ICRC | Integrated Care Resource Center

TIP SHEET

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Tools for States on Exclusively Aligned Enrollment in Dual Eligible Special Needs Plans:

Key Policy Decisions and Considerations for States Preparing for Exclusively Aligned Enrollment

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Background

Exclusively aligned enrollment (EAE) is a policy tool for states interested in offering fully integrated Medicare and Medicaid benefits to people who are dually eligible for Medicare and Medicaid under a model that leverages Medicare Advantage Dual Eligible Special Needs Plans (D-SNPs).[1] EAE occurs when a state limits D-SNP enrollment to full-benefit dually eligible individuals[2] who receive their Medicaid benefits from the D-SNP or an affiliated Medicaid managed care plan offered by the same parent organization as the D-SNP. These requirements ensure that anyone who enrolls in the D-SNP is ultimately eligible for the same unified package of benefits and facilitate several important benefits for plan enrollees, providers, and states.

ABOUT THIS TIPSHEET

This tip sheet summarizes **four key policy decisions** for states preparing to implement EAE, as well as **four factors that states may wish to consider** when making those policy decisions.

This tip sheet is part of a suite of tools developed for states by the Integrated Care Resource Center (ICRC) on exclusively aligned enrollment (EAE). The full set of tools, including a foundational tip sheet that provides a more basic introduction to EAE, is available at https://integratedcareresourcecenter.com/resources-by-topic/exclusively-aligned-enrollment.

The methods that individual states use to effectuate EAE vary, often based on unique environmental factors. Through interviews and discussions with states that have already implemented EAE and states that are planning to implement EAE in the future, Integrated Care Resource Center (ICRC) staff identified several key policy decisions and considerations that have helped states design successful EAE models across a variety of landscapes and circumstances. This tip sheet summarizes those key policy decisions and considerations to help states new to EAE develop an approach that will fit their unique circumstances.

Key Policy Decisions When Preparing for EAE

When planning to implement EAE, states must make a variety of important policy decisions, which include: (1) determining the scope and service area for EAE implementation; (2) selecting a contracting strategy for EAE implementation; (3) deciding whether to allow exceptions to state Medicaid managed care "lock-in" policies (if applicable) to facilitate enrollment into integrated D-SNPs; and (4) deciding

whether and how to address potential gaps Medicare and Medicaid enrollment start dates when a dually eligible individual requests enrollment into an exclusively aligned D-SNP late in the month. In making these decisions, states should bear in mind the "Key Considerations in Planning and Implementing EAE" described in later in this tip sheet. The following discussion provides more information on the key policy decisions outlined above:

1 Determine the scope and service area for implementing EAE

While some states have chosen to implement EAE on a statewide basis, requiring all D-SNPs within the state to operate with EAE, others have chosen to limit EAE implementation, initially or permanently, to specific service areas within the state or to only certain D-SNPs. States may want to consider factors like the current managed care landscape in the state or dually eligible individuals' current enrollment in D-SNPs and Medicaid managed care plans (both discussed later in this tool) when deciding the scope and service area for EAE. For example, if D-SNPs in a state do not operate within the same service areas as affiliated Medicaid managed care plans, expanding statewide may require time and investment. In some cases, such expansion may not even be possible if provider network adequacy requirements cannot be met in particular counties. In such cases, a state could choose to align D-SNPs with Medicaid managed care plans in certain service areas and only require the D-SNPs within those service areas to operate with EAE. A state's decisions about the scope and service area for EAE may also influence its decisions regarding a contracting strategy for EAE implementation, which is discussed in the next section.

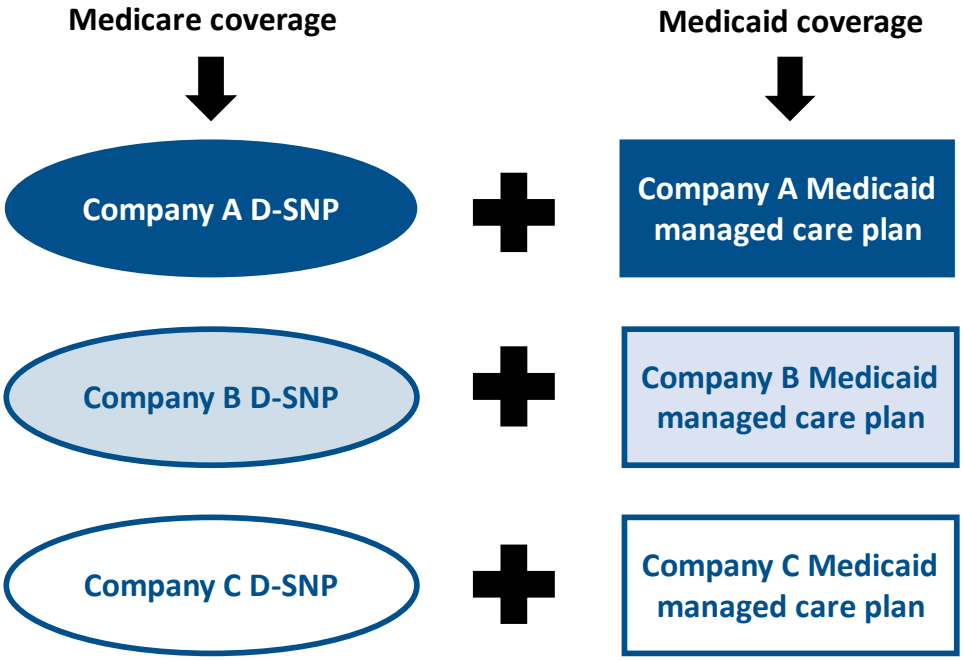
2 Select a contracting strategy for EAE implementation

States interested in pursuing EAE can use one – or a combination of – the three contracting strategies that follow to design an integrated care program that reflects each state's unique landscape and circumstances.

Contracting strategy 1: Selectively contracting with D-SNPs that have affiliated Medicaid managed care plans for dually eligible individuals and requiring them to operate with EAE

States that have Medicaid managed care programs that enroll dually eligible individuals (or that are planning to launch such a program) can choose to selectively contract with entities willing to offer both a Medicaid managed care plan and D-SNP in the same geographic area and require them to operate with EAE. As shown in **Figure 1**, this contracting strategy creates an "aligned plan" model, in which Parent Company A offers both a D-SNP and a Medicaid managed care plan, and dually eligible individuals who choose to enroll in the Company A's D-SNP must be enrolled into Company A's Medicaid managed care plan for their Medicaid benefits. This strategy is typically easiest to implement if: (1) the state has at least some existing alignment between the parent companies offering D-SNPs and the parent companies offering Medicaid managed care plans for dually eligible individuals in the state; or (2) the state is new to D-SNP contracting, Medicaid managed care contracting for dually eligible individuals, or both.

Figure 1. Aligned plan model that can be achieved when states selectively contract with D-SNPs and Medicaid managed care plans operated by the same parent companies



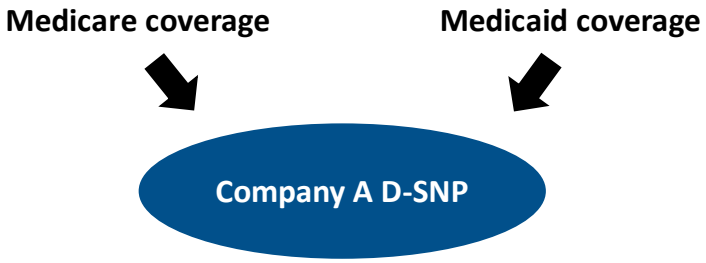
The stability of integrated D-SNP enrollment in states that use this contracting strategy relies somewhat on the ongoing success of the parent companies' performance in future Medicaid managed care procurements. If a Medicaid managed care plan that is affiliated with an integrated D-SNP loses a Medicaid re-procurement, the D-SNP will no longer be able to operate with EAE in the state,[3] which can disrupt enrollment and continuity of care for current enrollees in that integrated D-SNP. However, with support from CMS, states in this situation may be able to leverage the passive enrollment authority described at 42 CFR 422.60(g)(1)(iii) to passively enroll those individuals from the exiting D-SNP(s) into integrated D-SNP(s) that continue to operate in the state.

Contracting strategy 2: Contracting directly with D-SNPs to cover Medicaid benefits for D-SNP enrollees

States that do not enroll dually eligible individuals into Medicaid managed care programs or that wish to establish integrated D-SNPs through parent companies that do not offer Medicaid managed care plans for dually eligible individuals may be interested in a second strategy for achieving EAE – contracting directly with D-SNPs to cover Medicaid benefits for D-SNP enrollees. In this model, the state pays D-SNPs a capitated rate to cover Medicaid benefits for D-SNP enrollees instead of paying a Medicaid managed care plan to provide that coverage. As shown in **Figure 2**, the D-SNPs are then responsible for providing both Medicare and Medicaid benefits to enrollees.

When D-SNPs are capitated to cover Medicaid benefits, they function as Medicaid managed care plans and must meet the requirements described at 42 CFR 438. States must conduct the same kinds of oversight with directly capitated D-SNPs as with other Medicaid managed care plans that cover Medicaid benefits, including obtaining appropriate federal Medicaid managed care authority to operate the program.[4]

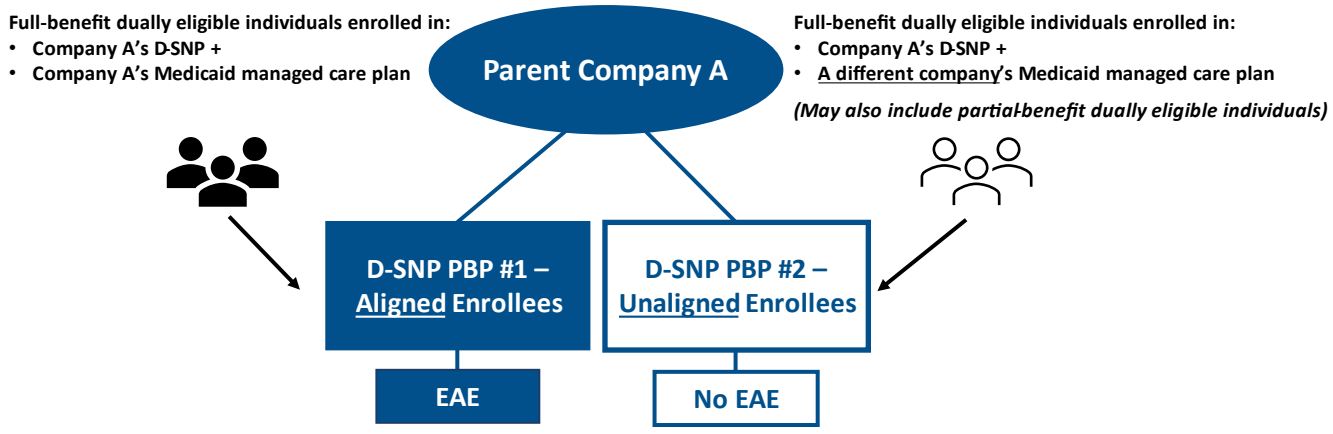
Figure 2. D-SNP coverage of Medicaid benefits, which can be achieved by states contracting directly with D-SNPs to cover Medicaid benefits for D-SNP enrollees



Contracting strategy 3: Require D-SNPs to use separate plan benefit packages (PBPs) to serve "aligned" and "unaligned" enrollees

A third strategy that states can use to achieve EAE in at least some D-SNPs, which can be used alone or in combination with either of the first two strategies mentioned previously, is to require D-SNPs to use separate plan benefit packages (PBPs) to serve "aligned" and "unaligned" enrollees. This strategy can be particularly helpful for states with dually eligible individuals whose Medicare and Medicaid enrollment is "unaligned" because they are enrolled in a D-SNP through one parent company and a Medicaid managed care plan through a different parent company. As shown in **Figure 3,** it enables the state to allow those individuals to remain enrolled in their chosen D-SNPs, while simultaneously requiring the D-SNPs to create separate PBPs for people whose enrollment is "aligned" (meaning they are enrolled in a D-SNP and a Medicaid managed care plan through the same parent company), so that the "aligned" enrollees can reap the benefits of EAE. This strategy can also be used as an incremental step in states that are not yet prepared to require all D-SNPs to operate with EAE but would like to enable EAE for at least some dually eligible individuals.

Figure 3. Requiring D-SNPs to use separate plan benefit packages (PBPs) to serve "aligned" and "unaligned" enrollees



3 Decide whether to allow exceptions to state Medicaid managed care "lock-in" policies to facilitate enrollment into integrated D-SNPs

Dually eligible individuals have multiple opportunities to change their Medicare plan in a given year.[5] By contrast, states (with CMS approval) can mandate enrollment in a managed care plan for some or all Medicaid benefits.[6] To ensure that dually eligible individuals can use Medicare enrollment periods to enroll into integrated D-SNPs, states that have implemented EAE have typically adjusted Medicaid enrollment to "follow" Medicare enrollment into an integrated D-SNP. In other words, when a dually eligible individual chooses to enroll in a D-SNP offered by Parent Organization A, the state (or the state's enrollment broker, when applicable) adjusts the person's Medicaid plan enrollment accordingly, so that the individual will receive their Medicaid benefits from Parent Organization A too.

To facilitate this process, some states have authorized exceptions to Medicaid managed care "lock-in" policies to allow for changes in dually eligible individuals' Medicaid managed care plan enrollment when they enroll into an integrated D-SNP outside of their annual Medicaid managed care open enrollment period. Otherwise, lock-in policies can hinder EAE by preventing the state from changing a dually eligible individual's Medicaid enrollment to match their chosen D-SNP if the individual is not within their annual Medicaid managed care open enrollment period. States with lock-in policies for Medicaid managed care programs may wish to consider: (1) developing an exception to the lock-in policy for integrated D-SNP enrollment; or (2) establishing enrollment into an integrated D-SNP as a reason that a dually eligible individual can change their Medicaid managed care plan for "cause."

4 Decide whether and how to address potential gaps between Medicare and Medicaid enrollment start dates when a dually eligible individual requests enrollment into an exclusively aligned D-SNP late in the month

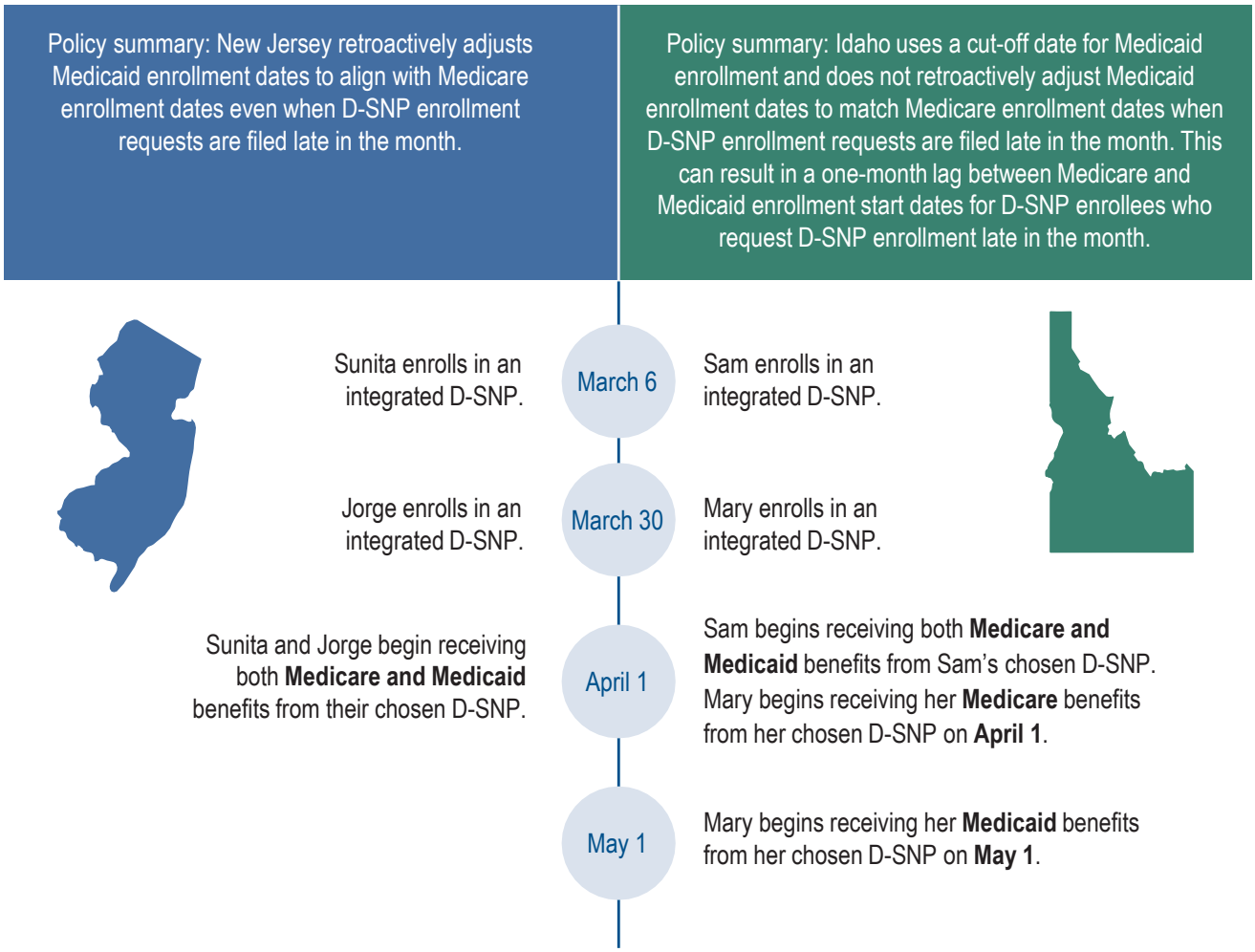
States planning for EAE implementation should consider whether Medicaid enrollment processes can be designed to align Medicaid enrollment effective dates with an individual's D-SNP enrollment effective date for Medicare benefits. Medicare Advantage plans, including D-SNPs, must process enrollment requests on a continuous basis, with any enrollment processed by the last day of a month becoming effective on the first day of the following month. In other words, if a dually eligible individual enrolls in a D-SNP on March 31 (and is determined to be eligible for the D-SNP), that individual's D-SNP enrollment will be effective April 1.

In Medicaid managed care programs, some states use cut-off date policies, such that any Medicaid managed care plan enrollment or disenrollment requests received after a monthly cut-off date become effective the first day of the second month after the request was received. In other words, if a state has an enrollment cut-off date of the 20th of the month, and the state (or the state's enrollment broker) receives a Medicaid managed care plan enrollment request on March 31, that enrollment request would be processed with an effective date of May 1.

If a state requires D-SNPs to operate with EAE but uses an enrollment cut-off date for Medicaid plan enrollment, this can lead to a one-month lag between D-SNP and Medicaid plan enrollment for dually eligible individuals who enroll into an EAE D-SNP late in the month. **Figure 4** describes New Jersey

and Idaho's Medicaid cut-off date policies and how the policies affect alignment of Medicare and Medicaid start dates for dually eligible individuals enrolling in an integrated D-SNP.

Figure 4. D-SNP Medicare and Medicaid enrollment start dates in New Jersey and Idaho



While alignment of Medicare and Medicaid enrollment start dates is an ideal situation in integrated care programs, it is worth noting that it is not a necessary component to achieving EAE. States like Idaho have implemented EAE with the one-month lag illustrated in Figure 4. In those circumstances, states should work with D-SNPs and other relevant entities to clearly convey the implications of that lag to enrollees.

Key Considerations in Planning and Implementing EAE

A variety of factors are important for states to consider when contemplating EAE requirements and deciding on a model for EAE implementation. In particular, states may want to consider: (1) the current landscape of D-SNPs and Medicaid managed care plans in the state, including the parent companies offering both types of plans, their service area overlap, existing relationship between managed care entities and the state, and managed care entities' relative market power; (2) dually eligible individuals' current enrollment in D-SNPs and/or Medicaid managed care plans, including the extent to which partial-benefit dually eligible individuals are already enrolled in D-SNPs; (3) the perspectives of

beneficiaries, providers, plans, and other key collaborators; and (4) staffing or resource investments that may be needed to support EAE implementation.

1 Current managed care landscape in the state

States may wish to consider the following key landscape factors when deciding whether to implement EAE, developing an approach, and selecting an appropriate EAE contracting strategy:

Current managed care entities and existing service areas

One consideration that is particularly relevant in selecting an EAE contracting strategy is **the extent to which D-SNPs and Medicaid managed care plans already enroll dually eligible individuals** within the state.

- If a state has both D-SNPs and Medicaid managed care plans that enroll dually eligible individuals, that state can then consider **the extent to which the same parent companies operate both D-SNPs and Medicaid managed care plans in the same or overlapping service areas**. This will help the state determine whether it may be able to selectively contract with D-SNPs and affiliated Medicaid managed care plans offered by the same parent company and requiring them to operate with EAE (contracting strategy 1). If such overlap is minimal, the state may wish to assess whether future procurement opportunities could lead new D-SNP and/or Medicaid managed care entrants and/or to service area expansions for existing D-SNPs and/or Medicaid managed care plans. Alternatively, these states could consider contracting directly with D-SNPs to cover Medicaid benefits for D-SNP enrollees (contracting strategy 2) if aligning D-SNPs with Medicaid managed care plans does not seem like a feasible option.

- States that do not have Medicaid managed care programs for dually eligible individuals, but that do have existing contracts with D-SNPs (or that have entities interested in contracting with the state to offer D-SNPs) can contract directly with D-SNPs to cover Medicaid benefits for D-SNP enrollees. For example, when the **District of Columbia** was looking to implement integrated Medicare and Medicaid benefits for dually eligible individuals, the District did not have a Medicaid managed care program that enrolled dually eligible individuals, but it did have existing D-SNP contracts, and it also had existing Medicaid managed care programs that served other Medicaid populations. As a result, the District had the contracting and Medicaid managed care oversight infrastructure in place to develop a program through which the District contracts directly with D-SNPs to cover Medicaid benefits for full-benefit dually eligible D-SNP enrollees. The District developed a Medicaid contract for its D-SNP, sought federal approval of an appropriate Medicaid managed care authority, conducted a readiness review with the plan, and established several oversight and reporting mechanisms that it now uses for ongoing monitoring and quality improvement with the D-SNP, which now operates with EAE.

Established relationships between the state and managed care entities

The state's existing relationships with the D-SNPs (and Medicaid managed care plans, where applicable) operating within that state and existing communications and information exchange can support or hinder the state's ability to work positively with those plans in the implementation – and

subsequent operation – of EAE within the state. States with strong working relationships with the health plans that involve regular communication and/or data sharing may be well-positioned to work with those plans to successfully implement EAE, as the development and ongoing operation of EAE typically requires regular communication and data sharing. States with weaker relationships and communication with the health plans that would be implementing EAE may need to thoughtfully establish processes and information-sharing infrastructure to support EAE implementation, depending on the EAE contracting strategy selected and the magnitude of EAE implementation. For example, requiring D-SNPs to use separate PBPs to serve aligned and unaligned enrollees does not require the same degree of data sharing and engagement from the state as implementing a statewide "aligned plan" EAE model.

Market power of managed care entities

When there are relatively few D-SNPs and/or Medicaid managed care plans operating in a state, those managed care entities may have more leverage in the state's decisions about integrated care program policy than when there are many D-SNPs and Medicaid managed care plans competing for market share. States with fewer plans may need to consider managed care entities' priorities more carefully when designing and implementing EAE. For example, if there are only two Medicaid managed care plans operating in the state, and one does not want to operate an aligned D-SNP, that state would need to consider that Medicaid managed care plan's business position carefully before requiring all its D-SNPs to operate with EAE. Engaging managed care entities early in the EAE design process can sometimes help to align state and managed care entity priorities. Alternatively, states can also clearly communicate their intentions regarding EAE ahead of time, as **Indiana** did in designing its aligned managed long-term services and supports (MLTSS) program to be launched in 2024.[7]

On the other hand, states with many D-SNPs and Medicaid managed care plans may face the challenge of wanting to consolidate or reduce the number of managed care entities and limit future enrollment in plans that do not offer aligned products. States in this position will need to consider how to communicate those changes to enrollees to help them understand their enrollment options and the benefits of enrolling in integrated products.

2 Dually eligible individuals' current enrollment in D-SNPs and Medicaid managed care plans

Reviewing dually eligible individuals' current enrollment in D-SNPs and/or Medicaid managed care plans and understanding how implementation of EAE could affect that existing enrollment can also help to facilitate selection of an appropriate EAE contracting strategy. This analysis can also help a state to estimate the number of dually eligible D-SNP enrollees who may benefit from EAE and assess the likelihood that particular managed care entities would support or oppose a state decision to require D-SNPs to operate with EAE.

Total number of dually eligible individuals enrolled in D-SNPs, Medicaid managed care plans, or both

States may first want to examine the total number of dually eligible individuals who are enrolled in D-SNPs (and Medicaid managed care programs, where applicable), as well as the number of dually eligible individuals enrolled in each individual D-SNP (and Medicaid managed care plan, where applicable). For example, states with a large number of existing D-SNP enrollees also may have the most to gain from implementing EAE, particularly if many of those existing D-SNP enrollees already have "aligned" enrollment or receive Medicaid benefits from fee-for-service Medicaid, as those existing enrollees could immediately reap the benefits of the shift to EAE if they choose to remain enrolled in the D-SNP.

Current enrollment of partial-benefit dually eligible individuals in D-SNPs

While most dually eligible individuals are full-benefit dually eligible individuals, meaning that they are entitled to full Medicaid benefits, partial-benefit dually eligible individuals only have Medicare Savings Program (MSP) coverage - not full Medicaid benefits.[8] D-SNPs that operate with EAE may not enroll partial-benefit dually eligible individuals because these individuals have no Medicaid benefits to "integrate" with the Medicare benefits in an EAE model.

If a state looking to implement EAE has D-SNPs with large numbers of existing partial-benefit dually eligible enrollees, those D-SNPs may be concerned about losing those enrollees during EAE implementation. These states could choose to allow those D-SNPs to continue enrolling partial-benefit dually eligible individuals but require them to serve the partial-benefit dually eligible enrollees through PBPs separate from the PBPs used to serve full-benefit dually eligible enrollees. This enables use of EAE in the PBPs for full-benefit dually eligible individuals, while preventing the partial-benefit dually eligible individuals from losing their D-SNP coverage entirely.

For example, **Tennessee** has many partial-benefit dually eligible individuals enrolled in D-SNPs. To achieve EAE in this environment without disrupting the coverage of those partial-benefit dually eligible D-SNP enrollees, Tennessee has opted to require the state's fully integrated D-SNPs (FIDE SNPs) to operate with EAE, while allowing other D-SNP PBPs to serve unaligned enrollees, including partial-benefit dually eligible individuals.

Existing "aligned" and "unaligned" enrollment

"Aligned" enrollment occurs when a full-benefit dually eligible individual is enrolled in a D-SNP and a Medicaid managed care plan through the same parent company. Dually eligible individuals may voluntarily align their enrollment by choosing to enroll in a D-SNP and a Medicaid managed care plan through the same parent company even if the state does not require EAE. As a result, some states without EAE, but with affiliated D-SNPs and Medicaid managed care plans, may have a high percentage of aligned enrollees, while others may not.

When a state implements EAE, enrollees who are in a Medicaid managed care plan that is unaligned with their current D-SNP will most likely move to the Medicaid managed care plan that is aligned with their current D-SNP. Alternatively, those individuals could choose to disenroll from their D-SNP and move to Medicare Advantage or fee-for-service (FFS) Medicare for their Medicare coverage.

Because most managed care companies are likely to prioritize maintaining enrollment when possible, D-SNPs that already have a high proportion of aligned enrollees will likely be in favor of state efforts to implement EAE. On the other hand, managed care companies that have large numbers of "unaligned" enrollees – people who are enrolled in the company's D-SNP or Medicaid managed care plan, but not both – may be more reluctant to make changes that could jeopardize that enrollment.

3 Perspectives of dually eligible individuals, providers, plans, and other key collaborators

States considering EAE may need to engage dually eligible individuals, providers, plans, advocates, and other key collaborators (such as state political leaders, Medicaid agency leaders, and other state agencies, such as departments of insurance or departments of aging) at a variety of stages in the planning process. This engagement can help the state understand the interests and goals of these different entities, all of whom could play important roles in influencing the success of EAE implementation. **Figure 5** highlights examples of the kinds of questions, comments and concerns that states might hear from different groups regarding EAE, based on different groups' varied goals and incentives.

Box 1. Identifying Aligned Enrollees

For details on identifying Medicare plan enrollment for dually eligible individuals, see ICRC's July 2020 guide on identifying aligned enrollees: https://www.integratedcareresourcecenter.com/resource/state-guide-identifying-aligned-enrollees-how-find-medicare-plan-enrollment-dually

Figure 5. Perspectives about adoption of EAE by role

Dually eligible individuals

GOALS

Easy access to quality, comprehensive healthcare

QUESTIONS AND CONCERNS

"How will my healthcare change?"
"Can I keep my same doctors?"
"Is this going to mean that fewer doctors will take my insurance?"
"What does this mean for my Medicaid-only services?"

OPPORTUNITIES FOR IMPROVED EXPERIENCE WITH EAE

Better care coordination, access to holistic package of benefits, and simplification of enrollee communication and materials

Providers

GOALS

Reducing administrative costs and burdens to ensure adequate resources to provide quality care to patients

QUESTIONS AND CONCERNS

"How will this change how we get reimbursement or authorization for services?"
"Will we have to update our software system or patient profiles?"
"Is this going to mean new forms, more training for staff, or more paperwork?"

OPPORTUNITIES FOR IMPROVED EXPERIENCE WITH EAE

Long-term simplification of payment mechanisms

Health plans

GOALS

Maximizing efficiency in paying for the health care of plan members

QUESTIONS AND CONCERNS

"Are we going to lose members?"
"Will we lose our current D-SNP/Medicaid managed care contract?"
"Will we be compensated for increased services?"
"What support will be available to help us through this transition?"

OPPORTUNITIES FOR IMPROVED EXPERIENCE WITH EAE

Potential opportunity to expand market share within the state and reduce per member costs across the D-SNP and Medicaid managed care plans

State leadership

GOALS

Develop and maintain a sustainable, cost-effective health care delivery system for dually eligible individuals

QUESTIONS AND CONCERNS

"Is this going to cost taxpayers more?"
"Am I going to hear from providers, health plans, and constituents that they are happy or upset about this new program?"
"Will this require changes to our statutes and regulations?"

OPPORTUNITIES FOR IMPROVED EXPERIENCE WITH EAE

Potential for cost savings and quality improvement in care for dually eligible individuals

4 State infrastructure, capacity, and investment

Another important consideration for states preparing to implement EAE is the extent to which staffing and/or resource investments may be needed prior to or during EAE implementation. Examples of staffing and resource investments that some states have made when preparing for EAE include:

- Hiring or establishing a dedicated Medicaid agency staff member to oversee the integrated care program;
- Dedicating time for IT and enrollment systems staff for processing Medicaid enrollment transactions to effectuate EAE;
- Training for state Medicaid agency staff (and/or staff at other state agencies or vendors with roles in EAE implementation);
- Upgrading Medicaid eligibility and enrollment systems;
- Developing new eligibility and enrollment program code and/or editing of existing program code to facilitate EAE transactions and rank-ordering of EAE transaction processing alongside other automated Medicaid enrollment transactions;
- Developing specifications for exchange of enrollment data files with D-SNPs; and
- Testing of enrollment data exchange with D-SNPs, Medicaid managed care plans, or other involved parties.

Box 2. Additional Resources for States on D-SNP Contracting

In addition to reviewing this guide, state Medicaid agency staff may be interested in reviewing ICRC's other resources for states on D-SNP contracting at https://www.integratedcareresourcecenter.com/resources-by-topic/dual-eligible-special-needs-plans

The extent to which these kinds of investments may be needed vary widely based on the state's chosen EAE contracting strategy, the magnitude of EAE implementation, the state's existing managed care landscape, and the state's existing policy and systems infrastructure. ICRC can provide individualized technical assistance to help states determine any resources or systems changes that may be needed to support EAE in specific state circumstances.

Summary

Because states' individual landscapes and circumstances vary widely, states' approaches to implementing EAE vary widely, as well. In this tip sheet, ICRC summarized several key policy decisions and considerations for states interested in using EAE to further integration of Medicare and Medicaid benefits for dually eligible individuals. Key policy decisions include determining the scope and service area for EAE implementation, selecting an EAE contracting strategy, deciding whether to allow exceptions to state Medicaid managed care enrollment policies (if applicable) to facilitate enrollment into integrated D-SNPs, and deciding whether and how to address potential gaps in Medicare and Medicaid enrollment start dates when a dually eligible individual requests enrollment into an exclusively aligned D-SNP late in the month. Key considerations include the state's existing managed care landscape; dually eligible individuals' current enrollment in D-SNPs (and Medicaid managed care plans, when applicable); the perspectives of dually eligible individuals, providers, plans or other interested parties; and the extent to which the state may need to invest resources or make changes to existing systems or processes to implement EAE. In addition to providing a suite of written tools for state use in planning for and implementing EAE (summarized in the next section), ICRC is available to provide individualized technical assistance to help states consider these and other relevant factors and

make the relevant policy decisions discussed within this tool. States interested in requesting individualized technical assistance about EAE can contact ICRC at ICRC@chcs.org or reach out to the CMS Medicare-Medicaid Coordination Office.

EAE Resources for States

ICRC has developed a suite of resources to support states considering EAE, including:

- A **recorded webinar for states** on using EAE to integrate Medicare and Medicaid benefits for dually eligible individuals;
- A **tip sheet** that provides an **introduction to EAE**, including a basic overview of EAE, as well as a summary of the benefits of EAE for dually eligible individuals, providers and states;
- A **tip sheet on key steps** in planning and implementing EAE; and
- A **set of tables** that states can use to plan the roles and responsibilities of key entities in effectuating exclusively aligned enrollment in a variety of enrollment and disenrollment scenarios.

ABOUT THE INTEGRATED CARE RESOURCE CENTER

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

Endnotes

[1] For an introduction to D-SNPs, see ICRC's Working with Medicare Webinar, "State Contracting with D-SNPs: Introduction to D-SNPs and D-SNP Contracting Basics" from December 2022 at: https://www.integratedcareresourcecenter.com/webinar/working-medicare-webinar-state-contracting-d-snps-introduction-d-snps-and-d-snp-contracting.

[2] Full-benefit dually eligible individuals qualify for full Medicaid benefits in their state, in addition to qualifying for Medicare benefits (and in some cases, for Medicare Savings Program benefits, as well). Partial-benefit dually eligible individuals qualify for Medicare Savings Program benefits, but do not qualify for full Medicaid benefits. For more information about full- and partial-benefit dual eligibility, see this CMS document about the categories of dual eligibility: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf.

[3] If a D-SNP no longer has an affiliated Medicaid managed care plan operating in the same service areas as the D-SNP, the D-SNP will lose its applicable integrated plan (AIP) designation. The state could choose to continue to let the D-SNP operate as a coordination-only (CO) D-SNP, assuming the state does not require all D-SNPs to operate with EAE.

[4] For more information about using Medicaid managed care authorities within integrated care programs, see ICRC's tip sheet at: https://www.integratedcareresourcecenter.com/resource/tips-help-states-select-medicaid-managed-care-authorities-they-design-integrated-care.

[5] In addition to being allowed to change their Medicare plan during the annual Open Enrollment Period (from October 15 – December 7 of every calendar year), dually eligible individuals qualify for a quarterly Special Enrollment Period (SEP) that enables them to change their Medicare plan once a quarter during the other three quarters of the year. Dually eligible individuals may also be allowed to change plans by qualifying for SEPs due to other changes in circumstances, such as a move to a new address or becoming newly eligible for Medicaid. Information about Medicare SEPs is available at: https://www.medicare.gov/sign-up-change-plans/joining-a-health-or-drug-plan/special-circumstances-special-enrollment-periods.

[6] Lock-in policies require Medicaid beneficiaries to remain in the same Medicaid managed care plan for periods of up to 12 months unless the beneficiary has "cause" to request disenrollment or a change in plan. Federal regulations regarding Medicaid managed care disenrollment are described at 42 CFR 438.56.

[7] Indiana has included an "Acknowledgment of Awareness" section in its D-SNP contract for a couple of years preceding the state's implementation of MLTSS in 2024 and exclusively aligned enrollment in 2025. That section has described the state's intentions to move toward implementation of exclusively aligned enrollment in 2025 and the relevant implications and expectations for D-SNPs. The state's 2023 D-SNP contract is available at: https://www.in.gov/medicaid/partners/medicaid-partners/dual-eligible-special-needs-plans/.

[8] For more information about full- and partial-benefit dual eligibility, see this CMS document about the categories of dual eligibility: https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/MedicareMedicaidEnrolleeCategories.pdf.