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ISSUE BRIEF

Dual Eligible Special Needs Plans (D-SNPs): What Advocates Need to Know

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Dual Eligible Special Needs Plans (D-SNPs) are a type of Medicare Advantage plan designed to serve individuals who are dually enrolled in Medicare and Medicaid ("dual eligibles" or "dually eligible individuals"). Enrollment in D-SNPs has doubled in the past four years, with current D-SNP membership at over five million individuals.[1]

An increasing number of states are focusing on D-SNPs as a primary vehicle for integrating care and improving coordination of services for their dual eligible populations.[2] At the same time, many enrollees in Medicare Advantage plans report that they experience narrower provider networks and more instances where their requested services will be subject to review and prior authorization. This makes it especially important for advocates to advance strategies for integrating care while maintaining and improving access to services and supports.

Yet many advocates know little about what D-SNPs are, what makes them unique, and how they operate. This issue brief provides advocates with basic information about D-SNPs, whom they serve, and their structure. It also identifies specific areas where advocates can engage with their states to ensure that D-SNPs work effectively to coordinate care and benefits for dually eligible individuals, including strategies in centering equity from the outset in the design of D-SNPs.

THE BASICS: WHAT ARE D-SNPS & WHOM DO THEY SERVE

Special Needs Plans (SNPs), a subset of plans within the Medicare Advantage program, were launched in 2006 to serve specific populations within Medicare managed care. There are three categories of SNPS: D-SNPs, which

serve individuals who are dually eligible for Medicare and Medicaid; I-SNPs, which serve individuals who are in institutions or receiving long-term services and supports in the community; and C-SNPs, which serve individuals with specific chronic conditions.[3] SNPs first began operating under temporary authority and were made permanent in 2018.[4]

D-SNPs form the largest category of SNPs, both in enrollment and in number of plans offered.[5] D-SNP enrollment is almost half (46%) of total Medicare Advantage enrollment, and is growing rapidly – from 2.5 million in 2019 to 5.2 million in 2023.[6] During the same time period, the number of D-SNP plans increased from 465 to 851.[7] As of January 2024, D-SNPs operate in the District of Columbia and every state except Alaska, Illinois, New Hampshire, North Dakota, and Vermont.[8] Although enrollment levels vary greatly by state and by region within states, 93% of dually eligible individuals live in a county where at least one D-SNP is available.[9]

Populations that have experienced systemic discrimination are disproportionately dually eligible. For example, **individuals facing health challenges, people who are low-income, and people of color are more likely to be dually eligible (compared to the Medicare only population)**.[10] See Appendix A. Because dually eligible individuals account for disproportionate percentages of Medicare and Medicaid spending compared to their percentage of enrollment, D-SNPs can play a role in coordinating care, preventing duplicative services, and reducing medical spending.[11]

D-SNPS ARE SUBJECT TO BOTH FEDERAL AND STATE OVERSIGHT

As a subset of Medicare Advantage plans, D-SNPs are subject to federal oversight and must comply with Medicare Advantage regulations and guidance.[12] For example, each D-SNP must develop an evidence-based Model of Care built around the characteristics of the population it serves and approved by the National Committee for Quality Assurance.[13] D-SNPs must coordinate Medicaid benefits; screen for transportation, housing, and food security needs; and establish and maintain an enrollee advisory committee.[14] The enrollee advisory committee must reasonably represent the population served by the D-SNPs and solicit member input to improve access to covered services, coordination, and health equity.[15]

D-SNPs are unique among Medicare Advantage plans because states also have a significant role in setting requirements and overseeing D-SNP performance. Each D-SNP sponsor must enter into a contract with the state in which the D-SNP operates.[16] Federal law sets out minimum requirements for these contracts, called State Medicaid Agency Contracts (SMACs).[17] States can impose additional requirements regarding enrollee categories, details of how plans will manage care and benefit coordination with Medicaid, cost-sharing responsibilities of D-SNPs and other matters.[18] For example, Oregon requires D-SNPs to develop and maintain more robust discharge planning policies, and Minnesota requires D-SNPs to submit communications and marketing materials to the state for review.[19]

Advocacy Opportunities

Many state Medicaid agencies have limited in-house expertise in Medicare programs and policies, particularly as they affect dually eligible enrollees. With the significant growth in D-SNP enrollment and the urgent need to address health disparities among dually eligible individuals, it is increasingly important for states to develop such expertise, with dedicated personnel and/or a dedicated office to address the needs of dually eligible individuals and specifically to oversee SMAC contracts. Advocates can work to ensure that their state recognizes this need and devotes appropriate resources to dual eligible issues.

Advocates can also work with their state to formalize avenues for advocates and consumers to participate in the process of developing performance criteria in SMACs as well as review oversight mechanisms. It is particularly important to incorporate voices from marginalized communities, since an important role of D-SNPs should be to address longstanding health inequities among dually eligible individuals. The newly required enrollee advisory committees can play an important role in lifting up these perspectives.

STATES HAVE OPTIONS FOR IMPOSING ENROLLMENT RESTRICTIONS FOR D-SNPS

As with any Medicare Advantage plan, enrollment in a D-SNP is limited to individuals with both Medicare Part A and Part B coverage.[20] Further, to be in a D-SNP an individual must be dually eligible for both Medicare and Medicaid coverage.[21] States have the option of setting additional enrollment restrictions.

Enrollment of Partial Duals. States may allow enrollment of "partial duals,"that is, individuals who are only enrolled in a Medicare Savings Plan such as Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Individual (QI). As of 2021, a majority of states (36) permit enrollment of partial duals into D-SNPs.[22] States may limit enrollment to full-benefit dually eligible individuals or set even more restrictive enrollment criteria through the SMACs. For example, a state may authorize a D-SNP that only enrolls individuals who are full benefit dually eligible individuals and receiving long-term services and supports in the community, or a D-SNP that only enrolls dual eligible individuals who require nursing facility level of care.[23]

Advocacy Opportunities

CMS and states are grappling with the question of whether to continue to permit D-SNPs to enroll individuals who only have Medicare Savings Program (MSP) coverage (partial dual eligibles) and do not have full Medicaid. Since these individuals are only receiving Medicare services and not entitled to any Medicaid services, it is questionable whether they derive any special benefit from D-SNP enrollment. At the same time, there is a portion of the partial dual population that switches to fully dually eligible and vice versa, and may benefit from continued coverage by the same plan.[24] This is an area that advocates can explore with their states and with D-SNP plan sponsors.

Aligned Enrollment. When a Medicaid Managed Care Organization (MMCO) has a particular relationship with a D-SNP (e.g. through a parent company)[25], that MMCO is considered "affiliated" with the D-SNP.[26] A person who receives their Medicaid benefits through the D-SNP or an affiliated MMCO are considered to have "aligned enrollment."[27] Because there is a relationship between the MMCO and D-SNP, and a shared financial incentive, many policy makers believe that plans will facilitate a more integrated experience when there is aligned enrollment.[28]

In states that use MMCOs to deliver its Medicaid benefits, states may encourage aligned enrollment by limiting D-SNP contracts to plan sponsors that also operate an MMCO in the same service area.

When a D-SNP's enrollment is limited to **only allow** individuals who receive their Medicaid benefits through the D-SNP or the D-SNP's affiliated MMCO, this policy is referred to as "**exclusively aligned enrollment.**"[29] D-SNPs with exclusively aligned enrollment do not allow enrollment by members who are in an unaligned MMCO or who are receiving their Medicaid benefits through fee-for-service Medicaid. Further, exclusively aligned D-SNPs may not enroll any members who are partial duals, since those members are not enrolled in any MMCO. Exclusively aligned enrollment has been promoted as a way to improve the experience of dually eligible individuals by facilitating coordination of benefits, integrated appeals, and integrated enrollee communication.[30] There are exclusively aligned D-SNPs in at least 12 states.[31] Note that some D-SNPs may have exclusively aligned enrollment without it being required to by the state.

Some states require D-SNPs to have exclusively aligned enrollment.[32] As of 2021, Idaho, Massachusetts, Minnesota, and New Hampshire had provisions in their SMACs that require exclusively aligned enrollment.[33] California requires exclusively aligned enrollment for some, but not all, D-SNPs.[34]

Advocacy Opportunities

The primary goal of the D-SNP model is better coordination of Medicare and Medicaid benefits. Currently, however, many dually eligible individuals are enrolled in a D-SNP operated by one insurance company and a Medicaid MMCO operated by another insurance company. Such misaligned enrollment generally hampers rather than facilitates care coordination across programs. Since most states do not restrict this misaligned enrollment, advocacy on this issue can be important. One avenue of advocacy is to ensure that, if misalignment is permitted, there are measures in place requiring that the unaligned plans share information and work together to coordinate care. Another avenue is to seek provisions in SMAC contracts that increase alignment, such as the sample language developed by the Integrated Care Resource Center (ICRC). [35]

Default Enrollment into a D-SNP. CMS permits default, or automatic, enrollment into a D-SNP when a Medicaid individual becomes newly eligible for Medicare either through age or disability, and the individual is in a Medicaid MMCO operated by the same sponsor as the D-SNP.[36] A D-SNP must meet certain criteria and have both state and CMS approval before using default enrollment.[37] As of 2023, 64 D-SNPs in 12 states and Puerto Rico use default enrollment.[38]

Before being subject to default enrollment, the individual must receive at least 60-day prior notice of the upcoming default enrollment and an opportunity to opt out.[39] D-SNP members, like all dually enrolled individuals, also have multiple opportunities during the year in which to change plans or move to Original Medicare.[40] Default enrollment is a mechanism states may use to increase aligned enrollment between D-SNPs and MMCOs.[41]

Example

Mr. Thomas resides in a state that permits default enrollment. He is currently enrolled in MMCO Beta and is about to turn age 65 and become Medicare eligible. D-SNP Beta sent Mr. Thomas a notice that he will be automatically enrolled into the D-SNP unless he opts out or makes a different Medicare enrollment choice.

Advocacy Opportunities

Experience with the Financial Alignment Initiative dual eligible demonstrations has shown that, if default enrollment is implemented, very strong consumer protections, both before and after enrollment, are necessary to avoid disruptions in access to care. Written notices—at least two—to potential enrollees must be clear, simple, available in multiple languages and formats, and consumer-tested so individuals can understand what is happening and how to exercise their choices. Individuals should have easy access to explanations and options counseling and outreach should be culturally competent. Strong continuity of care provisions for out-of-network providers are necessary to prevent disruption in access after a default enrollment. Significant outreach to providers before the start of default enrollment also is a critical piece so that advice they give to their patients about enrollment choices is accurate and also because provider awareness is essential for care continuity protections to work.[42] For all of these preparatory steps, advocate input is essential.

D-SNP LEVELS OF INTEGRATION WITH MEDICAID CAN VARY MARKEDLY

The extent to which D-SNPs coordinate with Medicaid varies significantly. CMS has developed several categories of D-SNPs, each with different definitions and minimum integration requirements. The landscape of D-SNP plans vary by state and often states only have one or two types of -D-SNPs.[43] See Appendix B.

The main categories of D-SNPs that this issue brief address are:

- **Fully-Integrated D-SNPs** (FIDE-SNPs), currently serving 400,000 people in 13 states and D.C.
- **Highly-Integrated D-SNPs** (HIDE-SNPs), currently serving 2.1 million people in 15 states and D.C.
- **Coordination-only D-SNPs** (CO DSNPs), currently serving 3.3 million people in 38 states and D.C.
- **Applicable Integrated Plans** (AIPs), which is a designation that can apply to FIDE-SNPs, HIDE-SNPs, and CO D-SNPs

The most integrated D-SNPs are **Fully-Integrated D-SNPs** (FIDE-SNPs). FIDE-SNPs are single plan entities that hold capitated contracts to provide both Medicare and Medicaid services and whose contracts on the Medicaid side cover essentially all Medicaid services, including long-term services and supports. FIDE-SNPs that have exclusively aligned enrollment also belong to a category called "Applicable Integrated Plans" (AIPs). See below for more on Applicable Integrated Plans. Starting in plan year 2025, all FIDE-SNPs will be required by CMS to have exclusively aligned enrollment, which will mean that all FIDE-SNPs will be AIPs by plan year 2025.[44]

Example

Ms. Smith belongs to Alpha Health, a FIDE-SNP. She gets all her Medicare and Medicare services from Alpha Health.

Highly-Integrated D-SNPs (HIDE-SNPs) hold Medicare and Medicaid contracts but can do so either directly or through separate entities controlled by the same sponsor. To qualify as a HIDE-SNP, the sponsor's Medicaid contracts must cover provision of most Medicaid services, including long-term services and supports or behavioral health, but are not required to cover both.[45] HIDE-SNPs that have exclusively aligned enrollment are AIPs, described in more detail below.

Example

Mr. Lopez belongs to Beta Health, a HIDE-SNP and also to Beta Health MMCO. He gets all his Medicare services through Beta Health HIDE-SNP and most of his Medicaid services through Beta Health MMCO. However, in his state, Medicaid behavioral health services are "carved out" of Medicaid managed care and provided directly by the counties. In other words, the Medicaid MMCO is not responsible for the provision of Medicaid behavioral health services. Beta Health HIDE-SNP helps him get an appointment for behavioral health services but does not provide the service itself.

If a D-SNP is not a FIDE-SNP or a HIDE-SNP, it is called a "**coordination only**" D-SNP (CO-DSNP). CO-DSNPs are not as integrated as FIDE-SNPs or HIDE-SNPs. Their obligations to coordinate with Medicaid services are only very generally defined in federal regulations.[46] The one specific federal obligation for CO- D-SNPs is that they must, for at least one subset of dually eligible enrollees, provide notice to the state when a member is admitted to a hospital or skilled nursing facility.[47] CO-DSNPs may or may not have aligned enrollment with a MMCO. See below for more on Applicable Integrated Plans.

Example

Mrs. Lopez belongs to Delta Health, a CO-DSNP and to Cap Health, a MMCO. Delta and Cap Health are not affiliated with each other. Ms. Lopez has two plan insurance cards, one for Delta Health and one for Cap Health. Ms. Lopez needs surgery and while Delta Health provides some care coordination, she still found it confusing and difficult to find care at home after her surgery. She not sure what the different rules were for her D-SNP and MMCO or which plan card to use or which plan to call to obtain care.

Applicable Integrated Plans (AIPs) are D-SNPs that meet certain requirements and can include FIDE, HIDE, and CO-DSNPs. D-SNPs that are AIPs must have a unified appeals and grievances process that takes into consideration both Medicare and Medicaid.[48] All AIP D-SNPs must have exclusively aligned enrollment and the D-SNP must cover some Medicaid benefits.[49] As discussed earlier, a FIDE or HIDE SNP can be an AIP if it operates with exclusively aligned enrollment. Like FIDE-SNPs and HIDE-SNPs, a CO-DSNP can also be an AIP, but must have an affiliated MMCO; cover, through the D-SNP or the affiliated MMCO, certain Medicaid services; and have exclusively aligned enrollment by limiting enrollment to individuals in the affiliated MMCO.[50]

States have power to limit the types of D-SNPs that operate in their state, and add requirements in D-SNP contracts that address concerns around access to care and integration. Though states have the option of adding other specific requirements in their contracts, most states have not yet exercised that option to any significant degree.[51]

Advocacy Opportunities

As more dually eligible individuals move into D-SNPs, care should be taken to monitor continued access to providers, services, and supports. Advocates can play a role in developing and supporting policies that require plans to provide transparency and to follow rules preserving access. Transitions can be particularly daunting when a state decides to move previously carved-out services, such as behavioral health, into managed care. Advocates can play an important role in helping to design integration protocols that maintain access to providers and ensure transitions happen smoothly. Safety nets and care continuity are of particular importance with any changes in delivery of behavioral health services.

The type of D-SNP that can operate in a state depends in part on that state's Medicaid managed care landscape. As of 2022, 28 states require dually enrolled individuals to enroll in an MMCO for some or all services.[52] Many states with Medicaid managed care leave out certain services from the managed care contract, often referred to as a "carve out."[53] As described above, if a state does not employ Medicaid managed care, or has carve outs for behavioral health or long-term care, this can limit what types of D-SNPs can operate in the state.

Financial Alignment Initiative and D-SNP Look-Alikes

D-SNPs are distinct from the fully capitated models tested by CMS in ten states in the Financial Alignment Initiative (often referred to as the duals demonstration).[54] In the FAI model, a participating plan provides all Medicare and Medicaid services, receiving fully capitated payments from both CMS and the state. Those payments can be used together for all covered and supplemental services under both programs. With D-SNPs, even if they are FIDE-SNPs, the financing remains distinct and cannot be merged. The FAI model has been discontinued, and will no longer operate after December 2025.[55]

In recent years, some Medicare Advantage plan sponsors started to offer plans that are not D-SNPs but appeal almost exclusively to dually eligible individuals because of their cost and benefit structure. The dual eligible membership in these plans, known as "D-SNP look-alikes," sometimes topped 95% but these plans did not have the enrollee protections, care coordination requirements, and state oversight of D-SNPs.[56] Close to 200,000 dual eligibles have enrolled in look-alike plans in 13 states.[57] Concerned with this development, CMS has stopped approving or renewing look-alike plans with more than 80% of total enrollment being dually eligible individuals and has recently proposed lowering this enrollment threshold to 60%.[58] CMS does, however, allow plan sponsors to transition members of those plans into a D-SNP operated by the same plan sponsor.[59]

D-SNP BENEFIT PACKAGES CAN INCLUDE SUPPLEMENTAL BENEFITS

As with other Medicare Advantage plans, D-SNPs may offer supplemental benefits beyond those offered by Medicare Part A or Part B. These can include extra health-related benefits such as coverage for dental visits or adult day health services, as well as non-medical benefits such as pest control or transportation for non-medical needs.[60] Through the SMAC contracting process, states have leverage to help ensure that supplemental benefit packages are appropriate for and accessible to D-SNP enrollees.[61]

One issue of concern is supplemental benefits that duplicate or overlap with Medicaid benefits already available to dually eligible D-SNP enrollees. CMS permits D-SNPs to offer such benefits, for example, a D-SNP may offer Non-Emergency Medical Transportation services or some dental coverage that overlaps with benefits also provided under the state's Medicaid program.[62] In many cases overlapping services are of limited benefit to the plan member and can be difficult for the member to navigate. States can, however, use the contracting process to require that D-SNPs offer supplemental benefits that complement, rather than duplicate Medicaid benefits.

Another important issue regarding supplemental benefits offered by D-SNPs is that information is limited. D-SNP enrollees do not necessarily have access to clear information about whether they may be eligible for supplemental benefits and how to access them. At the same time, information is limited concerning how many D-SNP enrollees actually receive the supplemental benefits offered and, importantly, whether those who are most disadvantaged and those with the most needs have full access to the benefits. Data collection concerning uptake of supplemental

benefits, including specifically demographic data is a necessary first step to determining whether supplemental benefits are being distributed equitably.

The limited information that is available raises concerns. For example, a county-level analysis of the availability of supplemental benefits found that the number of Medicare Advantage Plans, including but not limited to D-SNPs, that offered any non-medical supplemental benefit was, on average, lowest in counties with the highest poverty rates.[63] CMS has taken strides to improve this information. In December 2023, CMS finalized its rule to require MA plans to report utilization and cost data for all supplemental benefit offerings, though this information is not required to be broken out by demographic data.[64] CMS has also proposed helping improve information available to enrollees, including proposing a mid-year notification of supplemental benefits they may be eligible for.

Advocacy Opportunities

Advocates can work with their state and with D-SNPs serving their area to ensure that supplemental benefits are robust and responsive to the needs of dually eligible individuals, and that they complement, rather than duplicate, benefits available through the Medicaid program. Advocates can also encourage their states to fill current information gaps by requiring data collection about use of supplemental services, with an emphasis on data that will allow an equity analysis. Without basic demographic data, it is impossible for D-SNPs to know how well they are addressing equity and for regulators and stakeholders to evaluate their performance. Advocates can also encourage their states to require D-SNPs provide clear information about who is eligible for supplemental benefits and how they can be accessed.

SOME D-SNPS MUST OFFER INTEGRATED APPEALS AT THE PLAN LEVEL

CMS requires that all D-SNPs with an AIP designation use unified, integrated appeal processes.[65] In other words, if a service might be covered by Medicare or Medicaid, the plan must review the request, applying all applicable Medicare and Medicaid coverage criteria, and send a single notice addressing both elements.[66] If a plan member appeals a denial, the plan must also undertake an integrated review and issue an integrated reconsideration notice.

Example

Mr. Smith requests coverage from his FIDE-SNP for a power wheelchair prescribed by his physician. In its organizational determination, the plan must review his request under both Medicare's use-in-the-home standard and Medicaid's more expansive coverage criteria. If the plan denies the claim and Mr. Smith appeals, the D-SNP must conduct an integrated redetermination and again review the request under both standards.

CMS encourages plans that are not AIPs to integrate their appeal processes as much as possible. At a minimum, D-SNPs are expected to assist members in filing Medicaid appeals. [67] CMS also expects D-SNPs to assist in gathering medical documentation from providers in support of a Medicaid appeal.[68]

Advocacy Opportunities

Advocates can work with their state and with D-SNPs to ensure that all D-SNPs, including D-SNPs with minimal integration, have robust measures in place to assist members in navigating Medicaid appeals. This assistance should be available in all states, including those with fee-for-service Medicaid.

LOOKING AHEAD

D-SNPs are here to stay and their enrollment continues to grow. For advocates, understanding D-SNPs is important both for assisting clients and for policy advocacy. Advocates need to be aware of the levers available to states and federal agencies to affect D-SNP design and to engage as stakeholders, particularly at the state level, to help ensure that requirements for plans and their actual operations work effectively to meet the complex needs of dually eligible individuals and promote health equity in the delivery of services. Because dually eligible individuals are often people of color, people with disabilities and chronic conditions, the ability of D-SNPs to address equity in health care access should get particular attention. For example, there is a need to assess how effective a D-SNP's care coordination and coordination of benefits is at improving enrollee experience and access to services, and how disruptive D-SNP prior authorization and network restrictions are to enrollee care.

This advocacy starts with an understanding of the extent of D-SNP penetration in the state, the state's D-SNP enrollment rules, and the scope of D-SNP services, both to assist clients with enrollment choices, and to help them navigate issues that arise with the delivery of services. We encourage advocates to explore and understand the D-SNP landscape in their state and the policies the state has implemented with D-SNPs. Please see Appendix C for a list of resources to get started.

This area of advocacy is complicated. A growing number of organizations and experts are turning to D-SNP policy to help shape a better health care landscape for older adults and people with disabilities.

Justice in Aging is engaging in an educational campaign on D-SNPs. Learn more and get involved.

APPENDIX A

A SNAPSHOT OF DUALLY ELIGIBLE INDIVIDUALS

As of 2021, there were about 13.2 million people who were dually enrolled in Medicaid and Medicare. 9.8 are full dually eligible individuals, meaning that they are enrolled in full Medicaid. And 3.4 million are partial dually eligible individuals, meaning that the only Medicaid program they are enrolled in is a Medicare Savings Program.[69]

The dually eligible population tends to be more racially diverse (more likely to be Black or Hispanic), have lower incomes, and face greater health challenges than the general Medicare population.[70] See Figures 1, 2, and 3.

FIGURE 1

Characteristics of dually eligible and Medicare-only populations, 2020.

Source: KFF analysis of the Medicare Current Beneficiary Survey, Maria T. Peña, KFF, A Profile of Medicare-Medicaid Enrollees (Dual Eligibles) (Jan. 31, 2023)

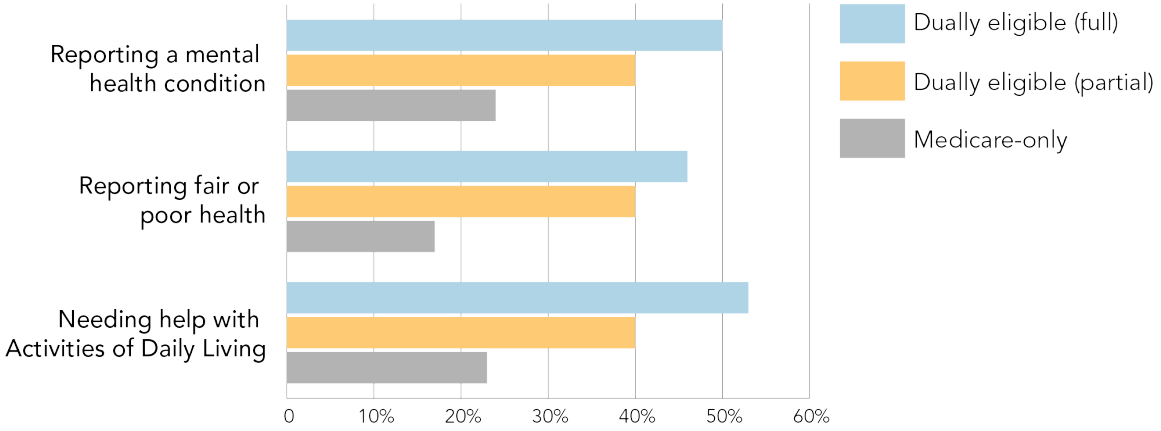


FIGURE 2

Medicare enrollee, by type of enrollee, race, and ethnicity, 2020

Source: KFF analysis of the Medicare Current Beneficiary Survey, Maria T. Peña, KFF, A Profile of Medicare-Medicaid Enrollees (Dual Eligibles) (Jan. 31, 2023)

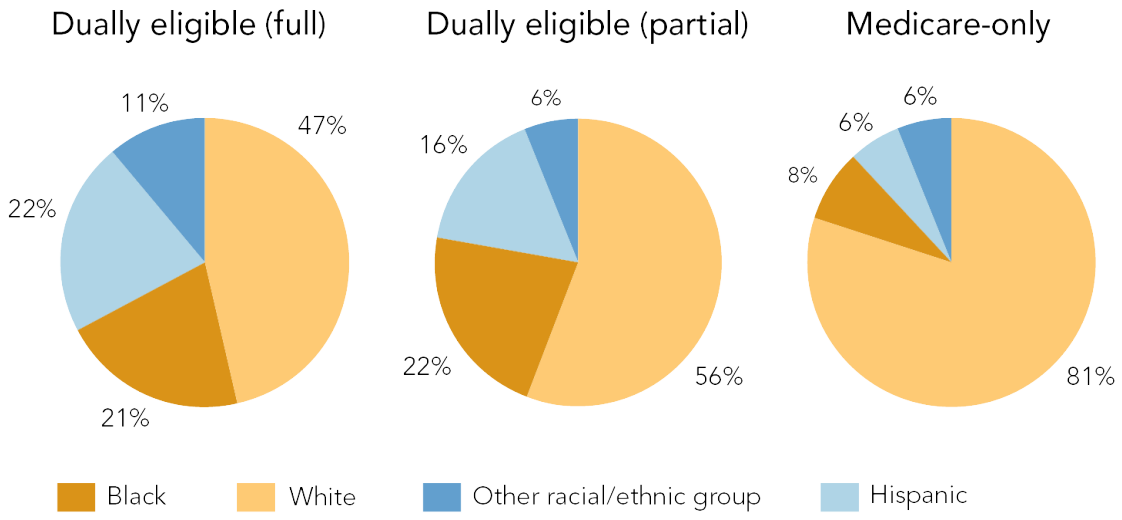
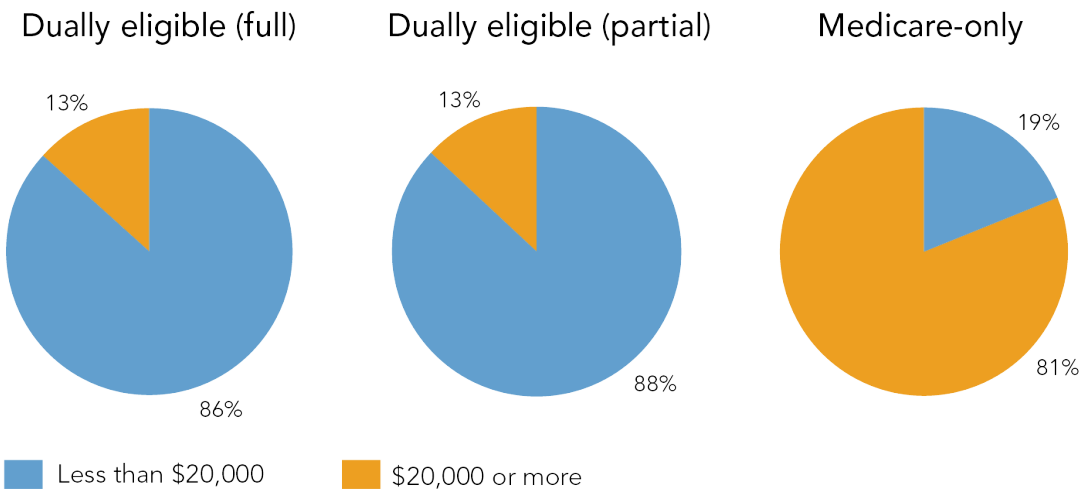


FIGURE 3
Medicare enrollees, by type of enrollee and income, 2020

Source: KFF analysis of the Medicare Current Beneficiary Survey, Maria T. Peña, KFF, A Profile of Medicare-Medicaid Enrollees (Dual Eligibles) (Jan. 31, 2023)



APPENDIX B

CATEGORIES OF D-SNPS

Figure 4. Categories of D-SNPs

Type	Coverage	Enrollment restrictions	Enrollment	States
FIDE-SNP that is an AIP	The FIDE-SNP must cover the following **Medicaid** services: - Primary and acute care services - Long-term services and supports (LTSS) Starting in 2025: - Behavioral health - Home health - Medical equipment, supplies, and appliances - Medicare cost sharing	Enrollment in the FIDE-SNP is **limited** to individuals in affiliated Medicaid managed care organizations (MMCOs)	336,300	CA, DC, FL, HI, ID, MA, MN, NJ, NY, TN, VA, WI
FIDE-SNP that is NOT an AIP*	The FIDE-SNP must cover the following **Medicaid** services: - Primary and acute care services - Long-term services and supports (LTSS)	Enrollment in the FIDE-SNP is **NOT limited** to individuals in affiliated MMCOs	78,400	AZ, PA, VA

Type	Coverage	Enrollment restrictions	Enrollment	States
HIDE-SNP that is an AIP	The HIDE-SNP or affiliated MMCO must cover the following **Medicaid** services: - LTSS or behavioral health	Enrollment in the FIDE-SNP is **limited** to individuals in affiliated MMCOs	22,800	DC, FL, MN
HIDE-SNP that is NOT an AIP	The HIDE-SNP or affiliated MMCO must cover the following **Medicaid** services: - LTSS or behavioral health	Enrollment in the FIDE-SNP is **NOT limited** to individuals in affiliated MMCOs	1,817,600	AZ, FL, HI, KS, KY, NE, NM, NY, OR, PA, TX, VA, WA, WI
CO-DSNP that is an AIP	The CO-DSNP or the CO-DSNP's affiliated MMCO must cover the following Medicaid benefits: - Primary and acute care benefits - Medicare cost-sharing - One of the following: (a) Behavioral health services; (b) LTSS; (c) Home health services, or (d) Medical supplies, equipment, and appliances. The CO-DSNP must follow federal requirements to coordinate care across delivery systems.	Enrollment in the CO-DSNP is **limited** to individuals in affiliated MMCOs	292,700	CA
CO-DSNP that is NOT an AIP	The CO-DSNP must follow federal requirements to coordinate care across delivery systems.	Enrollment in the CO-DSNP is **NOT limited** to individuals in affiliated Medicaid managed care organizations (MMCOs)	3,003,100	AL, AR, CA, CO, CT, DC, DE, FL, GA, IA, ID, IN, KY, LA, MD, ME, MI, MO, MS, MT, NC, NE, NV, NY, OH, OK, OR, PA, RI, SC, SD, TN, TX, UT, VA, WA, WI, WV

** FIDE-SNPs must have exclusively aligned enrollment in the 2025 plan year, which means at that time all FIDE-SNPs will be AIPs.*

Source for enrollment numbers and states: CMS, Comprehensive Data for January 2024

APPENDIX C

SOURCES FOR MAPPING THE D-SNP LANDSCAPE IN A STATE OR LOCAL AREA

This Appendix lists resources for advocates wishing to get more information on D-SNPs in their area. The Integrated Resource Center has published a similar brief[71], aimed at states, that can also be used for more detailed data.

1. Types of D-SNPs in an area

   High-level Medicare Advantage data by state. KFF offers a number of tables that give basic information by state on the type of Medicare Advantage plans available by state.[72]

   Detailed D-SNP data by state. CMS offers a monthly spreadsheet detailing D-SNP plans by name, state, type, and enrollment.[73] See Figure 7 in Appendix B for an example of information available.

   County and local level data. The list of SNPs in the back of the Medicare & You Handbook for the local area (the list immediately follows the list of regular Medicare Advantage plans) or the Plan Compare feature at the Medicare.gov website are good starting points for county information on D-SNP availability.[74] Local State Health Insurance Assistance Programs (SHIPs) also are a resource on D-SNP availability. CMS offers monthly spreadsheets with enrollment by county for all Medicare Advantage plans, but the data may be difficult to tie to D-SNP plans.[75]

2. Requirements that D-SNPs must follow

   Publications. ICRC has published sample SMAC language that include some SMAC language by state.[76] Advocates can ask their state for a copy of the current SMACs and for information on what, if any, additional provisions are in the contracts beyond the minimum federal requirements.

ENDNOTES

1 Nancy Ochieng et. al., KFF, "Medicare Advantage in 2023: Enrollment Update and Key Trends" (Aug. 9, 2023)

2 This is expected to continue, especially with the discontinuation of another approach to integrating care for dually eligible individuals, the Financial Alignment Initiative. See MACPAC, Medicare-Medicaid Plan Demonstration Transition Updates and Monitoring, slide 7 (Dec. 2022).

3 42 U.S.C. § 1395w-28(b)(6)) (Section 1859(b)(6)) of the Social Security Act)

4 Bipartisan Budget Act of 2018 (P.L. 115-123).

5 Ochieng et. al. 2023, supra note 1.

6 Id. Author analysis of CMS, SNP Comprehensive Data and CMS, Monthly Enrollment by Contract/Plan/State/County

7 Meredith Freed et. al., KFF, "Medicare Advantage 2024 Spotlight: First Look" (Nov. 15, 2023)

8 Author analysis of CMS, SNP Comprehensive Data

9 MACPAC, Improving Integration for Dually Eligible Beneficiaries: Strategies for State Contracts with Dual Eligible Special Needs Plans, p.204 (June 2021) ("MACPAC, Improving Integration").

10 Maria T. Peña, KFF, A Profile of Medicare-Medicaid Enrollees (Dual Eligibles) (Jan. 31, 2023).

11 Dually eligible individuals account for 35% percent of Medicare spending while only making up 19% of Medicare enrollees and accounts for 27% of Medicaid spending while only comprising 13% of the total Medicaid population. MACPAC, Data book: Beneficiaries dually eligible for Medicare and Medicaid, p. 36 (Jan. 2024).

12 See, e.g., 42 U.S.C. § 1395w-28(b)(6), 42 C.F.R. § 422.101(f), and Medicare Managed Care Manual, Ch. 16(b).

13 42 U.S.C. § 1395w-28(f)(5)(A) and (7) (§ 1895(f)(5)(A) and (7) of the Social Security Act); see also CMS webpage "Model of Care" NCQA webpage "What is a Model of Care?"

14 42 C.F.R. 422.101(f)(1)(i); 422.107; and 422.562(a)(5). See also Erin Weir Lakhmani, ICRC, "Definitions of Different Medicare Advantage Dual Eligible Special Need Plan (D-SNP) Types in 2023 and 2025," (Dec. 2022).

15 42 CFR §422.107(f)(1).

16 42 U.S.C. § 1395w-28(f)(3) (Section 1859(f)(3) of the Social Security Act)

17 42 CFR §422.107; SMACs have eight minimum requirements: the MA organization's responsibilities to provide or arrange for Medicaid benefits; categories of eligibility for dually eligible beneficiaries to be enrolled under the D-SNP, including the targeting of specific groups; Medicaid benefits covered under the D-SNP; cost-sharing protections covered under the D-SNP; information about Medicaid provider participation and how that information is to be shared; verification process of an enrollee's eligibility for both Medicare and Medicaid; service area covered under the SNP; and the period of the contract (MACPAC, Improving Integration, fn 12).

18 42 U.S.C. § 1395w-28(f)(3)(D) (Section 1859(f)(3)(D) of the Social Security Act); 42 C.F.R. §422.107. For most plans, the minimum requirements are very limited, requiring D-SNPs generally to coordinate the delivery of Medicaid benefits, and specifically to notify the state Medicaid agency when a member of a subgroup designated in the contract is admitted to a hospital or skilled nursing facility. The Integrated Care Resource Center (ICRC) has developed model language for plans to implement both basic elements to meet federal requirements and optional elements to further regulate D-SNPs. See ICRC, "Sample Language for State Medicaid Agency Contracts (SMACs) with Dual Eligible Special Needs Plans" (2024)

19 ICRC, "Sample Language for State Medicaid Agency Contracts with Dual Eligible Special Needs Plans (D-SNPs): Optional Language Applicable to All D-SNPs," pages 6 and 20 (Jan. 2024)

20 42 C.F.R. § 422.50.

21 42 U.S.C. § 1859(f)(3) (Section 1859(f)(3) of the Social Security Act). Additional D-SNP enrollment restrictions are currently in proposed regulation (requiring exclusively aligned enrollment in certain circumstances and in certain circumstances limiting D-SNP enrollment to more integrated plans). 88 Fed. Reg. 78,476, 78,562.

22 MACPAC, Improving Integration for Dually Eligible Beneficiaries: Strategies for State Contracts with Dual Eligible Special Needs Plans, p.224 (June, 2021) ("MACPAC, Improving Integration").

23 D-SNPs limiting membership to dually eligible individuals in institutional settings are rare but a small number exist including, for example, a few in Southern California. Note that these D-SNPs are distinct from Institutional SNPS (I-SNPs), which serve individuals in institutions but do not limit their enrollment to dually eligible individuals.

24 Lianlin Lei and Andrea Wysocki, Mathematica, "Assessing the Value of D-SNP Enrollment for Partial-Benefit Dually Eligible Individuals: D-SNP Enrollment Among Full and Partial-Benefit Dually Eligible Individuals—Final Report," (Aug. 24, 2023).

25 Specifically, when the MMCO contract is between the state and the D-SNP's Medicaid organization; between the state and the D-SNP's parent organization; or between the state and an entity that is owned and controlled by the D-SNP's parent organization.

26 42 CFR § 422.2.

27 Id.

28 Erin Weir Lakhmani, ICRC, "Definitions of Different Medicare Advantage Dual Eligible Special Need Plan (D-SNP) Types in 2023 and 2025," (Dec. 2022).

29 CMS, Guidance for States Seeking to Leverage New Opportunities for Integrated Care Programs, p.2 (Aug. 2022).

30 Integrated Care Resource Center, "Using Exclusively Aligned Enrollment to Integrate Medicare and Medicaid Benefits for Dually Eligible Individuals," (slide 15) (June 2023).

31 Author analysis of CMS SNP data from January 2024, counting the number of states with D-SNPs that are Applicable Integrated Plans. One requirement for a D-SNP to be an Applicable Integrated Plan is to have exclusively aligned enrollment. CMS, SNP Comprehensive Data (Jan. 2024)

32 For sample contract language for limiting enrollment categories, see ICRC, Sample SMAC language, supra note 18. Note that, since partial dual eligibles (a term referring to individuals enrolled in a Medicare Savings Program but not full Medicaid) are not enrolled in MMCOs, policies that require exclusively aligned enrollment means that partial dual eligibles would not be allowed to enroll in the D-SNP.

33 MACPAC, Improving Integration, p. 212.

34 California Department of Health Care Services, 2024 Exclusively Aligned Enrollment State Medicaid Agency Contract Boilerplate, p. 1 (2024).

35 ICRC, Sample SMAC language, supra note 18.

36 42 C.F.R. §422.66(c)(2); CMS, Default Enrollment Policy and Data on Approved Medicare Advantage Plans, (Oct. 2023).

37 42 C.F.R. §422.66(c)(2); CMS, Default Enrollment Policy and Data on Approved Medicare Advantage Plans, (Oct. 2023).

38 CMS, Default Enrollment Policy and Data on Approved Medicare Advantage Plans, (Oct. 2023).

39 42 C.F.R. § 422.66(c)(4) A model notice is available at ICRC, Default Enrollment Model Notice (Oct. 2018).

40 Currently, dually eligible individuals have a Special Enrollment Period that allows them to join, drop, or switch plans once per quarter. See CMS, Special Enrollment Periods, for this and other opportunities to join, drop, or switch Medicare Advantage Plans. There is a proposed regulation that would allow dually eligible individuals to join, drop, or switch Medicare Advantage plans more often (monthly). In certain circumstances, the proposed rule would also restrict enrollment in D-SNPs only for more integrated plans. 88 Fed. Reg. 78,476, 78,562

41 For a fuller discussion of default options for states, see Ryan Stringer, Using Default Enrollment to Align Coverage for Dually Eligible Medicare-Medicaid Beneficiaries (ICRC, July 2019).

42 See, e.g., Financial Alignment Initiative, New York Fully Integrated Duals Advantage (FIDA) Program, First Evaluation Report, pp. 31-32 (Sept. 2019).

43 MACPAC, Integrating Care for Dually Eligible Beneficiaries: Different Delivery Mechanisms Provide Varying Levels of Integration," Figure 2-1, p. 44 (June, 2023).

44 42 C.F.R. § 422.2

45 42 C.F.R. § 422.2

46 In commentary, but not regulatory text, CMS stated that it generally expects plans to assist enrollees in finding appropriate Medicaid contacts, assist with filling out Medicaid forms, assist with obtaining documentation for filing a Medicaid appeal and the like. 84 Fed. Reg. 15680, 15696 et seq. (April 16, 2019). See also Justice in Aging, CMS Regulations Set Ground Rules for D-SNPs (2019).

47 42 C.F.R § 422.107(d).

48 42 C.F.R. §422.107(c)(9); 42 CFR 422.629.

49 42 C.F.R. 422.561.

50 Erin Weir Lakhmani, ICRC, "Definitions of Different Medicare Advantage Dual Eligible Special Need Plan (D-SNP) Types in 2023 and 2025," (Dec. 2022).

51 MACPAC, "Integrating Care for Dually Eligible Beneficiaries: Different Delivery Mechanisms Provide Varying Levels of Integration," (June, 2023). See ICRC, Sample SMAC language, supra note 18.

52 Maria T. Peña, Maiss Mohamed, and Alice Burns, KFF, "Medicaid Arrangements to Coordinate Medicare and Medicaid for Dual-Eligible Individuals," (April 27, 2023)

53 For example, a state that offers managed care to its dually enrolled population, but offers behavioral health outside of managed care through fee for service, is said to have a behavioral health carve out.

54 For details on the capitated models, see the CMS webpage "Capitated Model" and references cited therein. The ten states that participated in the capitated model were: California, Illinois, Massachusetts, Michigan, New York, Ohio, Rhode Island, South Carolina, Texas, and Virginia.

55 89 Fed. Reg. 27,704, 27,796. See also MACPAC, Medicare-Medicaid Plan Demonstration Transition Updates and Monitoring (Dec. 2022).

56 85 Fed. Reg. 9,002 at 9,019 (Feb. 18, 2020).

57 Id. At 9,020.

58 42 C.F.R. § 422.514(d). A recent proposed rule would expand the look-alike restrictions to more plans, setting a 60% threshold. 88 Fed. Reg. 78,476.

59 42 C.F.R. § 422.514(e). For a fuller discussion of the final rule, see 85 Fed. Reg. 33,796, 33,805-820 (June 2, 2020).

60 For a discussion of the statutory and regulatory authority for different types of supplemental benefits, see ATI Advisory, Nonmedical Supplemental Benefits in Medicare Advantage in 2024, p. 5, and ATI Advisory, Advancing Non-Medical Supplemental Benefits in Medicare Advantage: Considerations and Opportunities for Policymakers, pp. 4-5.

61 CMS, Frequently Asked Questions on Coordinating Medicaid Benefits and Dual Eligible Special Needs Plans Supplemental Benefits (May 27, 2021).

62 Id. (CMS, Frequently Asked Questions on Coordinating Medicaid Benefits and Dual Eligible Special Needs Plans Supplemental Benefits (May 27, 2021).)

63 ATI Advisory, Delivering on the Promise of the CHRONIC Care Act: Progress in Implementing Non-Medical Supplemental Benefits (2021), pp. 11-12.

64 CMS, "Medicare Part C Technical Specifications Document Contract Year 2024," p. 43 (Dec. 27, 2023).

65 42 C.F.R. § 422.630. For an in-depth discussion of the integrated appeals regulations and suggestions to states for implementing their requirements, see ICRC, Integrated Appeal and Grievance Processes for Integrated D-SNPs with "Exclusively Aligned Enrollment" (June, 2020).

66 42 C.F.R. § 422.561. For specific requirements see 42 C.F.R. §§ 422.629, 422.631-422.634. These regulations implement the statutory mandate found at 42 U.S.C. 1395w-28(f)(8)(B).

67 42 C.F.R § 422.562(5).

68 42 CFR 422.562(a)(5)(i)(C)

69 MACPAC. Medicaid Enrollment by State, Eligibility Group, and Dually Eligible Status

70 Maria T. Peña, KFF, A Profile of Medicare-Medicaid Enrollees (Dual Eligibles) (Jan. 31, 2023).

71 Danielle Chelminsky, ICRC, "How States Can Better Understand their Dually Eligible Beneficiaries: A Guide to Using CMS Data Resources," (Oct. 2020).

72 Kaiser Family Foundation, Medicare Advantage Special Needs Plan (SNP) Contracts, by SNP Type.

73 CMS, SNP Comprehensive Data

74 The county/region inserts in the Medicare & You Handbook are not available on-line but a paper copy can be requested from 1-800-Medicare. The Plan Compare feature is available at Medicare.gov.

75 CMS, SNP Comprehensive Data

76 ICRC, SMAC sample language, supra note 18.