Preventing and Addressing Unnecessary Medicaid Eligibility Churn Among Dually Eligible Individuals: Opportunities for States

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IN BRIEF

People who are dually eligible for Medicare and Medicaid benefits often have multiple chronic physical and behavioral health conditions, and many use long-term services and supports (LTSS).[1] Unfortunately, a relatively high proportion of dually eligible individuals cycle in and out of Medicaid eligibility, often due to lack of response to state Medicaid renewal notices. This creates disruptions in coverage and care, which can result in adverse health outcomes and increased costs for individuals and states.

This technical assistance brief summarizes steps that states can take in partnership with Dual Eligible Special Needs Plans (D-SNPs) to: (1) prevent unnecessary Medicaid eligibility loss among dually eligible populations; and (2) mitigate the impact of temporary Medicaid eligibility losses among D-SNP enrollees when such losses occur.

Introduction

More than 12 million people in the United States are dually eligible for Medicare and Medicaid benefits. This population has high rates of comorbid physical and behavioral health conditions, and more than 40 percent of dually eligible individuals use long-term services and supports (LTSS).[2] For individuals with multiple chronic conditions and/or need for complex behavioral health services or LTSS, continuity of care is paramount to maintaining well-being and preventing costly, avoidable inpatient care.

Unfortunately, a relatively high proportion of dually eligible individuals cycle in and out of Medicaid eligibility, creating disruptions in coverage and care. For example, researchers have found that 15.6 percent of full-benefit dually eligible (FBDE) individuals lost Medicaid eligibility at least once in a 36-month period, and 51.3 percent of FBDE individuals who lost Medicaid eligibility regained coverage within three months.[3] Another study found that lack of beneficiary response to eligibility redetermination notices was the most commonly reported reason for loss of Medicaid eligibility among FBDE individuals, and nearly 30 percent of individuals who lost Medicaid eligibility in their first 12 months of dual eligibility only lost Medicaid coverage for a period of one to three months, implying that those eligibility losses may likely have been related to administrative processes rather than a genuine change in the individuals' financial or categorical eligibility for state Medicaid programs.[4]

Unnecessary Medicaid coverage churn can result in adverse health outcomes for dually eligible individuals and increased long-term costs for Medicaid programs. It can also leave low-income older adults and people

with disabilities facing exorbitant medical costs during periods of lost eligibility. Additionally, when dually eligible individuals enrolled in integrated care plans, such as integrated Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs) lose Medicaid eligibility, they are ultimately forced to disenroll from their integrated plan, which can disrupt their continuity of care with the plan's network of health care providers, as well as their relationships with plan care managers who help coordinate their care. Given the relatively high needs and costs of dually eligible populations, states may want to consider taking steps to minimize and mitigate unnecessary Medicaid eligibility churn among dually eligible individuals, particularly those enrolled in integrated D-SNPs.

Fortunately, D-SNPs can be effective partners for states in this work. In one of the previously mentioned studies, researchers found that dually eligible individuals enrolled in D-SNPs were less likely to lose Medicaid eligibility than dually eligible individuals enrolled in non-D-SNP Medicare Advantage plans or fee-for-service Medicare, potentially because the D-SNPs were taking actions to help prevent and/or mitigate those losses.[5] In this technical assistance brief, the Integrated Care Resource Center (ICRC) summarizes steps that states can take – in partnership with D-SNPs – to: (1) prevent unnecessary Medicaid eligibility loss among dually eligible populations; and (2) mitigate the impact of temporary Medicaid eligibility losses among D-SNP enrollees when such losses occur.

Partnering with D-SNPs to Prevent Unnecessary Medicaid Eligibility Loss

States can help dually eligible D-SNP enrollees remain enrolled in Medicaid by: (1) requiring D-SNPs to assist their members with recognizing and responding to Medicaid eligibility redetermination notices; (2) providing D-SNPs with timely and accurate information on member eligibility redeterminations to support D-SNP outreach and assistance; and (3) developing and implementing simple, consumer-friendly eligibility redetermination systems.

Strategy 1: Require D-SNPs to Help Members Recognize and Respond to Medicaid Eligibility Redetermination Notices

States can require D-SNPs (and/or their affiliated Medicaid managed care plans) to help members recognize and respond to Medicaid eligibility redetermination notices through State Medicaid Agency Contracts (SMACs) with D-SNPs and/or their contracts with D-SNPs' affiliated Medicaid managed care plans. For example, states like **Pennsylvania** and **New Mexico** have required D-SNPs to: (1) conduct member education regarding maintenance of Medicaid eligibility; (2) monitor Medicaid financial eligibility termination dates and conduct outreach to members approaching their termination date; and (3) assist members with Medicaid applications and redeterminations. States can also establish "pay-for-performance" incentives to encourage D-SNPs to assist their members with Medicaid redetermination processes (see ***Box 1*** for Pennsylvania's SMAC requirements).

D-SNPs are well positioned to help enrollees maintain Medicaid eligibility by assisting with eligibility redetermination processes. D-SNP staff interviewed for this brief cited several effective approaches to supporting plan members with maintaining Medicaid eligibility, including: (1) conducting outreach to remind and educate members of upcoming redetermination dates, (2) working with their network providers and/or community-based organization partners to remind members of renewal dates and (3) directly assisting members with completing redetermination processes.

Box 1. Pennsylvania's Contract Requirements for Promoting D-SNP Outreach and Support to Beneficiaries with the Medicaid Eligibility Redetermination Process

Pennsylvania requires D-SNPs to facilitate Medicaid eligibility redeterminations for their members, and the state also noted in its 2020 Community HealthChoices Managed Long Term Services and Supports (MLTSS) program agreement that the state "may" establish a pay-for-performance program to incentivize their Medicaid managed care plans to help prevent unnecessary Medicaid eligibility loss among their membership:

- **Section B.1.h. of Pennsylvania's 2020 D-SNP SMAC states,** *"The D-SNP must facilitate Medicaid eligibility redeterminations for members, including assisting with applications for medical assistance and conducting member education regarding maintenance of Medicaid eligibility."*

- **Section CC.2.6. of the state's Community HealthChoices Agreement notes,** *"The Department may establish a Pay for Performance (P4P) Program to provide financial incentives for CHC-MCOs to assist Participants to remain financially eligible by successfully completing the redetermination process with their local CAOs. The Department may establish other P4P programs designed to provide incentives to meet quality goals in subsequent years."*

Sources: Pennsylvania Department of Human Services Medicare Improvements for Patients and Providers Act Contract, 2020, Section B.1.h. and Pennsylvania Community HealthChoices Agreement, 2020, Section CC.2.6.

1) **Outreach to members.** D-SNPs can use a variety of outreach methods – such as live or automatic calls, postcard reminders, and text messages – to educate individual plan members about their Medicaid eligibility redetermination dates and the importance of submitting redetermination paperwork or responses by designated deadlines. D-SNPs can also conduct membership-wide outreach and education through newsletters and community presentations and events. D-SNP staff interviewed for this brief stressed the importance of educating and assisting members with Medicaid redeterminations through multiple, simultaneous outreach methods. For example:

   - **Presbyterian Health (New Mexico)** includes Medicaid redetermination dates in its members' care plans. The plan's care coordinators use those care plan notes to remind members during regular check-ins of their Medicaid eligibility redetermination date and ask if they need assistance in re-certifying their eligibility.

   - **UPMC (Pennsylvania)** mails members educational notices 60 days prior to their redetermination date. The notice informs members of their approaching redetermination deadline and stresses the importance of submitting the requested information to keep their Medicaid coverage. The plan also sends a text message reminder to members who have cell phone numbers registered with the plan.

   - **HealthPartners (Minnesota)** educates its members about Medicaid redeterminations upon initial plan enrollment, including informing members of their redetermination date. The plan's care coordinators take a person-centered approach, assess individual need for assistance with submitting the redetermination paperwork, and identify informal supports, such as family members, who can assist members with the redetermination process. If members need additional assistance, the D-SNP covers Independent Living Services (ILS) as a supplemental benefit, and the D-SNP's care coordinators will schedule an ILS assistant to visit the member's home and help them

with their redetermination paperwork. In addition, as members' Medicaid redetermination date approaches, the county eligibility office copies the member's D-SNP care coordinator on notifications sent to the member. The plan's care coordinators are copied on all communication sent by the county and receives a hard copy of beneficiary notices related to Medicaid, SNAP, and other public benefits.

2) **Collaborating with providers and community-based organizations (CBOs).** Plans can share Medicaid redetermination dates directly with individual providers to remind their patients of approaching redetermination dates. Some D-SNPs have also contracted with CBOs, such as Area Agencies on Aging or other providers of community-based services to older adults, disability advocacy groups, or benefit counselors who serve people with disabilities, and/or legal services/legal assistance organizations, to conduct outreach and education regarding Medicaid eligibility redeterminations. Because health care providers and CBOs may have close relationships and be in continuous communication with D-SNP enrollees, and they also often share the D-SNPs' goal of helping members maintain Medicaid eligibility, D-SNPs can leverage contractual relationships with these entities to further educate and assist D-SNP enrollees with the Medicaid redetermination process.

3) **Assisting members with completing Medicaid redetermination processes.** Interviewed D-SNPs also recommend that plans help members maintain Medicaid eligibility by completing and submitting Medicaid redetermination paperwork on a member's behalf when needed.[6] For example:

- **Presbyterian Health (New Mexico)** has Community Health Workers (CHWs) on staff who help with contacting appropriate resources to assist with the Medicaid redetermination process . The plan's CHWs receive specialized training on the Medicaid redetermination process to understand available resources and help members maintain Medicaid eligibility.
- **Cigna HealthSpring (Pennsylvania)** hires a vendor to help members with initial Medicaid enrollment, the Medicaid eligibility redetermination process, and re-enrollment in Medicaid if inappropriately disenrolled. If members need assistance with completing and submitting the paperwork, the vendor sends authorization paperwork that members can complete to permit the vendor to submit Medicaid forms on their behalf.

Strategy 2: Provide D-SNPs with Timely and Accurate Information on Member Eligibility Redeterminations

For D-SNPs to support their members in understanding and responding to redetermination notices, states need to provide D-SNPs (and/or their affiliated Medicaid managed care plans) with up-to-date, accurate information on Medicaid eligibility redetermination dates and processes. States that use rolling redetermination schedules can provide data on D-SNP (or Medicaid managed care plan) enrollees' upcoming redetermination dates through monthly 834 eligibility/enrollment files or by providing plans access to state Medicaid eligibility portals that house this information.[7] States can also help D-SNPs work directly with local county Medicaid eligibility offices (for example, by providing point of contact information at each office) to validate eligibility information and Medicaid redetermination dates.

For example, **HealthPartners (Minnesota)** receives monthly files from the state containing information about when individuals are approaching their Medicaid redetermination date. Minnesota's local Medicaid eligibility offices send this monthly report to D-SNPs, so the plans know when to conduct outreach to members approaching their redetermination date. In addition, D-SNP care coordinators in Minnesota are granted

access to state and county data systems as an "enrolled provider." Because of this, plan care coordinators have direct access to member information, can directly communicate with county workers, and can view important member benefit notices.

Strategy 3: Develop and Implement Simple, Consumer-Friendly Eligibility Redetermination Systems

In addition to partnering with D-SNPs to improve beneficiary responses to redeterminations, states can also develop and implement eligibility redetermination systems that avoid overburdening dually eligible individuals who remain continuously eligible for Medicaid. The following are examples of steps that states can take to develop and implement consumer-friendly eligibility redetermination systems:

1) **Maximize use of ex-parte eligibility renewals with dually eligible populations.**[8] Because many dually eligible individuals have complex conditions and care needs,[9] this population may experience more frequent hospitalizations, which may inhibit their ability to respond to eligibility redetermination notices. Additionally, a higher proportion of dually eligible individuals have Alzheimer's disease or related dementia, than other individuals with Medicaid coverage,[10] making it likely that states' dually eligible populations may require more assistance in navigating redetermination processes than other beneficiary groups. Using ex-parte processes that leverage data already available to the state can help eligible Medicaid enrollees stay enrolled in Medicaid without having to respond during the redetermination process.

2) **Extend protections offered to MAGI eligibility groups to dually eligible individuals.** Federal regulations[11] require states to offer certain protections to Medicaid beneficiaries whose eligibility was determined using the Modified Adjusted Gross Income (MAGI) methodology. While required for MAGI eligibility groups, states can opt to extend some or all of those protections to other Medicaid eligibility groups, as well, including dually eligible individuals.[12] These protections include:

    - **Use of a 12-month renewal periods.** Many dually eligible individuals have fixed incomes and assets that are unlikely to change much over time. Therefore, redetermining eligibility for dually eligible individuals more frequently than once a year (except in cases where a state is made aware of a change in beneficiary circumstances) may impose unnecessary burdens on beneficiaries and state eligibility workers.

    - **Pre-populating redetermination forms to facilitate beneficiary response.**[13] Sending pre-populated forms can simplify the Medicaid eligibility redetermination process and help eligible beneficiaries retain their Medicaid benefits. In 2019, 30 states reported that they pre-populated redetermination forms for older adults and people with disabilities and another five states indicated that they may implement this option in the future.[14]

    - **Providing early beneficiary notification and a reasonable period of time for response.** States must allow individuals in non-MAGI Medicaid eligibility groups "a reasonable period" of time to respond to eligibility redetermination notices, but states can choose to extend the minimum 30-day response period required for MAGI-based eligibility groups for all populations (or at least, for dually eligible populations).[15] States should start the Medicaid redetermination process early enough to complete a redetermination of eligibility prior to the end of the renewal period, including providing the beneficiary with a reasonable amount of time to respond to the renewal notice, if requested.

- **Offering a 90-day reinstatement period.** Extending the 90-day reinstatement period required for MAGI-based eligibility groups to dually eligible individuals can help to prevent unnecessary gaps in coverage for dually eligible individuals who temporarily lose Medicaid coverage (for example, due to an initial lack of beneficiary response to a redetermination notice). It also reduces state administrative burden associated with processing new applications for beneficiaries who remain eligible and must otherwise re-apply for benefits. When states offer dually eligible individuals a 90-day reinstatement period, they can also choose to align D-SNP deeming periods with that reinstatement period to promote continuity of care (see Strategy 5).

3) **Provide multiple methods through which beneficiaries and their representatives can respond to redetermination notices.** States can provide electronic, telephonic, mail, in-person, and/or fax options as redetermination notice response methods to maximize beneficiaries' ability to respond in a timely fashion.

4) **Offer help through objective assisters:** States can offer telephonic and/or in-person assistance for members throughout the renewal process. This kind of assistance can be particularly critical for dually eligible individuals who lack computer access, need help understanding renewal application questions or interpreting notices, and/or need assistance with gathering and providing necessary financial documentation.

Partnering with D-SNPs to Mitigate the Impact of Temporary Losses of Medicaid Eligibility among D-SNP Members

In addition to taking the steps above to prevent unnecessary Medicaid eligibility loss among dually eligible individuals, states can also mitigate the impact of such losses when they do occur. In particular, by requiring or allowing D-SNPs to use eligibility "deeming" periods, states can help to maintain continuity of coverage and care when dually eligible individuals lose Medicaid eligibility for a temporary period of time. States also can implement retroactive enrollment policies to facilitate re-enrollment into the individuals' prior Medicaid managed care (or integrated care) plan when Medicaid eligibility is re-established.

Strategy 4: Require or Allow D-SNPs to offer Eligibility "Deeming" Periods

States can reduce the risk of temporary Medicaid eligibility gaps by requiring or allowing D-SNPs to offer their members an eligibility "deeming" period – a limited period of continued enrollment in the D-SNP following a loss of Medicaid eligibility for individuals who lose Medicaid eligibility but are expected to regain Medicaid coverage within six months (see ***Box 2*** for criteria for implementing deeming periods and deeming period requirements).[16] Meant to reduce unnecessary enrollment churn in situations where dually eligible individuals lose and regain Medicaid eligibility within a short period of time, deeming periods keep D-SNP members connected to critical health care providers, D-SNP supplemental benefits, and care coordination while they seek to regain Medicaid eligibility.

Box 2. Criteria for Implementing Deeming Periods and Deeming Period Requirements

Per Section 50.2.5 of Chapter 2 of the Medicare Managed Care Manual (Medicare Advantage Enrollment and Disenrollment), Medicare Advantage Special Needs Plans, including D-SNPs, can implement deeming periods of one to six months in length (in whole month increments) to continue to provide care for plan members who "no longer [meet] the unique eligibility criteria of the plan (i.e., special needs status) if the individual can reasonably be expected to again meet the special needs criteria within a period of time not to exceed six (6) months." Because Medicaid eligibility is a "special needs" criterion for D-SNP enrollment, D-SNPs may use this authority to implement deeming periods for individuals who have lost Medicaid eligibility but could reasonably be expected to regain Medicaid eligibility within a six-month period. Additionally, because Special Needs Plans must provide members who lose special needs status with at least 30 days advance notice of disenrollment, all D-SNPs effectively implement a deeming period of at least 30 days.

D-SNPs must apply deeming period criteria consistently to all of their plan members and inform plan members of their deeming period policy. They must also provide written notice to plan members regarding a member's loss of special needs status within 10 calendar days of learning about the member's loss of special needs status (for example, a D-SNP member's loss of Medicaid eligibility). That notice should "provide the member an opportunity to prove that he or she is still eligible to be in the plan" and "include information regarding the period of deemed continued eligibility, including its duration, a complete description of the [Medicare Special Enrollment Period] for which such individuals are eligible…, the consequences of not regaining special needs status within the period of deemed continued eligibility and the effective disenrollment date."

A deeming period begins the first day of the month following the month in which information is available to the D-SNP (and communicated to the member) regarding the member's loss of special needs status, including in cases of retroactive Medicaid benefit terminations.

If a D-SNP member does not re-qualify for the D-SNP (by regaining Medicaid eligibility or otherwise meeting the special needs status required for enrollment in the plan) within the deeming period, the D-SNP must involuntarily disenroll the member from the plan and issue a disenrollment notice to the member explaining why they are being disenrolled from the plan (see Exhibit 33 in Chapter 2 of the Medicare Managed Care Manual for a model notice).

Source: Section 50.2.5 of Chapter 2 of the Medicare Managed Care Manual (Medicare Advantage Enrollment and Disenrollment), available at: https://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol.

While the Centers for Medicare & Medicaid Services (CMS) allows D-SNPs to use deeming periods, they are optional; D-SNPs are not required to offer a deeming period unless the state Medicaid agency requires it in its SMAC. The following are two key considerations for states when developing deeming period SMAC requirements.

1) **Deeming period duration.** CMS allows D-SNPs (or states) to determine the duration of the deeming period – a deeming period may be as short as 30 days or as long as 180 days (six months), in 30-day increments.[17] Once selected by the plan or determined by the state, the D-SNP's deeming period is the same for all of the plan's enrollees. Some states, such as **Oregon,** have established a general

policy in their SMACs that requires D-SNPs to offer a deeming period, but allows each D-SNP to determine the length of the deeming period that they will offer. Alternatively, some states, like **Pennsylvania** and **New Jersey**, have established in their SMACs a single deeming period length or range of acceptable period lengths to ensure consistency in application of the deeming period benefit across participating D-SNPs. (See ***Box 3*** for sample contract language from New Jersey, Oregon and Pennsylvania.)

Some states may even wish to align the duration of D-SNPs' deeming periods with the state's policy for reinstatement of Medicaid benefits, an approach that is described in detail in Strategy 5.

2) **Coverage of benefits during deeming periods.** While D-SNPs will continue to receive capitated payments from Medicare during deeming periods, D-SNPs are not required to continue paying for capitated Medicaid services during a Medicaid eligibility gap. For example, when states capitate D-SNPs for coverage of Medicare cost sharing and/or other Medicaid benefits, D-SNPs are not required by CMS to provide coverage during the deeming period for benefits for which the beneficiary has lost eligibility. As a result, when D-SNP members lose that coverage due to a Medicaid eligibility lapse, they may face cost-sharing responsibility for care received through D-SNP network providers during the deeming period.

   States and D-SNPs can take steps to avoid imposing this sudden cost sharing on individuals. Specifically, **D-SNPs may continue to pay for Medicaid-covered services during a deeming period at their own discretion and cost** (for example when the plan decides that continuing such coverage would be in the best interest of the member and/or could reduce the individual's risk of costly service utilization) as long as those benefits are covered by the D-SNP, in its capacity as a Medicaid plan, or its affiliated Medicaid plan. States can collaborate with their D-SNPs to encourage this kind of coverage, particularly by providing retroactive payment to the D-SNP (or its affiliated Medicaid managed care plan) for Medicaid costs covered during the deeming period for members whose coverage is reinstated before the end of the deeming period. For example, **Minnesota offers its D-SNPs retroactive capitation payments for Medicaid benefits that the D-SNPs cover for members who lose Medicaid coverage but regain it with the D-SNPs' 90 day deeming period.** (See Strategy 5 for more information about aligning deeming periods with Medicaid reinstatement periods.)

Box 3. Sample SMAC Language Requiring D-SNPs to Use Deeming Periods

New Jersey SMAC language: *"Deeming Period and Automatic Re-enrollment. … NJ [D-SNP] Contractors shall file for a minimum of 60-days deeming period, but a 90-day or greater period is preferred."*

Oregon SMAC language: *"[D-SNP] shall use CMS deeming process to provide a deemed continued eligibility period for individuals who lose Medicaid eligibility, as long as the individual can reasonably be expected to regain Medicaid eligibility within CMS specified period."*

Pennsylvania SMAC language: *"As allowed by CMS guidance, D-SNPs shall provide deemed continued eligibility for 6 months to maintain continuous coverage when a member temporarily loses Medicaid eligibility."*

Sources: New Jersey Department of Human Services, Division of Medical Assistance and Health Services, 2020 D-SNP contract, Section 10.5.4J.F.6.a.; Oregon Health Authority Coordination of Benefits Agreement, 2021 (DOJ approved May 19, 2020), Section 4.D.3; Pennsylvania Department of Human Services Medicare Improvements for Patients and Providers Act Contracts for HIDE SNPs and FIDE SNPs, 2021. Section B.1.g.

Strategy 5: Align D-SNP Deeming Periods with Medicaid Reinstatement and/or Automatic Re-enrollment Time Periods to Promote Continuity of Coverage

In a research study cited in earlier in this brief, researchers found that approximately half of FBDE individuals who lost Medicaid coverage had their coverage reinstated within three months.[18] Federal Medicaid managed care regulations permit states to: (1) retroactively reinstate Medicaid eligibility for individuals who show proof of retained eligibility within 90 days of their eligibility loss;[19] and (2) automatically re-enroll those individuals into their previous Medicaid managed care plans if they regain Medicaid eligibility within 60 days of the eligibility loss.

States that contract with D-SNPs for coverage of Medicaid benefits can choose to align D-SNP deeming periods with a 90-day retroactive reinstatement period for Medicaid benefits (see Strategy 2) to maintain D-SNP enrollment long enough for most individuals to regain Medicaid coverage for the full deeming period and avert a serious disruption to coverage and coordination.[20] Additionally or alternatively, states can leverage their Medicaid automatic re-enrollment authority to automatically re-enroll individuals back into their former D-SNP (if the D-SNP is directly capitated for coverage of Medicaid benefits) or the Medicaid MCO affiliated with their integrated D-SNP within 60 days of disenrollment following the loss of Medicaid coverage. For sample contract language from Minnesota and New Jersey regarding automatic re-enrollment of integrated D-SNP members back into their prior D-SNP after a short-term loss of Medicaid eligibility, see ***Box 4***.

Box 4. Sample Contract Language Regarding Automatic Re-enrollment into Integrated D-SNPs When Plan Members Lose Medicaid Eligibility and Regain It Quickly

Minnesota SMAC language: *"A [D-SNP] or [Medicaid managed care plan] Enrollee who is identified within ninety (90) days of losing Medical Assistance eligibility for not more than three months, or for any break of time within a three-month period and establishes continuous Medical Assistance eligibility with no break in eligibility may be re-enrolled for the month following disenrollment and subsequent months in the same MCO without completing a new enrollment form."*

New Jersey SMAC language: *"Deeming Period and Automatic Re-enrollment. Individuals may be automatically re-enrolled [for Medicaid benefits] into the last FIDE SNP plan in the DMAHS eligibility and enrollment record if disenrolled for eligibility reasons. In the absence of another plan election, individuals may be automatically re-enrolled within 60 days. NJ FIDE SNP Contractors shall file for a minimum of 60-days deeming period, but a 90-day or greater period is preferred."*

Sources: Minnesota Department of Human Services Minnesota Senior Health Options (MSHO) and Minnesota Senior Care Plus (MSC+) contract, 2020, Section 3.5.8.1; New Jersey Department of Human Services, Division of Medical Assistance and Health Services, 2020 D-SNP contract, Section 10.5.4J.F.6.a.

Conclusion

This brief summarized five strategies that states can use to partner with D-SNPs to prevent unnecessary Medicaid eligibility loss among D-SNP members and mitigate the impact of temporary Medicaid eligibility losses when they occur: (1) requiring D-SNPs to help members recognize and respond to Medicaid eligibility redetermination notices; (2) providing D-SNPs with timely and accurate information on member eligibility redeterminations; (3) developing and implement simple, consumer-friendly eligibility redetermination systems; (4) requiring or allowing D-SNPs to offer eligibility "deeming" periods; and (5) aligning D-SNP deeming periods with federal Medicaid eligibility reinstatement and/or automatic re-enrollment authorities to promote continuity of coverage in integrated care plans for dually eligible individuals who temporarily lose Medicaid eligibility. States can use these strategies individually or collectively to promote continuity of care for dually eligible D-SNP members and reduce the likelihood of costly avoidable hospitalizations and emergency department visits among this population.

ACKNOWLEDGEMENTS

To inform the content of this tool, ICRC staff reviewed D-SNP contracts from several states and conducted interviews with staff from state Medicaid agencies in New Mexico and Pennsylvania and five D-SNPs — Cigna, HealthPartners, Presbyterian Health Plan, UnitedHealthcare, and UPMC. We are very grateful for their time and contributions to the examples provided in this tool.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

The ***Integrated Care Resource Center*** is a national initiative of the Centers for Medicare & Medicaid Services Medicare-Medicaid Coordination Office to help states improve the quality and cost-effectiveness of care for dually eligible individuals. The state technical assistance activities provided by the *Integrated Care Resource Center* are coordinated by Mathematica and the Center for Health Care Strategies. For more information, visit www.integratedcareresourcecenter.com.

[1] Integrated Care Resource Center (ICRC). "Dually Eligible Individuals: The Basics." March 2021. Available at: https://www.integratedcareresourcecenter.com/resource/dually-eligible-individuals-basics.
[2] Ibid.
[3] Riley, G.F., Zhao, L. and Tilahun, N. "Understanding Factors Associated with Loss of Medicaid Coverage Among Dual Eligibles Can Help Identify Vulnerable Enrollees." *Health Affairs*, 33(1), January 2014: 147-152. Available at: https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.0396
[4] Feng, Z., Vadnais, A., Vreeland, E., Segelman, M., Ferrell, A., Wiener, J.M., and Baker, B. "Loss of Medicare-Medicaid Dual-Eligible Status: Frequency, Contributing Factors and Implications." RTI Policy Brief prepared for the Office of the Assistant Secretary for Planning and Evaluation (ASPE), May 2019. Available at: https://aspe.hhs.gov/sites/default/files/private/pdf/261716/DualLoss.pdf
[5] Riley, op. cit.
[6] In many states, this kind of assistance may require the D-SNP care coordinator to be an authorized representative for the member.
[7] For more information about data exchange processes that states can use to share key Medicaid information with D-SNPs, see: ICRC. "State Options and Considerations for Sharing Medicaid Enrollment and Service Use Information with D-SNPs." December 2019. Available at: https://www.integratedcareresourcecenter.com/resource/state-options-and-considerations-sharing-medicaid-enrollment-and-service-use-information-d
[8] For information about ex-parte renewal processes, see: Medicaid and CHIP Learning Collaboratives. Coverage Learning Collaborative. "Medicaid and CHIP Renewals and Redeterminations." January 13, 2021. Available at: https://www.medicaid.gov/resources-for-states/downloads/renewals-redeterminations.pdf.
[9] Seventy percent of dually eligible individuals have three or more chronic conditions; 41 percent have a behavioral health disorder; and more than 40 percent use long-term services and supports. For more information, see: ICRC. "Dually Eligible Individuals: The Basics." March 2021. Available at: https://www.integratedcareresourcecenter.com/resource/dually-eligible-individuals-basics.
[10] In CY2009, 45 percent of dually eligible individuals had a diagnosis of Alzheimer's disease or related dementia, compared to 38 percent of individuals with only Medicaid coverage. See: MedPAC and MACPAC. "Data Book: Beneficiaries Dually Eligible for Medicare and Medicaid." Exhibit 20. December 2013. Available at: https://www.macpac.gov/wp-content/uploads/2020/07/Data-Book-Beneficiaries-Dually-Eligible-for-Medicare-and-Medicaid-December-2013.pdf.
[11] 42 CFR 435.916(a)
[12] For more information, see. CMS. State Health Official Letter #20-004. "RE: Planning for the Resumption of Normal State Medicaid, Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Operations Upon Conclusion of the COVID-19 Public Health Emergency." December 22, 2020. Available at: https://www.medicaid.gov/sites/default/files/2020-12/sho20004.pdf.
[13] States are required to use pre-populated forms to redetermine eligibility for Medicaid beneficiaries in eligibility groups for which the state uses MAGI-based financial methodologies (42 CFR 435.916[a][3]), but states are not federally required to issue pre-populated forms to beneficiaries in non-MAGI eligibility groups (such as the aged, blind, and disabled (ABD) eligibility groups). However, states can choose to use pre-populated forms to simplify the Medicaid renewal process for all Medicaid beneficiaries, including dually eligible individuals who are in non-MAGI eligibility groups.
[14] Kaiser Family Foundation. "Medicaid Financial Eligibility for Seniors and People with Disabilities: Findings from a 50-State Survey." June 14, 2019. Available at: https://www.kff.org/report-section/medicaid-financial-eligibility-for-seniors-and-people-with-disabilities-findings-from-a-50-state-survey-issue-brief/.
[15] CMS. Center for Medicaid and CHIP Services (CMCS). Information Bulletin "Medicaid and Children's Health Insurance Program (CHIP) Renewal Requirements." December 4, 2020. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib120420.pdf
[16] Some eligibility changes do not result in a deeming period, and some causes for loss of Medicare and/or Medicaid eligibility result in involuntary disenrollment prior to the exhaustion of the deeming period. If a D-SNP member loses special needs status and faces one of the reasons for disenrollment listed in Section 50.2 of Chapter 2 of the Medicare Managed Care Manual (Required Involuntary Disenrollment), enrollment may be terminated within 30 days. For more information about eligibility deeming periods in D-SNPs, see Section 50.2.5 of Chapter 2 an Section 40.4 of Chapter 16b of the Medicare Managed Care Manual.

[17] See Section 50.2.5 of Chapter 2 of the Medicare Managed Care Manual for information about deeming period increments. D-SNP enrollees who lose Medicaid eligibility complete the full enrollment month in which the eligibility loss occurs before beginning a deeming period. D-SNPs must provide at least 30-days advance notice of pending enrollment termination, even when the plan does not otherwise have a deeming policy in place, and deeming periods always start after that notice of eligibility loss has been communicated to the beneficiary.

[18] Riley, G.F., Zhao, L. and Tilahun, N. "Understanding Factors Associated with Loss of Medicaid Coverage Among Dual Eligibles Can Help Identify Vulnerable Enrollees." Health Affairs, 33(1), January 2014: 147-152. Available at https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.0396

[19] 42 CFR 435.916(a)(3)(iii)

[20] If the duration of a D-SNP's deeming period is shorter than the time frame within which beneficiaries may request reinstatement of Medicaid benefits, an individual's deeming period may be exhausted before they regain Medicaid eligibility. In those circumstances, the individual's Medicaid benefits remain terminated, and they will be disenrolled from the D-SNP. They will return to fee-for-service Medicare coverage (including a transition into a standalone Medicare Part D plan for prescription drug coverage with the option to enroll in a Medicare Advantage plan if they choose.