA
5. Require D-SNPs to send data or reports to the state for oversight purposes	States can require D-SNPs to submit data and/or reports that enable state oversight of plan operations and quality of care—for example, Medicare encounter data, grievance and appeal data, and reports on the plan's performance on certain quality measures or chronic care improvement projects, financial statements, or service cost information.	AZ, MA, MN, NJ, NM, OR, TN, VA
6. Review Medicaid information in D-SNP materials	States can require D-SNPs to submit certain marketing and enrollee communication materials for state review before using them so that the state can ensure that the Medicaid information in those materials is accurate, appropriate, and clear. In addition (or alternatively), the state can provide template language about Medicaid benefits and require D-SNPs to use that language to ensure consistency in messaging across D-SNPs.	ID, MA, MN, NJ, TN, WI
Strategies applicable to states with Medicaid managed care programs that enroll dually eligible individuals		
7. Selectively contract with D-SNPs and/or Medicaid managed care plans that offer affiliated plans	States with Medicaid managed care programs for dually eligible individuals can choose to contract only with D-SNPs that offer an affiliated Medicaid managed care plan (through the same parent organization) and/or to contract only with Medicaid managed care plans that offer an affiliated D-SNP to promote aligned enrollment (enrollment in a D-SNP and a Medicaid plan through the same organization).	AZ, HI, MA, MN, NJ, TN,[c] VA
8. Require complete service area alignment	States that use selective contracting can require affiliated D-SNPs and Medicaid managed care plans to operate in fully aligned service areas so that all D-SNP-eligible individuals will have the option of enrolling in affiliated plans for coverage of Medicare and Medicaid benefits, regardless of their geographic location within the state. Achieving complete service area alignment can be difficult in states with substantial rural or frontier areas. See Chapter III.B.	AZ, NJ
9. Coordinate state Medicaid procurement cycles with Medicare timelines	States that use selective contracting can coordinate their Medicaid procurement cycle with Medicare timelines for approval of D-SNP contracts to maintain consistent affiliations between the D-SNPs and Medicaid managed care plans operating in the state.	None

Table II.1 (*continued*)

Contracting strategy	Brief definition or explanation	State examples[a]
10. Automatically assign D-SNP enrollees to affiliated Medicaid plans	In states with affiliated D-SNPs and Medicaid managed care plans for dually eligible individuals, state Medicaid agencies can use Medicaid auto-assignment algorithms to align dually eligible individuals' Medicaid managed care enrollment with their D-SNP enrollment to promote aligned enrollment.	AZ (on a limited basis)
11. Allow (or require) D-SNPs to use default enrollment	D-SNPs that meet the requirements described at 42 CFR 422.66(c)(2) may use default enrollment to enroll newly dually eligible individuals into a D-SNP through the same parent organization as their current Medicaid managed care plan (as long as the individuals will continue to be enrolled in Medicaid managed care once they are eligible for Medicare).	AZ, PA, OR, TN, VA

[a] Based on Mathematica analysis of 2020 (and in some cases, 2021) state contracts with D-SNPs. Not all states' D-SNP contracts are publicly available. For this analysis, Mathematica reviewed contracts that were publicly available, as well as a few contracts that states shared with Mathematica for informational purposes.

[b] When Medicare Advantage Organizations submit applications to CMS to operate Medicare Advantage plans (including D-SNPs), they submit proposed plan benefit packages (PBPs). Each PBP has a specific proposed set of health benefits, cost sharing, premiums, and supplemental benefits. A single Medicare Advantage contract may contain multiple PBPs, and those PBPs may operate in a single state or span multiple states. A single contract may also contain D-SNP PBPs and non-D-SNP PBPs. When a state requires a D-SNP to use separate PBPs to enroll full- and partial-benefit dually eligible individuals, both populations can enroll in a D-SNP through the same parent company, but each population is effectively enrolled in a different "plan" from an administrative perspective.

[b] D-SNPs that operated in Tennessee before 2014 are exempt from the state's selective contracting requirement.

III. Findings

In this chapter, we describe the factors that promote or hinder state adoption of D-SNP contracting strategies, the challenges to contracting with D-SNPs to serve rural and frontier areas, and the specific benefits of and challenges to adopting each strategy. We conclude with some additional D-SNP contracting strategies that interviewees suggested may be helpful in further integrating Medicare and Medicaid benefits.

A. Factors influencing state adoption of D-SNP contracting strategies

Several contextual factors seem to promote or hinder states' interest in or use of D-SNP contracting strategies generally, in addition to sometimes influencing the adoption of specific strategies. Some of these factors concern the D-SNP market in each state. Some are related to state Medicaid policies and programs. Some are specific to the dually eligible population in each state. Others include state resources, federal priorities, and stakeholder support or opposition.

> *Many [contracting strategies] are pretty easy, but how easy and how effective they are is really dependent on what the starting point is. The easy next step for Arizona is not the easy next step for Maine."*
>
> —Stakeholder interviewee

1. Current D-SNP operations

The presence (or absence) of D-SNPs within a state, and the number of D-SNPs operating within it, can play an important role in the state's interest in using D-SNP contracting to integrate care for dually eligible individuals, as well as in which strategies to implement. States that already have contracts with D-SNPs could leverage those contracts to cover Medicaid benefits, which would increase enrollment more quickly than could occur in states that launched an integrated care program for the first time. On the other hand, if states without current D-SNP contracts could find willing D-SNP contractors, they may be able to reach higher levels on the continuum of integration (including contracting with fully integrated D-SNPs that operate with exclusively aligned enrollment) in their initial D-SNP contracts than states with existing contracts that may be concerned about disrupting current enrollee coverage.

2. Medicaid managed care programs for dually eligible individuals

Another factor influencing state D-SNP contracting choices is whether states already enroll dually eligible individuals in Medicaid managed care and whether the plans contracted to provide Medicaid benefits are offered by the same organizations that operate D-SNPs in the state. As shown in Table II.1, certain D-SNP contracting strategies can be used only in states that operate (or are planning to launch) Medicaid managed care programs for dually eligible individuals. For example, aligning D-SNP and Medicaid managed care service areas is relevant only to states that selectively contract with D-SNPs and affiliated Medicaid managed care plans. However, states without Medicaid managed care programs can contract directly with D-SNPs to cover and coordinate Medicaid benefits for dually eligible beneficiaries. (See Figure III.1 for a decision tree designed to help states identify the contracting strategies applicable in their particular context.)

Figure III.1. Determining which D-SNP contracting strategies may be used in specific states

The following D-SNP strategies may be used by any state that contracts with D-SNPs, regardless of whether they have Medicaid managed care for dually eligible individuals.

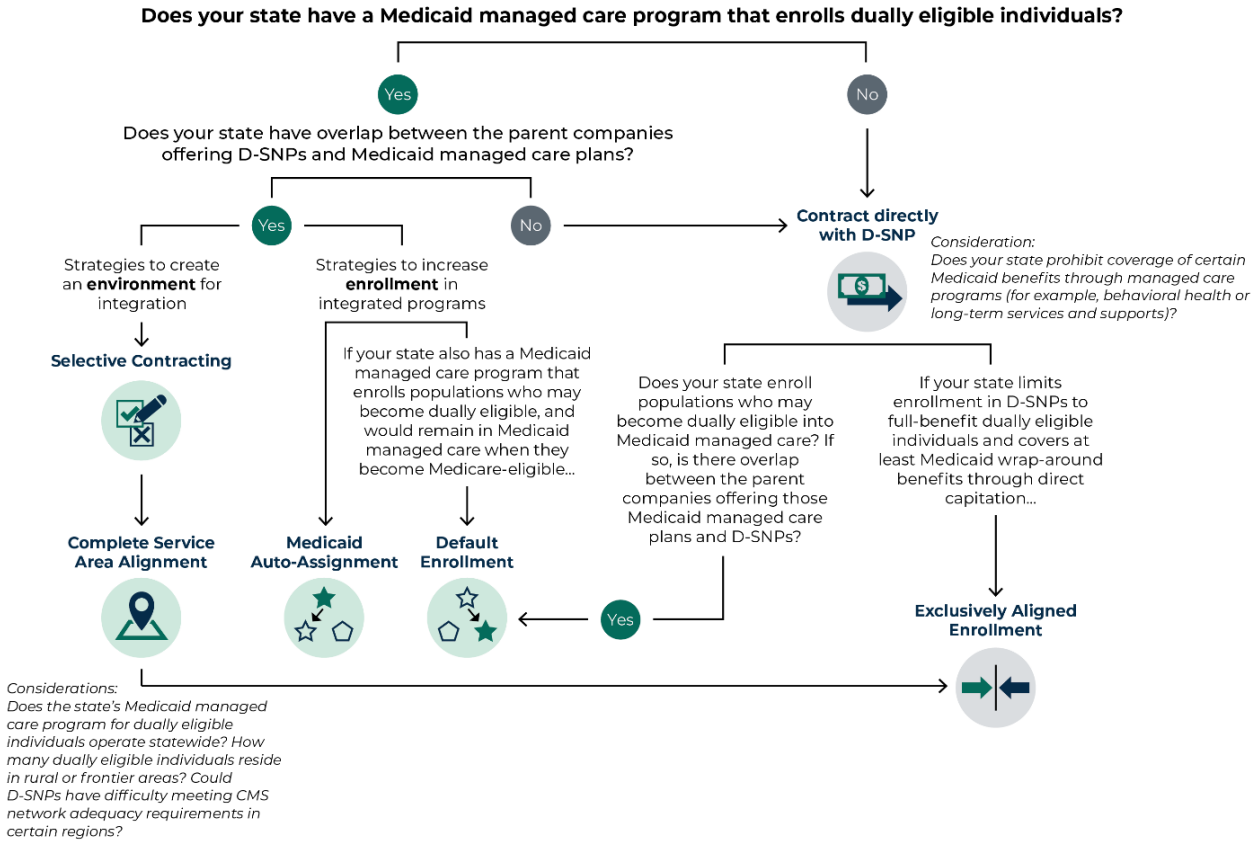
Limiting D-SNP enrollment to FBDE individuals
Considerations: Does your state have a substantial enough FBDE population to provide a viable market for D-SNPs? Does your state have a large number of partial-benefit dually eligible individuals already enrolled in D-SNPs?

Requiring D-SNPs to use enhanced care coordination methods or integrate Medicaid requirements into care coordination processes

Requiring D-SNPs to send data or reports to the state for oversight purposes

Requiring state review of Medicaid information in certain D-SNP marketing and enrollee communication materials

The decision tree below illustrates which of the remaining strategies could be implemented, based on state context, starting with whether the state enrolls dually eligible individuals into Medicaid managed care.



3. Other factors

Additional factors that may influence state adoption of D-SNP contracting strategies include:

- **State policies that carve out populations or benefits from managed care.** State laws that carve out certain benefits from Medicaid managed care or prohibit enrollment of dually eligible individuals (or subsets of the state's dually eligible population, such as LTSS users) in managed care programs can prevent a state from directly contracting with D-SNPs or Medicaid managed care plans to cover those benefits or populations—which impacts the level of integration that may be achieved.
- **Existence of other integrated care initiatives.** States that already operate demonstrations under the Financial Alignment Initiative may be less likely to leverage D-SNP contracting strategies to integrate Medicare and Medicaid benefits in geographic areas already served by demonstration Medicare-Medicaid Plans (MMPs), because D-SNPs and MMPs would ultimately compete with each other for dually eligible enrollees.
- **Location and characteristics of a state's dually eligible population.** States with a significant proportion of their dually eligible population in rural or frontier areas may face challenges with D-SNP contracting in those areas that could impact the state's ability to require complete service area alignment between D-SNPs and Medicaid managed care plans (see Section III.B). In addition, states that have small numbers of dually eligible individuals overall may have difficulty attracting D-SNPs to the state. States where FBDE individuals make up a relatively small share of all dually eligible individuals (for example, less than half) also may have difficulty limiting D-SNP enrollment to FBDE individuals because there may be too few to provide a viable or sustainable market for D-SNPs without including partial-benefit dually eligible individuals (see section III.C).
- **State resources and staffing.** State budgets must be balanced, and Medicaid agency resources are often stretched thin across several competing priorities (even more so now because of the COVID-19 public health emergency), which limits a state's capacity to develop integrated care programs. Many state Medicaid agencies also lack Medicare Advantage policy expertise and face turnover in key staff—for example, staff champions for integrated care or staff with key subject matter expertise—that can jeopardize the state's ability to implement new strategies. Because implementing integrated care initiatives can take many years, the loss of an integrated care champion can leave gaps in crucial institutional knowledge and expertise and even result in the state reverting to an earlier stage of implementation (or derail the state's integration plans entirely). Moreover, turnover in state leadership can dictate new state strategies and priorities that may or may not include integrating care for dually eligible individuals.
- **State reaction to federal actions.** Two of the state representatives interviewed for this study commented that their efforts to develop integrated care initiatives using D-SNPs have been influenced in part by federal government action. One state representative said that the permanent authorization of D-SNPs in the BBA of 2018 led the state to consider D-SNP contracting as a platform for integration. The other state representative noted that CMS's interest in promoting integrated care for dually eligible individuals prompted its own interest in new contracting strategies. In addition, one stakeholder said more states are considering new D-SNP contracting strategies as they implement D-SNP integration requirements established by the BBA and subsequent CMS regulations.[8]

[8] Medicare Advantage and Prescription Drug final rule for 2020 and 2021, CMS-4185-F, published at 84 FR 15680.

- **Stakeholder support or opposition.** When key stakeholders, including plans, providers, and beneficiary advocates, support a particular strategy, the state may be more likely to implement that strategy. When stakeholders oppose a strategy, the state may be reluctant to implement it because the lack of stakeholder buy-in could jeopardize the strategy's success. For example, providers and beneficiary advocates can play important roles in influencing beneficiary enrollment, so provider or advocate opposition could hinder enrollment in integrated D-SNPs. Likewise, if D-SNP health plans oppose a particular strategy, they may refuse to continue operating in the state, leaving the state without a platform for integration and forcing their enrollees to revert to less integrated plan options.

B. Barriers to D-SNP contracting in rural areas

According to the interviewees, three major factors influence health plans' decisions to operate D-SNPs in rural areas: (1) member recruitment, (2) payment rates, and (3) network adequacy concerns. Other factors include beneficiary and provider receptivity to managed care in rural areas and existing penetration of Medicare Advantage and Medicaid managed care plans.

1. Member recruitment and payment rates

Several state and health plan interviewees noted that D-SNP contracting is less attractive to Medicare Advantage organizations in rural areas with a small number of dually eligible residents. Because D-SNPs can enroll only dually eligible individuals, they may have difficulty recruiting enough members to sustain a financially healthy business model in such areas. This challenge is particularly important in rural counties with low population density among dually eligible residents because Medicare Advantage organizations may need to cover multiple counties (and meet network adequacy requirements in those counties) to access enough potential members.

> *"We often make strategic decisions to operate D-SNPs in areas where there are many individuals enrolled in marketplace plans who will age into Medicare and are likely to become eligible for Medicaid [thereby increasing the dually eligible population]."*
>
> —Health plan interviewee

In addition to small dually eligible populations, relatively low Medicare Advantage payments to plans in rural areas can make it less financially attractive for D-SNPs to operate in these regions. Although CMS payments to Medicare Advantage plans (including D-SNPs) are risk adjusted depending on the characteristics and care needs of enrollees, a number of factors in the payment system, such as benchmark rates that reflect the Medicare fee-for-service spending levels in each county, can combine to make payments to plans in rural areas less attractive than payments in urban areas.[9,10,11]

[9] For information about the Medicare Advantage payment system, see MedPAC's October 2020 Medicare Advantage Payment Basics summary (MedPAC 2020).

[10] In 2021, most Medicare Advantage plans were paid in excess of their costs; however, regional Preferred Provider Organizations (PPOs), which cover broad regions in one or more states and include both urban and rural counties, are paid less than other Medicare Advantage plans. For more information, see Table 12-5 in MedPAC's March 2021 Medicare Advantage program: Status report, at http://www.medpac.gov/docs/default-source/reports/mar21_medpac_report_ch12_sec.pdf?sfvrsn=0.

[11] Recent estimates of weighted Medicare Advantage payment rates show them to be lower in rural counties than in urban counties. For details, see https://www.kff.org/medicare/state-indicator/local-benchmarks-

2. Network adequacy

Both state and health plan interviewees also mentioned concerns regarding CMS network adequacy requirements for D-SNPs. However, they noted that it was too early to tell if recent changes to those requirements will have any impact.[12] Often, rural areas have few providers (in number and in type, such as behavioral health and specialty providers), which can make it difficult for D-SNPs to meet network adequacy requirements. In addition, the few providers who operate in those counties can demand payment rates that aren't feasible for D-SNPs, or otherwise use their leverage—for example, by contracting with only a single D-SNP)—which may prevent D-SNPs from meeting CMS network adequacy requirements. One health plan interviewee noted that even if a D-SNP is able to meet federal network adequacy standards, networks with provider gaps often make a plan less attractive to enrollees in rural areas.

> *"[When considering whether to operate a D-SNP in a rural area], first we look at network adequacy requirements. Then, we consider the possible provider networks in those areas and the current competitive space. The number of potential [enrollees] is a factor as well."*
>
> —Health plan interviewee

When there are too few enrollees to distribute risk, too few providers to deliver services to those enrollees, and long travel distances to reach network providers, Medicare Advantage organizations are often hesitant to operate D-SNPs. However, strong name recognition and long-standing relationships in the community can mitigate these issues. One health plan interviewee explained that the plan's ability to develop statewide networks with minimal provider gaps in primarily rural states has been largely attributable to its long-standing presence in the rural communities and the trust that the company has built with beneficiaries and providers in those areas.

weighted/?currentTimeframe=0&selectedRows=%7B%22wrapups%22:%7B%22all-urban-counties%22:%7B%7D,%22all-rural-.

[12] In its CY 2021 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, and Medicare Cost Plan Program final rule (CMS-4190-F), CMS codified new federal network adequacy standards for Medicare Advantage plans that (1) allowed plans to use more telehealth options, (2) relaxed requirements related to provider types with certificate of need requirements; and (3) strengthened accessibility.

Interviewee policy suggestions: Options to improve D-SNP financial viability and meet CMS network adequacy requirements in rural areas

Interviewees suggested several policy options to improve D-SNP financial viability and create more flexibility in CMS network adequacy requirements for D-SNPs.

Improving financial viability

- One interviewee said that states with county-owned health plans could use county-based selective contracting strategies to give those plans contracting exclusivity in the rural counties that they serve, which would result in a higher volume of enrollees for each plan.

Meeting CMS network adequacy requirements[1]

- One state interviewee suggested that CMS could create Medicare waiver authority for D-SNPs that cannot meet CMS network adequacy requirements in certain areas but need to operate statewide to meet state selective contracting requirements.
- Two interviewees noted that states could work to increase the use of telehealth in rural areas, particularly for mental health services, because CMS updated its Medicare network adequacy guidance in 2020 to allow for greater use of telehealth in rural areas.[2]
- One D-SNP interviewee said that states and CMS could use the network adequacy policies and practices that were developed for the Financial Alignment Initiative demonstrations to inform the development of network adequacy requirements for D-SNPs.

1 In addition to the recommendations suggested by our interviewees, former MACPAC Commissioner Charles Milligan has offered several policy suggestions in a 2020 policy brief entitled "Expanding Opportunities to Integrate Care for Dual Eligibles: Rethinking Federal Approaches to Measuring Network Adequacy for D-SNPs," available at https://www.milligan-consulting.com/policybriefs/expanding-opportunities-to-integrate-care-for-dual-eligiblesrethinking-federal-approaches-to-measuring-network-adequacy-for-dsnps

2 See the Medicare network adequacy guidance, updated June 17, 2020, at https://www.cms.gov/files/document/medicareadvantageandsection1876costplannetworkadequacyguidance6-17-2020.pdf

C. Benefits and challenges of adopting 11 specific D-SNP contracting strategies

In this section, we summarize the benefits and challenges to adopting each of the contracting strategies, identify contextual factors that support or hinder their adoption by states, and share suggestions from interviewees on how to reduce barriers and unintended consequences. We first discuss six contracting

strategies applicable to all states, then five strategies that are applicable to states that enroll dually eligible beneficiaries into Medicaid managed care.

1. Contracting strategies applicable to all states

The following strategies may be implemented in any state: (1) limiting D-SNP enrollment to FBDE individuals, (2) contracting directly with D-SNPs to cover Medicaid benefits, (3) requiring D-SNPs to operate with exclusively aligned enrollment, (4) requiring D-SNPs to use specific or enhanced care coordination methods, (5) requiring D-SNPs to send data or reports to the state for oversight purposes, and (6) reviewing Medicaid information in D-SNP marketing or enrollee communication materials.

a. Limiting D-SNP enrollment to FBDE individuals

One of the simplest D-SNP contracting strategies to implement (in most states) is limiting D-SNP enrollment to FBDE individuals. Partial-benefit dually eligible individuals qualify only for coverage of Medicare premiums and, in some cases, Medicare cost sharing.[13] Because partial-benefit dually eligible individuals do not qualify for full Medicaid benefits, D-SNPs that enroll them must use different approaches to care coordination, different benefit descriptions in enrollee materials, and different benefit administration methods than they use for their FBDE enrollees. Restricting D-SNP enrollment to only FBDE individuals has several advantages:

- **Uniform delivery of care coordination.** All D-SNP members are entitled to care coordination services. However, when full- and partial-benefit dually eligible individuals are enrolled in the same plan, care coordinators must have detailed knowledge of multiple complex coverage scenarios to appropriately assist each group. On the other hand, D-SNPs that only enroll FBDE individuals can train their care coordinators to understand and navigate one set of benefits available to FBDE individuals. The D-SNP Model of Care (MOC) can also be designed specifically for FBDE populations, rather than having to specify different processes for coordinating care for FBDE individuals versus those for partial-benefit dually eligible individuals.

- **Simpler, clearer enrollee materials.** Because all FBDE D-SNP enrollees are eligible for the same coverage, a D-SNP that enrolls only FBDE individuals can present information about covered benefits and applicable cost sharing more simply and clearly in enrollee materials, thus making it easier for enrollees to identify and access the benefits they qualify for as well as for providers to understand who should be billed for covered services. Restricting D-SNP enrollment to FBDE individuals also supports the provision of zero-dollar cost sharing benefits for all D-SNP enrollees, which can further simplify delivery of benefit and cost sharing information for plan enrollees. When a D-SNP enrolls both full- and partial-benefit dually eligible individuals, information about cost sharing obligations must be specified for each group, which can be confusing. For example, a Specified Low-Income Medicare Beneficiary without full Medicaid benefits could face a 20 percent coinsurance liability for outpatient provider visits, whereas an FBDE individual might have zero liability for those visits.

[13] For information about categories of dual eligibility and the benefits offered under each category, see the CMS document "Dually Eligible Individuals—Categories" at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf.

Limiting D-SNP enrollment to only FBDE individuals may be more challenging to implement in states where D-SNPs already enroll large numbers of partial-benefit dually eligible individuals, because those individuals would be forced to disenroll from the D-SNP and enroll in another Medicare Advantage plan or fee-for-service Medicare. It may also be challenging (or prohibitive) to implement in states where the total number of FBDE individuals is not large enough to offer an attractive, viable, and sustainable enrollee market for the D-SNPs.

Interviewees cited the following additional considerations:

- Some interviewees asserted that although partial-benefit dually eligible individuals may not qualify for full Medicaid benefits, they could still benefit from the care coordination and supplemental benefits offered by D-SNPs.
- One interviewee noted that enrollment of partial-benefit dually eligible individuals in D-SNPs could help states better understand their health care needs and service utilization if states requires D-SNPs to submit assessment data, encounter data, or other reports on enrollees' needs and service use.

States interested in achieving greater simplicity and integration in D-SNP care coordination and enrollee materials while maintaining enrollment of partial-benefit dually eligible individuals in D-SNPs can utilize an alternative strategy: requiring D-SNPs to enroll FBDE individuals and partial-benefit dually eligible

Interviewee policy suggestions: Crosswalking D-SNP enrollees (moving enrollees from one PBP to another)

One interviewee suggested that to ease the process of using separate PBPs to serve FBDE and partial-benefit dually eligible individuals, CMS could allow D-SNPs to "crosswalk" enrollees into the PBP that is most appropriate for them. For example, if an FBDE individual is enrolled in a D-SNP PBP that serves only FBDE individuals, and the FBDE transitions into partial-benefit dual eligibility, then the D-SNP would be allowed to transfer that individual into its PBP that serves partial-benefit dually eligible individuals, rather than having to disenroll the individual from the FBDE PBP and manually reenroll in the PBP for partial-benefit dually eligible individuals (with the enrollee's permission). Similarly, if a partial-benefit dually eligible individual became FBDE, that individual could be crosswalked into the PBP for FBDE individuals with more extensive and comprehensive benefits and care coordination.

Currently, D-SNPs are allowed to use a crosswalking exception described at 42 CFR 422.530(c)(4) to crosswalk full- or partial-benefit dually eligible individuals into different PBPs at the beginning of a new contract year if a state requires the D-SNP to use separate PBPs to serve these two populations. This guidance was codified into regulation by a final rule issued by CMS on January 19, 2021. If an individual D-SNP member transitions from full- to partial-benefit dual eligibility midyear and the D-SNP is designed to serve only FBDE individuals, the D-SNP must still use a manual disenrollment process (and, if applicable, a manual reenrollment process to transfer the individual to the parent company's other D-SNP PBP that serves partial-benefit dually eligible individuals).

individuals in separate PBPs.[14] Because each PBP within a D-SNP contract has its own set of covered benefits and cost-sharing structure, D-SNPs can design separate enrollee materials for each PBP (one for FBDE and one for partial-benefit dually eligible individuals). Using separate PBPs enables the same simplification of enrollee materials as restricting D-SNP enrollment to FBDE individuals. Although use of separate PBPs may not simplify the D-SNP Model of Care (unless the PBPs operate under separate contracts),[15] these arrangements can help D-SNPs simplify care coordination—for instance, by assigning care coordinators to members in accordance with the population(s) eligible for each PBP.

b. Contracting directly with D-SNPs to cover Medicaid benefits

Another strategy that can be used by any state is contracting directly with D-SNPs to cover Medicaid benefits. With this strategy, states pay a capitated amount per enrollee to the D-SNP for coverage of most or all Medicaid benefits. This means that one health plan becomes responsible for providing comprehensive coverage, which makes it possible to fully integrate Medicare and Medicaid benefits. When a single plan covers both sets of benefits, coordination of Medicare and Medicaid benefits can be simpler to manage than with selective contracting and related strategies, which require more work to coordinate because the benefits are covered under two separate plans (D-SNPs and affiliated Medicaid managed care plans operated by the same parent company). In addition, direct contracting avoids the procurement pitfalls associated with selective contracting. That said, direct contracting may not be particularly attractive to states that already operate Medicaid managed care programs for dually eligible individuals, because those states already have a managed care system covering Medicaid benefits for dually eligible populations.

For states that have D-SNP contracts but not Medicaid managed care programs for dually eligible individuals, this strategy can be a useful step toward greater integration. Because D-SNP enrollment is voluntary for beneficiaries, if they or their providers distrust managed care, direct contracting with D-SNPs enables a state to build credibility in integrated care with beneficiaries, providers, and other stakeholders without launching a full Medicaid managed care program for dually eligible individuals. Specifically, one state reported that first rolling out a voluntary integrated model using direct contracting allowed them to demonstrate positive results, which made the transition to mandatory Medicaid managed care more widely accepted by the community.

> *"Paying D-SNPs to cover Medicare cost sharing could result in a more seamless benefit and improved processes for providers, which might improve access to care and can have a wider impact than stricter integration strategies like exclusively aligned enrollment."*
>
> —Stakeholder interviewee

Direct contracting can also be used to implement integrated care incrementally and to leverage the expertise and networks of existing D-SNPs. For example, one stakeholder commented that states can

[14] When Medicare Advantage organizations submit applications to CMS to operate Medicare Advantage plans (including D-SNPs), they submit proposed PBPs. Each PBP has a proposed set of health benefits, cost sharing, premiums, and supplemental benefits. A single Medicare Advantage contract may contain multiple PBPs, and those PBPs may operate in a single state or span multiple states. A single contract may also contain D-SNP PBPs and non-D-SNP PBPs. When a state requires a D-SNP to use separate PBPs to enroll full- and partial-benefit dually eligible individuals, both populations can enroll in a D-SNP through the same parent company, but each population is effectively enrolled in a different "plan" from an administrative perspective.

[15] D-SNP Models of Care (MOCs) are developed at the contract level, so a single MOC dictates the care coordination procedures of all D-SNPs included under that contract.

begin by contracting with D-SNPs to cover certain benefits, such as Medicare cost sharing, then carve in other benefits later. Similarly, a health plan interviewee stated that contracting directly with D-SNPs to cover a limited set of Medicaid benefits, such as coverage of Medicare cost sharing, non-emergency transportation, or dental benefits, can be a stepping-stone to integrating LTSS and behavioral health benefits.

In addition, for states without a Medicaid managed care program for dually eligible individuals, this strategy enables Medicare-Medicaid benefit integration without a lengthy, burdensome Medicaid procurement process. However, the strategy may be easier to implement for states that already use managed care with other populations because they have tools, policies, and expertise for such functions as procurement, rate setting, quality management, and oversight.

Several interviewees noted potential challenges to using this strategy. First, one stakeholder noted that it requires significant state resources and investment for planning and implementation. In addition, three interviewees emphasized that using a more incremental contracting strategy—that is, contracting with D-SNPs for coverage of certain Medicaid benefits (while other Medicaid benefits remain carved out)—can confuse beneficiaries and providers trying to navigate delivery of benefits. For example, when multiple payers are involved in administering benefits, beneficiaries may have difficulty finding out whether a particular benefit is covered (by the D-SNP or by fee-for-service Medicaid, or both) and providers may have difficulty determining which entity to bill for particular services.

> *"When you carve out certain Medicaid benefits, it becomes really confusing for beneficiaries and providers. The value of contracting with D-SNPs for coverage of Medicaid benefits depends on the types of benefits that would be covered."*
>
> —Health plan interviewee

Interviewee policy suggestions: Minimizing Medicaid benefit carve-outs

One health plan interviewee suggested that states try to minimize the extent to which Medicaid benefits are carved out when states directly contract with D-SNPs, to promote the fullest amount of integration possible and the least confusion for enrollees, providers, and other stakeholders.

In addition, one health plan interviewee stressed that this strategy depends on whether D-SNPs understand complex state Medicaid rules and policies that they may not be familiar with. For example, because many D-SNPs are often medically focused, they may not have experience contracting with certain types of Medicaid providers, such as providers of home- and community-based services, and they may have limited experience addressing food insecurity and other social determinants of health. Finally, because dually eligible individuals enroll in D-SNPs voluntarily, this strategy may not necessarily result in a large number of individuals enrolled in the integrated care program. Therefore, states may have to consider the potential trade-off between benefit integration and increased enrollment when considering whether to implement this strategy.

c. Requiring D-SNPs to operate with exclusively aligned enrollment

Requiring D-SNPs to operate with exclusively aligned enrollment is a slightly more complex but especially impactful strategy that states can use to pursue the highest level of Medicare-Medicaid benefit integration. When D-SNPs operate with exclusively aligned enrollment and substantially all Medicaid benefits are covered by the D-SNPs or their affiliated Medicaid managed care plans, enrollees' Medicare and Medicaid benefits are provided through a single entity—which offers the most Medicare-Medicaid benefit integration of all the contracting strategies examined in this study. One interviewee called exclusively aligned enrollment the "gold standard" for integrated care. Although D-SNPs still hold separate contracts with CMS and the state Medicaid agency, exclusively aligned enrollment results in a D-SNP product that is closest to an MMP. Several interviewees also highlighted how exclusively aligned enrollment reduces confusion for beneficiaries and providers and simplifies administration of benefits. For example, plans operating with exclusively aligned enrollment can issue streamlined and fully integrated member materials, use unified plan-level appeal and grievance processes, coordinate enrollees' care in a more holistic and straightforward way, and simplify provider billing. States and D-SNPs can achieve exclusively aligned enrollment in a couple of ways, depending on the state's Medicaid managed care landscape:

- States with Medicaid managed care programs for dually eligible individuals can require those who enroll in D-SNPs to receive their Medicaid benefits from the D-SNP's affiliated Medicaid managed care plan, as long as the state's D-SNPs have affiliated Medicaid managed care plans. In these states, selective contracting and requiring complete service area alignment can be helpful steps toward implementing exclusively aligned enrollment.
- States without Medicaid managed care for dually eligible individuals can achieve exclusively aligned enrollment by capitating D-SNPs for coverage of Medicaid benefits.

Existing state infrastructure—particularly the state's existing contracts with D-SNPs and Medicaid managed care plans—affects ease of implementation. Specifically, as one interviewee noted, exclusively aligned enrollment typically works well in an environment where Medicare and Medicaid players are consistent over time. Similarly, another interviewee pointed out that states without existing D-SNP contracts can more easily require new D-SNPs to operate with exclusively aligned enrollment. By contrast, implementing exclusively aligned enrollment can be difficult in situations where D-SNPs have many enrollees who receive Medicaid benefits through a different parent organization than the organization operating their D-SNP.

Interviewees also identified several challenges. First, state interviewees mentioned that implementing exclusively aligned enrollment requires state investment and resources to modify existing IT systems and other infrastructure; it also requires a certain level of Medicare policy expertise and capacity that some states may not possess. One state interviewee did not believe the state was ready to manage the processes needed to implement exclusively aligned enrollment, particularly in rural areas. Second, exclusively aligned enrollment may decrease the number of D-SNP enrollees overall and, as a result, could jeopardize a D-SNP's financial viability (or at least concern D-SNPs enough that they may choose to leave the market). If states with existing D-SNPs with

> *"If you're starting from a blank slate, exclusively aligned enrollment is the most impactful policy decision, and it's relatively easy.… It becomes harder when you have infrastructure."*
>
> —Stakeholder interviewee

unaligned enrollees converted to exclusively aligned enrollment, those D-SNPs could lose members. In addition, members who were forced to change their Medicare plan could end up in a nonintegrated plan as a result, especially if dually eligible individuals who opt out of the exclusively aligned D-SNP have no other integrated options in their area. Third, one health plan interviewee noted that exclusively aligned enrollment creates an all-or-nothing approach to integration. Several interviewees warned that some beneficiary advocates may perceive this strategy as limiting beneficiary choice (despite the fact that enrollment in the exclusively aligned D-SNPs would still be voluntary). In addition, one interviewee expressed concerns that the state may not want to implement a strategy that could be perceived as government overreach, and that exclusively aligned enrollment could be politically difficult to achieve.

To address these concerns, states could require D-SNPs to operate with exclusively aligned enrollment going forward and use separate PBPs for new enrollees under exclusively aligned arrangements, while allowing current enrollees to retain their existing coverage in the established PBP. This would permit use of integrated enrollee materials, unified appeal and grievance procedures, and simplification of care coordination and provider billing in the exclusively aligned PBP. Similarly, states could allow D-SNPs to continue to enroll individuals who do not choose to receive their Medicaid coverage through a D-SNP's parent company but require the D-SNP to use separate PBPs for their exclusively aligned and non-exclusively aligned products.

> *"If people opt out [of the exclusively aligned D-SNP], they go back into fee-for-service. This creates a gray area without full integration when people can select whether or not they want to participate, so there may end up being a lot of people whose care isn't integrated."*
>
> —Health plan interviewee

d. Requiring D-SNPs to use specific or enhanced care coordination methods

All D-SNPs are required to coordinate the delivery of Medicaid benefits for their members to some degree—for example, by helping members understand how to request a service authorization or an appeal for a Medicaid-covered service. But D-SNPs' ability to coordinate Medicaid benefits that are covered by other plans or under Medicaid fee-for-service can be limited by the lack of formal communication channels with the entities providing those benefits.[16]

As of 2021, all D-SNPs must either cover Medicaid benefits or share information with state Medicaid agencies (or their designees) about inpatient hospital and skilled nursing facility admissions for high-risk dually eligible enrollees.[17] Beyond these rules, states can require D-SNPs to take additional steps to coordinate enrollees' care and communicate with Medicaid entities. Interviewees of all types described the inclusion of specific care coordination requirements in state D-SNP contracts as beneficial. Specifically, beneficiary advocates explained that enhanced or integrated care coordination requirements—like those described in Figure III.2—can improve quality of care for dually eligible beneficiaries and thus promote voluntary enrollment in D-SNP plans.

[16] See ICRC's tip sheet, "State Options and Considerations for Sharing Medicaid Enrollment and Service Use Information with D-SNPs," for more information: https://www.integratedcareresourcecenter.com/resource/state-options-and-considerations-sharing-medicaid-enrollment-and-service-use-information-d.

[17] CMS Medicare Advantage and Prescription Drug final rule for 2020 and 2021, CMS-4185-F, published at 84 FR 15680.

Approaches to these enhanced care coordination requirements can be tailored to the D-SNP landscape and related context within a state. For example, in states where D-SNPs (or their affiliated Medicaid managed care plans) are capitated for coverage of Medicaid benefits and have exclusively aligned enrollment, states could require those D-SNPs to integrate Medicaid care coordination requirements into their MOC—a document that all Medicare Advantage Special Needs Plans must develop explaining how they will meet the unique needs of their enrollees, including the specific care management and care coordination processes to be used.[18] States where D-SNPs do not cover Medicaid benefits could still require their D-SNPs to incorporate certain Medicaid information, such as training requirements for care coordinators, into the D-SNP MOC. However, states with fully integrated programs could leverage the MOC more expansively. (See Box III.1 for more information about integrating Medicaid requirements into the D-SNP MOC.) States could also require integration of Medicare and Medicaid assessments and care plans, as well as inclusion of key Medicaid providers in integrated care teams to streamline the care management experience for enrollees.

In states where D-SNPs (or their affiliated Medicaid managed care plans) are capitated for coverage of Medicaid benefits but the D-SNPs do not have exclusively aligned enrollment, care coordination requirements could be used to drive communication about beneficiaries' care and needs between care coordinators in D-SNPs and unaffiliated Medicaid managed care plans. For example, a state could require D-SNPs to notify their enrollees' Medicaid managed care plans about inpatient admissions, discharges, or specific aspects of inpatient stays, such as diagnoses and medications. States could also require D-SNPs and Medicaid managed care plans to share data on enrollees' Medicare and Medicaid care coordinator assignments or lists of key care coordination contacts to facilitate ease of collaboration. Finally, one stakeholder interviewee noted that states could use their SMACs with D-SNPs to describe the roles of D-SNP care coordinators, the roles of Medicaid managed care coordinators, and how those different roles would be communicated to key health care providers, such as primary care providers, who often don't rely on these care coordinators or, in some cases, even know that they exist.

Finally, in those states where D-SNPs and their affiliated Medicaid managed care plans are not capitated to cover specific Medicaid benefits, states could require D-SNPs to communicate and collaborate with fee-for-service Medicaid care managers (such as Medicaid home and community-based service waiver case management entities) or enrollees' primary care, behavioral health, or LTSS providers.

Although states can add contract provisions about care coordination relatively easily, state oversight and monitoring of D-SNP implementation of those requirements can be challenging. As one stakeholder described, states need to have staff, resources, and mechanisms to oversee plan compliance, which may require communication across multiple state agencies. Another plan interviewee explained that accountability mechanisms are critical for motivating meaningful plan action, but efforts should also be designed in ways that do not overburden plans with reporting requirements.

[18] All Medicare Advantage Special Needs Plans (SNPs), including D-SNPs, are required by Section 1859(f)(7) of the Social Security Act to develop an MOC that is approved by the National Committee for Quality Assurance. For more information about the MOC document and approval process, see the CMS web page at https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC.

Box III.1. Integrating Medicaid requirements into the D-SNP Model of Care

All Medicare Advantage Special Needs Plans, including D-SNPs, must have a Model of Care (MOC) that describes how the plan will meet the needs of its enrollee population. The MOC must explain how it will (1) assess enrollee needs; (2) develop individualized care plans; (3) establish and utilize integrated care teams; (4) and coordinate enrollees' care, including during care transitions. MOCs must be approved by the National Committee for Quality Assurance. They are developed at the Medicare Advantage contract level, meaning a single MOC may govern the care coordination activities of multiple D-SNPs under a single contract.

Although the MOC requirement assures a certain degree of coordination of Medicare benefits for D-SNP members, it does not address Medicaid benefits or the coordination of Medicare and Medicaid benefits for dually eligible D-SNP members. For example, although a D-SNP is required to have health risk assessment and care plan processes, CMS does not require the D-SNP to integrate information from an assessment of an enrollee's functional and cognitive status for someone who qualifies for Medicaid LTSS. States can use their contracts with D-SNPs to require this kind of coordination, and they can require D-SNPs to incorporate that coordination explicitly into the MOC. States can also require D-SNPs to incorporate a variety of state-specific Medicaid requirements into their MOCs to facilitate greater coordination of Medicare and Medicaid services.

For example, states can require D-SNPs to describe how they will train their care coordinators to help D-SNP enrollees navigate Medicaid services, authorizations, and appeals; to integrate Medicaid services and services to address food insecurity, housing instability, and other social determinants of health into integrated care plans; to communicate assessment and care plan information to enrollees' primary care providers or other key members of the integrated care team; and to coordinate delivery of LTSS or other key Medicaid services during inpatient discharge or other critical care transitions. For examples of actual state contract requirements regarding the D-SNP MOC, see the ICRC's tip sheet, "Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Integrating Medicaid Managed Long-Term Services and Supports" (Lester 2019).

In addition to requiring D-SNPs to incorporate specific provisions into their MOCs, states can also require D-SNPs to share their MOC with the state for review so that the state can confirm the accuracy of the description of the D-SNPs' dually eligible enrollee population, identify any inconsistencies between the MOC and state SMAC requirements, or identify other areas where state-specific language may be necessary or helpful.

All interviewee types, including half of the health plan representatives interviewed, described challenges regarding implementation of state care coordination requirements. For example, interviewees noted that plans may apply the requirements inconsistently or interpret them differently, which can inhibit successful communication and coordination across plans. Health plan representatives and one stakeholder also noted that D-SNPs may not be able to coordinate effectively with their enrollees' unaffiliated Medicaid managed care plans if they do not know where their D-SNP members are enrolled for Medicaid benefits—a situation that makes state sharing of data on D-SNP enrollees' Medicaid enrollment critical to integrated care coordination.[19]

[19] For information about ways states can share data on D-SNP enrollees' Medicaid managed care plan enrollment or providers with D-SNPs, see ICRC's December 2019 tip sheet for states on sharing Medicaid enrollment and service

Interviewees also mentioned challenges with the data sharing required for care coordination. One health plan representative noted the need to have interoperable systems in place. In addition, a stakeholder worried that the information shared, as required by the state's D-SNP contracts, did not always reach the providers who delivered the care to help coordinate services.

Figure III.2. Examples of SMAC requirements to enhance or integrate D-SNP care coordination

States could incorporate a variety of care coordination requirements into their SMACs with D-SNPs to promote integration of Medicare and Medicaid benefits. Examples include requiring D-SNPs to:

	Incorporate Medicaid requirements into the D-SNP Model of Care.
	Train care coordination staff about state Medicaid benefits and systems, including eligibility, service authorization, and appeal processes, so they are well equipped to assist D-SNP enrollees in accessing Medicaid benefits in addition to Medicare benefits.
	Integrate Medicaid assessments into the D-SNP health risk assessment process or conduct assessments face-to-face for certain vulnerable populations. Without a state requirement, D-SNP and Medicaid assessment processes will not necessarily be integrated, leaving dually eligible D-SNP enrollees to complete multiple, separate assessment processes.
	Incorporate the coordination of Medicaid services and social services into individualized care plans for members to ensure that care coordinators work actively with D-SNP members on obtaining needed Medicaid and social services.
	Involve family members or caregivers in health risk assessment and care planning processes, in accordance with the D-SNP member's wishes.
	Share copies of care plans with enrollees' primary care providers and other key contacts.
	Communicate information about beneficiaries' eligibility for or receipt of Medicaid services to primary care providers and other members of the interdisciplinary care team.
	Use care management IT systems that meet certain standards to facilitate communication across entities (for example, between the D-SNP and Medicaid managed care plans or other Medicaid case management entities).
	Communicate with certain entities (for example, primary care providers or Medicaid managed care plans) when an enrollee transitions across care settings to coordinate delivery of post-acute care and LTSS upon discharge.
	Establish a protocol for coordinating delivery of LTSS or other key services during transitions in care, including hospital discharge.

Source: Barth and colleagues (2019) and Weir Lakhmani and colleagues (2020).

use information with D-SNPs at https://www.integratedcareresourcecenter.com/resource/state-options-and-considerations-sharing-medicaid-enrollment-and-service-use-information-d.

e. Requiring D-SNPs to send data or reports to the state for oversight purposes

States can also require D-SNPs to send them certain data or reports for oversight purposes, such as encounter data, quality measures or quality measure performance reports, and financial reports. One interviewee thought states had become more aware of their ability to require D-SNPs to send this kind of data as a result of their engagement with D-SNPs and CMS to implement new information sharing requirements for 2021.[20]

According to our interviewees, requesting data or reports from D-SNPs can yield clear benefits for states. First, three interviewees (one state representative, one beneficiary advocate, and one stakeholder) explained that requesting data and reports from D-SNPs promotes transparency and accountability and helps states monitor D-SNP performance. A beneficiary advocate also noted that states can use D-SNP encounter data to monitor use of Medicare-covered services and identify disparities in health outcomes and service use, which may be important to states' efforts to reduce health disparities.

Interviewee policy suggestions: Option to improve data sharing between states and D-SNPs to promote care coordination

Two interviewees (one health plan representative and one stakeholder) suggested that states, in addition to requesting data from D-SNPs, might provide data to D-SNPs in a timelier manner, including reliable eligibility information and data on where D-SNP enrollees were enrolled for their Medicaid benefits. This is primarily relevant in states that have Medicaid managed care for dually eligible individuals and do not require exclusively aligned enrollment in D-SNPs.

Although one stakeholder said that implementing this strategy should be relatively easy for states, interviewees also mentioned some potential challenges. For example, one interviewee said that, although collecting data from D-SNPs can be helpful, it can be difficult for states to operationalize; another interviewee noted that when states collect data from D-SNPs, the data may not always be collected in formats that are readily accessible or usable by the state. If states ask for data that they can't use, then it imposes an unnecessary burden on D-SNPs without imparting any real benefit. Two health plan interviewees and a state interviewee echoed the core of this concern, asserting that states should request only data and information that they actually intend to use. Finally, one health plan representative mentioned that timing is important to data sharing, because lagged claims data do not help with real-time intervention and care coordination.

f. Reviewing Medicaid information in certain D-SNP marketing and enrollee communication materials

States can require D-SNPs to obtain state review and approval of marketing and communication materials about the delivery of Medicaid benefits. They can also develop templates to describe Medicaid benefits, policies, and processes and require that D-SNPs use this information in their enrollee materials.

[20] New integration requirements for D-SNPs, starting in CY 2021, were described in the CMS Medicare Advantage and Prescription Drug final rule for 2020 and 2021, CMS-4185-F, published at 84 FR 15680.

Standardizing Medicaid-relevant texts for use in D-SNP enrollee materials can assure the quality and consistency of Medicaid information in those materials while streamlining or replacing state review.

Interviewees noted several benefits of this strategy. First, state review of D-SNP materials (and even more so, development of template language) would promote consistency in Medicaid benefit descriptions and instructions among D-SNPs, reducing confusion for providers, beneficiaries, and family members or others assisting beneficiaries in selecting plans. Requiring state review of these materials would also ensure that D-SNPs distribute accurate information. One interviewee noted that this strategy holds plans accountable in confirming that their messaging is on track. Finally, as one beneficiary advocate noted, this strategy provides advocates and other key stakeholders with a single clear channel for feedback (the state), obviating the need to provide feedback to multiple individual plans.

> *"States should take a more proactive stance on defining messages and themes to be conveyed to duals about aligned plans and ensure that this is used across multiple plans."*
>
> —Stakeholder interviewee

Challenges may remain, however. One plan representative noted that conflicting requirements between Medicare and Medicaid and different state and CMS timelines can be difficult for plans to navigate. This misalignment could make it challenging for D-SNPs to design materials that meet both sets of requirements in effective ways. Another health plan representative said that CMS should serve as the "source of truth" and that states should not be involved as a secondary approver. In addition, two plan interviewees noted that requiring state review of marketing and communication materials would put additional administrative burden on both the plans and the state, which would slow the process but not add value for the D-SNP enrollees.

Finally, one health plan representative said that state template language regarding Medicaid benefits is "helpful, as long as it is customer friendly," noting that state agencies can sometimes be technically oriented. That interviewee thought that provision of template language, along with an allowance for D-SNPs to customize the language to suit their enrollees, could be better than a simple requirement that D-SNPs use the state's template verbatim.

Interviewee policy suggestion: Option for using a joint federal-state review process for integrated D-SNP materials

One health plan representative suggested that states and CMS could work together to produce a single set of rules and review processes for the marketing and communication materials of integrated D-SNPs, as has been done for MMP materials under the Financial Alignment Initiative demonstrations.

2. Contracting strategies applicable to states that enroll dually eligible individuals and individuals becoming dually eligible into managed care plans for coverage of Medicaid benefits

The following strategies are options for states that already have (or are planning to implement) Medicaid managed care programs that enroll dually eligible individuals: (1) using selective contracting, (2)

requiring complete service area alignment, (3) aligning Medicaid procurement cycles with Medicare timelines for D-SNPs, (4) using Medicaid enrollment algorithms to automatically assign D-SNP enrollees to affiliated Medicaid managed care plans, and (5) allowing (or requiring) D-SNPs to implement default enrollment.

a. Using selective contracting

Selective contracting refers to a policy in which states contract only with D-SNPs that offer affiliated Medicaid managed care plans to promote aligned enrollment. This is a popular strategy among states that do not require D-SNPs to have exclusively aligned enrollment. Selective contracting is easier for states to implement if they already have some affiliated D-SNPs and Medicaid managed care plans in the state.

Interviewees identified several benefits to selective contracting. One interviewee noted that it ensures that no unaffiliated D-SNPs or Medicaid managed care plans compete with the integrated options. Another interviewee argued that limiting the number of D-SNPs and Medicaid managed care plans could make it easier for the state to oversee and manage quality of care in those plans. One other interviewee said that selective contracting could be used as a stepping-stone to complete service area alignment and exclusively aligned enrollment. (See Figure III.1 and Appendix C for a visual representation of how these strategies connect to one another and relevant considerations for states).

Interviewees also identified some disadvantages and challenges with selective contracting. The main drawback cited was that it can disrupt coverage for dually eligible individuals. For example, if an affiliated Medicaid managed care plan lost a Medicaid re-procurement bid, then enrollees in that plan would need to either (1) switch plans to maintain enrollment in an aligned plan or (2) remain in the plan without the benefits of integration. A few interviewees shared examples of this occurring in New Mexico and Pennsylvania. Such changes can affect continuity of care and lead to fewer enrollees in integrated products overall.

Misalignments between Medicaid procurement cycles and Medicare timelines for D-SNP operations can further exacerbate these challenges because those misalignments may create a gap between winning or losing a Medicaid managed care contract and signing new or renewed D-SNP contracts.

In addition, when considering selective contracting, states need to consider the potential trade-offs between offering highly integrated options (via selective contracting) or a larger number of plan options that represent a range of integration levels. Several interviewees noted that selective contracting means that plans compete for fewer D-SNP contracts, which can incentivize plans that lose Medicaid contracts to establish non-D-SNP Medicare Advantage plans and enroll their former D-SNP members into those non-D-SNP plans. For example, if one state offered only three Medicaid managed care plan contracts and the state required D-SNPs to offer affiliated Medicaid managed care plans, then only three D-SNPs would be available. Plan interviewees noted that they want to be able to continue enrolling dually eligible individuals, regardless of whether they also win a Medicaid managed care procurement. Consequently,

D-SNPs that do not win Medicaid managed care contracts may discontinue the D-SNP, begin to operate a non-D-SNP Medicare Advantage plan and try to persuade their former D-SNP enrollees to enroll in the nonintegrated Medicare Advantage plans, rather than lose the member to an integrated D-SNP.[21]

[21] This establishment of non-D-SNP Medicare Advantage plans is possible because states do not play a role in Medicare Advantage plan contracting and CMS permits any non-D-SNP Medicare Advantage plan that meets CMS

Finally, one state interviewee pointed out that it can be difficult for small, local Medicaid managed care plans with no Medicare experience to implement a D-SNP because of the steep learning curve and barriers in developing Medicare provider networks. As a result, selective contracting may inadvertently favor large regional or national plans that already have experience in both Medicare and Medicaid.

Interviewee policy suggestion: Option to promote enrollment of dually eligible individuals in integrated Medicare Advantage plans

Although selective contracting could minimize the number of D-SNPs operating in a particular state, it would not alter the number of non-SNP Medicare Advantage plans operating and marketing their plans to dually eligible individuals (including D-SNP look-alike plans[1]). One interviewee noted that the large number of Medicare Advantage plan options offered was detrimental to beneficiary choice, because dually eligible individuals cannot examine all the plans available to them and meaningfully differentiate their options. Another interviewee suggested that CMS consider restricting the types of Medicare Advantage plans available to dually eligible individuals in areas where integrated plans are offered, to prevent dually eligible individuals from enrolling in regular (non-SNP) Medicare Advantage plans that do not offer them any care coordination or targeted benefits.

[1]D-SNP look-alike plans are Medicare Advantage plans that are not D-SNPs but in which 80 percent or more of the plan's enrollees are dually eligible. In the contract year (CY) 2021 Medicare Advantage and Part D final rule (CMS-4190-F1), CMS codified new contracting limitations for D-SNP look-alikes. Specifically, starting in CY 2022, CMS will not enter into a contract with a non-D-SNP Medicare Advantage plan that projects 80 percent or more of its enrollment to be dually eligible. In CY 2023, CMS will no longer contract with renewing non-D-SNP Medicare Advantage plans that have at least 80 percent dually eligible actual enrollment, with some exceptions.

b. Requiring complete service area alignment

In conjunction with and as a supplement to selective contracting, states could choose to require complete service area alignment between D-SNPs and affiliated Medicaid managed care plans. Requiring identical service areas for affiliated D-SNPs and Medicaid managed care plans would build a foundation for aligned enrollment and other D-SNP contracting strategies that could further integrate care and promote enrollment in integrated care plans.

> *"Service area alignment is a key decision influencer for whether [a plan] launches D-SNPs in particular areas—that is, whether the plan has Medicaid products in the same areas and aligned provider networks."*
>
> —Health plan interviewee

requirements to operate in any states the plan chooses. While CMS has announced new measures to address the proliferation of D-SNP look-alike plans (non-D-SNP Medicare Advantage plans that mostly enroll dually eligible individuals) starting in 2022,[21] non-D-SNP Medicare Advantage plans will likely continue to compete with D-SNPs in many states, and plans that remain beneath the look-alike thresholds may draw dually eligible enrollees away from integrated options.

Several health plan and state interviewees commented on implementation challenges and other limitations to requiring complete service area alignment. One state interviewee noted that without affiliated D-SNPs and Medicaid managed care plans in the state, this strategy would be impossible to implement. For states where this would be a viable strategy, differences between CMS and state Medicaid network adequacy requirements could make service area alignment difficult and sometimes impossible, especially in rural areas. (See Section III.B for information about barriers to D-SNP contracting in rural areas.) In addition, one plan interviewee reported that differences between CMS and state Medicaid timelines for contracting with plans could hinder implementation of complete service area alignment between two plan products.

c. Coordinating Medicaid procurement timelines with Medicare timelines for D-SNPs

Because of the concerns noted above, we asked interviewees about the potential benefits and challenges of coordinating state Medicaid procurement timelines with Medicare timelines for D-SNPs. Although two health plan representatives noted that alignment of state Medicaid procurement cycles would be helpful, many interviewees (including one of the plans that said this would be helpful) told us that achieving this would likely require significant state resources and could cause delays in implementation of new Medicaid managed care programs. Perhaps most importantly, interviewees noted that state procurement timelines often aligned with state fiscal years, which could not be easily altered, and that health plan protests of contract award decisions could cause timelines to shift. Overall, the interviewees did not consider this strategy to be as important in achieving Medicare-Medicaid integration or promoting enrollment in integrated D-SNPs as other strategies. As an alternative, one health plan representative noted that the plan received a one-year grace period to implement a D-SNP within a certain time frame of its Medicaid managed care award, a strategy that other states could consider. Two state interviewees also mentioned that directly contracting with D-SNPs for coverage of Medicaid benefits inherently coordinates the state contract timeline with the Medicare timeline.

Interviewee policy suggestion: Option to coordinate open enrollment periods

Although interviewees did not think it was worthwhile or even possible to coordinate Medicaid procurement cycles with Medicare timelines, one interviewee noted that it could be helpful for states to coordinate their Medicaid managed care open enrollment periods for dually eligible enrollees with Medicare's open enrollment period (in states that use annual open enrollment periods during which Medicaid managed care enrollees can switch plans without cause, per 42 CFR 438.56). Such coordination, when paired with appropriate beneficiary education, could lead more dually eligible individuals to voluntarily enroll in fully integrated plans or in affiliated D-SNPs and Medicaid managed care plans. Although dually eligible individuals are granted a special enrollment period that allows them to change their Medicare plan quarterly, the marketing and publicity surrounding the Medicare annual enrollment period could present an opportunity for states to educate dually eligible individuals about the value of enrolling in integrated plans.

d. Using Medicaid enrollment algorithms to automatically assign D-SNP enrollees to affiliated Medicaid managed care plans

In states with at least some alignment between the organizations that offer D-SNPs and Medicaid managed care plans for dually eligible individuals, the state Medicaid agency could incorporate D-SNP enrollment into its Medicaid managed care auto-assignment algorithm for dually eligible individuals. For example, a state could regularly review dually eligible individuals' Medicare enrollment during annual Medicaid open enrollment periods (in states that use such periods) and automatically assign those individuals to a Medicaid plan operated by the same parent company as their D-SNP enrollment, where applicable. Similarly, when a Medicaid managed care plan leaves a market, the state could review the Medicare enrollment of dually eligible individuals in the exiting plan and reassign them to a Medicaid managed care plan operated by the same parent company as their D-SNP, where possible. In each of these examples, the beneficiaries must still be granted the right to make an active plan choice, as required by 42 CFR 438.54. Nonetheless, by using auto-assignment algorithms to make individuals' default Medicaid enrollment align with their D-SNP enrollment, states could promote enrollment in such aligned arrangements and thereby improve integration of Medicare and Medicaid benefits for these enrollees.

While some interviewees said that Medicaid automatic assignment might be perceived as limiting beneficiary choice, other interviewees explained that this practice simply nudges dually eligible individuals into more-integrated care arrangements, given that beneficiaries would retain choice for how they receive their Medicare benefits. (See Box III.2 for a summary of key federal regulations guiding the use of passive and default enrollment in Medicaid managed care programs.) In addition, because many states already use algorithms to assign dually eligible individuals to Medicaid managed care plans, incorporating D-SNP enrollment into those algorithms would not be a substantive change in the choices available to individual enrollees; it would merely require consideration of an additional factor in determining assignments.

Although many states already use auto-assignment algorithms in Medicaid managed care, interviewees noted that some states may find implementing this strategy difficult because they lack technical resources and capacity. States would need to obtain timely information about D-SNP enrollment, incorporate that information into their internal IT systems, and then reprogram their auto-assignment algorithms to use the data to support Medicaid plan assignment. While states can use Medicare Modernization Act (MMA) files, which all states exchange with CMS at least monthly,[22] to identify which dually eligible individuals are enrolled in D-SNPs and in which D-SNPs,[23] they also need to have the resources and capacity to cull and save those data and program their auto-assignment algorithm accordingly.

[22] Starting April 1, 2022, all states will be required to exchange MMA files with CMS daily, per the Interoperability and Patient Access final rule (CMS-9115-F) issued by CMS on March 9, 2020. As of December 2020, 17 states and the District of Columbia exchanged MMA files with CMS daily, 20 states exchanged MMA files with CMS weekly, and 13 states exchanged MMA files with CMS monthly (ICRC 2020b).

[23] See Chelminsky and colleagues (2020), "State Guide to Identifying Aligned Enrollees: How to Find Medicare Plan Enrollment for Dually Eligible Individuals in Medicaid Managed Care Plans," available at https://www.integratedcareresourcecenter.com/resource/state-guide-identifying-aligned-enrollees-how-find-medicare-plan-enrollment-dually-0.

Box III.2. Federal Medicaid managed care regulations regarding passive and default enrollment into Medicaid managed care plans and automatic assignment criteria

Per 42 CFR 438.54(c), states with voluntary managed care programs may use a passive enrollment process through which the state assigns beneficiaries to a designated Medicaid managed care plan, as long as the state provides beneficiaries with an enrollment period during which they can make an active plan choice and gives them proper notification of their options and rights, the implications of active choice and passive enrollment, the length of the enrollment period, and instructions for making an active plan election. This means that in states where dually eligible individuals can choose to voluntarily enroll in a managed care plan and to receive their Medicaid benefits through fee-for-service Medicaid, the state may still make managed care the default option (as opposed to making fee-for-service Medicaid the default option). In these instances, the state must send a notification to the beneficiaries that explains that, if they do nothing, they will be enrolled into a managed care plan; however, they have the option to opt out of the enrollment and remain in fee-for-service Medicaid. That notification must also explain the beneficiary's other rights with regard to the enrollment process, as well as the steps that they should take to remain in fee-for-service or enroll in a different managed care plan.

Per 42 CFR 438.54(d), states with mandatory managed care programs may also use a passive enrollment process and must use a "default" enrollment process to assign beneficiaries to a managed care plan when the beneficiary does not make an active choice. These states must take the same steps as states that use passive enrollment into voluntary managed care programs, including notifying beneficiaries of their options, rights, and processes for making enrollment choices and changes. The key difference between states with voluntary managed care programs and mandatory managed care programs is that the default enrollment option in states with mandatory managed care must be a managed care plan; it cannot be fee-for-service Medicaid. Therefore, states with mandatory managed care programs must assign beneficiaries to a managed care plan if the beneficiaries do not actively choose one.

42 CFR 438.54(c) (7)(ii) and 438.54(d)(5)(ii) permit states to consider a variety of criteria in assigning Medicaid beneficiaries to Medicaid managed care plans through passive or default enrollment processes, including the enrollment preferences of family members, previous plan assignment of the beneficiary, quality assurance and performance improvement, procurement evaluation elements, accessibility of provider offices for people with disabilities (when appropriate), and other reasonable criteria that "support the objectives of the managed care program" (in the case of passive enrollment in voluntary managed care programs) or "[relate] to a beneficiary's experience with the Medicaid program" (in the case of default enrollment in mandatory managed care programs). These regulations allow states to incorporate D-SNP enrollment into their automatic assignment algorithms for Medicaid managed care enrollment.

e. Allowing (or requiring) D-SNPs to use default enrollment

Under default enrollment, newly dually eligible individuals are automatically enrolled into D-SNPs that are operated by the same parent company as their existing Medicaid managed care plans, as long as the individuals will remain enrolled in the Medicaid managed care plan when they become dually eligible. To do this, states must experience one of the following situations:

1. The state contracts with D-SNPs, enrolls dually eligible individuals in Medicaid managed care plans, and serves populations that may become dually eligible in managed care. At least some of the state's

contracted D-SNPs have affiliated Medicaid managed care plans that enroll dually eligible individuals as well as managed care plans that serve populations that may become dually eligible.

2. The state serves Medicaid populations that may become dually eligible through managed care plans and contracts directly with D-SNPs for coverage of Medicaid benefits to D-SNP enrollees. At least some of the state's contracted D-SNPs also have managed care plans that serve populations that may become dually eligible. (This situation is less common than the first one.)

Box III.3 provides details about the federal regulations guiding the use of "passive" and "default" enrollment into D-SNPs.

States that have alignment in organizations offering D-SNPs, Medicaid managed care plans for dually eligible individuals (if the state does not contract directly with the D-SNP for coverage of Medicaid benefits), and Medicaid managed care plans for populations that may become dually eligible are well positioned to implement default enrollment. In these situations, one interviewee explained, implementing default enrollment can encourage integration "without disrupting the existing marketplace." This interviewee saw default enrollment as an ideal next step in advancing integration once states have "set the stage" for alignment using other D-SNP approaches, such as selective contracting.

State, plan, and stakeholder interviewees commented that default enrollment promotes alignment and integration, with one plan representative suggesting that default enrollment is the "single step that can have the most impact on alignment." Interviewees also suggested that default enrollment can increase the number of members in integrated plans. As one explained, D-SNPs can benefit from potentially increased and more sustainable enrollment as a result of default enrollment. This may be especially relevant in Medicaid expansion states, which have a population of Medicaid-eligible adults aging into Medicare. However, some states that expanded Medicaid eligibility to low-income adults exempted the expansion population from default enrollment if their Medicaid eligibility determinations could not be completed in advance of default enrollment processes.

In addition, stakeholders, beneficiary advocates, and plan representatives all noted that default enrollment can have benefits for beneficiaries. In particular, interviewees highlighted that default enrollment can encourage continuity of care and reduce disruption when a beneficiary is newly eligible for Medicare.

Default enrollment also promotes enrollment in integrated plans. As a few interviewees described, without default enrollment, beneficiaries may end up in fee-for-service Medicare without the supplemental benefits and care coordination offered by integrated plans. With default enrollment, beneficiaries automatically experience these added benefits of integration and can opt out if the plan is not the right choice for them.

> *"When a member has been in Medicaid for a long time and they age into Medicare … it's easier to just transition into a plan through the same company. This makes it easier for them to maintain their existing provider relationships."*
>
> —Health plan interviewee

Even so, default enrollment may be perceived as limiting beneficiary choice. One beneficiary advocate explained that beneficiaries, particularly those residing in areas with a strong culture of independence and self-reliance, might perceive default enrollment as taking away their choice. Therefore, advocates, state representatives, and stakeholders all noted, it is important to implement default enrollment thoughtfully, by educating beneficiaries and key stakeholders (such as beneficiary

Box III.3. Federal regulations regarding the use of passive and default enrollment in D-SNPs

In Medicare, the term "passive enrollment" is commonly used to describe a certain type of automatic enrollment into MMPs under state Financial Alignment Initiative demonstrations. Passive and default enrollment are also used to describe different processes related to automatic enrollment into D-SNPs. (Note that these terms have different meanings in Medicaid managed care programs; see Box III.2 for those definitions.)

Passive enrollment into MMPs

In the context of capitated model Financial Alignment Initiative demonstrations, passive enrollment means that a state may automatically enroll dually eligible individuals who are eligible for the state's demonstration into an MMP without the individuals having to take any affirmative action, as long as the state has followed all CMS rules for properly notifying the individuals of the upcoming passive enrollment and their rights and options, including their right to opt out (disenroll). States are allowed to passively enroll dually eligible individuals into MMPs at the outset of a new demonstration and on an ongoing basis (for example, monthly, quarterly, or annual) when individuals become newly eligible for the demonstration. Certain individuals may not be passively enrolled into an MMP—for example, individuals who have already opted out of the demonstration and individuals who have been automatically enrolled into a Medicare Part D plan by CMS. For more information about MMP passive enrollment, see Section 30.2.5 of the CMS National Enrollment and Disenrollment Guidance.[24]

Passive enrollment into D-SNPs

States may also passively enroll dually eligible individuals into D-SNPs, but only in very limited circumstances. When a dually eligible individual is enrolled in a fully or highly integrated D-SNP (FIDE SNP or HIDE SNP) whose contract is ending, states may passively enroll those individuals into other FIDE SNPs or HIDE SNPs that meet specific requirements to facilitate ongoing access to integrated Medicare and Medicaid benefits.[25]

Default enrollment into D-SNPs

State Medicaid agencies can grant permission to specific D-SNPs to use default enrollment to facilitate continuity of coverage for individuals enrolled in Medicaid managed care plans who become newly eligible for Medicare. As permitted by 42 CFR 422.66(c)(2), dually eligible individuals can be automatically ("default") enrolled into a D-SNP when they first become eligible for Medicare if all the following criteria are met:

- At the time that the dually eligible individuals become eligible for Medicare, they are enrolled in a Medicaid managed care plan through the same parent organization as the D-SNP.
- The dually eligible individuals will remain eligible for Medicaid and enrolled in the D-SNP's affiliated Medicaid managed care plan after becoming eligible for Medicare.
- The state has approved the D-SNP's use of default enrollment and provides the data necessary for the D-SNP or its affiliated Medicaid managed care plan to identify Medicaid enrollees who are in their initial coverage election period for Medicare.
- CMS has approved the D-SNP's use of default enrollment after its acceptable submission of a default enrollment application.
- The D-SNP has a quality rating of at least three stars (if the contract is not a low-enrollment contract) and is not subject to a ban on new enrollment.
- The D-SNP issues the dually eligible individual a notice that complies with the requirements described in 42 CFR 422.66(c)(2)(iii).

advocacy organizations and health care providers), obtaining their buy-in, and considering their input throughout the implementation process.

One interviewee also noted that default enrollment can be technically challenging to implement and may require states and D-SNPs to make changes to their IT systems. Specifically, states must be able to identify beneficiaries who are becoming eligible for Medicare (through state-CMS file exchange processes) and inform D-SNPs of the beneficiaries eligible for default enrollment. As one state interviewee described from experience, states that have systems in place to exchange these data with CMS frequently are well positioned to identify these individuals and begin default enrollment.

Once D-SNPs are informed of the beneficiaries who are eligible for default enrollment, they are required to notify the beneficiary 60 days prior to the enrollment effective date (Stringer and Kruse 2019). States can often easily identify when an individual will age into Medicare by looking at the individual's birth date, and thus can prepare notices of default enrollment in advance. However, one interviewee noted that it is more difficult to identify and inform individuals who are newly eligible for enrollment into Medicare based on their disability status.[26]

D. Additional D-SNP contracting strategies

In addition to the contracting strategies specifically examined in this study, some of our interviewees suggested three additional strategies that states could use to further integration of Medicare and Medicaid benefits:

1. **To reduce duplication across Medicare and Medicaid benefits and extend extra benefits to dually eligible beneficiaries, states could partner with D-SNPs to develop supplemental benefit packages that complement the Medicaid benefits already available to FBDE individuals**. D-SNPs could use "rebate dollars" generated through the Medicare Advantage bid process to provide supplemental benefits to their enrollees.[27,28] Initially, plans were able to provide supplemental benefits such as dental, vision, and hearing services that were "primarily health related," not covered by traditional Medicare, and for which the plan incurred a nonzero direct medical cost, as long as those

[24] Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/MMPInformationandGuidance/MMPEnrollment.

[25] See 42 CFR 422.60(g)(1)(iii)-(g)(2), which describes these requirements.

[26] Individuals who become eligible for Medicare due to disability receive Medicare benefits based on their receipt of Social Security disability benefits, which can be more difficult for states to identify than birth dates. To identify these individuals, states can submit "PROspective" records in MMA files for Medicaid enrollees with disabilities. For more information, see the ICRC tip sheet, "Using Medicare Modernization Act (MMA) Files to Identify Dually Eligible Individuals," at https://www.integratedcareresourcecenter.com/resource/using-medicare-modernization-act-mma-files-identify-dually-eligible-individuals.

[27] For information about the Medicare Advantage payment system, including generation of rebate dollars, see MedPAC's October 2020 Medicare Advantage Payment Basics tool (MedPAC 2020).

[28] In December 2020, MedPAC staff estimated that the average Medicare Advantage plan would have approximately $139 per enrollee in rebate dollars in CY 2021 to provide supplemental benefits. See page 216 of the December 3, 2020, meeting transcript: http://www.medpac.gov/docs/default-source/meeting-materials/dec2020_public_meeting_transcript_sec.pdf?sfvrsn=0.

benefits were uniformly offered to all plan enrollees.[29] Beginning with bids for the 2019 plan year, CMS expanded this definition to enable Medicare Advantage plans to offer expanded supplemental benefits, including adult day care services, home-based palliative care, in-home support services, caregiver supports, medically approved non-opioid pain management, memory fitness benefits, home and bathroom safety devices and modifications, transportation, and coverage for over-the-counter medications and items.[30]

At the same time, CMS reinterpreted the uniformity requirement described at 42 CFR 422.100(d)(2) to enable Medicare Advantage plans to target certain supplemental benefits to enrollees with particular chronic conditions.[31] In 2019, CMS issued guidance in response to the BBA of 2018 that enabled Medicare Advantage plans to begin providing Special Supplemental Benefits for the Chronically Ill (SSBCI) in CY 2020. These benefits do not need to be primarily health related and may be offered nonuniformly to enrollees with particular chronic conditions or diseases. Examples of SSBCI offered in 2020 include food and produce benefits, home-delivered meals, pest control services, nonmedical transportation, indoor air quality equipment and services, social needs benefits, complementary therapies, services supporting self-direction, structural home modifications, and service animal supports (Long-Term Care Quality Alliance and ATI Advisory 2020).

Given the potential for overlap between these new supplemental benefit offerings and Medicaid benefits, states are beginning to work collaboratively with D-SNPs to ensure that the D-SNPs' supplemental benefits will do the following:

- **Expand the full package of benefits available to D-SNP enrollees** by covering benefits not already covered by Medicaid or offering LTSS-like benefits to individuals who would not otherwise qualify for Medicaid-covered LTSS.
- **Decrease state costs for coverage of Medicare cost sharing** by using rebate dollars to cover additional days of hospital care beyond those covered under original Medicare, decrease the Part A inpatient deductible, or decrease the plan's annual out-of-pocket limit, for example.

See Box III.4 for sample contract language from Arizona requiring D-SNPs to collaborate with the state in designing their SSBCI benefits for enrollees.

[29] CMS Health Plan Management System (HPMS) memo to Medicare Advantage Organizations and 1876 Cost Contract Plans, "Reinterpretation of 'Primarily Health Related' for Supplemental Benefits," April 27, 2018: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Weekly-Items/SysHPMS-Memo-2018-Week4-Apr-23-27.

[30] Ibid.

[31] CMS HPMS memo to Medicare Advantage Organizations and Section 1876 Cost Plans, "Reinterpretation of the Uniformity Requirement," April 27, 2018: https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/HPMS/HPMS-Memos-Archive-Weekly-Items/SysHPMS-Memo-2018-Week4-Apr-23-27.

Box III.4. Arizona SMAC language regarding collaboration on the development of D-SNP supplemental benefits

"The [D-SNP] shall collaborate with [the state Medicaid agency] regarding discretionary health-related supplemental benefits to be offered through Special Supplemental Benefits for the Chronically Ill (SSCBI) as provided by CMS in the Medicare Advantage CY2020 Final Call Letter issued April 1, 2019. Such coordination shall include proposed prospective SSCBIs that have a reasonable expectation of improving or maintaining the health or overall function of such an [Arizona Medicaid] Dual Eligible Member as tailored to the individual's needs, for those who are enrolled with the [D-SNP]. [Arizona's state Medicaid agency] seeks to improve Medicare-Medicaid program coordination of such SSCBIs so as to reduce service delivery fragmentation and promote improved health outcomes. Examples of such coordinated SSCBIs include, but are not limited to: home delivered foods/meals, home environmental modifications, transportation for non-medical needs, and other identified social determinant of health needs on a per identified and defined chronically ill Dual Eligible Member basis as documented in their care management/care treatment plan."

Source: Section 2.15.1 of Arizona's CY 2021 SMACs, available at https://www.azahcccs.gov/Resources/OversightOfHealthPlans/SolicitationsAndContracts/medicareagreements.html

2. **To improve the quality of care provided to dually eligible beneficiaries, states can incorporate Medicaid quality improvement priorities into D-SNP contracts.** Although any state can incorporate quality improvement priorities into its contracts with D-SNPs, this strategy may be of particular interest to states that use direct contracting to pay per-enrollee rates to D-SNPs for coverage of Medicaid benefits or to states where Medicaid managed care plans have affiliated D-SNPs. Per 42 CFR 438.330 and 438.340, respectively, states are required to develop and implement Medicaid Quality Assessment and Performance Improvement (QAPI) programs and quality strategies for their Medicaid managed care programs. Quality strategies must include measurable goals and objectives for quality improvement; quality metrics and performance targets; and plans to identify, evaluate, and reduce health disparities based on age, race, ethnicity, sex, primary language, and disability status. QAPIs must include performance improvement projects (PIPs), collection and submission of performance measurement data, mechanisms to detect overutilization and underutilization of services, and mechanisms to assess the quality and appropriateness of care delivered to enrollees with special health care needs and enrollees who receive LTSS.

   When D-SNPs (or their affiliated Medicaid managed care plans) receive capitated payments from a state to cover Medicaid services, they are bound by the same Medicaid managed care regulations that guide Medicaid managed care plans[32] and therefore can be included in state efforts to achieve quality strategy goals. When D-SNPs operate alongside affiliated Medicaid managed care plans, states can require them to implement PIPs to address the needs of specific dually eligible populations of interest and reduce disparities within those populations. See Box III.5 for examples of ways that Minnesota has incorporated Medicaid quality improvement requirements and processes into its contracts with its fully integrated D-SNPs (FIDE SNPs).

[32] 42 USC 1396b(m) defines "Medicaid managed care organization" as including Medicare Advantage plans that provide Medicaid benefits.

Box III.5. Minnesota quality improvement requirements for Minnesota Senior Health Options D-SNPs

Through an administrative alignment Financial Alignment Initiative demonstration, Minnesota operates a fully integrated program known as Minnesota Senior Health Options (MSHO). MSHO D-SNPs are FIDE SNPs that operate with exclusively aligned enrollment and receive capitated payments from the state to cover a full array of Medicaid benefits. In its 2020 MSHO contract, Minnesota required MSHO FIDE SNPs to do the following:

- Incorporate the requirements described in 42 CFR 438, Subpart E, into their respective quality assessment and improvement programs.
- Develop effective mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs and submit written descriptions of those mechanisms to the state for review and approval.
- Cooperate with Medicaid External Quality Review studies.
- Conduct PIPs that comply with 42 CFR 438.330(b)(1) and (d) and submit to the state a written description of the plan's proposed PIP for state review and approval, as well as annual PIP performance reports.

Minnesota encourages MSHO FIDE SNPs to participate in PIP collaborative initiatives that coordinate PIP topics and designs between managed care plans, through which the state and its Medicaid managed care plans, including MSHO FIDE SNPs, select topics for PIPs to be conducted over a three-year period. The state also permits its FIDE SNPs to use information collected from Medicare or private accreditation reviews to replace information that would be collected by the state's External Quality Review Organization when the terms described at 42 CFR 438.360 are met.

Source: Sections 7.1.1, 7.1.5, 7.2, and 7.6 of Minnesota's CY 2020 MSHO SMAC, available at https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/managed-care-reporting/contracts.jsp

3. **To simplify billing and payment for providers who serve dually eligible individuals, states with Medicaid managed care programs for dually eligible individuals can work with their D-SNPs and Medicaid managed care plans to set up automated crossover claims payment processes for Medicaid payment of Medicare cost sharing**. One state interviewee noted that when dually eligible individuals can enroll in D-SNPs and Medicaid managed care plans through different parent organizations (in other words, the state does not require D-SNPs to operate with exclusively aligned enrollment), then setting up automated crossover processes for provider claims can make it easier for providers to bill appropriately and get paid in a timely fashion. In an automated crossover process, health care providers bill D-SNPs for services rendered to D-SNP enrollees. The D-SNP pays any applicable Medicare portion of the provider's claim, then sends the claim to the appropriate Medicaid managed care plan for Medicaid review and payment. As a result, the provider will receive all applicable Medicare and Medicaid payments without having to identify whether the service is covered by Medicare or Medicaid, or both, and without having to submit two separate claims to the D-SNP and the Medicaid managed care plan.

IV. Conclusions

Through this study, Mathematica identified several key conclusions of relevance for MACPAC's consideration of policy options to advance the integration of Medicare and Medicaid benefits and promote enrollment in integrated plans:

- **Context matters.** Although several of the D-SNP contracting strategies described in this report are available to any state that is interested in implementing them, some strategies are applicable only to states that enroll dually eligible individuals in Medicaid managed care programs. In addition, states that are new to D-SNP contracting may be in the best position to use several strategies to achieve full integration from the beginning, whereas states that have existing contracts with D-SNPs (and in some cases, Medicaid managed care plans) have a greater risk of disrupting continuity of care for current plan enrollees and encountering pushback from plans if they adopt additional strategies such as selective contracting or limiting D-SNP enrollment to FBDE individuals. For example, states new to contracting with D-SNPs could use direct contracting and exclusively aligned enrollment to create a fully integrated model from the outset. In states with existing D-SNP contracts, on the other hand, implementation of these strategies could disrupt coverage arrangements for current D-SNP enrollees and potentially lead to D-SNP disenrollment. For information about which contracting strategies may be most feasible in different state contexts, see Appendix D.
- **Resources and long-term commitment matter.** Interviewees clearly affirmed that states need to invest significant financial and staffing resources to advance integrated care initiatives—which reinforced the importance of MACPAC's June 2020 recommendation that Congress "provide additional federal funds to enhance state capacity to develop expertise in Medicare and to implement integrated care models" (MACPAC 2020b). Interviewees also said that many states do not yet have the Medicare policy expertise necessary to align D-SNP and Medicaid contracting strategies. In addition, they said that leadership buy-in and staff champions often play a critical role in whether a state considers advancing any state D-SNP contracting strategies at all, as well as which specific strategies are adopted. Finally, because implementing integrated care strategies generally takes multiple years, turnover in key state Medicaid agency staff or leadership can interrupt or derail state progress toward developing integrated care plans.
- **Implementing D-SNP contracting strategies often involves trade-offs.** The level of Medicare-Medicaid integration realized through certain strategies may involve trade-offs in terms of the degree of integration achieved and the number of dually eligible individuals enrolled.
  - **Requirements for greater integration can lead to reduced D-SNP enrollment.** Some contract requirements that lead to increased integration of Medicare and Medicaid benefits may lead to decreased enrollment in integrated plans, at least in the short term. For example, restricting D-SNP enrollment to FBDE individuals may mean that partial-benefit dually eligible individuals must disenroll from D-SNPs. However, restricting enrollment to FBDE individuals enables greater integration of enrollee materials, care coordination, and administration of Medicare and Medicaid benefits. Similarly, selectively contracting only with D-SNPs that offer Medicaid managed care plans in the state may mean that enrollees in D-SNPs that lose state contracts may no longer be enrolled in a D-SNP, unless they choose to switch to a different D-SNP that has a state contract. This could mean fewer D-SNP enrollees in the short term. However, selective contracting ensures that anyone who chooses to enroll in a D-SNP can also choose to enroll in an aligned Medicaid managed care plan, which promotes greater integration of benefits.

  - **Broader D-SNP enrollment can lay the groundwork for broader future integration.** Less stringent requirements that result in minimal integration can keep a greater share of dually eligible individuals enrolled in D-SNPs, which can set the stage for further integration in the future. D-SNPs with broader enrollment may have more incentives and resources to make investments that can support greater future integration, and more of their dually eligible individuals will have the opportunity to experience at least some degree of coordination of Medicare and Medicaid benefits. While interviewees believed that requiring exclusively aligned enrollment offered the greatest opportunity to advance integration, they also understood that it requires significant state investment and may limit the total number of dually eligible individuals enrolled in D-SNPs. In addition, enrollment in exclusively aligned plans could increase the number of dually eligible individuals in D-SNPs in the long run, as they realize the benefits of enrollment in a fully integrated plan, such as holistic care coordination, simplified enrollee materials, and streamlined access to benefits. However, most interviewees agreed that implementing exclusively aligned enrollment could decrease the number of enrollees in integrated D-SNPs in the short run, which could in some cases jeopardize D-SNPs' financial viability or at least their incentives and ability to invest in future integration initiatives.

> *"FIDE SNPs with exclusively aligned enrollment promote integration for those who need it most—the highest-risk beneficiaries with the highest need. They have the most evidence of integration improving outcomes, both in terms of Medicare hospitalization and in avoiding long-term institutionalization. But they're also the biggest lift. They can be politically difficult; they require different levels of expertise and capacity that not all D-SNPs that are medically focused have. There's the biggest payoff, but they only impact a subset of duals [LTSS users who are enrolled in the plans]. There are other strategies, like paying for cost sharing, that can impact a larger proportion of duals, including partial duals, and have a wider impact but that don't deal with the needs of the LTSS users."*
>
> —Stakeholder interviewee

- **Use of some D-SNP contracting strategies may generate unintended consequences that may not be easy (or possible) to resolve.** Several interviewees shared cautionary tales of selective contracting strategies that led to some aligned D-SNP enrollees becoming unaligned or being forced to change their D-SNP or Medicaid plan when a parent organization lost a Medicaid reprocurement bid. Although the interviewees largely agreed that misalignments between Medicaid procurement timelines and Medicare D-SNP bid and contracting timelines exacerbated these challenges, they expressed doubt that coordinating the timelines would be possible for states to achieve or worth the effort required.
- **States and D-SNPs continue to face challenges to D-SNP contracting in rural areas.** Interviewees cited small dually eligible populations and CMS network adequacy requirements as the main barriers to statewide D-SNP contracting in states with a large share of dually eligible beneficiaries living in rural or frontier regions. They offered several suggestions for policy changes that might help address these barriers. (See Box III.1.)

- **Federal requirements and CMS priorities for integrated care can influence state decisions about adopting D-SNP contracting strategies.** Two of the five state representatives interviewed for this study said that federal laws and priorities influenced their decisions to consider using D-SNPs as a platform for integrating care for dually eligible individuals. One stakeholder said that more states considered these D-SNP contracting strategies in 2020, because they had to work with their D-SNPs to implement the new D-SNP integration requirements established by the BBA of 2018 and subsequent CMS regulations.[33]
- **Stakeholder engagement and buy-in is critical to successful integrated care initiatives.** Health plans, providers, and beneficiary advocacy organizations often play important roles in dually eligible individuals' lives and may influence their enrollment into integrated (or nonintegrated) health plans. If states do not successfully engage these stakeholders and gain their support when implementing D-SNP contracting strategies to move toward full integration, any or all of the stakeholders may use their influence to steer potential enrollees away from integrated care. For example, health plans that are not selected for selective contracting may entice dually eligible individuals to enroll in nonintegrated Medicare Advantage plans. In addition, beneficiary advocates opposed to the use of default enrollment or other automatic enrollment mechanisms may encourage dually eligible individuals to opt out.

Integrating care for dually eligible beneficiaries is a complex endeavor that varies substantially by state. By taking into account the factors that influence state decisions and understanding which D-SNP contracting options are best suited to each state, federal and state policymakers can make more informed choices to advance integration through D-SNP contracting strategies that are most feasible and likely to succeed.

[33] CMS Medicare Advantage and Prescription Drug final rule for 2020 and 2021, CMS-4185-F, published at 84 FR 15680.

This page has been left blank for double-sided copying.

References

Archibald, N., M. Soper, L. Smith, and A. Kruse. "Integrating Care Through Dual-Eligible Special Needs Plans (D-SNPs): Opportunities and challenges." Report for the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. Hamilton, NJ, and Washington, DC: Center for Health Care Strategies and RTI International, 2019. https://aspe.hhs.gov/pdf-report/integrating-care-through-dual-eligible-special-needs-plans-d-snps-opportunities-and-challenges.

Barth, S., S. Silow-Carroll, E. Reagan, M. Russell, and T. Simmons. "Care Coordination in Integrated Care Programs Serving Dually Eligible Beneficiaries—Health Plan Standards, Challenges and Evolving Approaches." Report to the Medicaid and CHIP Payment and Access Commission. Lansing, MI: Health Management Associates, 2019. https://www.macpac.gov/wp-content/uploads/2019/03/Care-Coordination-in-Integrated-Care-Programs-Serving-Dually-Eligible-Beneficiaries.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. "Medicaid Managed Care Enrollment Report: 2018 Managed Care Enrollment Data." Washington, DC: CMS, 2018. https://www.medicaid.gov/medicaid/managed-care/enrollment-report/index.html.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. "Medicare-Medicaid Coordination Office FY 2019 Report to Congress." Washington, DC: CMS, 2019. https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/FY-2018-Report-to-Congress.pdf.

Centers for Medicare & Medicaid Services (CMS), U.S. Department of Health and Human Services. "Special Needs Plan Comprehensive Report." Washington, DC: CMS, 2020. https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data.

Chelminsky, D., A. Tourtellotte, and E. Weir Lakhmani. "State Guide to Identifying Aligned Enrollees: How to Find Medicare Plan Enrollment for Dually Eligible Individuals in Medicaid Managed Care Plans." Integrated Care Resource Center (ICRC) technical assistance tool. Washington, DC: Mathematica, 2020. https://www.integratedcareresourcecenter.com/resource/state-guide-identifying-aligned-enrollees-how-find-medicare-plan-enrollment-dually-0.

Ennslin Janoski, B., T. Betlach, and M. Herman Soper. "Integrated Care Programs for Dually Eligible Individuals in the Era of COVID-19: Response Efforts and Policy Recommendations." Report by Speire Healthcare Strategies and the Center for Health Care Strategies, Inc. Hamilton, NJ: Center for Health Care Strategies, October 2020. https://www.chcs.org/media/Integrated-Care-Programs-for-Dually-Eligible-Individuals-in-the-Era-of-COVID-19.pdf.

Integrated Care Resource Center (ICRC). "Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans." ICRC technical assistance tool. Hamilton, NJ, and Washington, DC: Center for Health Care Strategies and Mathematica, 2020a. https://www.integratedcareresourcecenter.com/resource/sample-language-state-medicaid-agency-contracts-dual-eligible-special-needs-plans.

Integrated Care Resource Center (ICRC). "Spotlight: New Interoperability and Patient Access Rule Will Affect Dually Eligible Individuals." ICRC e-alert. Hamilton, NJ, and Washington, DC: Center for Health Care Strategies and Mathematica, 2020b. https://www.integratedcareresourcecenter.com/sites/default/files/12%2015%2020%20Spotlight_%20New%20Interoperability%20and%20Patient%20Access%20Rule%20Will%20Affect%20Dually%20Eligible%20Individuals.pdf.

Integrated Care Resource Center (ICRC). "Glossary of Terms Related to Integrated Care for Dually Eligible Individuals." ICRC technical assistance tool. Hamilton, NJ, and Washington, DC: Center for Health Care Strategies and Mathematica, 2021. https://www.integratedcareresourcecenter.com/resource/glossary-terms-related-integrated-care-dually-eligible-individuals.

Lester, R. "Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Integrating Medicaid Managed Long-Term Services and Supports into D-SNP Models of Care." Integrated Care Resource Center tip sheet. Washington, DC: Mathematica, 2019. https://www.Integratedcareresourcecenter.com/resource/tips-improve-medicare-medicaid-integration-using-d-snps-integrating-medicaid-managed-long.

Long-Term Care Quality Alliance and ATI Advisory. "Providing Non-Medical Supplemental Benefits in Medicare Advantage: A Roadmap for Plans and Providers." Washington, DC: Long-Term Care Quality Alliance and ATI Advisory, 2020. https://atiadvisory.com/wp-content/uploads/2020/11/Providing-Non-Medical-Benefits-in-Medicare-Advantage-a-Roadmap-for-Plans-and-Providers.pdf.

Medicaid and CHIP Payment and Access Commission (MACPAC). "Evaluations of Integrated Care Models for Dually Eligible Beneficiaries: Key Findings and Research Gaps." Washington, DC: MACPAC, 2019. https://www.macpac.gov/publication/evaluations-of-integrated-care-models-for-dually-eligible-beneficiaries-key-findings-and-research-gaps/.

Medicaid and CHIP Payment and Access Commission (MACPAC). "Integrating Care for Dually Eligible Beneficiaries: Background and Context." In *Report to Congress on Medicaid and CHIP*. Washington, DC: MACPAC, 2020a. https://www.macpac.gov/publication/chapter-1-integrating-care-for-dually-eligible-beneficiaries-background-and-context/.

Medicaid and CHIP Payment and Access Commission (MACPAC). "Integrating Care for Dually Eligible Beneficiaries: Policy Issues and Options." In *Report to Congress on Medicaid and CHIP*. Washington, DC: MACPAC, 2020b. https://www.macpac.gov/publication/chapter-2-integrating-care-for-dually-eligible-beneficiaries-policy-issues-and-options/.

Medicare Payment Advisory Commission (MedPAC). "Promoting Integration in Dual-Eligible Special Needs Plans." In *Report to the Congress: Medicare and the Health Delivery System.* Washington, DC: MedPAC, 2019. http://www.medpac.gov/docs/default-source/reports/jun19_ch12_medpac_reporttocongress_sec.pdf?sfvrsn=0.

Medicare Payment Advisory Commission (MedPAC). "Medicare Advantage Program Payment System." MedPAC payment basics tool. Washington, DC: MedPAC, 2020. http://www.medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_ma_final_sec.pdf?sfvrsn=0.

Medicare Payment Advisory Commission (MedPAC) and Medicaid and CHIP Payment and Access Commission (MACPAC). "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid." Washington, DC: MedPAC and MACPAC, 2018. https://www.macpac.gov/wp-content/uploads/2020/07/Data-Book-Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-January-2018.pdf.

Milligan, C. "Expanding Opportunities to Integrate Care for Dual Eligibles: Rethinking Federal Approaches to Measuring Network Adequacy for D-SNPs." Milligan Consulting policy brief, 2020. https://www.milligan-consulting.com/policybriefs/expanding-opportunities-to-integrate-care-for-dual-eligiblesrethinking-federal-approaches-to-measuring-network-adequacy-for-dsnps.

Stringer, R., and A. Kruse. "Using Default Enrollment to Align Coverage for Dually Eligible Medicare-Medicaid Enrollees." Integrated Care Resource Center fact sheet. Hamilton, NJ, and Washington, DC: Center for Health Care Strategies and Mathematica, 2019. https://www.integratedcareresourcecenter.com/resource/using-default-enrollment-align-coverage-dually-eligible-medicare-medicaid-beneficiaries.

Talamas, A., K. Cowen, G. Torralba, and D. Perra. "State Contracting with D-SNPs: Introduction to D-SNPs and D-SNP Contracting Basics." Integrated Care Resource Center Working with Medicare webinar, December 14, 2020. Hamilton, NJ, and Washington, DC: Center for Health Care Strategies and Mathematica, 2020. https://www.integratedcareresourcecenter.com/webinar/working-medicare-webinar-state-contracting-d-snps-introduction-d-snps-and-d-snp-contracting.

U.S. Government Accountability Office (GAO). "Medicare and Medicaid: Alignment of Managed Care Plans for Dual-Eligible Beneficiaries." GAO 20-319. Washington, DC: GAO, 2020. https://www.gao.gov/products/GAO-20-319.

Verdier, J., A. Kruse, R. Sweetland Lester, A. Phillip, and D. Chelminsky. 2016. "State Contracting with Medicare Advantage Dual Eligible Special Needs Plans: Issues and Options." Integrated Care Resource Center technical assistance tool. Hamilton, NJ, and Washington, DC: Center for Health Care Strategies and Mathematica, 2016. https://www.integratedcareresourcecenter.com/PDFs/ICRC_DSNP_Issues__Options.pdf.

Weir Lakhmani, E., and A. Kruse. "Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Promoting Aligned Enrollment." Integrated Care Resource Center Tip Sheet. Hamilton, NJ and Washington, DC: Center for Health Care Strategies and Mathematica, 2018. https://www.integratedcareresourcecenter.com/resource/tips-improve-medicare-medicaid-integration-using-d-snps-promoting-aligned-enrollment.

Weir Lakhmani, E., and J. Verdier. "State Options and Considerations for Sharing Medicaid Enrollment and Service Use Information with D-SNPs." Integrated Care Resource Center Technical Assistance Brief. Washington, DC: Mathematica, 2019. https://www.integratedcareresourcecenter.com/resource/state-options-and-considerations-sharing-medicaid-enrollment-and-service-use-information-d.

Weir Lakhmani, E., D. Chelminsky, P. Saucier, and N. Archibald. "State Contracting with D-SNPs: Using D-SNPs to Integrate Care for Dually Eligible Individuals." Integrated Care Resource Center Working with Medicare webinar, December 17, 2020. Hamilton, NJ, and Washington, DC: Center for Health Care Strategies and Mathematica, 2020. https://www.integratedcareresourcecenter.com/webinar/working-medicare-webinar-state-contracting-d-snps-using-d-snps-integrate-care-dually.

This page has been left blank for double-sided copying.

Appendix A

Organizations Interviewed and State Characteristics

This page has been left blank for double-sided copying

Table A.1. Organizations interviewed, by state

State	Health plan	Beneficiary advocacy organizations	Other stakeholders
(National entity)	SNP Alliance		CMS MMCO
California	Anthem, Centene, LACare,* Molina, UnitedHealthcare	Justice in Aging	
District of Columbia	UnitedHealthcare		Claudia Schlosberg
Idaho	Anthem, Molina	SHIBA	SNP Alliance
Indiana	Anthem, Centene, UnitedHealthcare		
Virginia	Anthem, Molina, UnitedHealthcare		Suzanne Gore

CMS = Centers for Medicare & Medicaid Services; MMCO = Medicare-Medicaid Coordination Office; SHIBA = Senior Health Insurance Benefit Advisors; SNP = Special Needs Plan.

*LACare currently operates a Medicare-Medicaid Plan (MMP) in California but has operated a Dual Eligible Special Needs Plan (D-SNP) in the past and intends to operate a D-SNP in 2023 when the state transitions from its Financial Alignment Initiative demonstration into fully integrated D-SNP contracting.

Table A.2. Characteristics of states interviewed

State	D-SNP integration level	FAI demonstration?	MLTSS program serving duals?	Percentage of older adults residing in rural areas[a]	Percentage of dually eligible individuals enrolled in D-SNPs (Sept..2019)[b]
CA	Multiple	Yes	Yes (aligned with demonstration)	7.1	9.0
DC	Minimal	No	No	0.0	34.9
ID	Full	No	Yes	35.7	15.5
IN	Minimal	No	No	31.0	13.8
VA	Partial	No	Yes	32.7	19.0

D-SNP = Dual Eligible Special Needs Plan; FAI = Financial Alignment Initiative; MLTSS = managed long-term services and supports.

[a] Data taken from Symens Smith, Amy, and Edward Trevelyan. "The Older Population in Rural America: 2012–2016." American Community Survey Report (ACS-41), September 2019. Available at https://www.census.gov/content/dam/Census/library/publications/2019/acs/acs-41.pdf.

[b] The proportion of dually eligible individuals enrolled in D-SNPs was compiled using two data sources: D-SNP enrollment data (the numerator) was extracted from the September 2019 SNP Comprehensive Report, available at https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data. Data on the total number of dually eligible individuals in each state (the denominator) was extracted from the December 2018 CMS Monthly Enrollment Snapshots Report, available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.html.

This page has been left blank for double-sided copying

Appendix B

Detailed Explanations of the 11 State D-SNP Contracting Strategies Examined in Study

This page has been left blank for double-sided copying

Table B.1. State D-SNP contracting strategies that promote Medicare-Medicaid integration

Contracting strategy	Explanation
Strategies applicable to all states	
1. Limit Dual Eligible Special Needs Plan (D-SNP) enrollment to full-benefit dually eligible individuals	Per 42 CFR 422.107(c)(2), all state Medicaid agency contracts (SMACs) must identify "the category(ies) and criteria for eligibility for dual eligible individuals to be enrolled" in the D-SNP. Because partial-benefit dually eligible individuals qualify only for coverage of Medicare premiums and, in some cases, Medicare cost sharing, inclusion of partial-benefit dually eligible individuals in D-SNPs can dilute the level of Medicare-Medicaid integration that D-SNPs can provide (see Chapter III.C of this report for details). To ensure that D-SNPs can offer uniform benefits, cost sharing, and care coordination to all D-SNP enrollees (and present that information simply and clearly in enrollee materials), states can limit D-SNP enrollment to only individuals who qualify for full Medicaid benefits in the state or who are "full-benefit dually eligible (FBDE) individuals" (MedPAC 2019; Weir Lakhmani and Kruse 2018). Alternatively, states that wish to allow partial-benefit dually eligible individuals to enroll in D-SNPs can require D-SNPs to use separate Medicare Advantage plan benefit packages (PBPs) to enroll full- and partial-benefit dually eligible individuals.
2. Contract with D-SNPs to cover Medicaid benefits ("direct contracting")	States can contract directly with D-SNPs for coverage of Medicaid benefits (Verdier et al. 2016). Such direct contracting can take many forms, from simply contracting with D-SNPs to cover Medicare cost sharing for their enrollees, to contracting with D-SNPs to cover Medicare cost sharing and basic Medicaid wraparound benefits for dually eligible individuals who do not qualify for long-term services and supports (LTSS), to contracting with D-SNPs for a full package of Medicaid benefits, including behavioral health and LTSS. (Weir Lakhmani et al. 2020) Direct contracting may be especially helpful in states that do not currently have Medicaid managed care programs serving dually eligible individuals, states in which certain populations of FBDE individuals may not be eligible for existing Medicaid managed care programs (for example, dually eligible individuals who do not receive LTSS), or states where there is no overlap between the parent companies offering D-SNPs and those offering Medicaid managed care plans for dually eligible individuals.
3. Require D-SNPs to operate with "exclusively aligned enrollment"	Exclusively aligned enrollment occurs when a state limits enrollment in a D-SNP to FBDE individuals who receive their Medicaid benefits from the D-SNP or an affiliated Medicaid managed care plan offered by the same parent company as the D-SNP. Exclusively aligned enrollment maximizes the opportunity for integration of Medicare and Medicaid benefits, streamlines coverage of Medicare cost sharing, facilitates uniform delivery of benefits and care coordination, and enables issuance of simplified (even fully integrated) materials to D-SNP members. In 2021, fully integrated D-SNPs and highly integrated D-SNPs operating with exclusively aligned enrollment are also required to implement unified procedures for plan-level resolution of appeals and grievances (Talamas et al. 2020; Weir Lakhmani et al. 2020).
4. Require D-SNPs to use specific or enhanced care coordination methods	States can incorporate a variety of requirements into their D-SNP SMACs to enhance the amount or degree of care coordination provided to D-SNP enrollees. For example, states can require D-SNPs to (1) train care coordinators in state Medicaid benefits and systems to ensure that they are well-equipped to assist D-SNP enrollees in accessing those benefits; (2) incorporate Medicaid requirements into the D-SNP Model of Care, (3) integrate Medicaid assessments into the D-SNP health risk assessment process or conduct assessments face-to-face for certain vulnerable populations; (4) incorporate certain elements into enrollee care plans, including steps to be taken to address social determinants of health; (5) involve family members or caregivers in the assessment or care planning process, or both; (6) share copies of care plans with enrollees' primary care providers or other key contacts; (7) take certain measures or communicate with certain entities (for example, primary care providers or Medicaid managed care plans) when an enrollee is transitioning across care settings; or (8) use care management information technology systems that meet certain standards or facilitate communication across certain entities (for example, between the D-SNP and Medicaid managed care plans or other Medicaid case management entities). Incorporating state-specific care management requirements into the SMAC ensures that D-SNP enrollees receive the standard of care coordination that the state expects and requires in its Medicaid program and facilitates greater integration of Medicare and Medicaid benefits in the provision of D-SNP care coordination (Barth et al. 2019; Verdier et al. 2016).

Contracting strategy	Explanation
5. Require D-SNPs to send data or reports to the state for oversight purposes	States can require D-SNPs to submit data or reports that enable state oversight of plan operations and quality of care. For example, D-SNP submission of encounter data or Part D prescription drug event data can help the state obtain a full picture of Medicare and Medicaid service utilization for D-SNP enrollees, allowing it to identify areas for improvement in care coordination, cost reduction, or quality of care. States may also require D-SNPs to submit grievance and appeal data, reports on the plan's performance on certain quality measures, or reports on plan progress on chronic care improvement projects. Finally, states may require D-SNPs to submit financial statements or service cost information, which the state can use in developing capitated rates for coverage of Medicaid services, as well as for validation of D-SNP encounter data (Verdier et al. 2016; Weir Lakhmani et al. 2020).
6. Review Medicaid information in D-SNP marketing/ communication materials	States can require D-SNPs to submit certain marketing and enrollee communication materials for state review prior to use, so that the state can ensure that the Medicaid information provided in those materials is accurate, appropriate, and clear. Alternatively (or additionally), the state can provide template language about Medicaid benefits and require all D-SNPs to incorporate that language into their materials, which ensures consistency in messaging across D-SNPs, in addition to ensuring accuracy and clarity in the information presented.
Strategies applicable to states with Medicaid managed care programs that enroll dually eligible individuals	
7. Selectively contract with D-SNPs and Medicaid managed care plans that offer affiliated plans	States do not have to contract with D-SNPs—states can choose whether to contract with D-SNPs at all, and states may selectively contract with certain D-SNPs but not others (Talamas et al. 2020). In particular, states with Medicaid managed care programs that serve dually eligible individuals can choose to contract only with D-SNPs that offer an affiliated Medicaid managed care plan (through the same parent company) and/or to contract only with Medicaid managed care plans that offer an affiliated D-SNP (Verdier et al. 2016; Weir Lakhmani and Kruse 2018). This strategy, known as "selective contracting," creates a landscape in which dually eligible individuals have the opportunity to enroll in affiliated D-SNPs and Medicaid managed care plans for coverage of both Medicare and Medicaid benefits.
8. Require complete service area alignment	States that use selective contracting (defined above) can require affiliated D-SNPs and Medicaid managed care plans to operate in fully aligned service areas, so that in every county in which a particular parent company offers a Medicaid managed care plan, the same parent company offers a D-SNP, and vice versa. Requiring complete service area alignment ensures that all D-SNP-eligible individuals will have the option of enrolling in affiliated plans for coverage of Medicare and Medicaid benefits, regardless of their geographic location within the state. (One of the biggest challenges to achieving complete service area alignment is achieving aligned plan offerings in rural or frontier areas. For more information, see Chapter III.B of this report.)
9. Coordinate state Medicaid procurement cycles with Medicare timelines	States that use selective contracting may also wish to coordinate their Medicaid procurement cycle with Medicare timelines for approval of D-SNP contracts, in order to maintain consistent affiliations between the D-SNPs and Medicaid managed care plans. D-SNP contracts run on a calendar year cycle, but D-SNP contracting requires significant advance planning. For example, to operate a D-SNP in a particular calendar year, a Medicare Advantage organization must submit a bid to CMS in February of the preceding year and an executed SMAC in July of the preceding year. Additionally, if a D-SNP wishes to begin operating in a new state or in a new service area within a state, the D-SNP also has to file a "notice of intent to apply" (NOIA) in November of the year preceding its bid submission. In other words, if a Medicare Advantage organization wishes to begin operating a new D-SNP in CY 2022, it would need to first submit a NOIA in November 2020, then a bid in February 2021, and an executed SMAC in July 2021.
10. Use Medicaid enrollment algorithms to automatically assign D-SNP enrollees to affiliated Medicaid managed care plans	In states with affiliated D-SNPs Medicaid managed care plans for dually eligible individuals (regardless of whether the state uses selective contracting), state Medicaid agencies can use Medicaid auto-assignment algorithms to align dually eligible individuals' Medicaid managed care enrollment with their D-SNP enrollment during annual Medicaid open enrollment periods. Use of Medicaid automatic assignment in this way promotes "aligned enrollment" (enrollment in affiliated plans for coverage of Medicare and Medicaid benefits), which can simplify care coordination and benefits administration, as a single parent company is responsible for covering all Medicare and Medicaid benefits for the aligned enrollees.

Contracting strategy	Explanation
11. Allow (or require) D-SNPs to use default enrollment	D-SNPs that meet the requirements described at 42 CFR 422.66(c)(2) may use "default enrollment" to enroll individuals into the D-SNP who are enrolled in a Medicaid managed care plan operated by the D-SNP's parent company when those individuals become newly eligible for Medicare (as long as they will continue receiving Medicaid benefits through the company when they are Medicare eligible). To use default enrollment, a D-SNP must have permission from the state Medicaid agency (granted through the SMAC or a legally binding adjunct document), and the state must transmit data to the D-SNP in a timely enough fashion to support the processes necessary to effectuate the default enrollment (Stringer and Kruse 2019). Default enrollment promotes greater integration in integrated D-SNPs and achieves the same benefits of "aligned enrollment" that Medicaid automatic assignment confers (described above).

This page has been left blank for double-sided copying

Appendix C

D-SNP Contracting Decision Tree, Revised to Include Additional Strategies Suggested by Interviewees

This page has been left blank for double-sided copying

The list of D-SNP contracting strategies below expands on those listed in Figure III.1 in the report by including three additional strategies suggested by interviewees: (1) collaborating with D-SNPs to develop supplemental benefit packages that complement Medicaid benefits already available to full-benefit dually eligible (FBDE) individuals; (2) incorporating Medicaid quality improvement priorities into D-SNP contracts; and (3) working with D-SNPs (and Medicaid managed care plans, where applicable) to set up automated crossover claims processes for Medicaid payment of Medicare cost sharing.

Figure C.1. Determining which D-SNP contracting strategies may be used in specific states

Any state that contracts with D-SNPs, whether or not they have Medicaid managed care for dually eligible individuals, may use the following strategies:

Limiting D-SNP enrollment to FBDE individuals
Considerations: Does your state have a substantial enough FBDE population to provide a viable market for D-SNPs? Does your state have a large number of partial-benefit dually eligible individuals already enrolled in D-SNPs?

Requiring D-SNPs to use enhanced care coordination methods or integrate Medicaid requirements into care coordination processes

Requiring D-SNPs to send data or reports to the state for oversight purposes

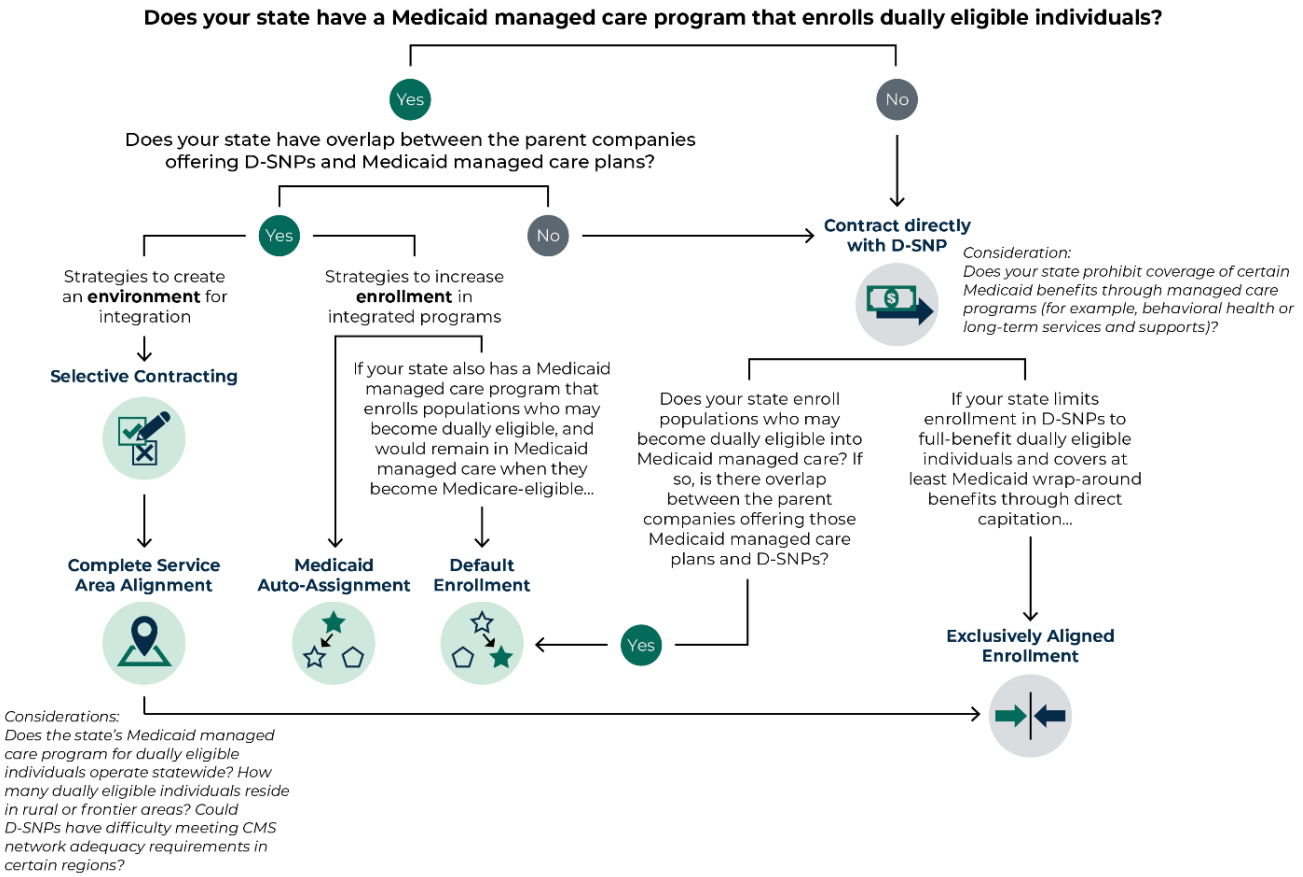
Requiring state review of Medicaid information in certain D-SNP marketing and enrollee communication materials

Collaborating with D-SNPs to develop supplemental benefit packages that complement Medicaid benefits already available to full-benefit dually eligible (FBDE) individuals

Working with D-SNPs (and Medicaid managed care plans, where applicable) to set up automated crossover claims processes for Medicaid payment of Medicare cost sharing.

Incorporating Medicaid quality improvement priorities into D-SNP contracts. *(This strategy is possible in all states but may be most impactful in states that capitate D-SNPs or their affiliated Medicaid managed care plans for coverage of Medicaid benefits.)*

The decision tree on the next page illustrates which of the remaining strategies could be implemented, based on state context, starting with whether the state enrolls dually eligible individuals into Medicaid managed care.


Does your state have a Medicaid managed care program that enrolls dually eligible individuals?
Yes
No
Does your state have overlap between the parent companies offering D-SNPs and Medicaid managed care plans?
Yes
No
Contract directly with D-SNP
Consideration: Does your state prohibit coverage of certain Medicaid benefits through managed care programs (for example, behavioral health or long-term services and supports)?
Strategies to create an environment for integration
Strategies to increase enrollment in integrated programs
Selective Contracting
If your state also has a Medicaid managed care program that enrolls populations who may become dually eligible, and would remain in Medicaid managed care when they become Medicare-eligible...
Does your state enroll populations who may become dually eligible into Medicaid managed care? If so, is there overlap between the parent companies offering those Medicaid managed care plans and D-SNPs?
If your state limits enrollment in D-SNPs to full-benefit dually eligible individuals and covers at least Medicaid wrap-around benefits through direct capitation...
Complete Service Area Alignment
Medicaid Auto-Assignment
Default Enrollment
Yes
Exclusively Aligned Enrollment
Considerations: Does the state's Medicaid managed care program for dually eligible individuals operate statewide? How many dually eligible individuals reside in rural or frontier areas? Could D-SNPs have difficulty meeting CMS network adequacy requirements in certain regions?

Appendix D

Potential Use of D-SNP Contracting Strategies in Hypothetical State Scenarios

This page has been left blank for double-sided copying

The scenarios described in this appendix provide examples of the D-SNP contracting strategies that states could use to advance the integration of Medicare and Medicaid benefits. (For explanations of each of these contracting strategies and definitions of key terms involved in each, see Appendix B.) The primary circumstantial difference across states is whether the state serves dually eligible individuals (or other populations) through Medicaid managed care programs. Moreover, state D-SNP contracting options also may be influenced by (1) whether the state currently contracts with D-SNPs, (2) the proportion of dually eligible individuals currently enrolled in D-SNPs, (3) the size of the state's dually eligible population and the shares of that population that are eligible for full or partial Medicaid benefits, and (4) the extent to which partial-benefit dually eligible individuals are already enrolled in D-SNPs.

The following scenarios are hypothetical, intended to illustrate how varying state circumstances can determine which D-SNP contracting options are possible (and, in some cases, which options are most practical). They present four situations: two in which states currently enroll dually eligible individual in Medicaid managed care plans, and two in which the states do not. Note that these scenarios do not necessarily cover all possible options and situations.

All states, regardless of their circumstances, can use the following contracting strategies to enhance the breadth and quality of care coordination provided to dually eligible D-SNP enrollees. Because these contracting strategies are possible in all states, we have not included them in any of the scenarios below.

Require D-SNPs to use enhanced care coordination methods and/or integrate Medicaid requirements into care coordination processes

Require D-SNPs to send data or reports to the state for oversight purposes

Require state review of Medicaid information in certain D-SNP marketing and enrollee communication materials

Collaborate with D-SNPs to develop D-SNP supplemental benefit packages that complement Medicaid benefits already available to full-benefit dually eligible (FBDE) individuals in the state

Incorporate Medicaid quality improvement priorities into D-SNP contracts

D-SNP contracting options for states that currently enroll dually eligible individuals into Medicaid managed care programs

State A

State A enrolls dually eligible individuals into a Medicaid managed care program with four contracted managed care plans. This program enrolls all Medicaid-eligible populations, including Aged, Blind and Disabled (ABD) adults and Medicaid expansion adults.

In addition, State A currently contracts with nine D-SNPs, including four offered by parent companies that also operate Medicaid managed care plans in the state. No D-SNP has more than 2,000 enrollees, and more than 90 percent of the state's D-SNP enrollees are FBDE individuals; only 950 partial-benefit dually eligible individuals are enrolled in D-SNPs. State A has very few rural areas, and all of its Medicaid managed care plans and D-SNPs currently operate statewide.

D-SNP contracting strategies that state A could consider:

Limit D-SNP enrollment to full-benefit dually eligible individuals. Because the vast majority of current D-SNP enrollees are FBDE individuals, state A could limit enrollment in D-SNPs to FBDE individuals relatively easily, without worrying about the potential to disrupt coverage for large numbers of partial-benefit dually eligible individuals already enrolled in D-SNPs (a concern in states in which large portions of current D-SNP enrollees are partial-benefit dually eligible individuals).

Selectively contract only with D-SNPs that also offer Medicaid managed care plans. Limiting the number of D-SNPs with which the state contracts to those with parent companies that also offer Medicaid managed care plans would help to promote the possibility of aligned enrollment and may also simplify state oversight of D-SNP performance and quality.

Require complete service area alignment of D-SNPs and affiliated Medicaid managed care plans. Alongside selective contracting, requiring D-SNPs and Medicaid managed care plans to operate in the same service areas ensures that dually eligible individuals residing in any portion of a D-SNP's service area can enroll in the D-SNP's affiliated Medicaid managed care plan (and vice versa). Additionally, because all of state A's D-SNPs and Medicaid managed care plans operate on a statewide basis, it is unlikely that the plans in state A would push back on this requirement.

Require exclusively aligned enrollment. If state A elects the first three options above (limiting enrollment in D-SNPs to FBDE individuals, selective contracting, and complete service area alignment), the state may also wish to consider requiring D-SNPs to operate with exclusively aligned enrollment to promote integration of Medicare and Medicaid benefits and simplify care coordination and enrollee materials.

Implement default enrollment. Because state A has overlap in the parent companies offering D-SNPs, Medicaid managed care plans for dually eligible individuals, and Medicaid managed care plans for people who may become dually eligible (for example, ABD and Medicaid expansion populations under age 65), the state can promote aligned enrollment and continuity of care by implementing default enrollment into D-SNPs for Medicaid-only beneficiaries when they first become eligible for Medicare if its D-SNPs meet all of the requirements described at 42 CFR 422.66(c)(2).

Employ Medicaid auto-assignment to align Medicare and Medicaid enrollment. If state A does not require D-SNPs to operate with exclusively aligned enrollment, it could assign dually eligible individuals who do not choose a plan during their annual Medicaid enrollment period to the Medicaid managed care plan operated by the same parent company as the person's D-SNP, which would promote aligned enrollment.

Work with D-SNPs (and Medicaid managed care plans) to set up automated crossover claims payment processes for Medicaid payment of Medicare cost sharing. If state A does not require D-SNPs to operate with exclusively aligned enrollment, automated crossover claims processes can streamline payment processes for providers and administration of benefits for D-SNPs and Medicaid managed care plans.

D-SNP contracting strategies that would be impractical in state A:

Direct contracting. Because state A already has an existing Medicaid managed care program that enrolls dually eligible individuals, using direct contracting to capitate D-SNPs for coverage of enrollees' Medicaid benefits would be duplicative.

State B

State B enrolls dually eligible individuals into a Medicaid managed care program that contracts with three plans, two of which also operate managed care plans that enroll Medicaid expansion adults under age 65. State B also contracts with seven D-SNPs, two of which also operate Medicaid managed care plans serving dually eligible individuals and Medicaid expansion adults.

State B has been contracting with D-SNPs for eight years, and each D-SNP has more than 10,000 enrollees. Approximately 40 percent of the dually eligible individuals enrolled in these D-SNPs are partial-benefit dually eligible individuals.

D-SNP contracting strategies that state B could consider:

Default enrollment. Because there is overlap in the parent companies offering D-SNPs, Medicaid managed care plans for dually eligible individuals, and Medicaid managed care plans for Medicaid expansion adults (who may become dually eligible), state B can promote aligned enrollment and continuity of care by implementing default enrollment into D-SNPs when Medicaid-only beneficiaries become Medicare eligible if its D-SNPs meet all of the requirements described at 42 CFR 422.66(c)(2).

Medicaid auto-assignment. State B could use Medicaid auto-assignment to periodically align Medicaid managed care enrollment with dually eligible individuals' D-SNP enrollment.

Working with D-SNPs (and Medicaid managed care plans) to set up automated crossover claims payment processes for Medicaid payment of Medicare cost sharing. If state B does not require D-SNPs to operate with exclusively aligned enrollment, automated crossover claims processes can streamline payment processes for providers and administration of benefits for D-SNPs and Medicaid managed care plans.

D-SNP contracting strategies that would be impractical in state B:

Limiting D-SNP enrollment to FBDE individuals. Because state B has a large number of partial-benefit dually eligible individuals enrolled in D-SNPs already, state B may not wish to limit enrollment in D-SNPs to FBDE individuals, as that could disrupt Medicare coverage for all of the partial-benefit dually eligible individuals enrolled in D-SNPs. As an alternative, to simplify enrollee materials and administration of benefits for full- and partial-benefit D-SNP enrollees, state B may wish to consider requiring its D-SNPs to use separate plan benefit packages (PBPs) to serve full- and partial-benefit dually eligible members.

Selectively contracting only with D-SNPs that also offer Medicaid managed care plans. Because five of the seven D-SNPs in state B do not have Medicaid managed care contracts within the state, and those D-SNPs all serve large numbers of dually eligible individuals, selectively contracting only with D-SNPs that also offer Medicaid managed care plans could result in a large number of dually eligible individuals losing their current D-SNP coverage.

Complete service area alignment of D-SNPs and Medicaid managed care plans. If state B does not choose to use selective contracting, complete service area alignment is irrelevant.

Alignment of procurement cycles. If state B does not choose to use selective contracting, alignment of procurement cycles is irrelevant.

Direct contracting. Because state B already has an existing Medicaid managed care program that enrolls dually eligible individuals, using direct contracting to capitate D-SNPs for coverage of Medicaid benefits would be duplicative and unnecessary.

Exclusively aligned enrollment. If state B does not use selective contracting or direct contracting, requiring D-SNPs to operate with exclusively aligned enrollment is not feasible.

D-SNP contracting options for states that do not currently enroll dually eligible individuals into Medicaid managed care programs

Because states C and D (below) do not enroll dually eligible individuals into Medicaid managed care programs, they will not be able to use any of the following D-SNP contracting strategies:

Selectively contracting only with D-SNPs that also offer Medicaid managed care plans

Complete service area alignment of D-SNPs and Medicaid managed care plans

Alignment of procurement cycles

Medicaid auto-assignment

State C

State C does not contract with managed care plans for any of its Medicaid populations. However, State C contracts with three D-SNPs, and each D-SNP currently has between 400 and 1,200 enrollees. Twenty percent of all dually eligible individuals in State C are partial-benefit dually eligible individuals.

D-SNP contracting strategies that state C could consider:

Limiting D-SNP enrollment to FBDE individuals. Because the D-SNPs in state C currently have relatively low enrollment and the vast majority of dually eligible individuals in state C are FBDE individuals, limiting enrollment in D-SNPs to FBDEs should not disrupt coverage for many partial-benefit dually eligible individuals.

Direct contracting. Because state C does not contract with managed care plans to deliver Medicaid benefits, the state may wish to consider contracting directly with D-SNPs (by making capitated payments to D-SNPs) to cover Medicaid benefits for D-SNP enrollees. Direct contracting facilitates integration of Medicare and Medicaid benefits and reduces the incentive to shift costs across programs and payers. Additionally, because D-SNP enrollment is completely voluntary for beneficiaries, direct contracting does not require them to receive their Medicaid benefits through a managed care entity. If state C does not have existing managed care infrastructure and experience to build from, the state may want to start by directly contracting with D-SNPs to cover only certain benefits at first, then build up to more comprehensive capitation over time—for example, by contracting directly with D-SNPs for coverage of Medicare cost sharing first, before expanding the contracts to include other Medicaid benefits.

Exclusively aligned enrollment. If state C chooses to contract directly with D-SNPs to cover Medicaid benefits, the D-SNPs will operate with exclusively aligned enrollment as a result of the direct contracting model.

Working with D-SNPs (and Medicaid managed care plans) to set up automated crossover claims payment processes for Medicaid payment of Medicare cost sharing. If state C does not choose to implement direct contracting or require D-SNPs to operate with exclusively aligned enrollment, automated crossover claims processes between the D-SNPs and the state can streamline administration of benefits and payment processes for providers. (If state C does choose to implement direct contracting and exclusively aligned enrollment, this strategy would not be necessary, as D-SNPs would be responsible for covering Medicare cost sharing for their enrollees.)

D-SNP contracting strategies that are not possible in state C:

Default enrollment. Because state C does not contract with managed care plans for any of its Medicaid populations, state C will not be able to implement default enrollment, even if it uses direct contracting to make capitated payments to D-SNPs for coverage of Medicaid benefits for D-SNP enrollees.

State D

State D does not enroll dually eligible individuals into Medicaid managed care plans; it provides all Medicaid coverage for dually eligible individuals on a fee-for-service basis. State D does enroll other Medicaid populations into managed care plans, however, including Medicaid expansion adults. Each of the four parent companies operating plans in state D's Medicaid managed care program also offer D-SNPs. State D's four D-SNPs have enrollment ranging from 6,000 enrollees to 22,000 enrollees, and nearly half of the enrollment in the two largest D-SNPs is made up of partial-benefit dually eligible individuals.

D-SNP contracting strategies that state D may wish to consider:

Direct contracting. Because state D does not use managed care to deliver Medicaid benefits to dually eligible individuals, the state may wish to consider contracting directly with D-SNPs (by making capitated payments) to cover Medicaid benefits for D-SNP enrollees. Direct contracting facilitates integration of Medicare and Medicaid benefits and reduces the incentive to shift costs across programs and payers. Additionally, because D-SNP enrollment is completely voluntary for beneficiaries, direct contracting does not require them to receive their Medicaid benefits through a managed care entity.

If state D chooses to use direct contracting, state D may also wish to consider the following:

Exclusively aligned enrollment. If state C chooses to capitate D-SNPs for coverage of Medicaid benefits and require D-SNPs to use separate PBPs for full- and partial-benefit dually eligible individuals (an alternative to limiting enrollment in D-SNPs to FBDE individuals), the D-SNPs will operate with exclusively aligned enrollment.

Default enrollment. Because there is overlap in the parent companies offering D-SNPs and Medicaid managed care plans for Medicaid expansion adults (who may become dually eligible), if (and only if) state D chooses to directly contract with its D-SNPs to cover Medicaid benefits for D-SNP enrollees, state D can promote aligned enrollment and continuity of care by implementing default enrollment into D-SNPs when Medicaid-only beneficiaries become

Medicare eligible if its D-SNPs meet all of the requirements described at 42 CFR 422.66(c)(2).

If state D does not choose to use direct contracting, state D may wish to consider the following:

Working with D-SNPs (and Medicaid managed care plans) to set up automated crossover claims payment processes for Medicaid payment of Medicare cost sharing. If state D does not implement direct contracting or require D-SNPs to operate with exclusively aligned enrollment, automated crossover claims processes can streamline administration of benefits and payment processes for providers. (If state D does implement direct contracting and exclusively aligned enrollment, this strategy would not be necessary, as D-SNPs would be responsible for covering Medicare cost sharing for their enrollees.)

D-SNP contracting strategies that would be impractical in state D:

Limiting D-SNP enrollment to FBDE individuals. Because state D has a large number of partial-benefit dually eligible individuals enrolled in D-SNPs already, state D may not wish to limit enrollment in D-SNPs to FBDE individuals, as that could disrupt coverage for all of the partial-benefit dually eligible individuals currently enrolled in D-SNPs. As an alternative, state D may wish to consider requiring its D-SNPs to use separate PBPs to serve full- and partial-benefit dually eligible members.

Appendix E

State Characteristics and Integrated Care Models

This page has been left blank for double-sided copying

Table E.1 lists key state characteristics and indicators that may influence state adoption of certain D-SNP contracting strategies. The definitions of the indicators in each column of Table E.1, and the relevance of each to state D-SNP contracting decisions, are briefly described below. Data sources are listed at the end of the table.

1. **Current state contracts with D-SNPs (column 1)**: Indicates whether each state contracts with D-SNPs in 2021 and whether those D-SNPs have qualified as fully integrated D-SNPs (FIDE SNPs) or highly integrated D-SNPs (HIDE SNPs) for the 2021 contract year by covering at least some Medicaid long-term services and supports or behavioral health benefits. Coordination-only D-SNPs are D-SNPs that do not cover Medicaid benefits but must at least coordinate Medicaid benefits in accordance with federal rules (42 CFR 422.107).
2. **Relevance to state D-SNP contracting decisions**: Existing contracts with D-SNPs provide a platform on which states can begin to build integrated care programs for dually eligible individuals. FIDE SNPs and HIDE SNPs must cover at least some Medicaid benefits through the D-SNP or an affiliated Medicaid managed care plan, which enables greater integration with Medicare benefits.
3. **Proportion of dually eligible individuals enrolled in D-SNPs (column 2)**: Indicates the proportion of all dually eligible individuals enrolled in D-SNPs in each state, using 2020 D-SNP enrollment data and 2019 data on the total number of dually eligible individuals, by state. In states that limit D-SNP enrollment to full-benefit dually eligible (FBDE) individuals, the proportion of FBDE individuals enrolled in D-SNPs may be higher than the estimates shown because the denominator includes both full-benefit and partial-benefit dually eligible individuals.
   - **Relevance to state D-SNP contracting decisions**: States with higher proportions of dually eligible populations already enrolled in D-SNPs are better positioned to leverage D-SNP contracts to further integrate care for a significant share of the state's dually eligible individuals. However, states with a high share of dually eligible individuals already enrolled in D-SNPs may be more hesitant to implement certain D-SNP contracting strategies—for example, selectively contracting only with D-SNPs that offer affiliated Medicaid managed care plans or restricting D-SNP enrollment to FBDE individuals—that could disrupt coverage arrangements for existing D-SNP enrollees.
4. Proportion of the state's older adult population residing in rural areas (column 3): Indicates the average number of each state's older adult population (adults age 65 and older) residing in rural areas as a share of the state's total population age 65 and older between 2012 and 2016.
   - **Relevance to state D-SNP contracting decisions**: Data on the proportion of dually eligible individuals of all ages residing in rural areas in each state are not readily available. However, the share of older adults living in rural areas can help to highlight potential challenges in implementing certain D-SNP contracting strategies in these areas, such as provider shortages that hinder D-SNPs' ability to satisfy federal network adequacy requirements. As a result, certain D-SNP contracting strategies, like selective contracting and requiring complete service area alignment, may be impracticable in states with high shares of older adults residing in rural areas.
5. **Medicaid managed care programs that enroll FBDE individuals (column 4)**: Indicates whether a state has one or more comprehensive Medicaid managed care programs enrolling FBDE individuals on a mandatory or voluntary basis. "Varies" indicates multiple Medicaid managed care programs in the state that enroll FBDE individuals, some on a voluntary basis and others on a mandatory basis. "No MMC program" indicates states that do not have any Medicaid managed care, and "No MMC program for this population" indicates states that do not enroll FBDE individuals in Medicaid

managed care programs. Financial Alignment Initiative (FAI) demonstrations and behavioral health organizations (BHOs) are not considered Medicaid managed care programs for the purposes of this column, as states would not "align" FAI demonstration plans with D-SNPs the way that they could align Medicaid managed care plans with D-SNPs, and BHOs do not cover comprehensive benefits.

- *Relevance to state D-SNP contracting decisions*: Certain D-SNP contracting strategies are possible only in states that enroll dually eligible individuals in Medicaid managed care programs, including selective contracting, complete service area alignment, aligning Medicaid procurement cycles with Medicare timelines, Medicaid auto-assignment, and default enrollment.

6. **Medicaid managed care program(s) enroll ABD adults, ACA adults, or both (column 5):** Indicates whether individuals who are not dually eligible, but enrolled in Medicaid through an Aged, Blind, and Disabled (ABD) or Medicaid expansion (Affordable Care Act [ACA] adult) pathway are enrolled into comprehensive Medicaid managed care programs on a mandatory or voluntary basis. States with an "ABD" indicator enroll ABD-eligible individuals into managed care, but not ACA adults. States with an "ACA" indicator enroll ACA adults into managed care programs, but not ABD-eligible individuals. States with an indicator of "Both" enroll ACA adults and ABD-eligible adults into managed care programs on either a mandatory or voluntary basis. States with an indicator of "Neither" do not enroll ACA adults or ABD-eligible adults into managed care programs. "No MMC program" indicates states that do not have any Medicaid managed care. Financial Alignment Initiative demonstrations and behavioral health organizations BHOs are not considered Medicaid managed care programs for the purposes of this column, for the reasons cited in the explanation for column 4 above.

   - ***Relevance to state D-SNP contracting decisions*:** In order to be default enrolled into a D-SNP, an individual who is becoming dually eligible must already be enrolled in a comprehensive benefit Medicaid managed care program through the same parent company as the D-SNP. If a state does not currently enroll non-dually eligible Medicaid populations in managed care, that state will not be able to implement default enrollment. It is important to note, however, that while column 5 provides a summary of which states have taken this initial step, the data in column 5 may not be used in isolation to identify states that can implement default enrollment into D-SNPs. To implement default enrollment, the D-SNPs in a state must meet all of the requirements described at 42 CFR 422.66(c)(2) and overlap must exist in the parent companies operating D-SNPs and Medicaid managed care plans, as well as in their service areas.

7. **Financial Alignment Initiative demonstrations** (column 6): Indicates whether a state operates FAI demonstrations in 2021, including the type of model—capitated, managed fee-for-service, or administrative alignment. In capitated models, Medicare-Medicaid Plans (MMPs) are responsible for covering substantially all Medicare and Medicaid benefits for FBDE enrollees through three-way capitated contracts with the state and the Centers for Medicare & Medicaid Services. One state (Washington) operates a managed fee-for-service model, which provides comprehensive care coordination to certain dually eligible individuals who meet specific criteria; the state is eligible to receive a portion of the Medicare savings that are generated. One state (Minnesota) operates an administrative alignment model in which the state leverages its existing FIDE SNPs to fully integrate Medicare and Medicaid services, and aligns enrollee materials and other elements across both programs.

   - *Relevance to state D-SNP contracting decisions*: States that already operate FAI demonstrations may not want to contract with D-SNPs in the same geographic regions where demonstration MMPs operate to avoid competition between the two models.

8. Programs of All-Inclusive Care for the Elderly (PACE) (column 7): Indicates whether a state has one or more PACE organizations operating in 2021. The PACE model provides fully integrated Medicare and Medicaid services to individuals who are age 55 and older and require a nursing home level of care and reside in the community. In 2018, 81 percent of PACE enrollees were dually eligible (CMS 2018).

- *Relevance to state D-SNP contracting decisions*: PACE is a unique integrated care model that enrolls a small share of dually eligible enrollees and generally does not influence states' use of other models, but we have included it in Table E.1 to provide a comprehensive overview of states' use of the three main integrated care models for dually eligible individuals.

Table E.1. State characteristics and use of integrated care models to serve dually eligible individuals

State	Current state contracts with D-SNPs (2021)	Percentage of dually eligible individuals enrolled in D-SNPs (2019–2020)	Percentage of state's older adult population residing in rural areas (2012–2016)	Medicaid managed care program(s) enroll FBDE individuals on a mandatory or voluntary basis (2018–2021)	Medicaid managed care program(s) enroll ABD adults, ACA adults, or both (2018)	Financial Alignment Initiative demonstration (2021)	PACE (2020)
AK	*n.a.*	0.0	37.1	*No MMC program*	*No MMC program*	*n.a.*	No
AL	Coordination-only D-SNPs	38.6	45.0	*No MMC program*	*No MMC program*	*n.a.*	Yes
AR	Coordination-only D-SNPs	19.6[a]	50.5	Yes - Mandatory for select populations[b]	ABD[b]	*n.a.*	Yes
AZ	FIDE SNPs and HIDE SNPs	45.4	13.1	Yes - Mandatory	Both	*n.a.*	No
CA	FIDE SNPs and coordination-only D-SNPs	9.4	7.1	Yes - Varies	Both	Capitated model	Yes
CO	Coordination-only D-SNPs	18.3	18.6	Yes - Varies	Both	*n.a.*	Yes
CT	Coordination-only D-SNPs	25.0	13.0	*No MMC program*	*No MMC program*	*n.a.*	No
DC	Coordination-only D-SNPs	38.1[c]	0.0	*No MMC program for this population*	Both	*n.a.*	No
DE	Coordination-only D-SNPs	18.5[c]	20.6	Yes - Mandatory	Both	*n.a.*	Yes
FL	FIDE SNPs, HIDE SNPs, and coordination-only D-SNPs	46.1	9.3	Yes - Mandatory	ABD	*n.a.*	Yes
GA	Coordination-only D-SNPs	30.2[d]	32.3	*No MMC program for this population*	Neither	*n.a.*	No
HI	HIDE SNPs	60.5	8.8	Yes - Mandatory	Both	*n.a.*	No
IA	Coordination-only D-SNPs	19.3	41.1	Yes - Mandatory	Both	*n.a.*	Yes
ID	FIDE SNPs	19.9	35.7	Yes - Mandatory	Neither	*n.a.*	No
IL	*n.a.*	0.0	14.7	Yes - Mandatory	Both	Capitated model	No
IN	Coordination-only D-SNPs	14.0	31.0	*No MMC program for this population*	Both	*n.a.*	Yes

State	Current state contracts with D-SNPs (2021)	Percentage of dually eligible individuals enrolled in D-SNPs (2019–2020)	Percentage of state's older adult population residing in rural areas (2012–2016)	Medicaid managed care program(s) enroll FBDE individuals on a mandatory or voluntary basis (2018–2021)	Medicaid managed care program(s) enroll ABD adults, ACA adults, or both (2018)	Financial Alignment Initiative demonstration (2021)	PACE (2020)
KS	HIDE SNPs	13.2	32.3	Yes - Mandatory	Both	*n.a.*	Yes
KY	HIDE SNPs and coordination-only D-SNPs	23.2	44.4	Yes - Mandatory	Both	*n.a.*	No
LA	Coordination-only D-SNPs	37.4	28.9	*No MMC program for this population*[e]	Both	*n.a.*	Yes
MA	FIDE SNPs	19.5	9.1	*No MMC program for this population*	Both	Capitated model	Yes
MD	Coordination-only D-SNPs	5.9[c]	15.8	*No MMC program for this population*	Both	*n.a.*	Yes
ME	Coordination-only D-SNPs	21.7	62.7	*No MMC program*	*No MMC program*	*n.a.*	No
MI	Coordination-only D-SNPs	14.6	29.9	Yes - Voluntary	Both	Capitated model	Yes
MN	FIDE SNPs and HIDE SNPs	35.1	32.4	Yes - Mandatory for select populations[f]	Both[b]	Administrative alignment model	No
MO	Coordination-only D-SNPs	26.7[a]	34.2	*No MMC program for this population*	ABD	*n.a.*	No
MS	Coordination-only D-SNPs	20.0	54.7	*No MMC program for this population*	ABD	*n.a.*	No
MT	Coordination-only D-SNPs	6.7	49.6	*No MMC program*	*No MMC program*	*n.a.*	No
NC	Coordination-only D-SNPs	22.4[g]	39.2	*No MMC program*[h]	*No MMC program*	*n.a.*	Yes
ND	*n.a.*	*n.a.*	46.5	*No MMC program for this population*	ACA	*n.a.*	Yes
NE	HIDE SNPs and coordination-only D-SNPs	22.2	35.0	Yes - Mandatory	Both	*n.a.*	Yes
NH	*n.a.*	*n.a.*	43.3	Yes - Mandatory	Both	*n.a.*	No
NJ	FIDE SNPs	25.5	5.8	Yes - Mandatory	Both	*n.a.*	Yes
NM	HIDE SNPs	29.3	25.6	Yes - Mandatory	Both	*n.a.*	Yes

State	Current state contracts with D-SNPs (2021)	Percentage of dually eligible individuals enrolled in D-SNPs (2019–2020)	Percentage of state's older adult population residing in rural areas (2012–2016)	Medicaid managed care program(s) enroll FBDE individuals on a mandatory or voluntary basis (2018–2021)	Medicaid managed care program(s) enroll ABD adults, ACA adults, or both (2018)	Financial Alignment Initiative demonstration (2021)	PACE (2020)
NV	Coordination-only D-SNPs	*n.a* [i]	8.2	*No MMC program for this population*	ACA	*n.a.*	No
NY	FIDE SNPs, HIDE SNPs, and Coordination-only D-SNPs	40.4	14.2	Y - Varies	Both	Capitated model	Yes
OH	Coordination-only D-SNPs	22.3 [j]	23.5	Yes - Mandatory	Both	Capitated model	Yes
OK	Coordination-only D-SNPs	8.7	39.8	*No MMC program*	*No MMC program*	*n.a.*	Yes
OR	HIDE SNPs and coordination-only D-SNPs	16.0	26.8	Yes - Voluntary	Both	*n.a.*	Yes
PA	FIDE SNPs, HIDE SNPs, and coordination-only D-SNPs	36.0	23.5	Yes - Mandatory	Both	*n.a.*	Yes
PR	HIDE SNPs	78.0[k]	*Data not available*	Yes - Mandatory	Both	*n.a.*	No
RI	Coordination-only D-SNPs	11.0	9.9	*No MMC program for this population* [l]	Both	Capitated model	Yes
SC	Coordination-only D-SNPs	28.1[d]	36.1	*No MMC program for this population*	ABD	Capitated model	Yes
SD	*n.a.*	*n.a.*	49.4	*No MMC program*	*No MMC program*	*n.a.*	Yes
TN	FIDE SNPs and coordination-only D-SNPs	43.3	39.2	Yes - Mandatory	ABD	*n.a.*	Yes
TX	HIDE SNPs and coordination-only D-SNPs	35.4	21.5	Yes - Varies	ABD	Capitated model	Yes
UT	Coordination-only D-SNPs	20.6	13.1	Yes - Varies	Both	*n.a.*	No
VA	FIDE SNPs, HIDE SNPs, and coordination-only D-SNPs	28.8[g]	32.7	Yes - Mandatory	Both	*n.a.*	Yes
VT	*n.a.*	*n.a.*	65.3	Yes - Mandatory	Both	*n.a.*	No

State	Current state contracts with D-SNPs (2021)	Percentage of dually eligible individuals enrolled in D-SNPs (2019–2020)	Percentage of state's older adult population residing in rural areas (2012–2016)	Medicaid managed care program(s) enroll FBDE individuals on a mandatory or voluntary basis (2018–2021)	Medicaid managed care program(s) enroll ABD adults, ACA adults, or both (2018)	Financial Alignment Initiative demonstration (2021)	PACE (2020)
WA	HIDE SNPs and coordination-only D-SNPs	33.1	20.6	*No MMC program for this population*[e]	Both	Managed fee-for-service model	Yes
WI	FIDE SNPs, HIDE SNPs, and coordination-only D-SNPs	27.7	35.1	Yes - Voluntary	Both	*n.a.*	Yes
WV	Coordination-only D-SNPs	14.7[j]	52.5	*No MMC program for this population*	Both	*n.a.*	No
WY	*n.a.*	*n.a.*	40.6	*No MMC program*	*No MMC program*	*n.a.*	Yes

Source:

- Types of D-SNPs available in each state were drawn from the November 2020 CMS MMCO list of D-SNPs' integration status by state for calendar year 2021: https://www.cms.gov/files/document/smacdsnpintegrationstatusesdata.xlsx.
- Data on state Medicaid managed care plans enrolling dually eligible individuals and ACA and ABD-eligible adults were drawn from the 2018 Medicaid managed care enrollment report (https://www.medicaid.gov/medicaid/managed-care/enrollment-report/index.html) and supplemented with Mathematica staff knowledge of more recently launched Medicaid managed care programs.
- Data on state Financial Alignment Initiative demonstrations were drawn from the CMS MMCO Financial Alignment Initiative webpage (January 15, 2021): https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/FinancialModelstoSupportStatesEffortsinCareCoordination.
- Data on PACE programs were drawn from the CMS Monthly Enrollment by Contract Report, December 2020: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Enrollment-by-Contract.
- Data on the proportion of older adults residing in rural areas between 2012 and 2016 were drawn from "Older Population in Rural America," available at https://www.census.gov/library/stories/2019/10/older-population-in-rural-america.html.
- The numerators for the proportions of dually eligible individuals enrolled in D-SNPs in each state were drawn from the December 2020 CMS SNP Comprehensive Report (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Special-Needs-Plan-SNP-Data) and the denominators were drawn from the December 2019 CMS Quarterly Enrollment Snapshots Report: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Analytics.

[a] The numerator for this percentage includes individuals enrolled in the UnitedHealthcare Dual Complete Choice Regional PPO D-SNP, which enrolls dually eligible individuals in Arkansas and Missouri. For the purpose of this table, we divided those enrollees evenly between the two states. Therefore, the percentage of dually eligible D-SNP enrollees in Arkansas and Missouri may be slightly lower or higher than the numbers presented here.

[b] In 2019, Arkansas implemented their mandatory PASSE program for certain individuals with developmental disabilities (DD) or who use certain behavioral health (BH) services. Medicaid enrollees who qualify for specific DD or BH services, including dually eligible individuals who qualify for those services, must enroll in a PASSE plan. The program provides comprehensive coverage for individuals with DD.

[c] The numerator for this percentage includes individuals enrolled in the Cigna-HealthSpring TotalCare Plus HMO D-SNP, which enrolls dually eligible individuals from Delaware and the District of Columbia, as well as individuals enrolled in the Cigna-HealthSpring TotalCare HMO D-SNP, which enrolls dually eligible individuals from Delaware, Maryland, and the District of Columbia. For the purpose of this table, we divided those enrollees evenly between the states in which the D-SNPs operate. Therefore, the percentage of dually eligible D-SNP enrollees in the District of Columbia, Delaware, and Maryland may be slightly lower or higher than the number presented here.

[d] The numerator for this percentage includes individuals enrolled in the UnitedHealthcare Dual Complete Choice Regional PPO D-SNP, which enrolls dually eligible individuals from Georgia and South Carolina. For the purposes of this table, we divided those enrollees evenly between the two states. Therefore, the percentages of dually eligible D-SNP enrollees in Georgia and South Carolina may be slightly lower or higher than the number presented here.

[e] Louisiana and Washington operate behavioral health organization (BHO) models that enroll FBDE individuals, but we only included comprehensive managed care programs in this table.

[f] Minnesota requires dually eligible individuals and ABD-eligible individuals who are age 65 or older to enroll in their Minnesota Senior Care Plus program unless those individuals enroll in the state's fully integrated D-SNP programs (Minnesota Senior Health Options and Special Needs Basic Care Plus).

[g] The numerator for this percentage includes individuals enrolled in the UnitedHealthcare Dual Complete RP Regional PPO D-SNP, which enrolls dually eligible individuals from North Carolina and Virginia. For the purpose of this table, we divided those enrollees evenly between the two states. Therefore, the percentage of dually eligible D-SNP enrollees in North Carolina and Virginia may be slightly lower or higher than the number presented here.

[h] North Carolina implemented a new Medicaid managed care program in 2019, but at the time of this report, dually eligible individuals were not covered through this program.

[i] Nevada did not have contracts with D-SNPs prior to 2021.

[j] The numerator for this percentage includes individuals enrolled in the Health Plan SecureCare SNP HMO D-SNP, which enrolls dually eligible individuals from Ohio and West Virginia. For the purpose of this table, we divided those enrollees evenly between the two states. Therefore, the percentage of dually eligible D-SNP enrollees in Ohio and West Virginia may be slightly lower or higher than the number presented here.

[k] Data on the number of dually eligible individuals in Puerto Rico are not available in the CMS Quarterly Enrollment Snapshot report from 2019 we used as the data source for the denominator in calculating the percentages in this column. Therefore, we used data from the 2018 Medicaid managed care enrollment report as the denominator and data from the December 2018 SNP Comprehensive Report for the numerator.

[l] Rhode Island ended its Medicaid managed care program in September 2018.

ABD = Aged, Blind, or Disabled; ACA = Affordable Care Act; D-SNPs = Dual Eligible Special Needs Plans; FBDE individuals = Full-benefit dually eligible individuals; FIDE SNPs = fully Integrated D-SNPs; HIDE SNPs = highly integrated D-SNPs; MMC = Medicaid managed care; *n.a.* = not applicable; PACE = Program of All-Inclusive Care for the Elderly

Mathematica

Princeton, NJ • Ann Arbor, MI • Cambridge, MA
Chicago, IL • Oakland, CA • Seattle, WA
Tucson, AZ • Woodlawn, MD • Washington, DC

EDI Global, a Mathematica Company

Bukoba, Tanzania • High Wycombe, United Kingdom

mathematica.org