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Dual Eligible Special Needs Plans (D-SNPs) Basics

Webinar Transcript

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Samantha Morales: Hello everyone and welcome to today's webinar presentation entitled Dual Eligible Special Needs Plans or D-SNPs Basics. I'm Samantha Morales, Senior Policy Advocate on the Health Team at Justice in Aging. Today I am joined by my colleagues, Tiffany Huyenh-Cho, Director California Medicare and Medicaid Advocacy, and Rachel Gershon, Senior Attorney on the Health Team. Next slide, please.

So before we begin, I would like to go over a few webinar logistics. Again, welcome to all participants. You are all on mute, but we welcome your participation in today's presentation through the Q&A function in the Zoom control panel. Also available in the Zoom control panel is the CC button, which enables closed captioning. I will be watching the participant questions as they come in throughout the webinar and I will uplift high level themes during the Q&A segment at the end of today's presentation. And any questions unanswered in today's webinar will be addressed via email following the conclusion of the presentation. You can also use the Q&A function to request technical assistance with Zoom and our staff will do their very best to assist you.

This webinar is being recorded and after the conclusion of this webinar, the slides and the recording of today's presentation will be available on our website and will be emailed to all registrants. We would also appreciate your participation in our post-webinar survey that will pop up on your screen following the close of the webinar. Next slide, please. Thank you.

So about Justice in Aging, as many of you know, we are a national organization that uses the power of law to fight senior poverty by securing access to affordable healthcare, economic security, and the courts for older adults with limited resources. Since our founding in 1972, our efforts have focused on fighting for people who have been historically marginalized and excluded from

justice, such as women, people of color, LGBTQ+ individuals and people with limited English proficiency. Next slide, please.

At Justice in Aging, we believe that to advance Justice in Aging, we must ensure that everyone has access to what they need as they age without discrimination and regardless of race, gender, gender identity, and sexual orientation, ability, language, or country of origin. We push for policies that will ensure that those experiencing the greatest barriers to economic security, healthcare, and housing can exercise their rights and fully access the services and programs they need. Next slide, please.

Justice in Aging produces a wealth of information like the webinar you are viewing today along with fact sheets, issue briefs, alerts, and other material to keep you up to date with important developments. If you're not already a member of our network, we encourage you to join by going to our website and signing up or simply emailing info@justiceinaging.org. So thank you for sticking with me through this background information and now I'm going to turn it over to Rachel who's going to get us started.

Rachel Gershon: Thank you so much, Sam, and welcome to this webinar. Today we will be covering D-SNP types, eligibility to enroll in D-SNPs, benefits, care coordinations, and protections for people enrolled in D-SNPs. First, I'm going to talk about the types of D-SNPs. So first of all, let's talk about what a D-SNP is. A D-SNP is a type of Medicare Advantage. Medicare Advantage plans are Medicare managed care, and we will note at the beginning that no one is required to enroll in Medicare managed care. So compared to original Medicare, Medicare Advantage has narrower provider networks, more prior authorizations, and can offer additional benefits.

So on the individual level, when making a choice about whether to enroll in Medicare Advantage, including the choice of whether to enroll in a D-SNP, there are pros and cons to consider. There are core elements unique to D-SNPs. Enrollment is limited to dually eligible individuals. That's folks who are enrolled in both Medicaid and Medicare and it can be even more limited than that. D-SNPs, the companies that run D-SNPs, they are governed by contracts with both the federal government and the state.

Now I'm going to talk about different Medicare Advantage types, and remember this is the Medicare managed care landscape. There are special needs plans including three different types. The first is dual eligible special needs plans or D-SNPs. That's what we'll be focused on today. There's also chronic condition special needs plans or C-SNPs and institutional special needs plans or I-SNPs. And then I also put down that there's other Medicare Advantage plans that also are more numerous than these special needs plans, but we'll be focused on a particular subset of Medicare Advantage called D-SNPs.

D-SNPs themselves have three different types, fully integrated D-SNPs or FIDE D-SNPs is how we often call them. And FIDE D-SNPs... Or, sorry, FIDE SNPs have a contract with the state to provide virtually all Medicaid services to its members. So that's either one entity or an affiliated entity that is offering virtually all Medicaid services. A highly integrated D-SNP or HIDE SNP, the D-SNP or its aligned Medicaid managed care organization has a contract with the state to provide most Medicaid services. And then finally, the least corporately integrated plan is called a coordination only D-SNP or CO D-SNP. Those D-SNPs must follow federal requirements to coordinate care across delivery systems.

Who regulates D-SNPs? Which can be very important if you have a client who's in a D-SNP and is facing challenges both to know who to go to complain to, but also who to talk to about maybe changes in the system that could be affected to fix things for individuals and patients. The centers for Medicare and Medicaid services set minimum ground rules for D-SNPs and then states can use their contracts, also called State Medicaid Agency Contracts or SMACs to impose additional requirements on D-SNPs, including enrollment and care coordination requirements. And we've really focused on SMACs in the last two years. We have a full Justice in Aging SMAC toolkit that comes out with different suggested languages, suggested language for different topics and state advocacy can be a really important lever for improving D-SNP performance.

Now going to give an example of Abby. Abby is a SHIP counselor who wants to put together a complete list of D-SNPs available in her state so that she can advise clients on the best D-SNP for them. She wants to include information about restrictions and provider network, available benefits and medications and how different plans coordinate with Medicare. She goes to a few different places.

First, she goes to Medicare Plan Finder to find the list of D-SNPs in her area and then also get some information from Medicare Plan Finder, including supplemental benefits, also known as additional benefits and also provider network options. She uses CMS's SNP data website to identify which designations apply to the D-SNP, which is not always available in Medicare Plan Finder, but there are spreadsheets available on a monthly basis from CMS that will tell you which D-SNP applies to which category. And these are a lot of acronyms, but the acronyms themselves will also inform what rules apply to the D-SNP.

So for Abby, who is a SHIP counselor who really wants to know her landscape, she wants to know what categories apply to which D-SNPs in her area. She looks up each plan's evidence of coverage document online to get more information about the benefits offered by each plan, including supplemental benefits like dental and like home-based care. And that allows her to really counsel individuals on an individual basis about what their needs might be and what exactly they're looking for in a managed care plan in terms of what they offer.

There's one piece of information that Abby is not able to find online. She can't find which D-SNPs and which Medicaid managed care organizations are affiliated and that can be important for understanding a variety of different factors in whether the person wants to be in that particular Medicaid managed care in alignment with the D-SNP. So she goes ahead and reaches out to the state Medicaid agency to ask which D-SNPs are affiliated with which Medicaid managed care organizations. Next slide. Oh, sorry, that's me. Now I'm going to turn it over to Tiffany to talk about eligibility for D-SNP enrollment.

Tiffany Huyenh-Cho: Thank you. Rachel. So like Rachel said, we will cover in this next section who can enroll in D-SNPs, how enrollment can be structured and other pieces to keep in mind when a person is considering whether or not to enroll into a D-SNP. Next slide please. So at a minimum to enroll into a D-SNP, a person must have full Medicare Parts A and B. They must live in the plan's service area and they also must be enrolled in Medicaid. Again, D-SNPs are only for people who are dually eligible or dually enrolled in Medicare and Medicaid. Beyond that, beyond those minimums, the states can set additional limits on eligibility such as limiting enrollment to only a subset of dually eligible individuals. For example, states can say enrollment in the D-SNPs in their state are limited to full dual eligibles only. Full dual eligibles are enrolled in Medicare and also have full Medicaid benefits. States can also choose to limit enrollment to only those who need a nursing facility level of care.

So states do have a lot of power to set limitations on eligibility for D-SNPs and they do so using those state Medicaid agency contracts or SMACs like Rachel mentioned earlier. And because states can individually set their own criteria, D-SNP eligibility can vary by state and by plan. So it's not always cut and dry and we know that makes it a lot more confusing to determine who is eligible for D-SNPs.

Because D-SNP enrollment requires a person to have both Medicare and Medicaid, losing Medicaid can jeopardize enrollment in a D-SNP. If someone is found ineligible for Medicaid for a period of time, that can threaten their enrollment in the D-SNP. And to protect against this, states can require D-SNPs to offer a deeming period, which is essentially a grace period to maintain D-SNP enrollment while that person fixes their Medicaid eligibility.

So deeming periods can run from 30 days or even longer. Some states or some plans offer six-month deeming periods and deeming is a great protection because it maintains D-SNP enrollment and reduces care disruptions during short periods of Medicaid ineligibility. Deeming gives folks the time to try and resolve or fix whatever's going on on the Medicaid side so that they can stay enrolled in Medicaid and also enrolled in the D-SNP plan. Next slide, please.

So we mentioned earlier that D-SNPs can be limited to only people that are full dual eligibles. You may have heard the term partial dual eligibles. These are people who have Medicare and a Medicare savings program but are not

enrolled in full Medicaid. Medicare savings programs only provide financial assistance for Medicare cost sharing like Part B premiums. So that means Medicare savings programs do not offer the full range of Medicaid benefits like transportation, home and community-based services, or stays in a long-term nursing facility. Medicare savings programs are a type of Medicaid, but it does not provide those full Medicaid benefits, whereas full dual eligibles do have full Medicaid benefits.

So that means D-SNPs do not always allow partial dual eligibles to enroll into the plan. By federal law, this group can enroll in a D-SNP, but states can narrow that criteria and prohibit the enrollment of people who are partial benefit dual eligibles. And again, they can do so using that state Medicaid agency contracts. And the reason behind prohibiting enrollment of partial dual eligibles is that there is a question about the usefulness of enrolling this group into a D-SNP. Partial dual eligibles don't have Medicaid services to coordinate and that is one of the main features of a D-SNP. But on the other hand, a D-SNP could be beneficial because it can offer supplemental benefits like vision or hearing benefits that aren't otherwise available under original Medicare. Next slide, please.

And today it is increasingly common to see D-SNPs paired with a Medicaid managed care plan also called MCO. D-SNPs will often have the Medicaid managed care plans affiliated with them. An affiliation like Rachel mentioned really just means there's a specific contractual relationship between the D-SNP and the MCO. And sometimes the D-SNP and MCO are operated by the same insurance company. So for example, Sigma MCO. So dual eligibles that enroll in the Sigma D-SNP for their Medicare will also be enrolled in the Sigma MCO for their Medicaid benefits. This type of arrangement is called aligned enrollment because their Medicare and Medicaid are managed by the same insurance company. The Medicaid and Medicare managed care plans are aligned.

And that does mean that for certain D-SNPs, aligned enrollment is a federal requirement. So for D-SNPs that are fully integrated plans, aka FIDE SNPs, they do require that dually eligible individuals that enroll into a FIDE SNP, they must have aligned enrollment. So they have to enroll their Medicare into the D-SNP and also their Medicaid into the same affiliated MCO. You cannot be in fee-for-service Medicaid or a different MCO in plans that require aligned enrollment.

And the idea behind aligned enrollment is that it creates a financial incentive to reduce unnecessary spending because the D-SNP and MCO have a financial risk for both services. The idea is also that it will reduce duplicative services and also foster communication between both sides because Medicare benefits and Medicaid benefits are being provided by the same entity and they are contractually connected together. Next slide, please.

So here's an example. Tatiana is enrolled in fee-for-service Medicaid and also original Medicare. She is debating whether to enroll in the Kappa D-SNP, which

is advertising a number of supplemental benefits. So Tatiana reaches out to a SHIP counselor to get more information and her counselor sees that the Kappa D-SNP does require aligned enrollment. So if Tatiana joins this Kappa D-SNP, she would also have to enroll her Medicaid into the Kappa MCO. So the counselor provides Tatiana information about the requirement to enroll in the Kappa Medicaid MCO and how it might affect Tatiana's Medicaid benefits. So this is something where a person will need to consider all of the consequences of joining a D-SNP that has aligned enrollment. It does mean that on the Medicaid side, you do have to see those providers in that network for your Medicaid services. Next slide, please.

Next in this next section, we'll talk a little bit about enrollment into a D-SNP and when people can enroll into a D-SNP and other related issues. Next slide. So a very common question that we get is, are you required to enroll in a Medicare managed care plan? Are dually eligible individuals required to enroll in a D-SNP? And the answer is no. Dual eligible individuals are not required to join a D-SNP or any other Medicare Advantage plan. No one is required to join Medicare managed care. So dually eligible individuals still have freedom of choice when deciding how to receive their Medicare benefits. So similar to other Medicare enrollees, people who are dually eligible have options. They can choose traditional fee-for-service or original Medicare. They can join a regular Medicare Advantage plan. They can join a D-SNP, or they may choose PACE, the Program of All-Inclusive Care for the Elderly.

There is a process that I'll know where dually eligible individuals could be automatically enrolled in a D-SNP and that is called default enrollment. In default enrollment, a person is automatically enrolled into a D-SNP when they first gain Medicare eligibility. And that's either at age 65 or through disability. However, to do default enrollment, the plan still must send prior notice beforehand and that notice must be in writing and dually eligible individuals always have the opportunity to opt out. They can decline the upcoming enrollment into a D-SNP. So they will get a notice and then make a decision before the actual enrollment date and they can choose to say, "No, I don't want to be enrolled into this D-SNP."

I want to emphasize that default enrollment is not used by every plan or in every state. So there are states where it does not exist at all and there are limits to who is enrolled via default enrollment as well as limits to which D-SNPs get to use this process. So D-SNPs do have to meet certain criteria, certain quality standards, and they need approval from both the state and federal government. And as always, if you are enrolled via default enrollment, you still have the right to disenroll after the fact if you choose to. If a plan or your state is contemplating default enrollment, there's also a lot of room for advocacy here. Federally, the minimum requirement is that the plan sends one notice beforehand, but advocates can also push their state to require the plan send two notices in advance. So there is some room here for a lot of advocacy. Next slide, please.

And then also people can enroll into D-SNPs in multiple ways. Insurance agents and brokers can market D-SNPs, but there are limits to how these people can directly interact with dually eligible individuals. People can choose to affirmatively enroll during the Medicare open enrollment period or the usual initial enrollment period when you first become Medicare eligible.

You can also leave your D-SNP at any time. Dually eligible individuals do have special enrollment periods that are specific to them so they can disenroll from a D-SNP or any Medicare Advantage plan throughout the year. And there are two new special enrollment periods that went into effect last year, the monthly special enrollment period as well as the monthly integrated special enrollment period. And the monthly SEP allows dually eligible individuals and people who have extra help, also known as low-income subsidy, to disenroll from a D-SNP or MA plan anytime of the year once a month and you can return to original Medicare.

We have listed on the slide a fact sheet that goes over in a lot more depth about this new monthly special enrollment period as well as the new integrated care special enrollment period. And then always the website, CMS's website, Joining a Plan, has a lot of information about enrollment periods, when you can switch and when you can drop your Medicare Advantage plans as well. Next slide, please.

All right. So let's go through an example of options someone has when they are enrolled in a D-SNP that may not fit their exact needs. So May is in a D-SNP and she was prescribed a medication not covered by her D-SNP. She has a few choices. She can ask for a Part D formulary exception to get her Medicaid covered through her existing D-SNP. She can also use an enrollment period to change to another D-SNP or another Medicare Advantage plan that covers her medication. She can also use the monthly special enrollment period to leave the D-SNP altogether, go back to original Medicare and pick a new Part D plan that will cover this specific medication.

So these are all of her options. May will work with a SHIP counselor to evaluate these options because disenrolling from a D-SNP or choosing another Medicare Advantage plan also has some considerations to think about as well that could impact other pieces of her care. If May has existing medical providers that she trusts within the D-SNP, she would need to think about whether another Medicare Advantage plan will allow her to keep seeing these current providers. So there are different things that May will need to think about in order to make an informed choice and also get the medications that she needs. And with that, I'll turn it over to Rachel.

Rachel Gershon: Thank you so much, Tiffany. So now we're going to turn to benefits within a D-SNP. So all Medicare Advantage plans, including all D-SNPs, must provide Part A and Part B benefits. And you can see the list below. It's not comprehensive. It's the list of benefits under your Medicare Part A and your Medicare Part B

benefit. For more information on Part A and Part B benefits, see CMS's Medicare and You handbook and medicare.gov. When I get questions about Medicare coverage, I often will start with Medicare and You because it's a very accessible document to start explaining what is covered under Medicare.

For Part D benefits, all D-SNPs must include a Part D prescription drug benefit. Different D-SNPs can cover different prescriptions like we saw in our last example where the person had a drug that was not on the formulary. You can use Medicare Plan Finder, clicking on plan details to research covered prescriptions and any limitations that may apply. When you first click into Medicare Plan Finder, you can enter the formulary for your client and then the list of plans will come up and they will explain how much your client will expect to pay with that formulary with that list of drugs that they're taking.

The low-income subsidy also known as Extra Help covers premiums and cost sharing for Part D. And I do want to highlight that for people enrolled in Medicare and Medicaid, Medicaid can offer very limited medication coverage for dually eligible individuals. It works differently than other benefits like a wheelchair or hospital coverage, where Medicaid typically picks up where Medicare drops off. For Part D benefits, Medicaid coverage can be much more limited.

So access to Medicare and Medicaid benefits when you are in a D-SNP or when your client is in a D-SNP. State Medicaid agencies must ensure that Medicaid benefits are available to MCO enrollees. So these Medicaid MCO enrollees must provide access to benefits. Medicare Advantage plans must ensure access to covered benefits, and that applies to almost all Medicare Advantage plans. All D-SNPs are required to offer assistance with Medicaid benefits, including request for service and navigating Medicaid appeals and grievances.

Supplemental benefits can include dental, vision, hearing, long-term care, nutrition, and other benefits. To find supplemental benefits, you can look at Medicare Plan Finder, click on more details and additional benefits, and also look for the plan's evidence of coverage document. I often just put into the search bar the plan name and evidence of coverage to see if it will come up. Note that it can be hard to distinguish Part A and B coverage from supplemental benefits in the evidence of care documents, evidence of coverage documents.

So coordination with Medicaid. So for folks with both Medicaid and Medicare, it can be confusing. It can be complicated regarding which payer pays what and in what order. So Medicaid will often cover care when Medicare coverage runs out. Medicaid is known as a payer of last resort and that means that Medicare typically pays first. We have a link here to a pretty technical document that goes on the ins and outs of when different payers will pay first in these scenarios. In a few states, joining a D-SNP can restrict eligibility for 1915(c) waiver services. So this is just a flag if somebody's enrolled in a 1915(c) also known as an HCBS

waiver to just check before enrolling in a D-SNP to make sure that that doesn't mean that they will lose coverage for those HCBS waiver services.

Here is an example. Maria is a dually eligible individual, so she's enrolled in both Medicaid and Medicare. She's enrolled in the Kappa D-SNP. She had a stroke recently, unfortunately, and needs a wheelchair for part-time work outside of her home. She cannot stand for long periods of time. Kappa D-SNP reviews Maria's request and covers it under her Medicaid benefits. So you'll notice even though Medicare typically pays first, in this case, Medicaid is going to cover that wheelchair.

Medicare will not cover the wheelchair because Maria's primary need for it is outside of the home. So that's some Medicare specific rules around wheelchair coverage that don't apply in Medicaid. So Maria ends up getting covered for her wheelchair through Medicaid. Medicaid's coverage criteria considers use outside of the home as well as inside. Now I'm going to turn it back over to Tiffany to talk about care coordination.

Tiffany Huyenh-Cho: Thanks, Rachel. All right, let's go over care coordination. Next slide. So care coordination is arguably one of the main points of a D-SNP. As we've noted throughout the presentation, D-SNPs are required to coordinate Medicaid services and there are certain minimums that all D-SNPs must do. First, all D-SNPs are required to develop a comprehensive person-centered care plan known as an individualized care plan for each member. This care plan outlines that individual's goals and objectives for their care. It includes measurable outcomes and specific services and benefits that will be provided. New federal requirements require that the individualized care plan be completed within 90 days of the initial health risk assessment or 90 days after enrollment, whichever is later.

The D-SNP must also use an interdisciplinary care team. This care team has to have demonstrated expertise and training on how to provide care and support to that individual to manage their care as well as actualize the care plan that we just discussed. And D-SNPs are also required to help their members with maintaining their Medicaid eligibility. This is especially important right now in the context of H.R. 1, given the concerns about loss of benefits. Although with this last point, you'll see variation across states and plans itself as to the extent of Medicaid assistance a plan will provide to maintain eligibility.

I also want to acknowledge that when we say coordination with Medicaid services, there is a wide spectrum of coordination that does exist among D-SNPs. Some D-SNPs do have stronger requirements around coordinating care for its members and across the delivery spectrum and others only provide the minimum that's set by the federal government. States can set stronger requirements on care coordination through the SMACs. For example, some states require the care managers in a D-SNP to have specific training and expertise such as training in community integration, expertise on Medicaid

home and community-based services, or expertise in health equity to strengthen care coordination within the plan. So there is advocacy that can be done in this space and our SMAC toolkit on care coordination has many examples of strong care coordination requirements by different states, and you'll see the link to that resource at the end of this PowerPoint. Next slide, please.

So here's an example. Gary is a full benefit individual with Medicaid and Medicare. He received a notice that his FIDE SNP had hit its maximum allowance cap for dental services. So he brought that notice to his advocate. The advocate found the notice confusing because Gary had only run out of the Medicare supplemental dental benefit, not his state's dental coverage under Medicaid. Next slide, please.

Since Gary exhausted his Medicare coverage, his Medicaid dental benefit should pay primary. It still exists and that as a virtue of being a dually eligible person, he can exhaust both his Medicare and Medicaid coverage. So a Medicare denial should not be necessary in order to use his Medicaid dental benefit. Gary's FIDE SNP should have alerted him to the dental benefits under Medicaid that were still available to him as well as given him information about which providers would be a network for his Medicaid dental.

Gary reached out to the FIDE SNP and was able to use the dental benefits under Medicaid with his SHIP counselor's help. He filed a complaint about the plan's failure to coordinate these dental benefits using the complaint tracking model. So like in this example, D-SNPs are required to coordinate all Medicaid services and not only ones that are provided within the D-SNP itself. So that coordination can extend to services outside of the D-SNP like here where the dental benefit was through a different delivery system. And next slide please. And with that, turn it back to Rachel.

Rachel Gershon: Thank you so much. We have one more section and then we will turn to questions. Thank you everyone for all the great questions we're seeing in the Q&A. So I'm going to talk about protections now. So for Medicare costs, so costs for your client's medical bills when they are enrolled in Medicare, Medicaid will often pay for premiums and Medicare cost sharing for a dually eligible person, whether or not that person is in managed care. A person does not have to enroll in a D-SNP in order to get Medicare premiums and Medicare cost sharing covered. There are some new requirements on D-SNPs, in particular FIDE SNPs. So those are the ones with the most integrated care. They're available in, I believe about 10 states. They're now required to pay all deductibles cost sharing and co-insurance. Again, if a person is enrolled in Medicaid, the state Medicaid agency will typically pay for those deductibles, co-insurance cost sharing, but this is an added layer of coverage.

Medicare Advantage plans are also required to guard against improper billing, meaning that if a person is getting a bill and they're dually eligible, they should

generally not be receiving medical bills and their Medicare Advantage plan, including if they have a D-SNP, should be helping them deal with those improper bills.

One of the main concerns about Medicare Advantage plans, including D-SNPs, is the prevalence of prior authorization where a plan will deny care and there are rules around these prior authorizations. For basic benefits and ongoing active treatment, prior authorization approvals must be in effect as long as the medical necessity continues. The Medicare Advantage organization must not disrupt or require reauthorization for an active course of treatment for new plan enrollees for a period of at least 90 days. So even if a person switches to a new plan, there are protections that exist. And finally, prior authorization is limited to specific circumstances. It's a little complicated to explain on this slide, but we did include the site so you can check out what additional limitations are on plans when they are conducting prior authorization.

There are also network adequacy requirements put onto Medicare Advantage plans and we often hear about folks who are having trouble finding providers when they enroll in plans. So here are some requirements. The Medicare Advantage plan must demonstrate an adequate provider network that allows for a meaningful access to covered services. They must meet for some services time and distance standards and other specific provider network standards. That means the provider has to be within a certain amount of time's drive or a certain amount of distance. When the Medicare Advantage network is insufficient to satisfy enrolling needs, plans are mandated to provide coverage of medically necessary covered benefits from out-of-network providers at in-network costs.

I'll turn now to talk of organizational determination, appeals and grievances. So this is when a person is denied, for example, a coverage of a service or a supply, or if they are not being treated well by the plan. All Medicare Advantage plans must follow federal requirements around organizational determinations, grievances, and appeals. I'll make a note. The organizational determination is a determination that a plan has to provide if asked by the enrollee. So an enrollee can ask, "Will you cover this service?" And the plan has to reply.

Applicable integrated plans, which are a type of D-SNPs, are required to integrate their determination and appeals. That means that they have to consider both Medicare and Medicaid rules when processing appeals rather than having the person have to appeal on both the Medicare side and the Medicaid side. In some circumstances, there's a continuation of benefits while the appeal is processing. These applicable integrated plans, again, you can look up whether a plan is an applicable integrated plan going to... We had earlier the SHIP counselor who is putting together a list of D-SNPs in her area. There's a specific link to the CMS SNP data where you can see a spreadsheet and it'll tell you if the plan is an applicable integrated plan.

Each D-SNP is required to have an enrollee advisory committee, so is required to be accepting enrollee feedback about things that are working well, things that aren't working well. There's also a chance to use 1-800-MEDICARE and speaking with a SHIP counselor to help resolve issues and also can give CMS feedback about plan performance. This feedback can be very important for letting CMS know when things are not working well, both for your client and for other clients enrolled with the plan. And now I'll turn it over to Tiffany.

Tiffany Huyenh-Cho: Thank you, Rachel. Okay. We'll briefly discuss some advocacy and resources. Next slide. So there's always room for advocacy in the D-SNP space, but we wanted to flag a few specific ones. First, we want to acknowledge the environment that we're in. Medicaid is fundamentally changing because of H.R. 1. So state governments are understandably often at capacity trying to implement H.R. 1 in very little time, but there is still the opportunity for advocates to influence better integration through different methods. First, as Rachel covered, all D-SNPs operate an enrollee advisory committee to gather feedback. These committees are required and give members a forum to provide that direct feedback and a voice in shaping their health coverage, benefits and care coordination. The committee is required to include members themselves, but other individuals can also participate. So we do encourage you to look into your local D-SNPs enrollee advisory committees, see how often these meetings occur and if you can join as an advocate as well.

It's also important to engage your state early and often. The state Medicaid agency contracts are finalized in the summer, but planning for these contracts can run the whole year and often really starts in the fall. So there's opportunity throughout the year to raise questions, to raise issues, areas for improvement. And we also encourage you to get involved and ask your state to provide input into the development of the SMAC itself. We know that there are a number of states that do involve advocate involvement in shaping the SMAC itself. So when advocates and members are involved in these sorts of conversations, it improves the delivery of plans and the offerings. So it's a good area to get involved in when possible. We also know that depending on the state, advocates don't have an effective or good relationship with the Medicaid agency itself, so that can be limiting.

Another opportunity is to review the SMAC itself. Not all SMACs are public. It's not required. So that is the one first priority is to get access to the SMAC if it's not publicly posted. Some states do post the SMAC online and you can find a list of those state SMAC contracts in our SMAC toolkit as well.

And then lastly, you can also connect with local SHIP counselors. The SHIPs also called HICAPs in some states are a great resource. They provide free services and there are objective counselors on Medicare benefits and plan options. So because they do a really important job of helping people navigate options, they work with Medicare enrollees every day and have an eye on what is happening on the ground as well. Next slide, please.

All right, so here are the resources that we've mentioned throughout the presentation today. We have the SMAC toolkit. There are several chapters, including one on member rights, provider network protections, care coordination, as well as eligibility and enrollment, and there's others on our page as well. It's an amazing resource and you can pull many advocacy ideas to input into SMACs from these resources directly.

We've also linked our brief D-SNPs, which what advocates need to know. This covers much of the same content that was included in today's presentation. And then our frequently asked questions document. These are the common questions that get asked about D-SNPs very often. And then lastly, a duals integration principles document. This outlines the core values and goals of integration from our perspective at Justice in Aging. And I will turn it over to Sam now.

Samantha Morales: Thank you so much, Tiffany. And thank you everyone who just engaged in our Q&A with such great questions, as Rachel mentioned. So I'm going to start with some... We definitely have some themes. So for example, we have several questions about D-SNP eligibility and a person's dual status. And so Tiffany or Rachel, can someone have Medicare and Medicaid QMB status and then qualify for D-SNPs?

Rachel Gershon: Yes. With a caveat that in some states, some D-SNPs only enroll full benefit. You can have QMB and also be on full Medicaid, so then that would be fine. But if you were on QMB and not full Medicaid, also known as partial dually eligible, you may be limited in the D-SNPs available to you. And it's a really local question. It depends on the state and the D-SNPs in your area.

Samantha Morales: And Rachel, I'll follow up to that. Where can a person determine D-SNP eligibility for their state? So for example, this person was asking for Hawaii, but in general, where could advocates go to find that?

Rachel Gershon: It can be a little tricky. If I were starting to look, if somebody asked me for a state, I would try to find a copy of the state's SMAC, which typically detail who is eligible for a D-SNP. We have all the public SMACs we could find in the frequently asked question document at the end, but we don't have public SMACs for all states.

Samantha Morales: Thank you, Rachel. And so for these sets of questions, we received several about D-SNPs as a type of managed care, for example, so really the definition of a D-SNP and the different categories within. So just overarching question here. I guess Tiffany, if you wanted to take this, in terms of D-SNPs, are they under Part C of Medicare?

Tiffany Huyenh-Cho: Yes. D-SNPs are a type of Part C plan. It is a type of Medicare Advantage. It's just a very specific segment or group and they are specifically only for people that are dually eligible for Medicare and Medicaid. So someone that has Medicare

only and has no tie to Medicaid could not enroll in a D-SNP, but yes, they are a type of Part C Medicare Advantage plan.

Samantha Morales: Thank you, Tiffany. And connected to that, can you explain a bit more about the differences, I guess, between FIDE and HIDE SNPs?

Tiffany Huyenh-Cho: Yeah, D-SNPs are very confusing. Within that own umbrella of D-SNP, there are separate categories of D-SNPs underneath the overall umbrella itself. So a FIDE SNP is the fully integrated D-SNP where in that version the Medicare and Medicaid benefits are provided by a single entity. It could be within the same plan itself or maybe two different plans, but it's the same insurance company that is providing all of their Medicare and Medicaid benefits. In a HIDE SNP, it's a little less integrated. The FIDE SNP is the most integrated of all, arguably, of all the D-SNP options and the HIDE is the second most integrated where it is Medicare and most Medicaid services provided by a single insurance company, but the caveat is that you could have some Medicaid benefits carved out and delivered through a different delivery system that could be home and community-based services or Medicaid behavioral health services as well. So one of those two could be carved out from the D-SNP itself.

And then if, like Rachel mentioned earlier, there's different requirements that apply to the different types of D-SNP. So whether you're in a FIDE SNP, there may be requirements about your enrollment in a Medicaid managed care plan and then differences for a HIDE as well.

Samantha Morales: Thank you so much for that, Tiffany. So we've also received several questions from advocates about really related to things to consider before folks should enroll in a D-SNP. So for example, for this question, if I already have full coverage with both Medicare and Medicaid, do I still need to sign up for a D-SNP?

Rachel Gershon: No, no. No one is required to enroll in a D-SNP and a person may face a worse situation if they enroll in a D-SNP. One of the main reasons we hear why people do want to is supplemental benefits including dental and vision. So it's important for the person to know what's available under their Medicaid plan. It may be that the benefits are already available under Medicaid and enrolling in a D-SNP isn't required to get those benefits.

I would also consider just network adequacy. Somebody asks, how do you figure out what the network is using Medicare Plan Finder? There is a feature to put in your provider in Medicare Plan Finder now, but we've heard reports that it's inaccurate. So currently I would go to the plan's website and try to find their provider directory there. And then also if it's a really important provider that the person really doesn't want to lose access to, just to double check with that office before switching.

Samantha Morales: Thank you, Rachel. And connected to that in that example with Tatiana, so can Tatiana stay in fee-for-service Medicare as well as the aligned Medicaid MCO, for example?

Rachel Gershon: It depends. You can usually be in a Medicaid managed care organization, a Medicaid MCO, and traditional Medicare fee-for-service Medicare. You don't have to enroll in Medicare managed care in order to access Medicaid managed care. I have heard in some states, not a lot, where specific Medicaid MCOs will also require alignment with Medicare Advantage plans, but that's not everywhere we look.

Samantha Morales: Thank you, Rachel. And we've received a few questions about deeming. And so Tiffany, I guess this is your section that you covered. Are all states required to provide a deeming period?

Tiffany Huyenh-Cho: No, unfortunately not. Deeming is not a requirement. States can require D-SNPs to offer it, but it's not required. There is variation with deeming as well where deeming just retains enrollment in the Medicare plan. If someone loses Medicaid eligibility for a period of time, they don't have Medicaid. So the plan may not be required to cover Medicaid services, but there are differences. Some states do require the D-SNP to provide more protection on the Medicaid side and some do not. The deeming period also can run for a certain amount of months or 30 days only. The minimum is 30 days. Some plans do offer much longer, but it is by their choice. The state can dictate how long a plan can offer a deeming period. So it does make it quite difficult because we don't have a uniform standard. There is a lot of variation because the states have those SMACs and can set their own individual rules.

Samantha Morales: Thank you, Tiffany. We've received a few questions really specific to Medicaid eligibility, so I'm going to uplift a question concerning just the Medicaid managed care portion and what it covers. So what does the MCO manage? Is that someone's home care through Medicaid, for example? How do we know if someone has Medicaid MCO?

Rachel Gershon: Yeah. So if a person has a Medicaid MCO, they should have a card with their Medicaid MCO name and typically you can search for the state that the person is in and Medicaid MCO and the list of MCOs will be listed. So you can kind of look for what you're looking for for that card. In terms of what a Medicaid MCO covers, that's up to the state in their contracting with the managed care organization. A lot of times you can find those contracts online, which will specify the scope.

There's also often stakeholder engagement where the state talks to people in open meetings to talk about what an MCO covers. For example, in some states, you might receive behavioral healthcare from the fee-for-service system for Medicaid while still enrolled in a Medicaid MCO or home care LTSS is also costs often not within the MCO scope. We say carved out. That's just the term that

means that it's not covered under the MCO, but you can get it through the Medicaid fee-for-service.

Samantha Morales: Thank you so much, Rachel. And I think with that, that's going to be our last question that we have time for today. So thank you for joining us today and thank you to Tiffany and Rachel, our expert presenters. As a reminder, any questions that went unanswered today will be addressed via email. Should you have additional questions post the webinar, feel free to reach out to our speakers later. Don't forget to complete the post webinar survey. Your feedback on these programs is incredibly important to us. And have a great rest of your day.