Chapter 6:

Improving Integration for Dually Eligible Beneficiaries: Strategies for State Contracts with Dual Eligible Special Needs Plans

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Key Points

- The 12.3 million individuals dually eligible for Medicaid and Medicare may experience fragmented care and poor health outcomes when their benefits are not coordinated. Integrated care models can improve the beneficiary experience and may reduce federal and state spending. However, only about 10 percent of dually eligible beneficiaries were enrolled in integrated care models in 2019.
- In this chapter, we focus on ways state Medicaid programs can use their contracts with Medicare Advantage dual eligible special needs plans (D-SNPs) to promote greater integration and increase enrollment in integrated plans. D-SNPs currently enroll over 3 million dually eligible beneficiaries and are available in 43 states and the District of Columbia.
- The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) requires D-SNPs to have contracts with the states in which they operate, sets minimum integration standards, and gives states the authority to add requirements for D-SNPs.
- MACPAC identified strategies states can use to exercise their MIPPA authority to better integrate Medicaid and Medicare and factors affecting states' ability to implement these strategies.
- Some MIPPA strategies can be deployed by any state. For example, states can contract directly with D-SNPs to cover Medicaid benefits, so that the plan covers both Medicaid and Medicare benefits. This strategy may be particularly useful for states that do not enroll dually eligible beneficiaries in Medicaid managed care.
- Other strategies are easiest to implement in states with experience using Medicaid managed care. For example, certain states can approve D-SNPs to automatically enroll a Medicaid member becoming eligible for Medicare if the D-SNP is of the same parent company as the beneficiary's current Medicaid plan. This strategy, known as default enrollment, can ensure a smooth transition from Medicaid-only coverage to integrated coverage for those dually eligible.
- States are at different stages of integrating care for their dually eligible populations. For example, a few states, such as Arizona, Idaho, and Tennessee, have maximized their MIPPA authority and are providing fully integrated care. Other states, such as North Dakota and Wyoming, do not have D-SNPs, and no other integrated options are available. Variation in how states exercise MIPPA authorities may also reflect variations in state capacity and competing priorities.
- Over the next year, the Commission will explore how federal policy could be used to raise the bar on integration.

CHAPTER 6: Improving Integration for Dually Eligible Beneficiaries: Strategies for State Contracts with Dual Eligible Special Needs Plans

Over the past several years, the Commission has focused on integrating care for the 12.3 million Americans who are covered by both Medicaid and Medicare, known as dually eligible beneficiaries (CMS 2020a; MACPAC 2020a, 2020b).[1] As noted in our prior work, dually eligible beneficiaries often experience fragmented care and poor health outcomes due to poor coordination of services across the two programs. Beneficiaries of color, who accounted for nearly half (48 percent) of all dually eligible beneficiaries in 2019, are particularly affected, experiencing additional barriers to access, such as language barriers, when navigating both Medicaid and Medicare (CMS 2020a, Sharma 2014). Moreover, dually eligible beneficiaries account for about one-third of total costs to the federal government and the states in each program, although they represent about 15 percent of Medicaid beneficiaries and 20 percent of Medicare beneficiaries (CMS 2020a, 2020b).

While integrating care for this high-cost, high-need population has the potential to improve beneficiaries' health and reduce federal and state spending, the number of beneficiaries enrolled in integrated models remains low, at just over 1 million (10 percent) full-benefit dually eligible beneficiaries in 2019 (CMS 2020b).[2] Moreover, while states and the federal government have been working together to develop and implement a variety of integrated models under managed care arrangements, often the focus has been on the Financial Alignment Initiative (FAI) or the Program of All-Inclusive Care for the Elderly (PACE).

In this chapter, we take a deeper look at the potential of dual eligible special needs plans (D-SNPs) to promote greater integration. D-SNPs, a type of Medicare Advantage (MA) plan designed to meet the specific needs of dually eligible beneficiaries, serve more beneficiaries than other integrated models with enrollment of over 3 million beneficiaries as of January 2021. In comparison, Medicare-Medicaid plans (MMPs) offered under the FAI and PACE enrolled 395,000 and 55,000 beneficiaries, respectively (CMS 2021a, ICRC 2021, NPA 2021). D-SNPs are currently available in 43 states and the District of Columbia (CMS 2021a).

Importantly, although D-SNPs are meant to address the unique needs of dually eligible beneficiaries, they do not always provide highly integrated coverage. States have authority under current law to improve integration under the D-SNP model. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) requires all D-SNPs to have contracts with Medicaid programs in the states in which they operate. These contracts define how D-SNPs will coordinate Medicaid and Medicare benefits. MIPPA requires that state contracts with D-SNPs meet a minimum set of requirements, described in 42 CFR 422.107(c) (Box 6-1) (CMS 2019a). Although the regulations include some minimal coordination between the D-SNP and the state, they do not result in fully integrated coverage (MedPAC 2019).

BOX 6-1. Regulatory Requirements for Dual Eligible Special Needs Plan Contracts with States

42 CFR 422.107 Special needs plans and dual eligibles: Contract with State Medicaid Agency.

(a) *Definition.* For the purpose of this section, a contract with a State Medicaid agency means a formal written agreement between an MA [Medicare Advantage] organization and the State Medicaid agency documenting each entity's roles and responsibilities with regard to dual eligible individuals.

(b) *General rule.* MA organizations seeking to offer a dual eligible special needs plan must have a contract consistent with this section with the State Medicaid agency.

(c) *Minimum contract requirements.* At a minimum, the contract must document—

(1) The MA organization's responsibility to—

(i) Coordinate the delivery of Medicaid benefits for individuals who are eligible for such services; and

(ii) If applicable, provide coverage of Medicaid services, including long-term services and supports and behavioral health services, for individuals eligible for such services.

(2) The category(ies) and criteria for eligibility for dual eligible individuals to be enrolled under the SNP [Special Needs Plan], including as described in sections 1902(a), 1902(f), 1902(p), and 1905 of the Act.

(3) The Medicaid benefits covered under a capitated contract between the State Medicaid agency and the MA organization offering the SNP, the SNP's parent organization, or another entity that is owned and controlled by the SNP's parent organization.

(4) The cost-sharing protections covered under the SNP.

(5) The identification and sharing of information on Medicaid provider participation.

(6) The verification of enrollee's eligibility for both Medicare and Medicaid.

(7) The service area covered by the SNP.

(8) The contract period for the SNP.

(9) For each dual eligible special needs plan that is an applicable integrated plan as defined in § 422.561, a requirement for the use of the unified appeals and grievance procedures under §§ 422.629 through 422.634, 438.210, 438.400, and 438.402.

(d) *Additional minimum contract requirement.* For any dual eligible special needs plan that is not a fully integrated or highly integrated dual eligible special needs plan, the contract must also stipulate that, for the purpose of coordinating Medicare and Medicaid-covered services between settings of care, the SNP notifies, or arranges for another entity or entities to notify, the State Medicaid agency, individuals or entities designated by the State Medicaid agency, or both, of

BOX 6-1. (continued)

hospital and skilled nursing facility admissions for at least one group of high-risk full-benefit dual eligible individuals, identified by the State Medicaid agency. The State Medicaid agency must establish the timeframe(s) and method(s) by which notice is provided. In the event that a SNP authorizes another entity or entities to perform this notification, the SNP must retain responsibility for complying with this requirement.

(e) Date of Compliance.

(1) Effective January 1, 2010—

(i) MA organizations offering a new dual eligible SNP must have a State Medicaid agency contract.

(ii) Existing dual eligible SNPs that do not have a State Medicaid agency contract—

(A) May continue to operate through the 2012 contract year provided they meet all other statutory and regulatory requirements.

(B) May not expand their service areas during contract years 2010 through 2012.

(2) MA organizations offering a dual eligible SNP must comply with paragraphs (c)(9) and (d) of this section beginning January 1, 2021 (42 CFR 422.107).

MIPPA authority can be a powerful tool, but few states have exercised it fully. This may be due to limited state experience using managed care to provide Medicaid coverage to dually eligible beneficiaries, a lack of Medicare expertise, and competing priorities. As a result, many D-SNPs do not provide much integration beyond the minimum requirements. However, a few states have used MIPPA contracts to require plans to cover certain Medicaid benefits and meet other standards for higher levels of integration.[3] Centers for Medicare & Medicaid Services (CMS) regulations classify this subset of D-SNPs as highly integrated dual eligible special needs plans (HIDE SNPs) or fully integrated dual eligible special needs plans (FIDE SNPs), depending on the Medicaid benefits they cover (42 CFR 422.107, CMS 2020c). HIDE SNPs must cover either behavioral health or long-term services and supports (LTSS). FIDE SNPs must cover both unless the state carves behavioral health services out of the capitation rate (MACPAC 2020a).

Although the D-SNP model has its limitations as an approach to integrating care, strengthening states' ability to leverage it can be an important step in increasing the extent to which care is integrated for beneficiaries. Over the past year, with the help of a contractor, MACPAC reviewed state contracts with D-SNPs and conducted interviews with a variety of stakeholders to identify contracting strategies authorized through MIPPA that states can deploy to better integrate Medicaid and Medicare services. We share the most promising approaches in this chapter, based on state ability to implement the strategies.

Building on the Commission's work thus far, over the coming year, we will explore incentives for states to improve integration for their dually eligible populations and how federal policy could be used to raise the bar on integration, keeping in mind that state efforts to integrate care are at different stages. State progress on integration reflects past

policy choices, features of health care markets, and current state capabilities and priorities. As such, we plan to engage with stakeholders, including states, plans, providers, and beneficiaries, to consider the merits and trade-offs associated with different approaches. Our goal is to expand the discussion of integrated care that we started several years ago to identify opportunities for which incentives for states could advance integrated care efforts and lead to more enrollment in integrated models.

Why Focus on D-SNPs?

Although a number of integrated models are authorized in law, we focus on D-SNPs in this chapter because of their wide availability across geographic areas, the growing number of dually eligible beneficiaries enrolled in them, and the availability of existing tools that states can use to integrate care for beneficiaries. Maximizing the use of existing D-SNP contracting authority could further integrate coverage for a large share of dually eligible beneficiaries, without federal legislative changes or rulemaking, particularly when combined with other state policies. Although other integrated care models, such as MMPs and PACE, offer higher levels of integration than some D-SNPs because all Medicaid and Medicare services are covered and coordinated by a single health plan or organization, expanding those models could require statutory changes (Box 6-2).

The terms used to describe integrated models can be confusing and can sometimes overlap. To be clear, throughout this chapter, we will use the following terms to describe relationships among plans serving dually eligible beneficiaries:

- Aligned plans are D-SNPs and Medicaid managed care plans that are owned by the same parent company.
- Aligned enrollment refers to beneficiaries receiving Medicaid and Medicare benefits through the same entity. This occurs when a beneficiary receives all benefits from a D-SNP or is enrolled in a D-SNP and a Medicaid managed care plan that are owned by the same parent company.
- Exclusively aligned enrollment occurs when the state's contract with the D-SNP limits enrollment to full-benefit dually eligible beneficiaries who receive Medicaid benefits from the D-SNP or an aligned Medicaid managed care plan owned by the D-SNP's parent company.

D-SNPs are widely available, and enrollment is increasing. As of January 2021, D-SNPs are available in 43 states and the District of Columbia, and 93 percent of dually eligible beneficiaries live in a county in which at least one D-SNP is available (Figure 6-1) (CMS 2021a, 2021b, 2020d).[4] The share of the dually eligible population that lives where D-SNPs are available is high because most dually eligible beneficiaries live in urban areas, where D-SNPs are more likely to be available (MACPAC and MedPAC 2018). Enrollment in D-SNPs has increased steadily since they first began operating in 2006 (Archibald et al. 2019). As of February 2021, about 3 million dually eligible beneficiaries were enrolled in D-SNPs, representing about 26 percent of the dually eligible population (CMS 2021a, CMS 2020a).[5] The majority, 1.7 million, were enrolled in minimally integrated D-SNPs, and the remainder were enrolled in HIDE SNPs or FIDE SNPs. Enrollment in HIDE SNPs represents about 34 percent of all D-SNP enrollment, and enrollment in FIDE SNPs represents about 9 percent (CMS 2021a).

BOX 6-2. Integrated Models on a Continuum

Low level of integration

- Dual eligible special needs plan (D-SNP). The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) contract with the state meets minimum requirements for coordination of Medicaid benefits (42 CFR 422.107(c) and (d)).

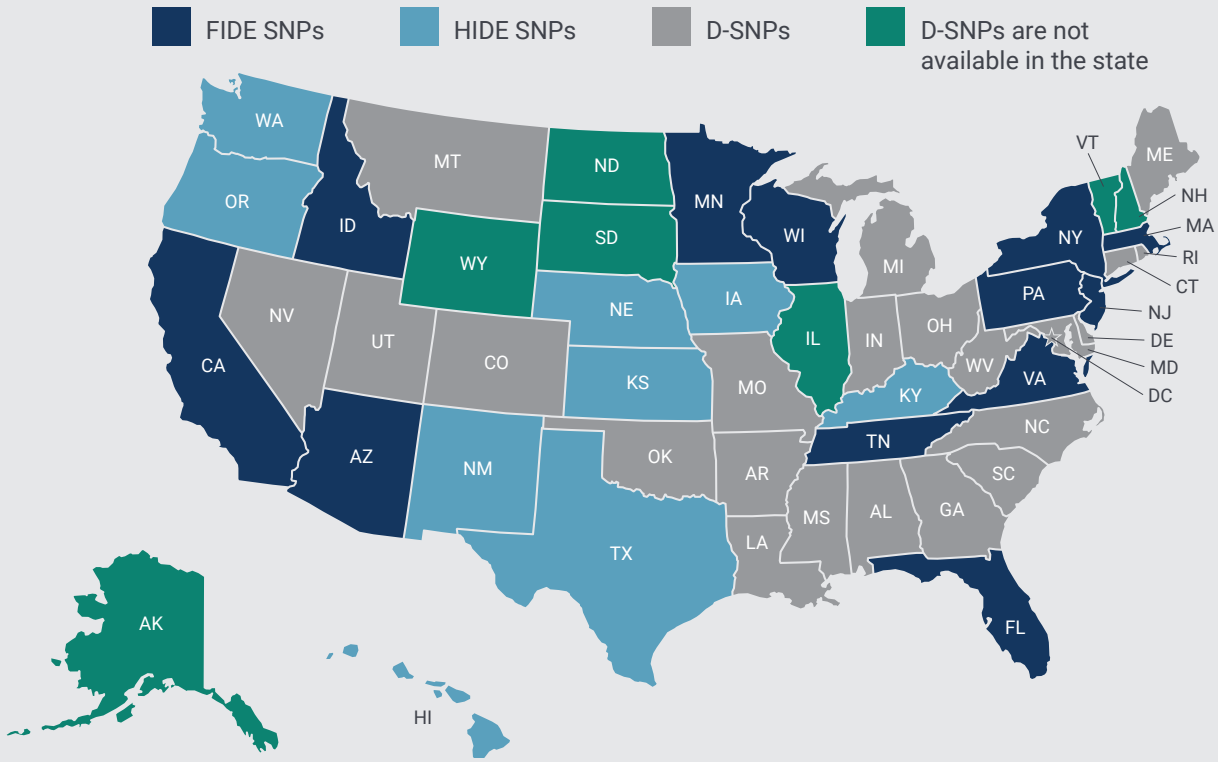
Moderate level of integration

- D-SNP plus Medicaid managed care. MIPPA contract reflects provision of some Medicaid benefits, like coverage of Medicare cost sharing, by the aligned Medicaid managed care plan, but LTSS is not covered.
- D-SNP plus managed long-term services and supports (MLTSS). MIPPA contract reflects provision of some Medicaid benefits, including LTSS, by the aligned MLTSS plan that is owned by the same parent company as the D-SNP.
- Highly integrated dual eligible special needs plan (HIDE SNP). Moderate level of coordination with Medicaid. MIPPA contract includes requirement to provide MLTSS or behavioral health or both.

High level of integration

- Fully integrated dual eligible special needs plan (FIDE SNP). Higher level of coordination with Medicaid. MIPPA contract includes requirement to provide MLTSS and behavioral health, unless the state carves behavioral health out of the capitation rate.
- Medicare-Medicaid plan (MMP). Under the Financial Alignment Initiative (FAI), MMPs enter into three-way contracts with CMS and the state to provide all Medicaid and Medicare benefits.
- Program of All-Inclusive Care for the Elderly (PACE). PACE organization contracts with CMS and the state to provide all Medicaid and Medicare benefits.

FIGURE 6-1. Most Highly Integrated Type of Dual Eligible Special Needs Plan Available by State, 2021



Notes: D-SNP is dual eligible special needs plan. FIDE SNP is fully integrated dual eligible special needs plan. HIDE SNP is highly integrated dual eligible special needs plan. This figure shows the most integrated type of D-SNP available in the state or District of Columbia as of January 2021. States may have more than one type of D-SNP available, and plans are not always available statewide. HIDE SNPs were first available starting in 2021.

In 2017, Illinois chose not to continue contracts with D-SNPs to focus on Medicare-Medicaid plans as a platform for integrating care (MedPAC 2019). Washington does not have comprehensive Medicaid managed care for dually eligible beneficiaries, but it does have HIDE SNPs formed by aligning D-SNPs with behavioral health organizations.

Source: MACPAC, 2021, analysis of Medicare Advantage special needs plan landscape file as of January 2021.

D-SNPs provide coverage to a diverse group of dually eligible beneficiaries, including individuals age 65 and older and younger people with disabilities, and the health needs of the population vary (MACPAC 2020a). They also serve both individuals eligible for full Medicaid benefits, known as full-benefit dually eligible beneficiaries, and individuals eligible for partial Medicaid benefits, known as partial-benefit dually eligible beneficiaries. Partial-benefit dually eligible beneficiaries are eligible for Medicaid assistance only with Medicare premiums and sometimes cost sharing. As discussed later in this chapter, states can use contract requirements to limit D-SNP enrollment to full-benefit dually eligible beneficiaries.

Implementation of Bipartisan Budget Act of 2018 Requirements

In 2019, CMS finalized new regulations for D-SNPs that updated classifications of plans depending on their level of integration (CMS 2019a). Those that offer higher levels of integration by covering

some Medicaid services can be designated as HIDE SNPs or FIDE SNPs. Beginning in 2021, D-SNPs are designated as HIDE SNPs if they have a contract with the state Medicaid agency to cover either LTSS or behavioral health services.[6] D-SNPs are designated as FIDE SNPs if they cover both LTSS and behavioral health services, in addition to other Medicaid benefits under their MIPPA contracts (MACPAC 2020a).[7]

The HIDE-SNP and FIDE-SNP designations affect plans' ability to participate in some states and the amount of Medicare payment received by the plan. States may require some or all plans applying to operate a D-SNP in the state to meet the criteria for designation as a HIDE SNP or FIDE SNP. For example, Idaho requires D-SNPs in the state to meet the FIDE SNP designation (Spencer et al. 2018). FIDE SNPs may also receive additional Medicare payments through a frailty adjustment if CMS determines beneficiaries enrolled in a FIDE SNP have an average level of frailty similar to those enrolled in PACE (MACPAC 2020a).

The Bipartisan Budget Act of 2018 (BBA 2018, P.L. 115-123), which permanently authorized D-SNPs, requires D-SNPs to take additional steps to promote integration, beyond what was required in MIPPA (42 CFR 422.107(d)) (Box 6-1). Specifically, it required D-SNPs to meet one of three criteria to improve integration or coordination of care: (1) meet the requirements to be designated as a FIDE SNP, (2) meet the requirements to be designated as a HIDE SNP, or (3) notify the state of hospital or skilled nursing facility admissions for at least one group of high-risk enrollees (CMS 2019b). For D-SNPs to comply with the third requirement, the state must specify, within its MIPPA contract, the group of high-risk individuals for whom a notification must be sent and the time frame and process for sending notifications to either the state or a designee of the state's choosing.[8] The BBA 2018 also unified the grievance and appeals process for some D-SNPs (42 CFR 422.107(d)) (Box 6-1).

MIPPA Strategies for State Contracts with D-SNPs

States can use their MIPPA contracts with D-SNPs to require these plans to take additional steps to better integrate coverage and care (Table 6-1). Some strategies can be implemented by all states, while others can be implemented only by states with Medicaid managed care for dually eligible beneficiaries.

TABLE 6-1. Strategies for State Contracts with Dual Eligible Special Needs Plans, 2021

Strategy
All states can use these strategies:
Limit D-SNP enrollment to full-benefit dually eligible beneficiaries
Contract directly with D-SNPs to cover Medicaid benefits
Require D-SNPs to use specific or enhanced care coordination methods
Require D-SNPs to send data or reports to the state for oversight purposes
Require state review of D-SNP materials related to delivery of Medicaid benefits
Partner with D-SNPs to develop supplemental benefit packages that complement Medicaid benefits
States with Medicaid managed care can use these strategies:
Selectively contract with D-SNPs or Medicaid managed care plans that offer aligned plans
Require complete service area alignment
Require D-SNPs to operate with exclusively aligned enrollment
Allow or require D-SNPs to use default enrollment
Automatically assign D-SNP enrollees to Medicaid plans under the same parent organization
Incorporate Medicaid quality improvement priorities into the D-SNP contract
Automate Medicaid crossover claims payment processes for payment of Medicare cost sharing

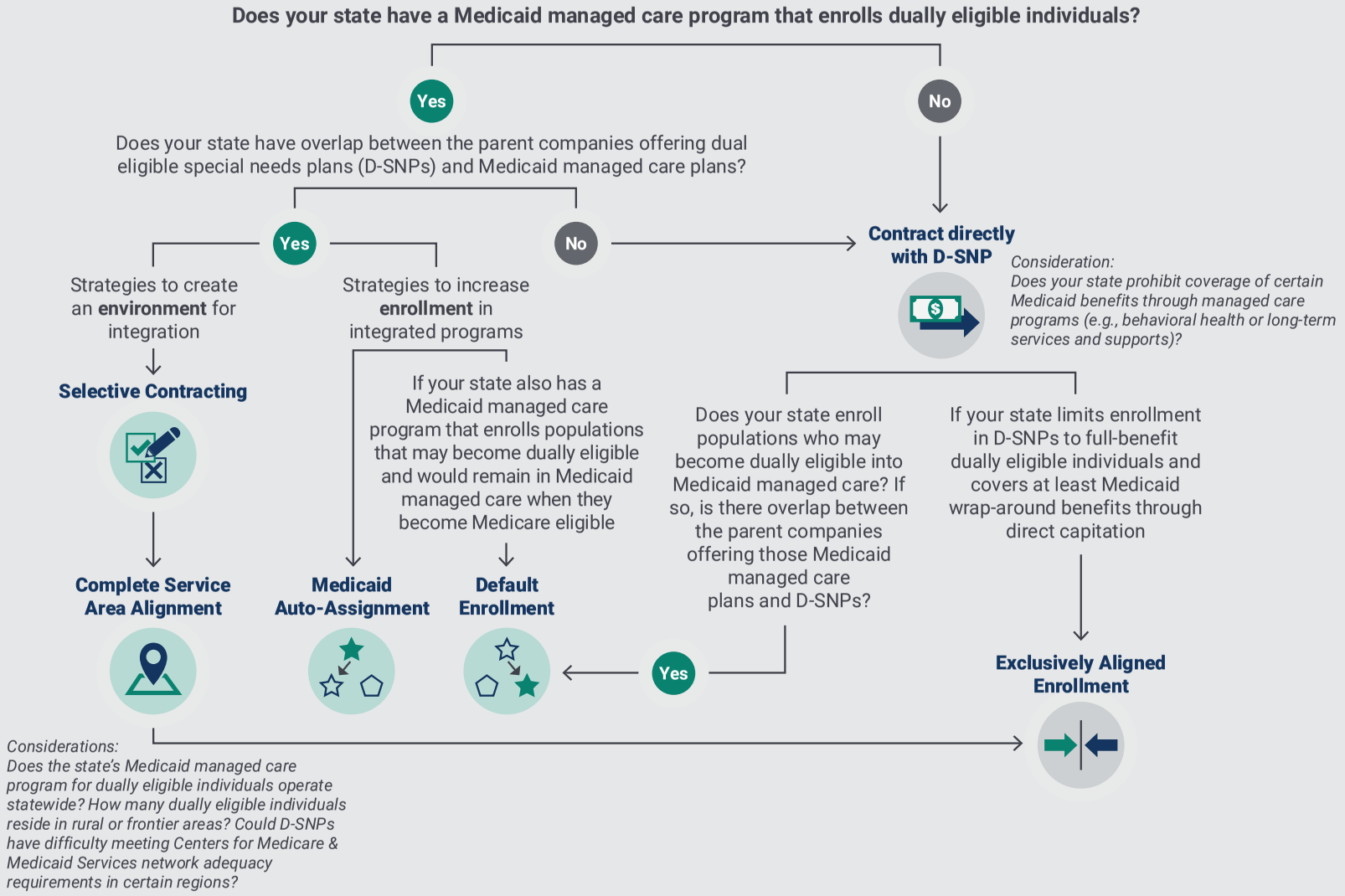
Notes: D-SNP is dual eligible special needs plan. These strategies are available to states under authority established in the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275). This list is not exhaustive. We chose these strategies based on state use of the strategies to advance integration and on interviews with stakeholders.

Source: Mathematica, 2021, analysis for MACPAC of MIPPA strategies for contract years 2020 and 2021 and interviews with stakeholders.

To explore opportunities for states to maximize their MIPPA contracting authority, we contracted with Mathematica to review state contracts with D-SNPs and conduct 16 semistructured interviews with representatives from four states (California, Idaho, Indiana, and Virginia) and the District of Columbia, five health plans, and two beneficiary advocacy organizations. The Mathematica team also spoke with officials at CMS. Specifically, we were interested in learning about the advantages and disadvantages of various contracting strategies, the factors affecting their use, and examples of states currently using them.

We briefly describe each of the MIPPA strategies available to states, including examples of states that are using them (Figure 6-2). These are described in more detail in Appendix 6A.

FIGURE 6-2. Determining Which Strategies States Can Use in Contracts with Dual Eligible Special Needs Plans, 2021



Source: Mathematica, 2021, analysis for MACPAC of MIPPA strategies states can use to improve integration in D-SNPs.

Strategies all states can use

The following are MIPPA strategies that all states can use:

Limit D-SNP enrollment to full-benefit dually eligible beneficiaries. States can require that D-SNPs limit enrollment to full-benefit dually eligible beneficiaries, as is now the case for MMPs. This strategy allows uniformity for plan enrollees, including a single set of benefits and rules around care coordination. However, requiring that partial-benefit dually eligible beneficiaries disenroll from D-SNPs and enroll in a regular MA plan potentially disrupts their coverage. Another potential drawback of requiring disenrollment is that partial-benefit dually eligible beneficiaries can still benefit from the supplemental benefits and care coordination offered by a D-SNP (that would not be available in a regular MA plan) even though they receive no Medicaid benefits. Examples of states using this strategy include Arizona, Hawaii, and Idaho.

As an alternative to limiting enrollment in D-SNPs to the full-benefit population, states could consider requiring D-SNPs to establish separate plan benefit packages for full- and partial-benefit dually eligible beneficiaries through their MIPPA contracts.[9] Some states, including Pennsylvania and Virginia, already do this. Establishing separate plan benefit packages may address concerns about diluting integration. It could also alleviate concerns around disruptions in coverage.

Although states can require D-SNPs to use separate plan benefit packages, the Commission would need to do additional research to better understand who would be affected and the implications for beneficiaries, states, and plans. We plan to explore the benefits and challenges of using separate plan benefit packages and the advantages of cross-walking or transitioning beneficiaries between plan benefit packages. This approach avoids an enrollment transaction and beneficiaries are not required to make an enrollment election in order to remain enrolled, something that CMS recently approved for D-SNPs, starting in 2022 (CMS 2021c).

Contract directly with D-SNPs to cover Medicaid benefits under a capitation payment. States can contract directly with D-SNPs for coverage of Medicaid benefits. This strategy can be useful for states that do not otherwise enroll dually eligible beneficiaries in Medicaid managed care or states in which there is no overlap between the parent companies of the D-SNP and Medicaid managed care plans. Examples of states using this strategy to cover some or all Medicaid benefits include Alabama, Florida, and Idaho.

States that contract directly with FIDE SNPs to cover all Medicaid benefits may also be able to use other strategies that are typically available only to states with Medicaid managed care, discussed in more detail later in this chapter. For example, states may be able to require that FIDE SNPs operate with exclusively aligned enrollment, meaning that beneficiaries would receive all their benefits from the FIDE SNP. Idaho is an example of a state using this strategy. States that have Medicaid managed care and directly contract with FIDE SNPs to cover Medicaid benefits may also be able to default enroll Medicaid beneficiaries into FIDE SNPs aligned with their Medicaid managed care plan when they become eligible for Medicare.

Require D-SNPs to use specific or enhanced coordination methods. States can add requirements to their MIPPA contracts to enhance care coordination. For example, they can require that D-SNPs train their care coordinators to be familiar with Medicaid benefits to help beneficiaries access these services. Examples of states using this strategy include Idaho, Massachusetts, and Minnesota.

Require D-SNPs to send data or reports to the state for oversight purposes. States can require that D-SNPs submit data or reports to states for oversight of operations and quality of care. For example, requiring D-SNPs to submit encounter data or data on Part D prescription drugs can help the state obtain a comprehensive picture of which Medicaid and Medicare services enrollees are using and identify areas for improvement, such

as added care coordination. Examples of states using this strategy include Arizona, Massachusetts, Minnesota, and Oregon.

Require state review of D-SNP materials related to delivery of Medicaid benefits. States can require that D-SNPs submit enrollee communication materials for state review, prior to use. D-SNP materials can be complicated for dually eligible beneficiaries because they may receive two sets of materials, one for their Medicaid benefits and one for their Medicare benefits. This strategy could ensure consistency in Medicaid benefit descriptions across D-SNPs in the state, reducing confusion among both beneficiaries and providers. It could also make enrolling easier for beneficiaries who may find the number of coverage options available to them confusing, especially on the Medicare side. Examples of states using this strategy include Idaho, Massachusetts, Minnesota, New Jersey, and Tennessee.

As an alternative to requiring state review, Congress could establish a joint CMS and state review process such as the one used for the MMPs.[10] The Medicare-Medicaid Coordination Office has recommended a joint review process for D-SNPs, most recently in its fiscal year 2019 report to Congress, building on the experience with the MMPs (CMS 2019c). We spoke with a health plan representative who suggested the same policy change.

More research will be needed to flesh out the advantages of state review of D-SNP materials and the process for implementing that review. We will also explore issues related to establishing a joint CMS and state review process for approving D-SNP materials, like the one used for the MMPs.

Partner with D-SNPs to develop supplemental benefit packages. States can partner with D-SNPs to develop supplemental benefit packages that complement the Medicaid benefits already available to full-benefit dually eligible beneficiaries, preventing duplication in what Medicaid and Medicare cover.[11] Like other MA plans, D-SNPs can use rebate dollars to provide supplemental benefits that are not covered by traditional Medicare (e.g., dental, vision, and hearing services) and to cover Medicare cost sharing. Compared with regular MA plans, D-SNPs may allocate more rebate dollars to benefits because Medicaid already covers Medicare cost sharing for dually eligible beneficiaries. D-SNPs may also be more likely to offer supplemental benefits targeted to the needs of dually eligible beneficiaries, such as adult day care services, home-based palliative care, in-home support services, caregiver supports, medically approved non-opioid pain management, home and bath safety devices and modifications, transportation, and coverage for over-the-counter medications and items. As of 2020, D-SNPs may also offer benefits such as home-delivered meals, pest control services, non-medical transportation, indoor air quality equipment, and structural home modifications (CMS 2019d). States partnering with D-SNPs to coordinate and expand the package of benefits available to dually eligible beneficiaries include Arizona, Hawaii, and New Jersey.

Strategies for states with Medicaid managed care

The following MIPPA strategies can be used in states that enroll dually eligible beneficiaries in Medicaid managed care. They can also be used by states that are planning to launch Medicaid managed care for the dually eligible population.

Selectively contract with D-SNPs or Medicaid managed care plans that offer aligned plans. Selective contracting refers to the practice of states contracting only with D-SNPs that offer Medicaid managed care plans under the same parent company.[12] Selective contracting allows states to improve integration and increase enrollment in D-SNPs—for example, by requiring D-SNPs to operate with exclusively aligned enrollment and default enrollment (discussed in more detail later in this chapter). This strategy assures that only D-SNPs offering a higher level of integration can enroll beneficiaries, preventing a situation in which

a minimally integrated D-SNP would compete for enrollment. Examples of states using this strategy include Arizona, Tennessee, and Virginia.

Selective contracting can be challenging to implement for several reasons. Medicaid procurement cycles and Medicare contracting with D-SNPs often occur on different timelines, which could create a gap for plans between winning a Medicaid managed care contract and obtaining state approval to operate a D-SNP. While states theoretically could align state Medicaid procurement cycles with Medicare timelines, interviewees told us that doing so would be challenging due to the state investment required and the unpredictability of Medicaid procurement decisions and health plan protests.

Another challenge is that many states periodically rebid Medicaid managed care contracts through a competitive process that permits a limited number of plans to operate. This may result in beneficiaries having to change plans if they are enrolled in a D-SNP offered by a parent company that loses its Medicaid contract. If the plan networks differ, beneficiaries will also have to change providers. This is especially true if either D-SNP uses a narrow network.

States considering this approach may also need to consider the existing role of small, local Medicaid managed care plans in serving the dually eligible population. It might be difficult for small, local health plans with no Medicare experience to implement a D-SNP contract, given the steep learning curve and challenges in developing Medicare provider networks.

Require complete service area alignment. States with Medicaid managed care and selective contracting could require complete service area alignment between D-SNPs and Medicaid managed care plans under the same parent company. However, interviewees told us this could be difficult to implement in certain cases. For example, differences between CMS requirements and state network adequacy requirements make it challenging to require complete service area alignment, especially in rural areas. Arizona and New Jersey are examples of states using this strategy.

Require D-SNPs to operate with exclusively aligned enrollment. Exclusively aligned enrollment occurs when a state limits enrollment in a D-SNP to full-benefit dually eligible beneficiaries who receive their Medicaid benefits through the D-SNP or aligned Medicaid plan. In short, under this strategy, one organization is responsible for both Medicaid and Medicare benefits for all its members. For example, plans operating with exclusively aligned enrollment can issue streamlined and fully integrated member materials, use unified plan-level appeal and grievance processes, provide more effective care coordination, and simplify provider billing. Examples of states using this strategy include Idaho, Massachusetts, Minnesota, and New Jersey.

Allow or require D-SNPs to use default enrollment. Default enrollment refers to the process by which Medicaid beneficiaries are enrolled in a D-SNP that is aligned with their current Medicaid managed care plan when they become eligible for Medicare.[13] Typically, D-SNPs allowed to use default enrollment have higher levels of integration because they operate under the same parent organization as the Medicaid managed care plan.[14] Default enrollment can ensure an uninterrupted transition from Medicaid-only coverage to an integrated arrangement with care coordination and supplemental benefits that are not available in Medicare fee for service (FFS). It is also important to note that default enrollment is the only MIPPA contracting strategy that directly increases enrollment in D-SNPs. To ensure freedom of choice, beneficiaries receive a notice 60 days prior to the default enrollment effective date, during which they have the right to opt out and choose to enroll in Medicare FFS or another MA plan.[15]

One state we interviewed reported low (less than 5 percent) opt-out rates. The state also reported few complaints, grievances, and appeals due to default enrollment. Even so, the state noted

that some stakeholders may perceive default enrollment as limiting beneficiary choice, and as a result gathering and incorporating input from beneficiaries and beneficiary advocates throughout the implementation process is crucial. States may also require additional enrollee protections during default enrollment, such as continuity of care protections, including allowing beneficiaries to continue seeing existing providers outside the D-SNP's network for a certain time period. Continuity of care is especially important because many newly dually eligible beneficiaries default enrolled in a D-SNP may have existing provider relationships.[16]

To implement default enrollment, states must have either Medicaid managed care arrangements in place or a plan to launch Medicaid managed care for the dually eligible population. Default enrollment may also require that states have information technology systems capable of identifying Medicaid managed care plan members who will soon become eligible for Medicare and share that information with the aligned D-SNP. States reported that the up-front investments to set up default enrollment are considerable. In addition, it is essential that state staff have Medicare expertise, especially experience with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) file that state Medicaid agencies exchange with CMS at least monthly to identify all individuals who are dually eligible in the state. We heard from one state that implementation took about a year, but once default enrollment was operational, the state did not need to hire additional staff to manage it. Of the 23 states in which default enrollment could be implemented, 9 are implementing it (Appendix 6B).[17] Among these, Arizona and Tennessee require default enrollment in their MIPPA contracts. Several other states have recently moved to encourage or require their contracted D-SNPs to use default enrollment, including Pennsylvania, New York, and Virginia. Colorado, Kentucky, Oregon, and Utah have one or two plans approved for default enrollment (CMS 2021d).[18]

States that would like D-SNPs to implement default enrollment may include a provision in their MIPPA contracts that either allows or requires the D-SNP to use default enrollment. States must also establish in their contracts a process to obtain prospective Medicare eligibility data and share the data with D-SNPs, so that plans can identify current Medicaid members who are about to become eligible for Medicare. States may do this by identifying the CMS data they will use, reviewing data at least monthly to monitor future eligibility for Medicare, and determining both the mechanism and the frequency with which the state will share data with D-SNPs (Stringer and Kruse 2019).

States that have elected not to use default enrollment may not have the appropriate infrastructure or may lack the Medicare expertise, resources, or staff capacity needed for implementation. Use of default enrollment may require states and D-SNPs to change their information technology systems to identify D-SNP members who are about to become eligible for Medicare. This is the kind of challenge noted in the Commission's June 2020 recommendation that Congress provide additional federal support for states to enhance their Medicare expertise and capacity to implement integrated care (MACPAC 2020b).

Automatically assign D-SNP enrollees to aligned Medicaid plans. States can use Medicaid auto-assignment algorithms to direct beneficiary enrollment into integrated models. For example, if a dually eligible beneficiary has enrolled in a D-SNP, states can automatically enroll the individual into an aligned Medicaid managed care plan offered by the same parent company. New Jersey and Minnesota are among the few states that currently incorporate D-SNP enrollment in their Medicaid auto-assignment algorithms, perhaps because it can require changes in information systems.

Medicaid auto-assignment may be viewed by beneficiary advocates as more limiting than default enrollment because beneficiaries may have fewer opportunities to change their Medicaid plans after

Medicaid auto-assignment compared with default enrollment. For example, beneficiaries often have the choice to opt out of the Medicaid managed care plan to which they were automatically assigned during the first three months, but after that period, they may be locked into that plan for the remaining nine months of the year. In contrast, dually eligible beneficiaries default enrolled in a D-SNP may opt out during the first 60 days and may also change their plans during the MA annual open enrollment period or during special enrollment periods that they may qualify for throughout the year.[19]

Dually eligible beneficiaries receiving Medicaid LTSS and behavioral health services through Medicaid managed care may have their provider relationships disrupted if auto-assignment switches them from one Medicaid managed care plan to another. On the other hand, many dually eligible beneficiaries, especially those without LTSS or behavioral health needs, often choose their D-SNPs based on their provider networks or supplemental benefits packages; Medicaid auto-assignment allows beneficiaries to stay in their D-SNPs of choice while moving to a more integrated arrangement.

Incorporate Medicaid quality improvement priorities into the D-SNP contract. States that contract directly with D-SNPs for Medicaid coverage can incorporate quality strategies used for their Medicaid managed care programs into their D-SNP contracts. This could advance state priorities for quality of care provided to dually eligible beneficiaries in D-SNPs. Minnesota is an example of a state using this strategy.

Automate Medicaid crossover claims payment processes for Medicaid payment of Medicare cost sharing. States with Medicaid managed care can work with D-SNPs and Medicaid managed care plans to automate the crossover claims payment process for providers who serve dually eligible beneficiaries. This would apply to cases in which a dually eligible beneficiary receives Medicaid and Medicare benefits through unaligned plans operated by different parent companies. An automated process could make it easier for providers to bill appropriately and get paid in a timely manner. However, we are not aware of any states using this strategy, which may indicate challenges associated with setting up this process.

State Ability to Use MIPPA Strategies

The ability of states to use strategies to promote integration depends on several factors. These include whether dually eligible beneficiaries are enrolled in Medicaid managed care, the availability of D-SNPs, whether D-SNPs are operated by the same parent company as those operating Medicaid plans in the service area, state priorities, and administrative capacity. Some strategies can be implemented easily, while others would require more effort, particularly if they require changes to Medicaid procurement processes and considerable staff resources and technical capacity for implementation. States are at different stages of integrating care for the dually eligible population, with some states providing fully integrated care by maximizing their contracting authority and other states not yet offering integrated options for reasons such as a lack of available D-SNPs. In the following sections, we characterize states based on their approach to integrating care.

The availability of Medicaid managed care for dually eligible beneficiaries varies widely by state. As of 2021, 27 states enrolled full-benefit dually eligible beneficiaries in comprehensive Medicaid managed care. Twenty-two used managed care arrangements for LTSS.[20] States in which D-SNPs and Medicaid managed care plans are offered by the same parent company are best positioned to use their MIPPA authority to improve integration.

Limited state capacity to set up contracts with D-SNPs remains a challenge for states. As the Commission previously noted, state resources and staffing are limited and stretched across competing priorities, more so with the demands created by the COVID-19 pandemic (MACPAC 2020a, 2020b).

States without Medicaid managed care may have difficulty implementing these strategies if they lack experience with contracting and procurement. Additionally, many states lack the Medicare expertise necessary to implement new MIPPA strategies. Because implementing an integrated model can take a number of years, staff turnover can impede progress.

States that are maximizing current authority

Some states, including Arizona, Idaho, and Tennessee, have been able to maximize use of MIPPA contracting authority and enroll a large share of dually eligible beneficiaries. Over 20 percent of dually eligible beneficiaries in these states are enrolled in integrated care (CMS 2019e).

These states have taken different paths. Arizona and Tennessee both have a long history of using Medicaid managed care and also use MLTSS. They use default enrollment to enroll Medicaid beneficiaries into D-SNPs when they first become eligible for Medicare. By contrast, Idaho launched its integrated care model in 2014, the same year it began enrolling beneficiaries in managed care. It was able to leverage MIPPA contracting authority to build an integrated care model based on a single FIDE SNP that provides all Medicare services and most Medicaid services, including LTSS (Spencer et al. 2018).[21]

States with D-SNPs aligned with Medicaid managed care

States that have D-SNPs aligned with Medicaid managed care plans can more easily leverage their existing contracts to promote integration and increase enrollment. In 2021, there are 24 states in which at least one D-SNP is aligned with a Medicaid managed care plan; in 13 states all the D-SNPs operating in the state are aligned with a Medicaid managed care plan (Appendix 6C) (CMS 2021b, HMA 2020). The latter can require the D-SNP to exclusively enroll full-benefit dually eligible beneficiaries who receive their Medicaid benefits from the aligned Medicaid managed care plan. At least four have done so.

States with D-SNPs aligned with MLTSS plans are best positioned to maximize integration because their Medicaid managed care plans cover LTSS. Of the 22 states with MLTSS programs, 15 states have D-SNPs that are aligned with MLTSS plans (CMS 2021b, MACPAC 2021, HMA 2020). While MLTSS plans are not always available statewide, in 2019, 1.6 million full-benefit dually eligible beneficiaries lived in areas in which the same parent company operated a D-SNP and an MLTSS plan. In these areas, 44 percent, or 690,000 beneficiaries, were enrolled in a D-SNP, and a smaller number was enrolled in both a D-SNP and an MLTSS plan (MedPAC 2019).

States without Medicaid managed care for dually eligible beneficiaries

States that do not enroll dually eligible beneficiaries in Medicaid managed care (23 states as of January 2021) have fewer alternatives to exercise their MIPPA authorities (Appendix 6D). These states can promote integration by contracting directly with D-SNPs to cover Medicaid benefits, but this requires substantial state resources and investment because this responsibility cannot be delegated to managed care plans. Contracting directly with D-SNPs to cover Medicaid benefits allows states to cover a range of Medicaid benefits in the D-SNP contract, and a number of states do so. For example, Mathematica found that Alabama includes Medicaid coverage of Medicare cost sharing in its D-SNP contracts, and Florida covers Medicaid wrap-around benefits. Because this strategy is resource intensive to implement, states could start by providing capitated payments directly to D-SNPs to cover just Medicare cost sharing or some basic Medicaid benefits as a stepping-stone to integrating more complex benefits, such as LTSS and behavioral health.

For states that cover at least Medicaid wrap-around benefits through direct capitation, this approach opens up the potential to use other MIPPA strategies that are otherwise available only to states with Medicaid managed care. For example, states that cover at least Medicaid wrap-around benefits through direct capitation and limit D-SNP enrollment to full-benefit dually eligible beneficiaries can also require exclusively aligned enrollment (Figure 6-2). Idaho uses this combination of strategies, which maximizes integration.

In addition, states that contract directly with FIDE SNPs may be able to use default enrollment. This strategy is relevant to states that enroll populations that are likely to become dually eligible (e.g., individuals with disabilities) in comprehensive Medicaid managed care.[22] Currently, 10 states and the District of Columbia enroll individuals with disabilities in comprehensive Medicaid managed care but do not enroll dually eligible beneficiaries, possibly due to legal or political barriers to mandatory enrollment (Appendix 6D). In these states, Medicaid beneficiaries who become eligible for Medicare would be disenrolled from their managed care plans. However, if the state contracted directly with FIDE SNPs to cover Medicaid benefits for their members and Medicaid managed care plans were aligned with the FIDE SNPs, the plans could default enroll their Medicaid managed care members into the FIDE SNP when they became dually eligible (Figure 6-2).[23]

Finally, contracting directly with D-SNPs may serve as an on-ramp to mandatory Medicaid managed care for dually eligible beneficiaries by creating an opportunity to demonstrate the benefits of integrated care to beneficiaries without requiring them to enroll. For example, one state reported that rolling out an integrated model in which beneficiaries voluntarily enrolled in FIDE SNPs allowed the state to build support for the program with stakeholders. This eased the state transition to an integrated care model based on mandatory Medicaid managed care.

States without D-SNPs

States that have no D-SNP experience have one advantage that others do not: they may be able to achieve higher levels of integration in their initial D-SNP contracts, as they do not have to worry about disrupting current enrollee coverage. Seven states do not contract with D-SNPs in 2021 (CMS 2021a).

Limitations of State MIPPA Authority

It is important to note that several additional factors beyond those discussed earlier in this chapter may limit states' ability to use D-SNPs as a vehicle for integration. These include whether the state carves out certain populations or benefits from Medicaid managed care, the presence of other integrated models, and whether a large proportion of dually eligible beneficiaries lives in rural areas.

Medicaid carve outs

Many states carve certain services, such as behavioral health, out of Medicaid managed care capitation payments, but this affects the level of integration that can be achieved by contracting with a D-SNP. Behavioral health services tend to be those most commonly carved out of comprehensive contracts. Other common carve outs include dental services, prescription drugs, and non-emergency medical transportation. When a benefit is carved out, the plan is not responsible for providing the benefit and does not receive payment for it. States may also prohibit certain dually eligible beneficiaries, such as LTSS users, from enrolling in managed care programs.

States carve out benefits for a number of reasons, including plans' ability to provide access to specialized providers (Inkelas 2005). Michigan carved out behavioral health services from its FAI demonstration, relying on prepaid inpatient health plans to provide those services (Holladay et al. 2019). One study noted that integrating

previously carved-out benefits can create substantial operational challenges for states (Holladay et al. 2019). Also, states have concerns such as continuity of care in the transition to new providers for populations with complex care needs (Soper 2016).

Presence of other integrated models

States may be hesitant to use MIPPA contracting authority if D-SNPs would compete for enrollment with other integrated models in the state. For example, the nine states that already operate demonstrations under the FAI may be less likely to leverage MIPPA strategies in geographic areas covered by MMPs because D-SNPs would compete with MMPs for dually eligible enrollees.[24]

Challenges in rural areas

States with fewer dually eligible beneficiaries or states where many dually eligible beneficiaries live in rural areas may find it difficult to contract with D-SNPs, as it may be hard to attract D-SNPs if there are too few covered individuals to make plans financially viable. D-SNPs may also find it challenging to build a provider network in such areas for several reasons. First, it may be difficult to meet Medicare network adequacy requirements in rural areas because of the absence of certain provider types and difficulty contracting with a small pool of providers. Second, rural providers may expect higher payment rates from plans because they are the only providers in the geographic area. Third, some providers may also have misgivings about managed care that make them less likely to contract with D-SNPs.

Dually eligible beneficiaries in rural areas may be reluctant to enroll in a D-SNP if their providers are not in the plan's network. One study that reviewed results from the Medicare Current Beneficiary Survey found that among MA enrollees in rural areas, switching from an MA plan to Medicare FFS was more common than among non-rural enrollees (Park et al. 2021). Among high-cost, high-need MA enrollees in rural areas, switching to FFS was even more common. Of the variables studied, dissatisfaction with access to care had the strongest association with plan switching, which could indicate issues with limited benefits or restrictive provider networks (Park et al. 2021).

States with no MA plans or only limited MA availability may find it particularly difficult to contract with D-SNPs. About 70,000 dually eligible beneficiaries live in rural counties where they can receive Medicare coverage only through FFS (CMS 2021b, 2020d). For example, Alaska currently has no MA plans. In North Dakota, South Dakota, and Wyoming, over 20 percent of dually eligible beneficiaries reside in rural counties where no MA plans are available.

Trade-offs between increasing levels of integration and increasing enrollment

States may face a trade-off between promoting integration and increasing enrollment in D-SNPs, at least in the short term. For example, selective contracting and requiring exclusively aligned enrollment can achieve a higher level of integration but may limit the number of D-SNPs in the state and may also limit the number of beneficiaries enrolled in the short run.

By definition, selective contracting makes fewer contracts available, which results in fewer D-SNPs available in the state and potentially lower D-SNP enrollment. For example, if a state offers five Medicaid managed care plan contracts, five aligned D-SNPs would be available. There is also a risk that companies that do not win D-SNP and Medicaid managed care contracts may also continue to operate D-SNP look-alike plans—that is until new CMS rules take effect in 2024. They also could operate regular MA plans rather than lose their members to a competitor D-SNP.[25] Therefore, selective contracting could result in an MA market with fewer integrated D-SNPs and more regular MA plans.

In addition, states with a large number of D-SNP enrollees may be hesitant to use strategies that could disrupt their coverage, even though these strategies would lead to more integration. For example, many existing D-SNPs enroll partial-benefit dually eligible beneficiaries as well as individuals enrolled in an unaligned Medicaid plan offered by a different parent company or through Medicaid FFS. These individuals would have to switch their coverage if a state required D-SNPs to move to exclusively aligned enrollment, and the plan would lose members. This dynamic may make it politically difficult for states with a large number of individuals currently enrolled in D-SNPs to move toward exclusively aligned enrollment.

Looking Ahead

As the Commission continues to explore ways to increase enrollment in integrated products, make integrated products more widely available, and promote greater integration in existing products, our focus over the next year will be on how federal policy could be used to help states move more rapidly in these directions. We recognize that some states are further along a path towards integration than others, and thus we will need to consider how the federal government can structure incentives to meet the needs of states just getting started as well as those that have already made long-standing commitments to integrated care.

We will also continue to monitor the FAI and other efforts to integrate care, including those focused on creating a wholly new approach to serving dually eligible beneficiaries by unifying Medicaid and Medicare benefits, financing, and administration under one umbrella. In addition, we plan to take advantage of the availability of new data from the Transformed Medicaid Statistical Information System (T-MSIS) to release updated information on the characteristics and health care use of dually eligible beneficiaries.

Endnotes

[1] See chapter 1 of MACPAC's June 2020 report to Congress for a description of the dually eligible population, including demographic characteristics, eligibility, and use of services and spending (MACPAC 2020a).

[2] Full-benefit dually eligible beneficiaries are eligible for all Medicaid benefits. They differ from partial-benefit dually eligible beneficiaries who are only eligible for Medicaid assistance with Medicare premiums and sometimes cost sharing.

[3] These contracts are also referred to as state Medicaid agency contracts.

[4] The states in which D-SNPs are not available tend to be rural states with smaller populations, including Alaska, New Hampshire, North Dakota, South Dakota, Wyoming, and Vermont. Illinois ended contracts with D-SNPs in 2017, choosing to focus instead on expanding MMPs statewide. D-SNPs are not available in rural counties in several states, including California, Colorado, Idaho, Maryland, Massachusetts, Michigan, Mississippi, Montana, Nebraska, Nevada, Oklahoma, South Dakota, Utah, Washington, and Wisconsin (CMS 2021b).

[5] This figure does not include 278,000 dually eligible beneficiaries in Puerto Rico who are enrolled in D-SNPs (CMS 2021a).

[6] D-SNPs are designated as HIDE SNPs if their parent organizations have a contract with the state to cover either LTSS or behavioral services or both. In the case in which Medicaid benefits are covered by an aligned Medicaid managed care plan, this would be a managed care contract. In the case in which D-SNPs directly contract to cover Medicaid benefits, this would be a MIPPA contract between the D-SNP and the state.

[7] D-SNPs are designated as FIDE SNPs when LTSS and behavioral health services are covered by the same legal entity as the D-SNP. FIDE SNPs must also use aligned care management and specialty care network methods to meet the needs of high-risk enrollees and "coordinate or integrate beneficiary communication materials, enrollment, communications, grievance[s] and appeals, and quality improvement" (42 CFR 422.2). FIDE SNPs are not required

to cover behavioral health services if the state carves them out of the capitation rate. More details on these models can be found in chapter 1 of MACPAC's June 2020 report to Congress (MACPAC 2020a).

[8] For example, Pennsylvania developed its own D-SNP data-sharing requirements in advance of the Bipartisan Budget Act of 2018 requirements that became effective in 2021. D-SNPs must send a notification of hospital and skilled nursing facility admissions for all D-SNP enrollees. The D-SNP shares information directly with the beneficiary's MLTSS plan within 48 hours of admission (ICRC 2019b). Other states have different approaches to information sharing.

[9] MA plans submit benefit packages to CMS for approval when they apply to operate a D-SNP. Each plan benefit package has a specific set of proposed benefits, cost sharing, premiums, and supplemental benefits (MedPAC 2004).

[10] During the public health emergency related to COVID-19, CMS suspended joint Medicare-Medicaid Coordination Office and state review of MMP marketing materials to reduce the burden on states and plans. States are using contract year 2020 marketing guidance for contract year 2021 (CMS 2020e).

[11] For example, if a D-SNP covers two dental cleanings per year and Medicaid covers four dental cleanings per year, the state could specify in its contract that the D-SNP would cover the beneficiary's first two cleanings under the Medicare supplemental benefit, and then the remaining cleanings would be covered under Medicaid. This arrangement would prevent a situation in which Medicaid and Medicare both calculate their capitation payment to the D-SNP expecting to pay for the beneficiary's first two dental cleanings, duplicating the payment the plan receives for the same service.

[12] This strategy is easier to implement if some alignment exists between organizations offering D-SNPs and Medicaid managed care plans in the state.

[13] It is important to note that beneficiaries in limited benefit Medicaid plans—such as prepaid inpatient health plans and prepaid ambulatory health plans or those from managed fee-for-service models, including primary case management, health homes, or accountable care organizations—are not eligible for default enrollment.

[14] If D-SNPs satisfy a range of other requirements, they may request approval to use default enrollment from both the state and CMS. Those requirements include the following: (1) have a minimum overall quality rating of at least three stars (although D-SNPs that are too new or have insufficient enrollment to receive a star rating are exempt from this requirement), (2) not be prohibited by CMS from enrolling new beneficiaries, (3) operate in a service area that is covered by the Medicaid managed care plan responsible for covering Medicaid benefits for members, (4) demonstrate state approval, and (5) document the state's agreement to provide the information necessary for D-SNPs to identify individuals in its Medicaid managed care plan who may become Medicare eligible.

[15] Beneficiaries may also use the MA annual open enrollment period to change health plans for three months following default enrollment and may qualify for other special enrollment periods throughout the year.

[16] In an analysis of pathways to dually eligible status using 2014 data, about two-thirds of dually eligible beneficiaries were initially Medicaid beneficiaries who became eligible for Medicare due to disability, and one-third of beneficiaries became eligible for Medicare when they turned age 65 (Feng et al. 2019). Slightly more than half (55 percent) who were initially Medicaid beneficiaries later qualified for Medicare based on receipt of Supplemental Security Income (Feng et al. 2019).

[17] Twenty-three states have the basic infrastructure for default enrollment, including D-SNPs aligned with Medicaid managed care plans for dually eligible beneficiaries and populations likely to become dually eligible. D-SNPs in these states must also operate in the same service areas as their aligned Medicaid managed care plans and meet a range of other requirements described in 42 CFR 422.66(c)(2). Some states may not approve D-SNPs for default enrollment if these plans would compete with other integrated models in the state, like MMPs.

[18] Puerto Rico has also approved five D-SNPs for default enrollment (CMS 2021d).

[19] Federal regulations in 42 CFR 423.38 permit dually eligible beneficiaries to qualify for a special enrollment period for MA plans that allows them to enroll, switch plans, or disenroll outside the annual open enrollment period. Beneficiaries can use the special enrollment period once per quarter for the first nine months of the year (i.e., three times per year) (CMS 2018, MACPAC 2020b).

[20] Massachusetts, Rhode Island, and South Carolina have MLTSS only through their FAI demonstrations, so their MLTSS plans cannot align with D-SNPs. These states are not included in our count of states with MLTSS.

[21] Idaho launched its integrated model with one FIDE SNP and, as of 2021, contracts with two FIDE SNPs.

[22] D-SNPs may default enroll beneficiaries only from comprehensive Medicaid managed care plans. That is, they may not enroll beneficiaries from limited-benefit Medicaid plans, such as prepaid inpatient health plans and prepaid ambulatory health plans, or from managed FFS models, including primary case management, health homes, or accountable care organizations (ICRC 2019a).

[23] FIDE SNPs must also meet the requirements described in 42 CFR 422.66(c)(2) to be approved for default enrollment.

[24] MMPs are present in nine states: California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, and Texas (ICRC 2021).

[25] D-SNP look-alike plans are MA plans with enrollment that is largely composed of dually eligible beneficiaries. In 2020, CMS finalized regulations intended to curb the growth of these plans. Beginning in 2022, CMS will not enter into an MA plan contract if 80 percent or more of projected enrollees in the plan bid are dually eligible beneficiaries. Beginning in 2023, CMS will not renew an MA plan contract if the plan has actual enrollment at this threshold as of January of the current year, unless the plan has been active for less than one year and has 200 or fewer enrollees. This requirement will apply only in states in which D-SNPs or another product (e.g., MMPs) are authorized to exclusively enroll dually eligible beneficiaries (CMS 2021c).

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APPENDIX 6A: Examples of Strategies for State Contracts with Dual Eligible Special Needs Plans

States can use a number of strategies to improve integration in their contracts with dual eligible special needs plans (D-SNPs) (Table 6A-1). Some strategies may be used in all states, while other strategies are easiest to use in states that enroll full-benefit dually eligible beneficiaries in Medicaid managed care. Some states are already using these strategies.

TABLE 6A-1. Examples of Strategies for State Contracts with Dual Eligible Special Needs Plans, 2021

Strategy	Description	Possible in	Examples of states using this strategy
Limit D-SNP enrollment to full-benefit dually eligible beneficiaries	Limiting enrollment to individuals eligible for full Medicaid benefits is a strategy used in the Medicare-Medicaid plans. It allows plans to establish a uniform set of benefits and uniform cost sharing and care coordination requirements as well as simpler enrollee materials tailored to the full-benefit dually eligible population. Alternatively, states can require D-SNPs to use separate plan benefit packages to enroll full- and partial-benefit dually eligible beneficiaries.	All states	Arizona, Hawaii, Idaho, Massachusetts, Minnesota, New Jersey, Pennsylvania,[1] and Virginia[1]
Contract directly with D-SNPs to cover Medicaid benefits	States can contract directly with D-SNPs to cover a range of Medicaid benefits. Making capitation payments to D-SNPs to cover Medicaid benefits ensures that the D-SNP is responsible for coverage of both Medicaid and Medicare benefits. States may contract directly with D-SNPs to cover the full range of Medicaid benefits, thereby creating a fully integrated dual eligible special needs plan (FIDE SNP). Other states may contract directly with D-SNPs to cover specific benefits such as Medicare cost sharing.	All states	Alabama, Florida, Idaho, and Massachusetts
Require D-SNPs to use specific or enhanced care coordination methods	States can incorporate requirements to enhance the amount or degree of care coordination, such as incorporating coordination of Medicaid services into the individualized care plans for members. This strategy could improve quality and beneficiary experience of care. States can also require D-SNPs to integrate Medicaid care coordination requirements into the D-SNP's model of care. Medicare Advantage plans, including D-SNPs, are required to establish models of care and submit them for approval to the Centers for Medicare & Medicaid Services (42 CFR 422.101). Models of care typically include a plan for care management and care coordination for the beneficiary.	All states	Idaho, Massachusetts, Minnesota, New Jersey, Tennessee, and Virginia

TABLE 6A-1. (continued)

Strategy	Description	Possible in	Examples of states using this strategy
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. Encounter data, quality measures, and financial reports can help states monitor overall D-SNP performance and advance goals such as health equity.	All states	Arizona, Idaho, Massachusetts, Minnesota, New Jersey, New Mexico, Oregon, Tennessee, and Virginia
Require state review of D-SNP materials related to delivery of Medicaid benefits	States can require D-SNPs to submit marketing materials for state review prior to use. This strategy could ensure consistency in Medicaid benefit descriptions and instructions across different D-SNPs, making them less confusing for beneficiaries and providers.	All states	Idaho, Massachusetts, Minnesota, New Jersey, Tennessee, and Wisconsin
Partner with D-SNPs to develop supplemental benefit packages that complement Medicaid benefits	States can partner with D-SNPs to develop supplemental benefit packages that complement the Medicaid benefits already available to full-benefit dually eligible beneficiaries. This can reduce duplication across Medicaid and Medicare payments.	All states	Arizona, Minnesota, New Jersey, and Pennsylvania
Selectively contracting with D-SNPs that also offer Medicaid managed care plans (or vice versa)	States with Medicaid managed care programs that enroll dually eligible beneficiaries can choose to contract only with D-SNPs that offer a Medicaid managed care plan through the same parent company as the D-SNP, or they can contract only with Medicaid managed care plans that offer a D-SNP through the same organization. This ensures that no unaligned D-SNP or Medicaid managed care organizations could enroll beneficiaries into non-integrated options.	States with Medicaid managed care for dually eligible beneficiaries	Arizona, Hawaii, Minnesota, New Jersey, Tennessee,[2] and Virginia
Require complete service area alignment between D-SNPs and aligned Medicaid managed care plans	States that use selective contracting can require D-SNPs and Medicaid managed care plans operated by the same parent companies to operate in the same service areas so that all eligible individuals will have the option to enroll in aligned plans for coverage, regardless of their geographic location in the state. This strategy makes exclusively aligned enrollment and default enrollment easier to implement.	States with Medicaid managed care for dually eligible beneficiaries	Arizona and New Jersey

TABLE 6A-1. (continued)

Strategy	Description	Possible in	Examples of states using this strategy
Require D-SNPs to operate with exclusively aligned enrollment	Exclusively aligned enrollment occurs when a state limits enrollment in a D-SNP to full-benefit dually eligible beneficiaries who receive their Medicaid benefits from the D-SNP or a Medicaid managed care plan offered by the same parent company. Requiring D-SNPs to enroll only members who are also enrolled in their aligned Medicaid plan ensures that Medicaid and Medicare benefits are provided through a single entity. To implement this strategy, states must either have overlap between plans offering Medicaid managed care and D-SNPs or directly capitate D-SNPs for Medicaid coverage.	All states	Idaho, Massachusetts, Minnesota, and New Jersey
Allow or require D-SNPs to use default enrollment	D-SNPs that meet the requirements at 42 CFR 422.66(c)(2) may use default enrollment to enroll newly dually eligible beneficiaries 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 Medicare eligible. This strategy would ensure an uninterrupted transition from Medicaid-only coverage to dual status, in which an individual's Medicaid and Medicare benefits are coordinated by the same parent organization. Beneficiaries can choose to opt out.	States with Medicaid managed care for dually eligible beneficiaries	Arizona, Colorado, Kentucky, New York, Oregon, Pennsylvania, Tennessee, Utah, and Virginia
Automatically assign D-SNP enrollees to Medicaid plans under the same parent organization	In states with overlap between the organizations offering D-SNPs and Medicaid managed care plans for dually eligible beneficiaries, this strategy ensures an individual's Medicaid and Medicare benefits are coordinated by the same parent organization. Beneficiaries can choose to opt out.	States with Medicaid managed care for dually eligible beneficiaries	Arizona,[3] Minnesota, and New Jersey
Incorporate Medicaid quality improvement priorities into the D-SNP contract	States that directly capitate D-SNPs for Medicaid benefits can incorporate their Medicaid quality improvement priorities into their D-SNP contracts because the direct capitation means they are bound by the same regulations that guide Medicaid managed care. Regulations at 42 CFR 438.330 and 42 CFR 438.340 require states to develop and implement Medicaid Quality Assessment and Performance Improvement programs. This strategy could improve the quality of care provided to dually eligible beneficiaries.	States with Medicaid managed care for dually eligible beneficiaries	Minnesota

TABLE 6A-1. (continued)

Strategy	Description	Possible in	Examples of states using this strategy
Automate crossover claims payment processes for Medicaid payment of Medicare cost sharing	States with Medicaid managed care programs for dually eligible beneficiaries 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. This arrangement applies only to cases in which the dually eligible beneficiary is covered by different plans for Medicaid and Medicare benefits because plans covering both do not make such payments. This can simplify billing and payment for providers who serve dually eligible beneficiaries.	States with Medicaid managed care for dually eligible beneficiaries	None

Notes: D-SNP is dual eligible special needs plan.

[1] Pennsylvania and Virginia require separate plan benefit packages for full- and partial-benefit dually eligible beneficiaries.

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

[3] Arizona does this on a limited basis.

Source: Mathematica, 2021, analysis for MACPAC of state contracts with D-SNPs for contract years 2020 and 2021 as well as interviews with stakeholders and review of federal regulations.

APPENDIX 6B: Implementing Default Enrollment

States can use default enrollment to automatically enroll Medicaid beneficiaries into a dual eligible special needs plan (D-SNP) aligned with their current Medicaid managed care plan when the beneficiary first becomes dually eligible for Medicaid and Medicare. This can increase enrollment of full-benefit dually eligible beneficiaries in D-SNPs.

To use default enrollment, states must have certain infrastructure in place. They must have Medicaid managed care plans and D-SNPs operating under the same parent company or must be contracting directly with D-SNPs to cover all Medicaid benefits. States must also have experience enrolling populations that are likely to become dually eligible, such as adults and individuals with disabilities, in comprehensive Medicaid managed care.

Who Can Be Default Enrolled?

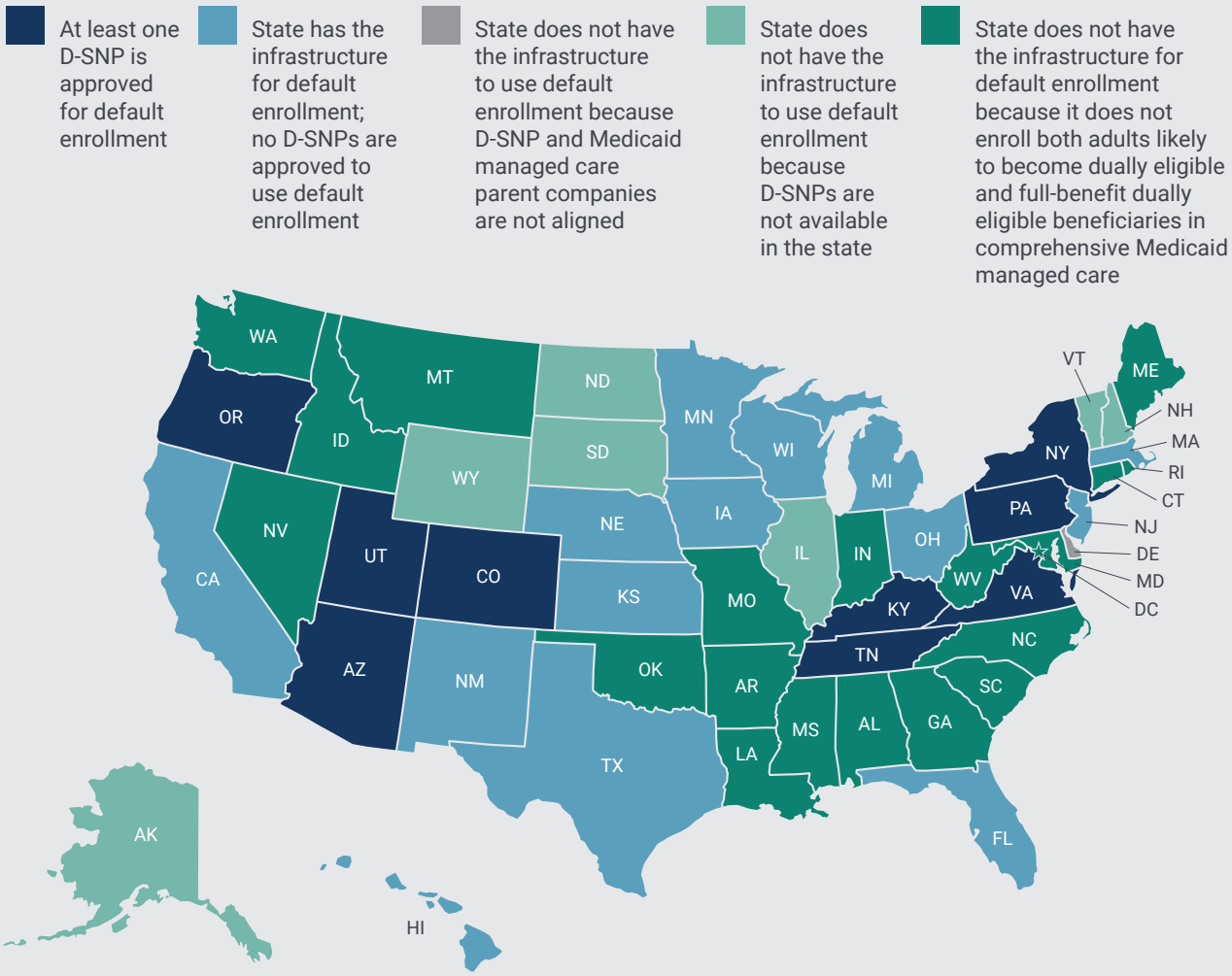
Medicaid beneficiaries who become eligible for Medicare due to age or disability become dually eligible for both programs as long as they retain their Medicaid eligibility. However, Medicaid beneficiaries not eligible due to disability or use of long-term services and supports (LTSS) may lose Medicaid when they turn age 65 or otherwise become eligible for Medicare because the method for determining their financial eligibility changes from modified adjusted gross income (MAGI) to another methodology. For example, the non-MAGI methodology applies an asset test, but the MAGI methodology does not. Becoming eligible for Medicare prompts a Medicaid eligibility redetermination to find out if the beneficiary still qualifies for Medicaid. Individuals who do not retain full-benefit Medicaid coverage upon enrolling in Medicare are not eligible for default enrollment into a D-SNP.

States vary in how they approach Medicaid redetermination and default enrollment. For example, states may exclude certain eligibility groups from default enrollment because they are unlikely to retain Medicaid eligibility after becoming eligible for Medicare or because of the difficulty completing the Medicaid redetermination process in time to meet the 60-day beneficiary notification requirement for default enrollment. In these states, only beneficiaries who are eligible for Medicaid based on a non-MAGI methodology, such as beneficiaries eligible for Medicaid based on disability or Supplemental Security Income, would be default enrolled into D-SNPs.

State Infrastructure Necessary to Use Default Enrollment

Twenty-three states have the basic infrastructure necessary to use default enrollment, and D-SNPs are approved for default enrollment in nine of these states (Figure 6B-1). These 23 states enroll full-benefit dually eligible beneficiaries in Medicaid managed care. They also enroll individuals likely to become dually eligible, such as individuals with certain disabilities, in Medicaid managed care. These states also have at least one parent company that operates both Medicaid managed care plans and D-SNPs or that contracts directly with D-SNPs to cover all Medicaid benefits for their members.

FIGURE 6B-1. States with the Infrastructure Necessary to Use Default Enrollment, 2021



Notes: D-SNP is dual eligible special needs plan. Several states enroll beneficiaries in a form of managed care, but we do not consider those state programs to provide comprehensive managed care coverage, so we have excluded those states. This includes Arkansas, which enrolls certain dually eligible beneficiaries into the Provider-Led Arkansas Shared Savings Entity program for beneficiaries with developmental disabilities and those who use certain behavioral health services. Also, Louisiana and Washington enroll dually eligible beneficiaries in behavioral health organizations (BHOs), but we do not consider BHOs comprehensive Medicaid managed care; however, it is possible for some BHOS and D-SNPs to align to create a highly integrated dual eligible special needs plan.

In addition to not having D-SNPs available in the state, Alaska, North Dakota, South Dakota, and Wyoming do not enroll full-benefit dually eligible beneficiaries in Medicaid managed care.

Source: MACPAC and Mathematica, 2021, analysis of data on special needs plans and Medicaid managed care plans from CMS and state websites.

APPENDIX 6C: Dual Eligible Special Needs Plans Aligned with Medicaid Managed Care Plans

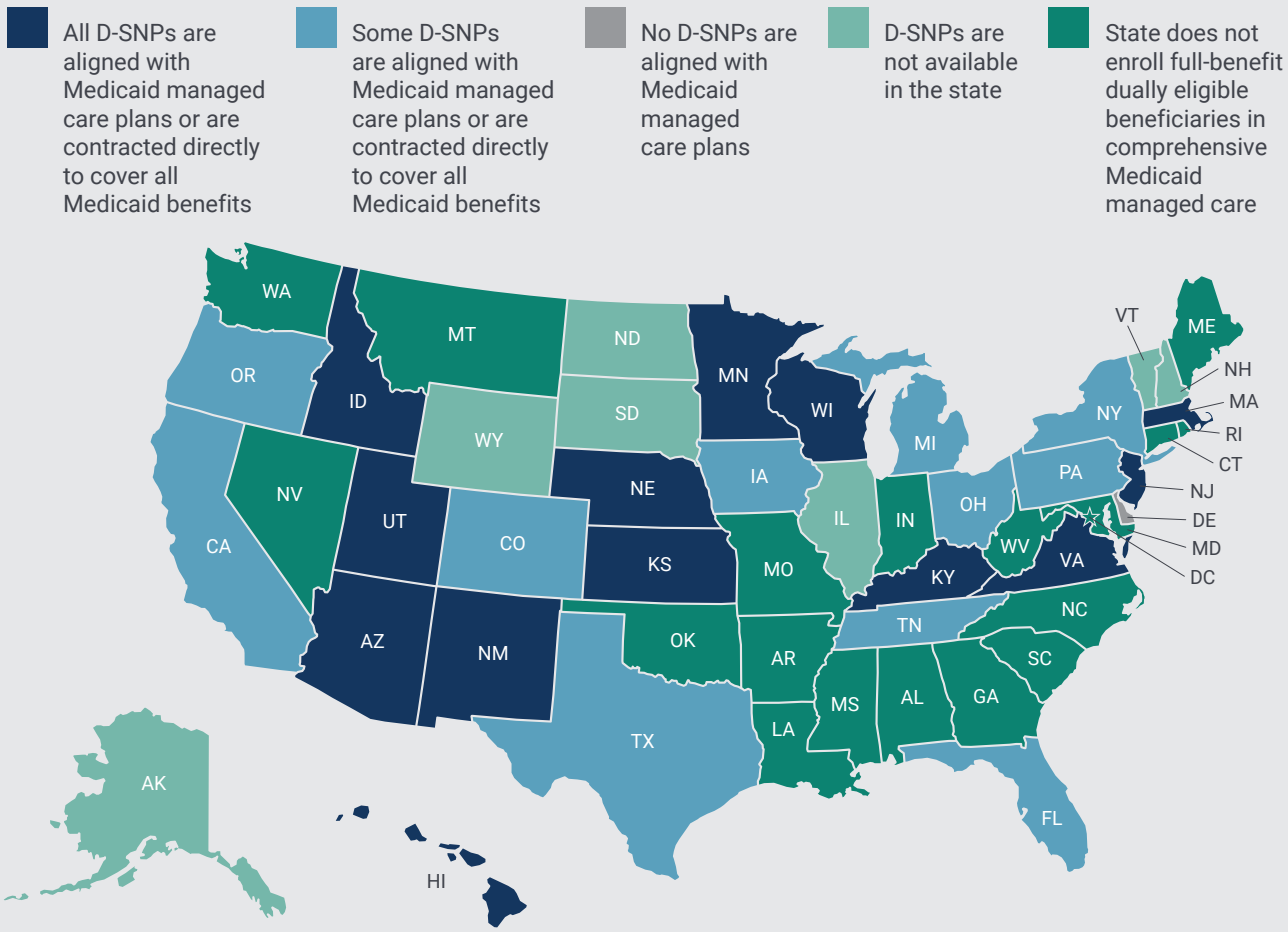
States in which dual eligible special needs plans (D-SNPs) are aligned with comprehensive Medicaid managed care plans offered by the same parent company are best positioned to maximize contracting strategies to improve integration in D-SNPs. States vary in the extent to which plans are aligned (Figure 6C-1). As an alternative for states that do not have D-SNPs aligned with Medicaid plans, states can contract directly with D-SNPs to cover Medicaid benefits and can require that the D-SNP be designated as a highly integrated dual eligible special needs plan (HIDE SNP) or fully integrated dual eligible special needs plan (FIDE SNP).

Twenty-five states have both D-SNPs and Medicaid managed care for dually eligible beneficiaries. Of these, 24 states have at least one parent company that operates a D-SNP aligned with a Medicaid managed care plan, or the state has contracted directly with a D-SNP designated as a HIDE SNP or FIDE SNP. Among the latter include the following:

- In 13 states, all D-SNPs cover Medicaid benefits for their members either directly or through an aligned Medicaid managed care plan.
  - In 4 of the 13 states, D-SNPs use exclusively aligned enrollment.
- In 11 states, some but not all D-SNPs are aligned with a Medicaid managed care plan.
  - These states could selectively contract with D-SNPs that offer aligned Medicaid managed care plans during their next D-SNP procurement cycle if they wanted to ensure that all D-SNPs operating in the state are aligned with a Medicaid managed care plan.

In 25 states and the District of Columbia, alignment is not possible because full-benefit dually eligible beneficiaries are not enrolled in comprehensive Medicaid managed care or D-SNPs are not available or both (Figure 6C-1).

FIGURE 6C-1. Dual Eligible Special Needs Plans Aligned with Medicaid Managed Care Plans by State, 2021



Notes: D-SNP is dual eligible special needs plan. States that use selective contracting include Arizona, Hawaii, Minnesota, New Jersey, Tennessee, and Virginia. Tennessee uses selective contracting for new D-SNP enrollment, but some grandfathered D-SNPs that are not aligned with a Medicaid managed care plan still operate in the state.

States that use exclusively aligned enrollment include Idaho, Massachusetts, Minnesota, and New Jersey.

Some fully integrated dual eligible special needs plans (FIDE SNPs) cover Medicaid services directly rather than through an aligned Medicaid managed care plan. Florida contracts directly with D-SNPs to cover all Medicaid managed care services, except home- and community-based services (HCBS), which are provided by a Medicaid managed care plan. Some D-SNPs are aligned with Medicaid managed care plans that cover HCBS and are designated as FIDE SNPs or highly integrated dual eligible special needs plans. Massachusetts contracts directly with D-SNPs to cover Medicaid and Medicare benefits, and all D-SNPs are designated as FIDE SNPs.

In addition to not having D-SNPs available in the state, Alaska, North Dakota, South Dakota, and Wyoming do not enroll full-benefit dually eligible beneficiaries in Medicaid managed care.

Several states enroll beneficiaries in a form of managed care, but we do not consider those state programs to provide comprehensive managed care coverage, so we have excluded those states. This includes Arkansas, which enrolls certain dually eligible beneficiaries into the Provider-Led Arkansas Shared Savings Entity program for individuals with

FIGURE 6C-1. (continued)

developmental disabilities and individuals who use certain behavioral health services. Also, Louisiana and Washington enroll dually eligible beneficiaries in behavioral health organizations (BHOs), but we do not consider BHOs comprehensive Medicaid managed care. However, it is possible for some BHOs and D-SNPs to align to create a highly integrated dual eligible special needs plan.

Rhode Island and South Carolina enroll full-benefit dually eligible beneficiaries into Medicare-Medicaid plans through the Financial Alignment Initiative demonstration, but outside the demonstration, dually eligible beneficiaries are not enrolled in Medicaid managed care plans that could align with D-SNPs.

Source: MACPAC and Mathematica, 2021, analysis of data on special needs plans and Medicaid managed care plans from CMS and state websites.

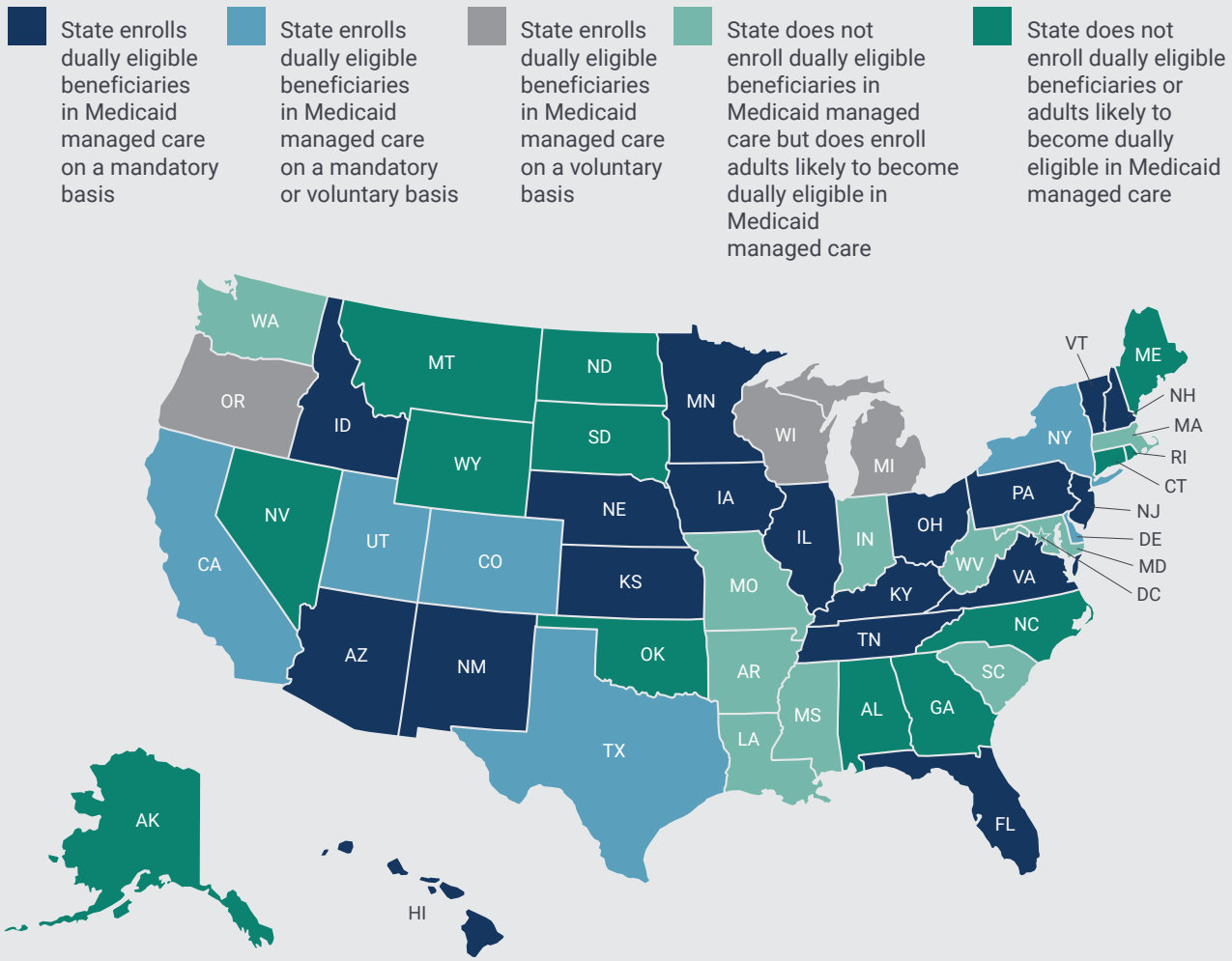
APPENDIX 6D: States Enrolling Full-Benefit Dually Eligible Beneficiaries in Medicaid Managed Care

States that enroll full-benefit dually eligible beneficiaries in Medicaid managed care have a greater ability to use contracting strategies to improve integration in dual eligible special needs plans (D-SNPs) (Figure 6D-1). States may enroll dually eligible beneficiaries in Medicaid managed care on a mandatory or voluntary basis. For example, states may enroll beneficiaries in certain counties or in select populations in mandatory Medicaid managed care, while other dually eligible beneficiaries are enrolled voluntarily in Medicaid managed care. States that enroll dually eligible beneficiaries in Medicaid managed care on a mandatory basis have a greater ability to use contracting strategies to improve integration and increase enrollment in D-SNPs.

On the other hand, states that do not have experience enrolling the dually eligible population in Medicaid managed care would have more difficulty implementing certain contracting strategies. Twenty-three states and the District of Columbia do not enroll full-benefit dually eligible beneficiaries in Medicaid managed care. These states could have a difficult time using the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275) strategies because they may lack the staff, tools, and experience necessary, such as procurement, rate setting, quality management, and plan oversight, to contract directly with D-SNPs to cover Medicaid benefits for dually eligible beneficiaries.

Of the 23 states that do not enroll full-benefit dually eligible beneficiaries in Medicaid managed care, 10 states and the District of Columbia do enroll populations that may become dually eligible in Medicaid managed care. These states may be able to leverage their experience with Medicaid managed care procurement for this population to contract directly with D-SNPs to cover Medicaid benefits for full-benefit dually eligible beneficiaries.

FIGURE 6D-1. States that Enroll Dually Eligible Beneficiaries in Medicaid Managed Care, 2021



Notes: For this figure, Medicaid managed care refers to comprehensive Medicaid managed care, and dually eligible beneficiaries refers to full-benefit dually eligible beneficiaries.

Alaska and Connecticut do not have any Medicaid managed care enrollment.

Several states enroll beneficiaries in a form of managed care, but we do not consider those state programs to provide comprehensive managed care coverage, so we have excluded those states. This includes Arkansas, which enrolls certain dually eligible beneficiaries into the Provider-Led Arkansas Shared Savings Entity program for beneficiaries with developmental disabilities and those who use certain behavioral health services, but we do not consider this program comprehensive Medicaid managed care. Louisiana and Washington enroll dually eligible beneficiaries in behavioral health organizations (BHOs), but we do not consider BHOs comprehensive Medicaid managed care. However, it is possible for some BHOs and dual eligible special needs plans (D-SNPs) to align to create a highly integrated dual eligible special needs plan.

Massachusetts does not have a stand-alone, comprehensive Medicaid managed care program for dually eligible beneficiaries and instead contracts directly with D-SNPs to cover all Medicaid benefits for the plans' members; all D-SNPs in the state are designated as fully integrated dual eligible special needs plans.

FIGURE 6D-1. (continued)

Minnesota and Nebraska enroll select populations of dually eligible beneficiaries in Medicaid managed care on a mandatory basis.

Nevada and North Dakota enroll adults eligible under the Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) into Medicaid managed care but do not enroll adults likely to become dually eligible or dually eligible beneficiaries in Medicaid managed care.

Rhode Island and South Carolina voluntarily enroll full-benefit dually eligible beneficiaries into Medicare-Medicaid plans through the Financial Alignment Initiative demonstration, but dually eligible beneficiaries outside the demonstration are not enrolled in Medicaid managed care.

Source: MACPAC and Mathematica, 2021, analysis of state use of managed care for the dually eligible population.