

Health Issue Brief

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

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

To improve care for dually eligible individuals who qualify for both Medicare and Medicaid, the Centers for Medicare & Medicaid Services (CMS) has worked with states and health plans to develop programs that integrate Medicare and Medicaid benefits for this vulnerable population. A particularly popular method of achieving such integration is to use state Medicaid agency contracts with Dual Eligible Special Needs Plans (D-SNPs) to facilitate coordination and integration of benefits. In late 2020, with support from the Medicaid and CHIP Payment and Access Commission, Mathematica conducted a study of factors that influence state use of a variety of D-SNP contracting strategies to facilitate integration of Medicare and Medicaid benefits. This issue brief summarizes the study methods, contracting strategies examined, and key findings and conclusions from that study, including the importance of state context, resources, and capacity; challenges that states face in contracting with D-SNPs to cover rural areas; the importance of stakeholder engagement; and the need to consider potential trade-offs and the unintended consequences of particular strategies.

Introduction

Dually eligible individuals, who are covered by both Medicare and Medicaid, account for disproportionate spending in both programs and experience a higher prevalence of social needs, chronic health conditions, and functional limitations when compared with beneficiaries who qualify for Medicare alone.¹ Because Medicare and Medicaid are separate programs, dually eligible individuals also face the obstacle of navigating two different, often conflicting systems to obtain services to address their complex care needs. Health care providers, states, and health plans similarly face challenges coordinating and delivering care across the programs.

To address these challenges and improve health outcomes for dually eligible individuals, the Centers

for Medicare & Medicaid Services (CMS) has worked with states and health plans to integrate services covered under both programs through a variety of integrated care initiatives,² the most popular of which has been to integrate benefits through state contracts with Dual Eligible Special Needs Plans (D-SNPs)—specialized Medicare Advantage plans designed to serve dually eligible individuals by covering Medicare benefits and at least coordinating Medicaid benefits. (Figure 1 depicts the growth of D-SNP enrollment between 2006 and 2020.) While all D-SNPs must hold contracts with state Medicaid agencies and at least coordinate Medicaid benefits, most D-SNPs do not provide fully integrated coverage. However, states can leverage their D-SNP contracting authority to advance integration of Medicare and Medicaid benefits and encourage beneficiary enrollment in these plans.

To identify ways in which states can maximize their D-SNP contracting authority to promote integration of benefits as well as enrollment in integrated plans, the Medicaid and CHIP Payment and Access Commission (MACPAC) contracted with Mathematica to study the advantages and disadvantages of states' D-SNP contracting strategies, identify factors that promote or inhibit state adoption of those strategies, and inform MACPAC deliberations about further steps that could increase the availability of and enrollment in integrated models. This issue brief summarizes the methods and key findings of that study and offers considerations for federal and state policy-makers as they leverage D-SNP contracting strategies to advance integration of Medicare and Medicaid benefits and promote enrollment in integrated plans.

Study methods

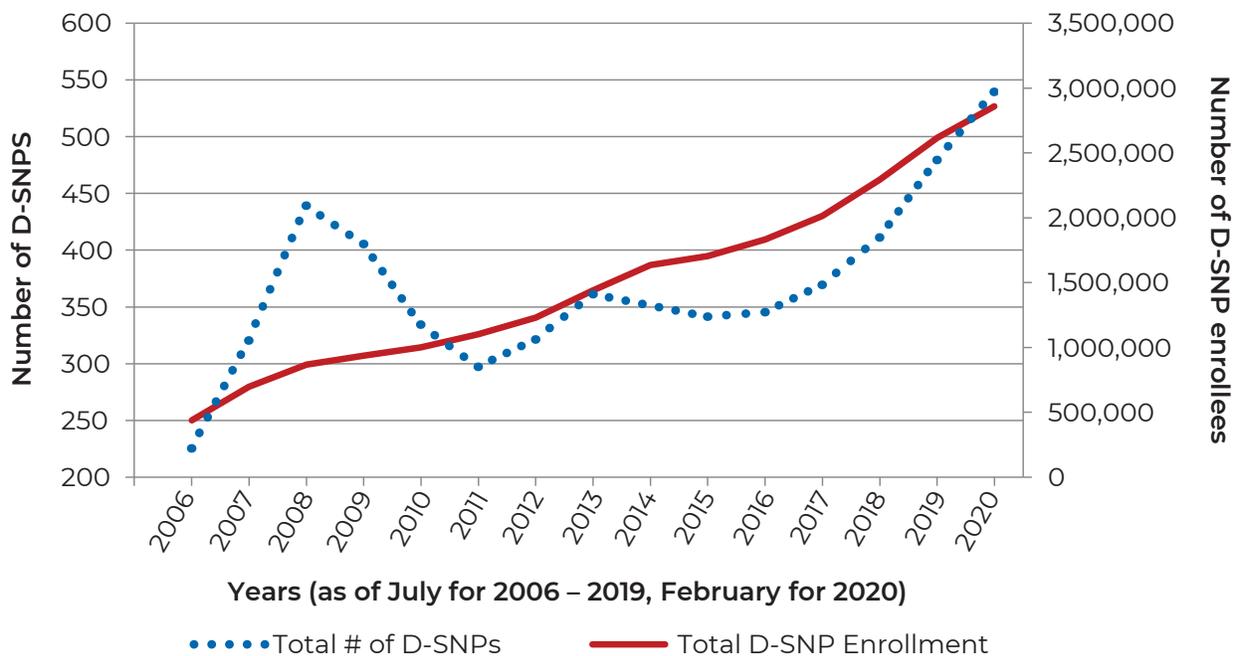
Mathematica conducted 16 semi-structured interviews with 42 individuals from state Medicaid agencies in four states and the District of Columbia (California, District of Columbia, Idaho, Indiana, and Virginia); five health plans; two beneficiary

advocacy organizations; and four other key stakeholders, including the CMS Medicare-Medicaid Coordination Office. The four states selected and

Box 1. Dual Eligible Special Needs Plans (D-SNPs)

D-SNPs are a type of Medicare Advantage plan designed to serve dually eligible individuals. D-SNPs were originally authorized by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) and permanently authorized by the Bipartisan Budget Act of 2018 (P.L. 115-123). All D-SNPs cover Medicare benefits and must at least coordinate Medicaid benefits. Since 2013, all D-SNPs must also hold contracts with the Medicaid agencies in their states of operation, in addition to contracts with CMS for coverage of Medicare benefits, and those contracts must include at least the minimally required elements described at 42 CFR 422.107. States may use these contracts to enforce additional requirements that promote integration of Medicare and Medicaid benefits—the focus of this issue brief. ▲

Figure 1. D-SNP enrollment, 2006–2020



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

the District of Columbia all contract with D-SNPs but have different degrees of integration (see Figure 2). In addition, they vary in their use of Medicaid managed care to serve dually eligible individuals, the proportion of older adults residing in rural areas, and the proportion of dually eligible individuals enrolled in D-SNPs.

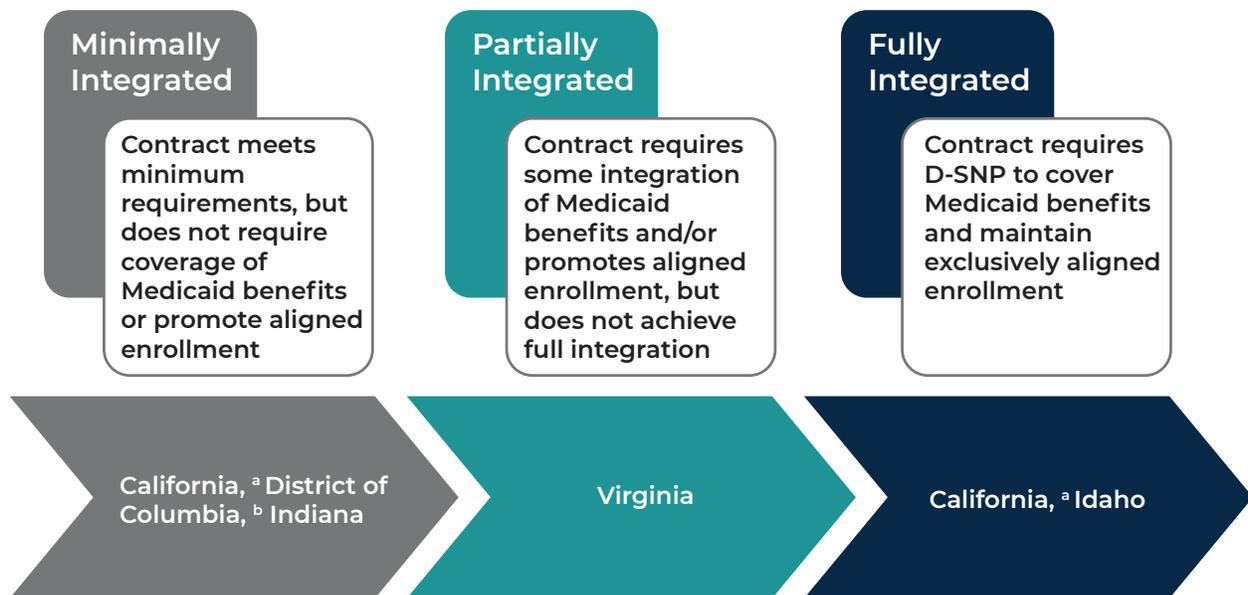
Interviewees discussed states' adoption of and experience with 11 specific contracting strategies (listed in Table 1), which were divided into two sets: (1) those that all states can implement and (2) those that are relevant only to states that operate Medicaid managed care programs that enroll dually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

Because these 11 strategies do not constitute an exhaustive list of contracting strategies that states may use to advance integration, Mathematica also asked interviewees about other strategies that states use or could use to support integration. In addition to asking about the use of each strategy, we asked interviewees about factors that support or prevent state adoption of each strategy, their advantages and disadvantages, and special challenges to D-SNP contracting in rural and frontier areas.

Key findings

Several themes emerged from our interviews regarding the benefits and challenges of implementing the D-SNP contracting strategies described in Table 1. In some cases, interviewees also suggested potential federal or state actions that could help address the challenges identified.

Figure 2. Continuum of integration in state D-SNP contracts



Source: Mathematica analysis of state contracts with D-SNPs.

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

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

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

Contracting strategy	Brief description
Strategies applicable to all states	
 <p>1. Limit D-SNP enrollment to full-benefit dually eligible individuals</p>	<p>To ensure that D-SNPs can offer uniform benefits, cost sharing, and care coordination to all D-SNP enrollees and present benefit information simply and clearly in enrollee materials, states can limit D-SNP enrollment to individuals who qualify for full Medicaid benefits in the state or full-benefit dually eligible (FBDE) individuals. Alternatively, states can require D-SNPs to use separate Medicare Advantage plan benefit packages^a to enroll full- and partial-benefit dually eligible individuals.</p>
 <p>2. Contract with D-SNPs to cover Medicaid benefits (direct contracting)</p>	<p>States can contract directly with D-SNPs to cover a range of Medicaid benefits, from simple coverage of Medicare cost sharing to a full package of Medicaid benefits, including behavioral health and long-term services and supports.</p>
 <p>3. Require D-SNPs to operate with exclusively aligned enrollment</p>	<p>Exclusively aligned enrollment occurs when a state limits enrollment in a D-SNP to FBDE individuals who receive their Medicaid benefits from the D-SNP or an affiliated Medicaid managed care plan offered by the same parent company as the D-SNP. This maximizes coordination because only one organization is responsible for Medicare and Medicaid benefits.</p>
 <p>4. Require D-SNPs to use specific care coordination methods</p>	<p>States can incorporate a variety of requirements into their D-SNP state Medicaid agency contracts (SMACs) to enhance the amount or degree of care coordination provided to D-SNP enrollees and facilitate greater integration of Medicare and Medicaid benefits. See Figure 3 for specific examples of care coordination requirements that states can incorporate into their SMACs.</p>
 <p>5. Require D-SNPs to send data or reports to the state</p>	<p>States can require D-SNPs to submit data or reports that enable state oversight of plan operations and quality of care—for example, Medicare encounter data, grievance and appeal data, and reports on the plan’s performance on certain quality measures or chronic care improvement projects, financial statements, or service cost information.</p>
 <p>6. Review Medicaid information in D-SNP materials</p>	<p>States can require D-SNPs to submit certain marketing and enrollee communication materials for state review before using them so that the state can ensure that the Medicaid information in the material is accurate, appropriate, and clear. In addition (or alternatively), the state can provide template language about Medicaid benefits and require D-SNPs to use that language to ensure consistency in messaging across D-SNPs.</p>

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

Contracting strategy	Brief description
Strategies applicable to states with Medicaid managed care programs that enroll dually eligible individuals or individuals becoming dually eligible	
 <p>7. Selectively contract with D-SNPs that offer affiliated Medicaid managed care plans</p>	<p>States with Medicaid managed care programs for dually eligible individuals can choose to contract only with D-SNPs that offer an affiliated Medicaid managed care plan (through the same parent organization) and/or to contract only with Medicaid managed care plans that offer an affiliated D-SNP to promote aligned enrollment (enrollment in a D-SNP and a Medicaid plan through the same organization).</p>
 <p>8. Require complete service area alignment</p>	<p>States that use selective contracting can require affiliated D-SNPs and Medicaid managed care plans to operate in fully aligned service areas so that all D-SNP-eligible individuals will have the option of enrolling in affiliated plans for coverage of Medicare and Medicaid benefits, regardless of their geographic location within the state. Achieving complete service area alignment can be difficult in states with substantial rural or frontier areas.</p>
 <p>9. Coordinate state Medicaid procurement cycles with Medicare timelines</p>	<p>States that use selective contracting can coordinate their Medicaid procurement cycle with Medicare timelines for approval of D-SNP contracts to maintain consistent affiliations between the D-SNPs and Medicaid managed care plans operating in the state.</p>
 <p>10. Automatically assign D-SNP enrollees to affiliated Medicaid plans</p>	<p>In states with affiliated D-SNPs and Medicaid managed care plans for dually eligible individuals, state Medicaid agencies can use Medicaid auto-assignment algorithms to align dually eligible individuals' Medicaid managed care enrollment with their D-SNP enrollment to promote aligned enrollment.</p>
 <p>11. Allow (or require) D-SNPs to use default enrollment</p>	<p>D-SNPs that meet the requirements described at 42 CFR 422.66(c)(2) may use default enrollment to enroll newly dually eligible individuals into a D-SNP through the same parent organization as their current Medicaid managed care plan (as long as the individuals will continue to be enrolled in Medicaid managed care once they are eligible for Medicare).</p>

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

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

Factors influencing state adoption of D-SNP contracting strategies

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

- / States already contracting with D-SNPs can leverage existing D-SNP contracts to require coverage of Medicaid benefits through either the D-SNP or an affiliated Medicaid plan (Medicaid managed care plans that are owned by the same parent company as the D-SNP). States that do not currently contract with D-SNPs may have more flexibility to adopt a range of integration strategies in new contracts, while other states would have to modify existing contracts and arrangements.
- / States with existing Medicaid managed care programs for dually eligible individuals, or those planning to implement one, can selectively contract with D-SNPs and Medicaid plans to promote integration, while those without Medicaid managed care can require D-SNPs to cover Medicaid benefits.
- / State policies that carve out dually eligible populations or certain benefits from Medicaid managed care can hinder use of D-SNP or Medicaid managed care contracts to integrate benefits.
- / States that already operate other integrated care initiatives (Financial Alignment Initiative (FAI) demonstrations, in particular) may be less inclined to use D-SNP contracts to integrate benefits if the two initiatives could compete with each other for enrollment.
- / States with a large number of dually eligible individuals residing in rural or frontier areas may face D-SNP contracting barriers. States with small populations of FBDE individuals or large numbers of partial-benefit dually eligible individuals may have difficulty limiting D-SNP enrollment to FBDE individuals.

“Many [contracting strategies] are pretty easy, but how easy and how effective they are is really dependent on what the starting point is. The easy next step for Arizona is not the easy next step for Maine.”

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

Barriers to D-SNP contracting in rural areas

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

Benefits and challenges of specific D-SNP contracting strategies

As noted in Table 1, 6 of the 11 contracting strategies examined in this study can be implemented by any state, while 5 are relevant only to states that operate Medicaid managed care programs that enroll dually eligible individuals or individuals becoming dually eligible. Key findings for each set of contracting strategies are discussed below.

Contracting strategies applicable to all states

/ **Limiting D-SNP enrollment to FBDE individuals.**

This is one of the simplest strategies to implement in most states. In addition, it enables uniform delivery of care coordination and information about enrollee benefits to all enrollees within a D-SNP. However, in states with a small FBDE population or a large number of partial-benefit dually eligible individuals currently enrolled in D-SNPs, limiting enrollment to FBDE individuals could make it difficult for D-SNPs to enroll enough members to sustain operations and could cause disruption in coverage for the partial-benefit dually eligible individuals already enrolled. As an alternative, states could require D-SNPs to enroll partial-benefit dually eligible individuals into separate plans, or plan benefit packages (PBPs). Having partial-benefit dually eligible individuals in separate PBPs from FBDE individuals could facilitate uniform delivery of care coordination and information within each PBP. If a state chooses to require D-SNPs to use separate PBPs to serve full- and partial-benefit dually eligible individuals, D-SNPs may request a crosswalking exception from CMS to move partial-benefit dually eligible individuals into a new PBP at the beginning of a new contract year (see Box 2).

/ **Contracting directly with D-SNPs to cover Medicaid benefits.** This strategy can be particularly useful in states that do not enroll dually eligible individuals in Medicaid managed care because it provides an opportunity to integrate Medicare and Medicaid benefits for D-SNP enrollees without having to enroll dually

Box 2. Crosswalking D-SNP enrollees (moving enrollees from one PBP to another)

42 CFR 422.530(a) defines “crosswalking” as the movement of enrollees from one PBP to another under a contract between the Medicare Advantage organization and CMS. In January 2019, CMS released a final rule (86 FR 5864 [January 19, 2021]) that became effective in March 2021 and codified policy at 42 CFR 422.530(c)(4) allowing D-SNPs to request a crosswalking exception from CMS if they wish to move a population of dually eligible individuals (for example, partial-benefit dually eligible individuals) from one D-SNP PBP to another within the same contract because those individuals no longer qualify for their current D-SNP (PBP), but would meet the eligibility criteria of the new D-SNP (PBP). This crosswalking exception may be particularly helpful to D-SNPs in states that decide to shift from allowing enrollment of all dually eligible individuals in D-SNPs to requiring D-SNPs to use separate PBPs to serve full- and partial-benefit dually eligible enrollees. ▲

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

/ **Requiring D-SNPs to operate with exclusively aligned enrollment.** Exclusively aligned enrollment occurs when a state’s contract with the D-SNP limits its enrollment to only FBDE individuals who receive Medicaid benefits from the D-SNP or an affiliated Medicaid managed care plan offered by the D-SNP’s parent company. This

strategy achieves the greatest degree of benefit integration. However, it can result in fewer dually eligible individuals enrolled in D-SNPs and requires significant state investment.

/ **Including care coordination and data sharing requirements in D-SNP contracts.** State-specific care coordination and data sharing requirements can promote better coordination of benefits for D-SNP members and enhance states' awareness of Medicare service utilization and disparities within their dually eligible population. For example, states can require D-SNPs to submit encounter data, quality measure data, and financial reports to the state to facilitate oversight of D-SNP performance and state knowledge of D-SNP enrollees' service utilization and care needs. States can also incorporate a variety of care coordination requirements into their state Medicaid agency contracts (SMACs) with D-SNPs to promote integration of Medicare and Medicaid benefits (see Figure 3 for examples). However, monitoring plan compliance with such requirements can be challenging. In addition, state requirements that D-SNPs share data or reports with the state for oversight purposes are useful only if states can (and do) use the data submitted. Two interviewees also noted that timely state sharing of Medicaid eligibility and enrollment data with D-SNPs facilitates better care coordination.³

/ **Reviewing Medicaid information in D-SNP marketing materials and enrollee notices.** When asked whether state review of Medicaid information in D-SNP marketing and enrollee materials was helpful, health plan interviewees often expressed concern about lengthy, duplicative, and sometimes contradictory state and CMS review processes. However, they were open to the idea of state provision of template language on Medicaid benefits for D-SNPs to include in their marketing materials and enrollee notices, such as summaries of the benefits covered by the plan and notices describing enrollee appeal and grievance rights and processes. Other interviewees, particularly beneficiary advocates, expressed support for state reviews of Medicaid information in D-SNP

materials. The advocates noted that it would be easier to share feedback on such materials with the state rather than with multiple D-SNPs. One health plan representative suggested that the states, along with CMS, could develop a single set of rules and review processes for integrated D-SNP materials, similar to the processes established for the FAI demonstrations.

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

The remaining five contracting strategies may be used only by states that operate Medicaid managed care programs that enroll dually eligible individuals or individuals who may become dually eligible. Figure 4 summarizes the state circumstances and policies relevant to the use of each of these strategies.

/ **Using selective contracting.** This strategy facilitates aligned enrollment—that is, when a dually eligible individual is enrolled in a D-SNP and a Medicaid managed care plan through the same parent organization—which increases the potential for better integration of Medicare and Medicaid benefits. However, Medicaid procurement decisions can dissolve aligned enrollment for individuals in D-SNPs and affiliated Medicaid managed care plans (managed care plans offered through the same parent companies as the D-SNPs) if the Medicaid plan loses a reprocurement bid, resulting in fewer enrollees in the integrated plans. In addition, in states that use selective contracting, plans that do not win Medicaid managed care contracts may aggressively market regular, non-D-SNP Medicare Advantage plans to dually eligible

“States should take a more proactive stance on defining messages and themes to be conveyed to dually eligible individuals about aligned plans [D-SNPs with affiliated Medicaid managed care plans] and ensure that this is used across multiple plans.”

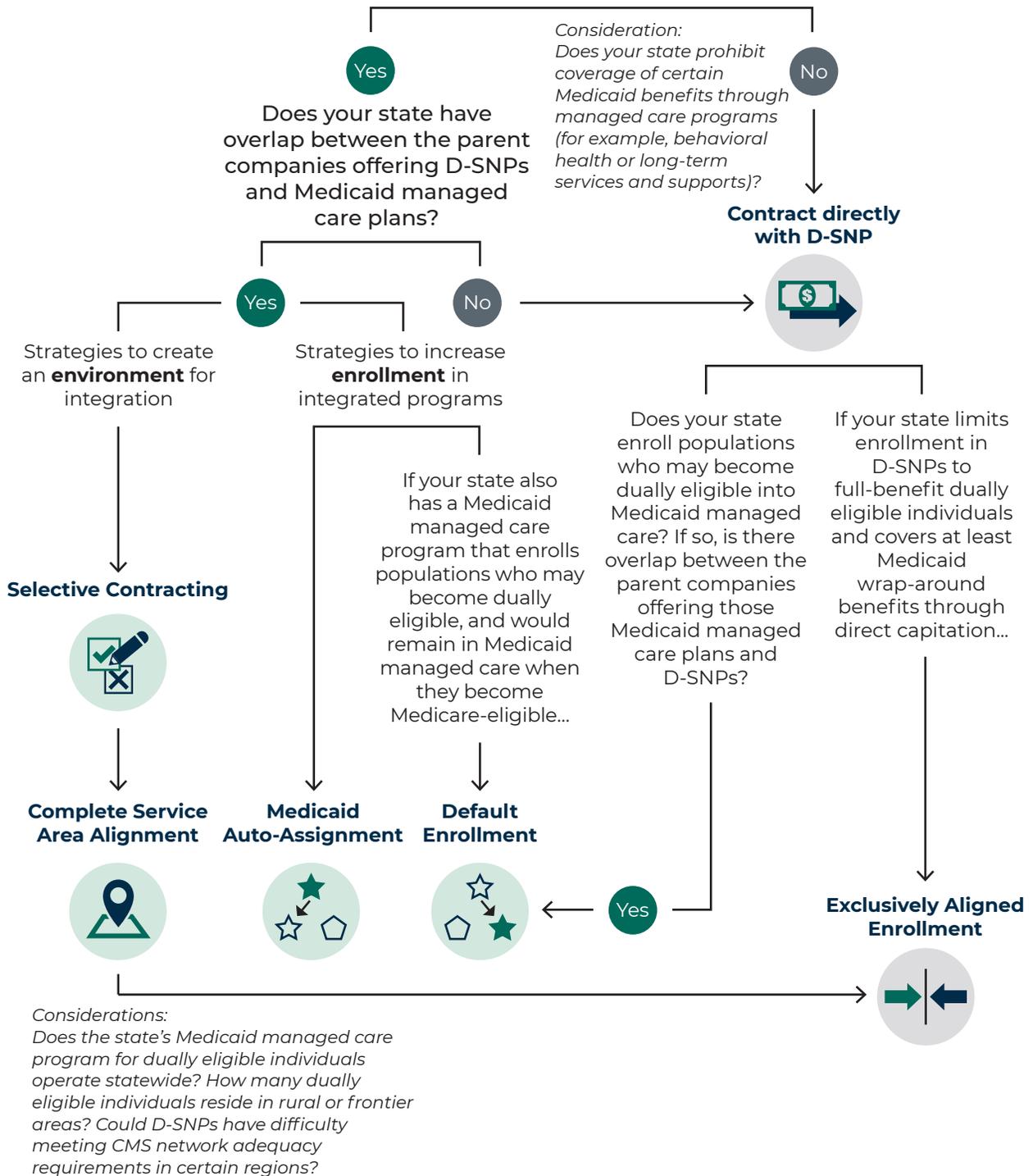
Figure 3. Examples of state SMAC requirements to enhance or integrate D-SNP care coordination

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

^a For information about incorporating Medicaid requirements into the D-SNP Model of Care, see the Integrated Care Resource Center's 2019 tip sheet "Tips to Improve Medicare-Medicaid Integration Using D-SNPs: Integrating Medicaid Managed Long-Term Services and Supports into D-SNP Models of Care," at <https://www.integratedcareresourcecenter.com/resource/tips-improve-medicare-medicaid-integration-using-d-snp-integrating-medicaid-managed-long>.

Figure 4. Decision tree for states operating Medicaid managed care programs for dually eligible individuals or individuals who may become dually eligible

Does your state have a Medicaid managed care program that enrolls dually eligible individuals?



individuals, ultimately steering them away from integrated plans. To address this issue, one interviewee suggested that CMS could consider restricting the types of Medicare Advantage plans available to dually eligible individuals in areas with integrated plans.

/ **Requiring completely aligned service areas.**

States that implement selective contracting can also require affiliated D-SNPs and Medicaid managed care plans to operate in the same geographic service areas, a strategy that further promotes integration and creates a framework for exclusively aligned enrollment. Obstacles to D-SNP contracting in rural areas may make this strategy impractical in certain states, however.

/ **Coordinating Medicaid procurement timelines with Medicare timelines.**

Variation between Medicare's timelines for launching and maintaining D-SNPs and state Medicaid managed procurement cycles can present challenges for states interested in implementing selective contracting. However, interviewees agreed that trying to fully coordinate these processes would not be worthwhile, given the amount of state investment required and the unpredictability of Medicaid procurement decisions and health plan protests. Instead, one interviewee thought coordinating Medicaid managed care enrollment periods with Medicare enrollment periods might be more effective in boosting beneficiary enrollment in affiliated plans. One health plan reported that one state allowed it to implement a D-SNP within one year of its Medicaid managed care award in lieu of coordinating the procurement timelines.

/ **Automatically assigning D-SNP enrollees to affiliated Medicaid plans or allowing (or requiring) D-SNPs to use default enrollment.**

Both of these strategies can help increase the number of dually eligible individuals enrolled in integrated plans. However, some interviewees stressed the importance of communicating with beneficiaries to ensure they understand the consequences of automatic assignment and retain the ability to select different coverage arrangements if they choose. In addition, some

“When a member has been in Medicaid for a long time and they age into Medicare...it's easier to just transition into a plan through the same company [via default enrollment]. This makes it easier for them to maintain their existing provider relationships.”

states lack the advanced information technology capabilities needed to implement these strategies. One interviewee suggested that CMS could encourage or incentivize states to use default enrollment. Others would like CMS to allow states to use waiver authority to implement “passive” enrollment into integrated D-SNPs, similar to what is now allowed in FAI demonstrations.⁴

Additional contracting strategies suggested by interviewees

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

/ **To reduce duplication across Medicare and Medicaid benefits and extend extra benefits to dually eligible individuals, states could partner with D-SNPs to develop supplemental benefit packages that complement the Medicaid benefits already available to FBDE individuals.**

D-SNPs could use “rebate dollars” generated through the Medicare Advantage bid process⁵ to provide expanded supplemental benefits to their enrollees, such as adult day care services, home-based palliative care, in-home support services, caregiver supports, medically approved non-opioid pain management, memory fitness benefits, home and bathroom safety devices and modifications, transportation, and coverage for over-the-counter medications and items. They can also provide targeted supplemental benefits to enrollees with particular chronic conditions, including food and produce benefits, home-delivered meals, pest control services, nonmedical transportation, indoor air quality equipment and services, social needs benefits, complementary therapies, services supporting self-direction,

structural home modifications, and service animal supports. Given the potential for overlap between these new supplemental benefit offerings and Medicaid benefits, states are beginning to work collaboratively with D-SNPs to ensure that the D-SNPs' supplemental benefits will accomplish the following:

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

/ **To improve the quality of care provided to dually eligible populations, states can incorporate Medicaid quality improvement priorities into D-SNP contracts to further advance states' quality improvement strategies for dually eligible individuals.** While all states could implement this strategy, it may be of most interest to states that enroll dually eligible individuals into Medicaid managed care programs or states that contract directly with D-SNPs for coverage of Medicaid benefits. States are required to develop and implement quality strategies and Medicaid Quality Assessment and Performance Improvement programs for their managed care programs, which include specific performance improvement projects (PIPs). When D-SNPs (or their affiliated Medicaid managed care plans) receive capitated payments from a state to cover Medicaid services, they are bound by the same Medicaid managed care regulations that guide Medicaid managed care plans, and therefore can be included in state efforts to achieve quality strategy goals. When D-SNPs operate alongside affiliated Medicaid managed care plans, states can require them to implement PIPs to address the needs of specific dually eligible populations of interest and reduce disparities within those populations.

/ **To simplify billing and payment for providers who serve dually eligible individuals, states with Medicaid managed care programs for dually eligible individuals can work with their D-SNPs and Medicaid managed care plans to set up automated crossover claims payment processes for Medicaid payment of Medicare cost sharing.** In an automated crossover process, health care providers bill D-SNPs for services rendered to D-SNP enrollees. The D-SNP pays any applicable Medicare portion of the provider's claim, then sends the claim to the appropriate Medicaid managed care plan for Medicaid review and payment. As a result, the provider will receive all applicable Medicare and Medicaid payments without having to identify whether the service is covered by Medicare, Medicaid, or both and without having to submit two separate claims to the D-SNP and the Medicaid managed care plan.

Key considerations for state and federal policymakers

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

/ **State context matters.** Whereas some D-SNP contracting strategies could be used by any state, others are applicable only to states that enroll dually eligible individuals in Medicaid managed care. In addition, it may be easier for states new to D-SNP contracting to implement a fully integrated program from the beginning; however, states with existing contracts may have a greater risk of disrupting continuity of care for current enrollees and encountering resistance from plans if they use selective contracting or limit D-SNP enrollment to FBDE individuals. For example, states new to contracting with D-SNPs could use direct contracting and exclusively aligned enrollment to create a fully integrated model from the outset. In states with existing D-SNP contracts, on the other hand, implementation of these strategies could disrupt coverage arrangements for current D-SNP enrollees and potentially lead to D-SNP disenrollment.

- / **Resources and long-term commitment matter.** States need to invest significant financial and staffing resources to advance integrated care initiatives, but many states do not yet have the Medicare policy expertise to navigate complexities in D-SNP contracting. Leadership buy-in and staff champions often play a critical role in advancing D-SNP contracting strategies, so turnover in key staff or leadership positions can interrupt or derail state progress toward integrated care.
- / **D-SNP contracting strategies often involve trade-offs between the level of integration and the number of individuals enrolled.** Some contract requirements that increase integration of Medicare and Medicaid benefits may decrease the share of dually eligible individuals enrolled in D-SNPs (at least in the short term). For example, restricting D-SNP enrollment to FBDE individuals allows the plan to better integrate care and member materials, but it could lead to substantially fewer enrollees if partial-benefit dually eligible individuals cannot enroll or are disenrolled from D-SNPs because of that restriction. Conversely, allowing partial-benefit dually eligible individuals to enroll in D-SNPs may mean that a greater share of dually eligible individuals enroll in D-SNPs, but those D-SNPs will be less integrated as a result.
- / **Some D-SNP contracting strategies may have unintended consequences that may not be easy (or possible) to resolve.** Several interviewees noted that selective contracting may lead to some aligned D-SNP enrollees becoming unaligned or being forced to change their D-SNP or Medicaid plan when an organization loses a Medicaid procurement bid.
- / **D-SNP contracting in rural areas is challenging.** Small dually eligible populations and CMS network adequacy requirements create obstacles to statewide D-SNP contracting in states with a large share of dually eligible individuals who live in rural or frontier regions. Some state and CMS policy changes might address these barriers.
- / **Federal requirements and CMS priorities for integrated care influence state decisions to adopt D-SNP contracting strategies.** Federal

laws and regulations, along with federal support for state initiatives, can accelerate states' use of D-SNPs as a platform for integrating care for dually eligible individuals.

- / **Stakeholder engagement is critical to successful integrated care initiatives.** Health plans, providers, and beneficiary advocacy organizations often influence enrollment into integrated (or nonintegrated) health plans. If states do not successfully engage these stakeholders and gain their support when implementing D-SNP contracting strategies to promote integration, the stakeholders may use their influence to steer potential enrollees away from integrated care.

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

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Endnotes

¹ Integrated Care Resource Center. “Dually Eligible Individuals: The Basics.” Integrated Care Resource Center Fact Sheet, March 2021. Available at <https://www.integratedcareresourcecenter.com/resource/dually-eligible-individuals-basics>.

² For background on the three major integrated care models designed for dually eligible individuals—Financial Alignment Initiative demonstrations, Programs of All-Inclusive Care for the Elderly (PACE), and integrated D-SNP programs—see Chapter 1 of the Medicaid and CHIP Payment and Access Commission’s June 2020 report to Congress at <https://www.macpac.gov/publication/chapter-1-integrating-care-for-dually-eligible-beneficiaries-background-and-context/>.

³ For information about ways that states can share Medicaid eligibility and enrollment information with D-SNPs, see the Integrated Care Resource Center’s 2019 tip sheet, “State Options and Considerations For Sharing Medicaid Enrollment and Service Use Information with D-SNPs,” at <https://www.integratedcareresourcecenter.com/resource/state-options-and-considerations-sharing-medicaid-enrollment-and-service-use-information-d>.

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

⁵ For information about the Medicare Advantage bid process and the rebate dollars that some Medicare Advantage plans gain through that process, see “Medicare Advantage Program Payment System” (Medicare Payment Advisory Commission, October 2020) at http://medpac.gov/docs/default-source/payment-basics/medpac-payment_basics_20_ma_final_sec.pdf?sfvrsn=0.

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