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Opportunities to Promote Financial Integration for Dual-Eligible Individuals

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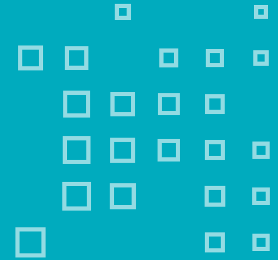

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Executive Summary

Over 12 million Americans are eligible for both Medicare and Medicaid, including roughly 7.5 million adults aged 65 and over and roughly 4.5 million people with disabilities under age 65. Many of these dual-eligible individuals have complex health care needs, contributing to their disproportionate share of Medicare and Medicaid program costs. Dual-eligible individuals represent 15%–20% of enrollment in each program but roughly one-third of each program's total spending.

Most dual-eligible individuals receive care in uncoordinated Medicare and Medicaid fee-for-service delivery systems, where Medicare pays for their hospital, primary care and preventive care services, and Medicaid pays for their long-term services and supports (LTSS), such as nursing facility and home health services, and most behavioral health care. The lack of coordination between Medicare and Medicaid benefits across these systems increases the likelihood that already high-risk individuals will experience suboptimal care and adverse health outcomes. It also encourages Medicare and Medicaid to shift costs to the other program, because there is no financial incentive to work together and allocate resources efficiently. Finally, it discourages Medicare and Medicaid health plans and providers from coordinating "whole-person" care for dual-eligible individuals, because they have limited incentive or data to do so.

Recognizing these disadvantages, federal and state policymakers have pursued various approaches for better coordinating care for dual-eligible individuals, nearly since the inception of the Medicare and Medicaid programs. These approaches include the Programs of All-Inclusive Care for the Elderly (PACE), Medicare Advantage (MA) dual-eligible special needs plans (D-SNPs), and the federal Financial Alignment Initiative (FAI) or "duals demonstration," which is set to expire by 2025. Despite these efforts, approximately 12% of dual-eligible individuals were enrolled in integrated care programs as of 2020.[1] One major barrier to their growth, particularly D-SNPs, is the lack of clear financial incentives for states to pursue developing them, including the ability for states to share in Medicare savings accruing from their investments in LTSS and behavioral health for dual-eligible individuals.

This report highlights two existing strategies state policymakers can deploy for improving the financial integration of Medicare and Medicaid and, to the extent possible, allowing states to share in savings accruing to Medicare from Medicaid investments, which was an explicit feature of the FAI. Implementing these strategies will help expand access to and grow enrollment in integrated care models for dual-eligible individuals. The report focuses on pursuing these approaches through fully integrated D-SNP, or FIDE-SNP, models (see Figure 3 for more information on these models), which are the most integrated and permanent care models for dual-eligible individuals under current Medicare and Medicaid rules despite representing only 10% of the D-SNP market. Additionally, the strategies themselves are permissible within the current Medicare and Medicaid statutory framework and do not require congressional action, although additional regulatory or programmatic guidance from the Centers for Medicare & Medicaid Services (CMS) may help clarify and encourage more states to pursue these approaches. Several states have already implemented the following two complementary strategies:

Benefit Design: States can influence the design of the FIDE-SNP benefit to drive efficient resource allocation across Medicare and Medicaid and seamless, holistic and equitable care for dual-eligible individuals. For example, states can leverage the D-SNP model of care (MOC) or Medicaid care management requirements as a vehicle for aligning and integrating care coordination across Medicare and Medicaid services within FIDE-SNPs. States also can require or encourage FIDE-SNPs to cover specific supplemental benefits that complement Medicaid-covered services or are designed to avert the need for intensive Medicaid-covered LTSS or nursing home services. States can implement this strategy by adding state-specific requirements to their State Medicaid Agency Contract (SMAC) with FIDE-SNPs in their state.

Medicaid Rate Setting: Working with their actuaries, states can assess and incorporate expected savings to their Medicaid programs arising from their aligned FIDE-SNP benefit design and integrated care more broadly in their Medicaid rate-setting processes. The preamble to CMS' CY 2023 Medicare Advantage and Part D Final Rule[2] confirms that Medicaid capitation rates can be actuarially sound if they consider "[t]he impact of MA supplemental benefits and any State-specific requirements for dual-eligible individuals on the projected costs and utilization of the Medicaid benefits covered by the Medicaid managed care capitation rates." That means that state Medicaid agencies can consider MA spending and requirements in Medicaid capitation rate determinations for FIDE-SNPs and the potential savings that could accrue from integration.

For each strategy described above, there are important state considerations related to the timing and processes for aligning benefit design and rate setting across the Medicare and Medicaid programs, as well as related to accessing Medicare data and to the impacts of these strategies on beneficiaries, FIDE-SNPs and providers.

Given these strategies, clear opportunity exists to improve the financial integration of Medicare and Medicaid to discourage cost-shifting across programs, incent states to pursue more integrated care models for dual-eligible individuals (particularly FIDE-SNPs) and, ultimately, to ensure the delivery of care across the two programs is as seamless and unified as possible for the beneficiary. Although these approaches currently are allowed under program rules, additional guidance, guardrails or technical assistance from CMS would be helpful for states and their actuaries to better understand and operationalize the opportunities.

Introduction

Over 12 million Americans are eligible for both Medicare and Medicaid. These individuals are eligible for Medicare because they are aged 65 or older or because of their long-term disability status, and they are eligible for Medicaid because they have low income and few assets. Over 60% of dual-eligible individuals are aged 65 and older, and many dual-eligible individuals have complex health care needs; for example:

60% have multiple chronic conditions, such as heart disease, diabetes or chronic obstructive pulmonary disease.

41% have at least one mental health diagnosis.

36% have cognitive impairments, such as Alzheimer's disease or other dementia and intellectual disabilities.

49% use long-term services and supports (LTSS).[3]

Dual-eligible individuals also account for a disproportionate share of spending in both programs; 20% of Medicare and 15% of Medicaid enrollees are dual-eligible, but they account for about one-third of spending in each program, with institutional care (e.g., hospital and skilled nursing facility) accounting for the most significant source of spending in both programs.[4] Compared with non-dual-eligible Medicare beneficiaries, dual-eligible individuals are disproportionately Black and Hispanic.[5]

Medicare and Medicaid have separate financing mechanisms, cover different benefits (see Figure 1) and are governed by different rules across a range of areas, such as eligibility and enrollment, provider networks, covered benefits, utilization management and quality measurement. This results in fragmented coverage and care that adversely impacts dual-eligible individuals, both programs, plans and providers. Dual-eligible individuals are among the highest-need beneficiaries in both programs and must navigate two disparate and often confusing programs to receive the care they require. This lack of coordination increases the likelihood that already high-risk individuals will experience adverse health outcomes and suboptimal care resulting from duplicative, uncoordinated or denied care. Furthermore, Medicare and Medicaid are financially disincentivized to coordinate care since they do not share in resulting savings from doing so and are, rather, encouraged to shift beneficiaries and their costs across settings and programs. Finally, health plans and providers have limited incentive or data to effectively impact service utilization or quality of care, or address whole-person care.

Figure 1: Summary of Medicare and Medicaid Covered Benefits

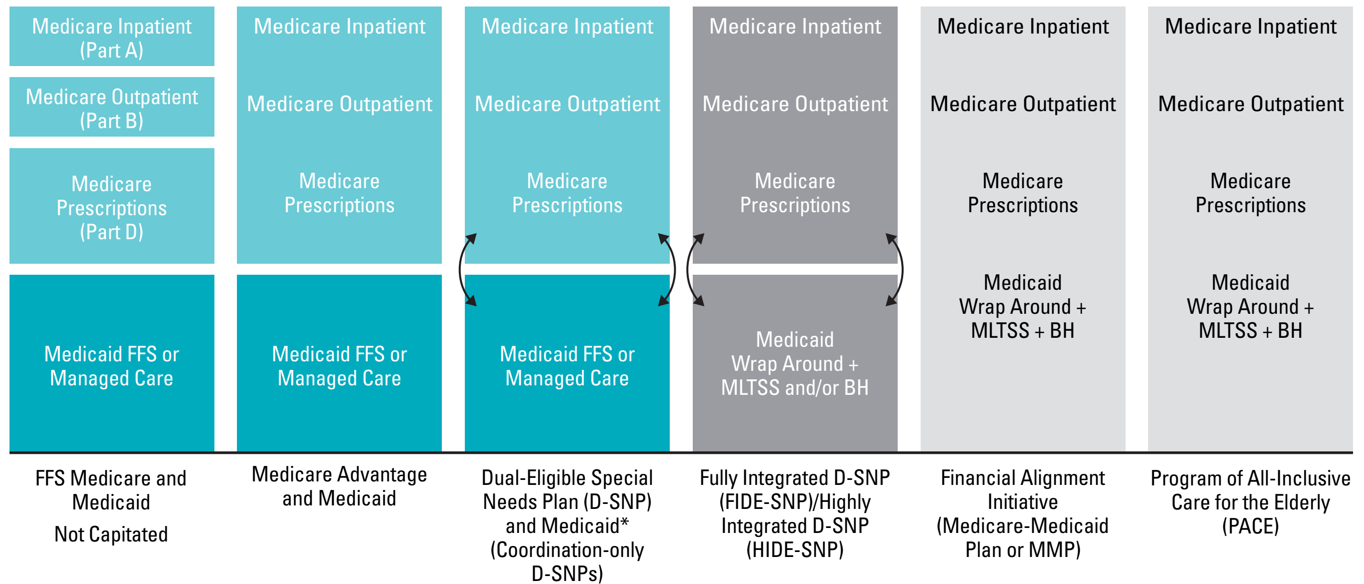
Medicare	Medicaid
• Part A—Hospital Insurance includes inpatient hospital, inpatient skilled nursing facility (SNF), hospice, and some home health services • Part B—Medical Insurance includes physician services, outpatient care, durable medical equipment (DME), lab and X-ray services, home health services, and many preventive services • Part D—Medicare-approved private insurance companies provide prescription drug coverage[6]	• Doctor visits • Inpatient and outpatient hospital services • Some nursing facility and home health services • Mental health services • Prescription drugs • Prenatal care, maternity care, and family planning services (for example, contraceptives) • Preventive care, like immunizations, mammograms, and colonoscopies • States also may cover home and community-based services, therapies, dental and vision services

Source: https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/medicare_beneficiaries_dual_eligibles_at_a_glance.pdf.

Since the inception of the Medicare and Medicaid programs, federal and state policymakers have recognized the disconnected systems of care for dual-eligible individuals and have pursued provider-based and health-plan-based approaches to better coordinate and align Medicare and Medicaid benefits and financing for these beneficiaries. These efforts include the creation of the Programs of All-Inclusive Care for the Elderly (PACE), Medicare Advantage (MA) dual-eligible special needs plans (D-SNPs), and the federal Financial Alignment Initiative (FAI). Beneficiaries in integrated care programs report high satisfaction with their care experiences and quality of life compared with beneficiaries in nonintegrated Medicare and Medicaid programs.[7] Additionally, a limited but growing body of evidence on spending, service utilization, quality and outcomes for dual-eligible beneficiaries in integrated care programs shows some reductions in nursing facility, inpatient hospital and emergency department use, with data on spending and outcomes mixed.[8]

Today, there is a spectrum of Medicare and Medicaid care delivery options for dual-eligible individuals (see Figure 2). Despite the promise of integrated care models, most dual-eligible individuals remain in fee-for-service or traditional Medicare. In Medicaid, roughly 49% of dual-eligible individuals are enrolled in managed care delivery systems.[9]

Figure 2: Spectrum of Care Delivery for Medicare and Medicaid

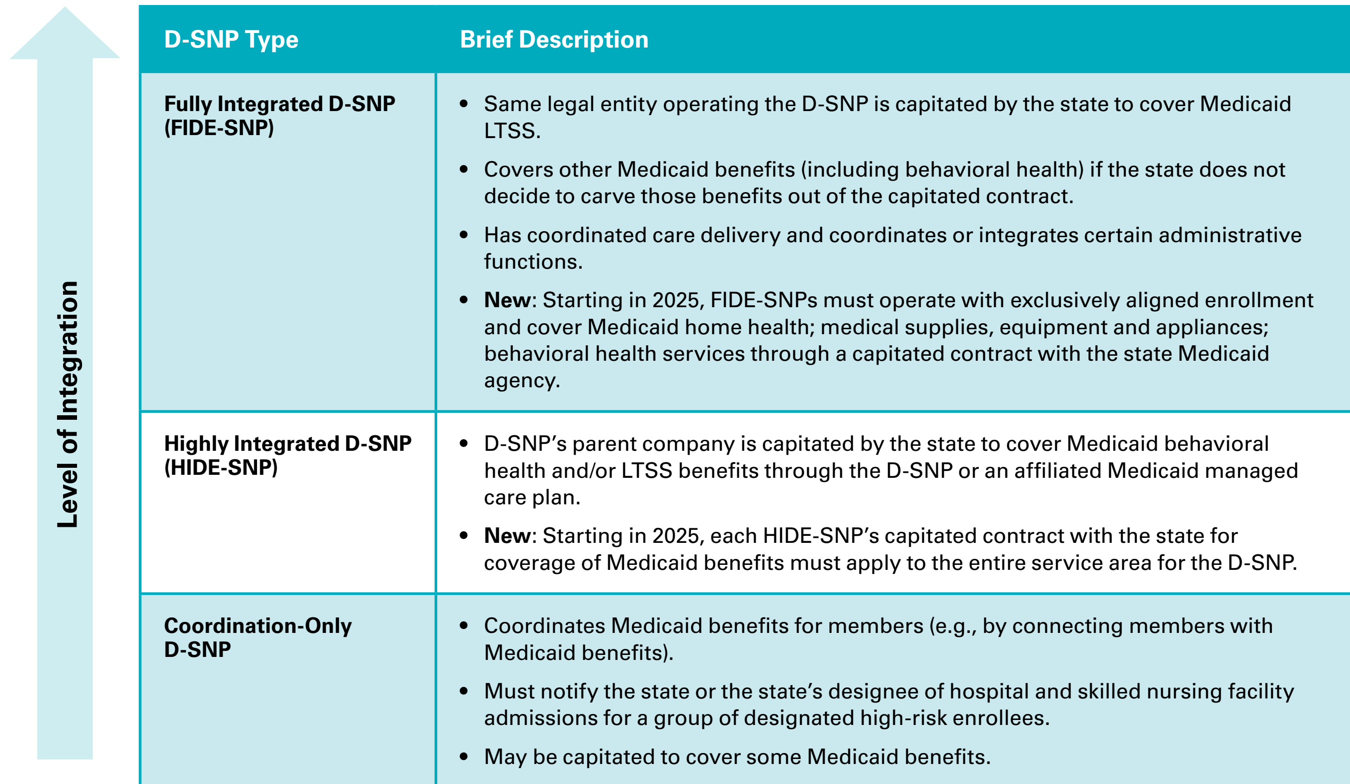


*D-SNPs vary greatly by state and can also be aligned with managed LTSS.

Source: Medicare 201: Actions States Can Take to Improve Quality and Coordination of Care for Dually Eligible Individuals, Integrated Care Resource Center, March 2021. Available at https://www.integratedcareresourcecenter.com/sites/default/files/WWM%20201%20Slide%20Deck_%20for%20508.pdf.

The Centers for Medicare & Medicaid Services (CMS) recently signaled its preference for fully integrated dual-eligible special needs plans (FIDE-SNPs) as the primary vehicle for integrating care for dual-eligible individuals in the CY 2023 Medicare Advantage and Part D Final Rule.[10] See Figure 3 for a description of the different types of MA D-SNPs.

Figure 3: Types of Dual-Eligible Special Needs Plans (D-SNPs)



D-SNP Type	Brief Description
Fully Integrated D-SNP (FIDE-SNP)	• Same legal entity operating the D-SNP is capitated by the state to cover Medicaid LTSS. • Covers other Medicaid benefits (including behavioral health) if the state does not decide to carve those benefits out of the capitated contract. • Has coordinated care delivery and coordinates or integrates certain administrative functions. • **New**: Starting in 2025, FIDE-SNPs must operate with exclusively aligned enrollment and cover Medicaid home health; medical supplies, equipment and appliances; behavioral health services through a capitated contract with the state Medicaid agency.
Highly Integrated D-SNP (HIDE-SNP)	• D-SNP's parent company is capitated by the state to cover Medicaid behavioral health and/or LTSS benefits through the D-SNP or an affiliated Medicaid managed care plan. • **New**: Starting in 2025, each HIDE-SNP's capitated contract with the state for coverage of Medicaid benefits must apply to the entire service area for the D-SNP.
Coordination-Only D-SNP	• Coordinates Medicaid benefits for members (e.g., by connecting members with Medicaid benefits). • Must notify the state or the state's designee of hospital and skilled nursing facility admissions for a group of designated high-risk enrollees. • May be capitated to cover some Medicaid benefits.

Source: Adapted from Kolber, M., et al. What Health Plans Should Know About Federal Changes for Dual Eligibles. December 2022. Available at https://www.manatt.com/Manatt/media/Documents/Articles/What-Health-Plans-Should-Know-About-Federal-Changes-for-Dual%c2%a0Eligibles-12-15-22_v4.pdf.

In the CY 2023 Medicare Advantage and Part D Final Rule, CMS also announced the end of the federal FAI—or duals demonstration—and corresponding Medicare and Medicaid Plans (MMPs) that participate in the FAI by 2025, and the application of select FAI features that promote integration to all D-SNPs to strengthen their ability to deliver integrated care for dual-eligible individuals (see Appendix A for more detail).

The D-SNP market has grown by 72% over the past five years, and D-SNPs now operate in most states.[11] However, D-SNP integration levels with state Medicaid programs vary significantly across states. In more than half of the states with D-SNPs, dual-eligible individuals are unable to access a HIDE-SNP or FIDE-SNP.[12] The variation in Medicaid delivery systems across states for dual-eligible individuals (e.g., whether they are enrolled in Medicaid managed care or whether LTSS is carved into the state's Medicaid managed care benefit) contributes to the patchwork access to integrated care models for dual-eligible individuals across the country. It is clear that significant barriers to the delivery of integrated care impede enrollment in integrated care models, particularly FIDE-SNPs, across states. Among the remaining barriers, clear opportunity exists to improve the financial integration of Medicare and Medicaid to discourage cost-shifting across programs, incent states to pursue more integrated care models for dual-eligible individuals (particularly FIDE-SNPs) and, ultimately, ensure the delivery of care across the two programs is as seamless and unified as possible for the beneficiary.

Financial Integration

Financial integration means aligning incentives and driving efficient allocation of resources across Medicare and Medicaid.

With support from Arnold Ventures, Manatt Health identified several strategies to improve financial integration of Medicare and Medicaid and allow states to share in savings accruing to Medicare from Medicaid investments, specifically through FIDE-SNP models. For each strategy, this paper presents an overview and a discussion of key implementation considerations informed by a literature review and the engagement of a diverse group of stakeholders, including consumers, consumer advocates, current and former state Medicaid officials, former federal officials, health care experts, plans and providers. (See Appendix B for a detailed methodology).

Financial Integration Is One Component of a Multifaceted Approach to Expanding the Growth in Integrated Care Programs

- The “wrong pocket problem,” or the inability of state Medicaid programs to share in Medicare savings generated from Medicaid investments, is one driver that influences the take-up of integrated care products across states.
- Successful integrated care strategies also include addressing factors such as member and provider engagement, using enrollment strategies to increase enrollment in integrated care programs, and data-sharing across programs.
- State support, including technical assistance and financial resources, also is needed to address:
  - State knowledge and sophistication on Medicare. State expertise on Medicare/D-SNP to partner strategically and effectively with D-SNPs varies significantly across states.
  - State capacity to focus on dual-eligible/D-SNP strategy—either holistically or to put responsibility on one person—is limited in some states due to bandwidth issues and competing priorities.

Overview of Financial Integration Strategies

This report discusses two complementary strategies for states and CMS to consider for promoting financial integration within the FIDE-SNP model. The following guardrails, informed by the literature review and the input of stakeholders, shape the design of the strategies described in this report:

- **Permissible Within Current Statutory Framework**. To promote ease of implementation, the strategies considered in this report are permissible within the current regulatory framework governing both Medicare and Medicaid, or require regulatory or sub-regulatory change. Strategies requiring **statutory** change are excluded from this report, given the difficulty of enacting legislation modifying Medicare and/or Medicaid statute. Therefore, the strategies discussed in this report achieve greater financial integration across the two programs than the status quo but do not achieve complete financial integration—whereby a plan receives one capitated payment from a single financing stream that covers both Medicare and Medicaid services—as current statutory requirements for Medicare and Medicaid separate the funding streams and rate-setting processes. The Dual Eligible Coalition's Title 22 Proposal for Integrated Care (see Figure 4) would establish an entirely new statutory construct for integrated Medicare and Medicaid services.
- **Focus on FIDE-SNPs With Ability to Extend to Other Models**. The discussion of the strategies below focuses on implementation within the FIDE-SNP model with the 2025 federal requirements, as outlined in the CY 2023 Medicare Advantage and Part D Final Rule in effect, as it is the most integrated and permanent of the integrated care models available. In particular, the strategies assume that FIDE-SNPs operate with exclusively aligned enrollment, required as of 2025, which means that full-benefit, dual-eligible individuals are effectively enrolled in the same D-SNP for their Medicaid and Medicare services. The strategies could extend to promote financial integration within other D-SNP models, such as coordination only D-SNPs and highly integrated dual-eligible special needs programs (HIDE-SNPs), though the level of financial integration that states could achieve is likely less in either of these models than in the FIDE-SNP model.
- **Challenge of Enabling Medicare Shared Savings**. The strategies presented below recognize the difficulty for states in calculating and capturing Medicare-related savings. Strategies require states to demonstrate that the integrated care program will result and has resulted in cost savings, including cost avoidance, and that no cost-shifting occurred across the two programs. Stakeholders emphasized the difficulty for states and their actuaries to demonstrate actual or projected savings to Medicare to the satisfaction of the CMS Office of the Actuary. Stakeholders also stressed that strategies for states to leverage Medicare-related savings must come from sources other than the Medicare Trust Fund, which is projected to run out of money by 2028.[13]

Figure 4: Title 22 Proposal for Integrated Care

Title 22 Proposal for Integrated Care

In July 2022, Sens. Sherrod Brown and Rob Portman introduced the Comprehensive Care for Dual Eligible Individuals Act in the Senate to amend the Social Security Act to create Title 22 as an optional state-administered program to provide fully integrated comprehensive and coordinated care for full-benefit dual-eligible individuals.[14] The Dual Eligible Coalition, a group of multisector stakeholders, including consumer advocates, managed care plans and providers, led by Leavitt Partners, designed the Title 22 proposal.[15]

The report focuses on two complementary strategies for promoting financial integration within FIDE-SNPs and enabling the state to share in any resulting savings:

- **Benefit Design**: States can influence the design of the FIDE-SNP benefit to drive efficient resource allocation across Medicare and Medicaid, and seamless, holistic care for dual-eligible individuals.
- **Medicaid Rate Setting**: States can incorporate savings to their Medicaid programs arising from their aligned FIDE-SNP benefit design in their Medicaid rate-setting processes.

For each of the strategies, the report presents:

- An overview of the strategy, including key programmatic and financial details, and how the strategy addresses barriers to financial integration
- Relevant state examples
- Implementation considerations, including:
  - Implementation authority, including federal authorities and/or policy changes needed
  - Expected impact of the proposal on beneficiaries, including how the proposal will promote care integration, improve health equity and address social risk factors
  - Expected impact of the proposal on states, the federal government, health plans and providers
  - Other considerations impacting feasibility

Strategy 1: Benefit Design

Overview

The first strategy involves states taking affirmative steps to engage with and become good integrated care design partners with the FIDE-SNPs in their state. States can work with their FIDE-SNPs to strategically design and align the FIDE-SNP benefit package to ensure seamless care delivery experiences for dual-eligible individuals; minimize confusion about their care providers, care managers and covered benefits; and enhance access to all Medicare and Medicaid services provided by the FIDE-SNP. This approach enables Medicare to offer a comprehensive benefits package under a single program umbrella that is more attractive to the individual than traditional Medicare or an MA plan and can help eliminate cost-shifting across programs. To the extent that states partner with FIDE-SNPs on benefit design in conjunction with provider network development, it also could result in more robust FIDE-SNP provider networks. This would enable individuals newly eligible for Medicare or Medicaid (e.g., who become dual-eligible individuals) and who choose to enroll in a FIDE-SNP to retain their existing Medicaid or Medicare providers.

This strategy addresses the fragmentation experienced by dual-eligible individuals, payers, providers and plans by creating a more unified, integrated product that is easier for dual-eligible individuals to understand and navigate, making it easier for them to receive the care they require. It also gives providers and plans the tools they need to better manage whole-person care and impact service utilization to ensure that dual-eligible individuals receive the right care at the right time. As noted above, this strategy optimally promotes financial integration in the FIDE-SNP model with exclusively aligned enrollment where the plan is responsible for most, if not all, of a dual-eligible individual's Medicare and Medicaid services, including Medicaid-covered LTSS and behavioral health services.

This strategy focuses on encouraging states to align benefits in two specific areas, the MA model of care (MOC) and supplemental benefits. Other opportunities for better aligning Medicaid and Medicare programs for dual-eligible individuals to promote financial integration may exist, including related to other Medicare and Medicaid benefits or cost-sharing requirements, utilization management and prior authorization, and administrative processes, but the following areas held the most promise according to stakeholders.

1. **Leveraging Medicare MOC requirements as a vehicle for aligning and integrating care coordination across Medicare and Medicaid services within the FIDE-SNPs**. FIDE-SNPs currently may be tasked with and reimbursed for overlapping care management and care coordination requirements for Medicare and Medicaid. CMS requires all D-SNPs, including FIDE-SNPs, to obtain National Committee for Quality Assurance (NCQA) approval for their MOC, which provides the framework for how the plan will meet the needs of each of its enrollees through the plan's care management and care coordination processes. Folding Medicaid requirements into Medicare MOC requirements encourages plans to assess and identify an individual's care and support needs more holistically, and to staff and deliver a unified care management benefit that is person-centered, simplifies beneficiary experience and is centered on the Medicare program, which covers primary, specialty and hospital care for dual-eligible individuals.

Spotlight on Washington and California

Washington is in the process of incorporating its health home program for dual-eligible individuals into the MOC requirements and State Medicaid Agency Contracts (SMACs) for their D-SNPs.[16] Washington's Health Home Managed Fee-for-Service FAI Demonstration, launched in July 2013 and slated to run through December 2022, integrates care for dual-enrolled individuals through intensive care coordination of Medicare and Medicaid services. As enrollment in the health home declined due to increasing enrollment among dual-eligible individuals in MA plans, the state, CMS and the D-SNPs worked together to devise an approach for integrating the health home into the D-SNP model. The state also has collaborated extensively with its D-SNPs in a years-long process that required the state to address challenges associated with benefit design, including the off-cycle MOC submissions (see below regarding timing alignment) and gaining state expertise in the Medicare bid and claims processes. In its 2023 SMAC, the state required its D-SNPs to include health homes in their D-SNP MOC along with requisite training for providers and staff.[17]

California is implementing enhanced care management (ECM), a high-touch, comprehensive care management program, for qualifying Medicaid beneficiaries. In recognition of the significant overlap across the Medi-Cal ECM and D-SNP MOC requirements, and to avoid duplication of services and confusion for beneficiaries, the state is strengthening its expectations for D-SNPs to provide comprehensive care coordination beginning in 2023. Over time, state-specific D-SNP MOC requirements will be more closely aligned with Medi-Cal ECM requirements.

2. **Optimize Medicare supplemental benefits**. States can require or incent FIDE-SNPs to cover supplemental benefits that complement Medicaid-covered services or are intended to avert the need for intensive Medicaid-covered LTSS or nursing home benefits. In addition to covering traditional Medicare Part A and B benefits, MA plans, including FIDE-SNPs, are allowed to use their plan rebates (e.g., the refund resulting from MA plan bids that are below the MA rate-setting benchmark) to provide additional or supplemental benefits and/or reduced cost-sharing for beneficiaries, including dual-eligible individuals.[18] In recent years, CMS has expanded the scope of supplemental benefits that MA plans can offer using a portion of their MA rebates to include LTSS and social determinants of health (SDOH)-related services, as well as allowed MA plans to cover Special Supplemental Benefits for the Chronically Ill (SSBCI) that are not primarily health-related for certain chronically ill beneficiaries.

   According to a Milliman analysis of the prevalence of the types of supplemental benefits offered by D-SNPs from 2018 to 2021, the most common supplemental benefits offered by D-SNPs include an over-the-counter drug card as well as dental, vision and hearing benefits. Most beneficiaries were not enrolled in MA plans, including D-SNPs, that offered SSBCI.[19] There is a clear opportunity for states to require or encourage their FIDE-SNPs to offer supplemental benefits that are geared toward dual-eligible individuals who tend to have greater medical, functional and social support needs than non-dual-eligible Medicare beneficiaries.

Additionally, this strategy requires states and their Medicaid actuaries to regularly collect and analyze detailed Medicare claims and utilization data in addition to Medicaid data, which may enable states to determine whether there are disparities in utilization by race, ethnicity, disability or urban/rural status. Based on their findings, states can work with their FIDE-SNPs to address disparities. To address any potential risk that incorporating Medicare-related savings into the Medicaid capitation rates negatively impacts beneficiaries and health equity (e.g., decreases in utilization, provider networks), states can make clear through monitoring and enforcement that plans are still required to meet contract requirements impacting beneficiary access (e.g., coverage of benefits, benefit authorization process and network adequacy).

Spotlight on New York

Via its SMACs, New York requires its D-SNPs[20] to work with the state in good faith to ensure its supplemental benefits will coordinate with Medicaid benefits in the next bid cycle and encourages its D-SNPs to use 10% of its full rebate dollar amount to cover Medicaid benefits as supplemental benefits. The state also instructs plans to adjudicate overlapping benefits first as claims under the supplemental benefit offered by a health plan's D-SNP(s) before treating such claims as Medicaid claims.[21]

Implementation Considerations

Authority

States can implement this strategy primarily through their SMACs with FIDE-SNPs. All D-SNPs are required to have executed SMACs—also known as Medicare Improvements for Patients and Providers Act or MIPPA contracts based on the legislative origins of these requirements—with the state Medicaid agencies that meet minimum contract requirements, including:[22]

- MA plan's responsibility to coordinate the delivery of Medicaid benefits and provide coverage for Medicaid-covered services that are specified as covered under the capitated contract
- Eligibility- and enrollment-related information, including categories and criteria for dual-eligible individuals to be enrolled in D-SNP and verifying an enrollee's Medicare eligibility
- Cost-sharing protections under the D-SNP
- Sharing information on Medicaid provider participation
- Service area and contract period for the D-SNP
- The use of the unified appeals and grievance procedures for D-SNPs that are applicable integrated plans[23]

States have the flexibility to impose additional requirements on FIDE-SNPs (and other D-SNPs) provided they do not conflict with Medicare requirements. States can require their FIDE-SNPs or D-SNPs to incorporate Medicaid-specific care management and care coordination requirements in their MOCs through the SMAC (as in Washington and California), as well as require or incent FIDE-SNPs to cover supplemental benefits (as in New York).

To ensure that these requirements, which aim to improve and streamline care for dual-eligible individuals, do not simply exist on paper, it is critical for states to monitor and enforce FIDE-SNP execution of these requirements as detailed in their SMACs. States can leverage performance review tools and other mechanisms to hold their FIDE-SNPs accountable for meeting integration-focused and all contract requirements through the following pathways:

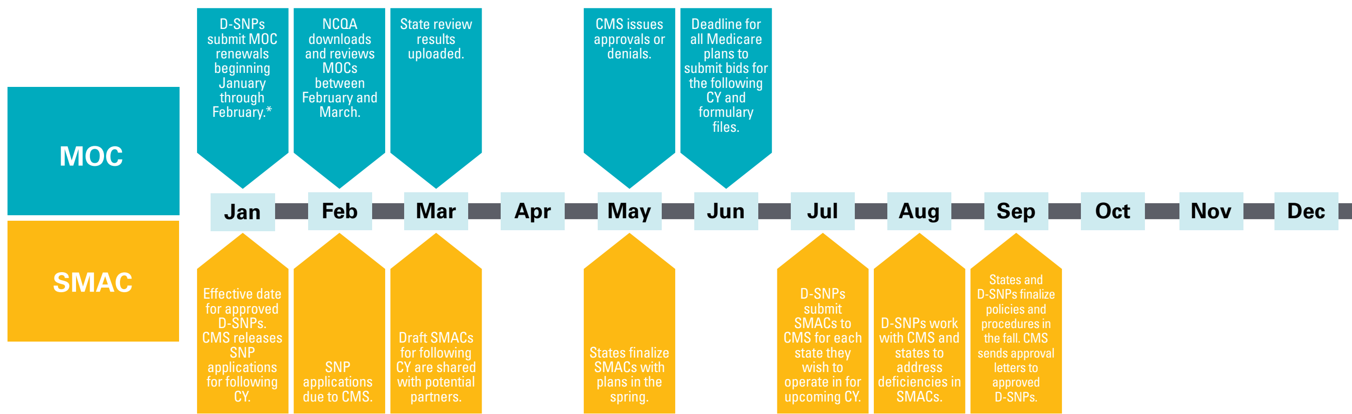
- **Organize State and Dual-Eligible Individual Accountability Approach**. The state can train and allocate dedicated staff to handle administrative oversight and promote shared understanding of the aligned Medicare and Medicaid requirements and goals for the delivery of integrated care for dual-eligible individuals. To ensure that the experience of dual-eligible individuals remains the focus of this effort, the state can also meaningfully engage individuals and advocates in their accountability approach via advisory groups and committees.
- **Review FIDE-SNP Performance**. The state can define measures that FIDE-SNPs will be held accountable for meeting, which could include targeted reporting requirements (e.g., care coordination reports), quality measures (e.g., NCQA, HEDIS), and consumer satisfaction surveys. Additionally, the state can establish readiness review requirements as FIDE-SNPs prepare to offer a new benefit or meet a new requirement, establish ongoing reporting requirements, and conduct audits of FIDE-SNPs as applicable to review compliance with requirements.[24]
- **Use "Carrots" to Encourage FIDE-SNP Performance**. The state can offer ongoing training and technical assistance to FIDE-SNPs and tie plan performance to advantages and financial incentives, such as preferred status in Medicaid managed care procurements and default enrollment in the FIDE-SNP's Medicaid managed care product.
- **Use "Sticks" to Penalize Poorly Performing FIDE-SNPs**. The state can subject FIDE-SNPs to escalating actions, including corrective action plans to address deficient compliance with requirements. For certain or repeated compliance violations, the state can impose sanctions on FIDE-SNPs, including allowing for self-help remedies (e.g., if the plan does not do X, the enrollee has the right to get X services that the plan will have to pay out of network), limiting default enrollment into the FIDE-SNP and/or allowing enrollee to switch plan enrollment, imposing liquidated damages, and refusing to contract with the FIDE-SNP.

Timing Alignment

States may need to address misalignments in the D-SNP MOC and Medicaid-D-SNP SMAC development timelines, as well as their own Medicaid contract and rate-setting timelines, in order to align care coordination or care management and other benefit design requirements. Both the MOC and SMAC development timelines are aligned to the calendar year—although D-SNP MOC submissions to NCQA are required in advance of states drafting and finalizing their SMACs with their D-SNP partners (see Figure 5)—while the Medicaid contract and rate year is most often tied to the state fiscal year, which commonly begins in July.

Additionally, MOCs are approved for a one-, two- or three-year term based on their NCQA score, which means that states may need to pre-empt the MOC approval term and require FIDE-SNPs to amend their MOCs.[25] Updates to the MOCs and SMACs need to precede the MA organization's formal bid submission for the following calendar year (covered in greater detail in the next section).

Figure 5: MOC and SMAC Submission Timelines



* Depending on the score received by NCQA, MOCs can be approved for 1, 2 or 3 years.

Sources: Integrated Care Resource Center. Key Medicare Advantage Dates and Action Items for States Contracting with Dual Eligible Special Needs Plans. September 2017. Available at https://www.integratedcareresourcecenter.com/sites/default/files/Key_MA_Dates_for_States_Contracting_with_D-SNPs.pdf; Medicare-Medicaid Coordination Office, CMS. CY 2021 Medicare-Medicaid Integration and Unified Appeals and Grievance Requirements for Dual Eligible Special Needs Plans (D-SNPs). October 7, 2019. Available at https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/DSNPsIntegrationUnifiedAppealsGrievancesMemorandumCY202110072019.pdf; Special Needs Plan Model of Care. Contract Year (CY) 2023 Submissions Timeline. Available at https://snpmoc.ncqa.org/resources-for-snps/timeline/. Accessed July 27, 2022.

Sizing the Opportunity

The scale of savings that states would be able to realize from aligning the benefit design across Medicare and Medicaid varies by sub-strategy. Regarding the impact of leveraging MOC requirements to drive integrated care coordination across Medicare and Medicaid, states like California and Washington that have invested in a robust Medicaid care management/coordination infrastructure and benefit may be able to realize more savings than other states that haven't invested as heavily in Medicaid care management.

The ability of states to draw down savings from optimizing FIDE-SNP supplemental benefits is likely to be limited even though plan rebates in 2022 reached a historic high—17% higher than in 2020—of $164 on average per month or $2,000 per beneficiary annually across all MA plans, including D-SNPs.[26] Comparable data for D-SNP rebates is not available for 2022, though the data available from 2019, where the average rebate for D-SNPs was $112 a month (compared with $106 for MA plans) and exceeded the average monthly rebate per beneficiary, suggests that

D-SNP Rebates (2019)
Average Allocation of Rebates:

- Part A & B cost-sharing: 11%
- Supplemental medical benefits: 78%
- Supplemental drug benefit: 3%
- Reduction in Part B premium: <1
- Reduction in Part D premium: 8%

D-SNP rebates have also risen considerably in recent years and may even exceed those of other MA plans.[27] Even so, Medicaid-covered LTSS can be expensive and likely outpace the amount of rebate dollars that D-SNPs could spend on similar benefits.

Stakeholder Perspectives

Figure 6 summarizes the impacts of this benefit design strategy on diverse stakeholders.

Figure 6: Stakeholder Perspectives on Benefit Design Strategy

Stakeholder	Perspectives
Dual-Eligible Individuals	• More integrated and aligned benefit package • Unified utilization management to help ensure the right services are used at the right time • Seamless care management, including access to a single plan care manager, that is inclusive of Medicare and Medicaid services • Ability to design benefit and care management requirements to promote health equity
States	• Can leverage Medicare to drive Medicaid efficiencies and further care integration and health equity goals • May be burdensome for states to implement due to (1) lack of Medicare expertise and (2) bandwidth concerns • Requires planning and preparatory work for states and their D-SNP partners
Federal Government	• Does not require additional Medicare spending or regulatory change • CMS has endorsed states' ability to reflect the impact of Medicare supplemental benefits on Medicaid capitation rates
FIDE-SNPs	• May have less flexibility regarding benefit design and supplemental benefits, which they use to differentiate themselves relative to other D-SNPs and MA plans • May inhibit their ability to grow their enrollment, particularly for regional FIDE-SNPs already in a less competitive position relative to national FIDE-SNP sponsors • Without state intervention, minimal incentive to offer supplemental benefits that are also Medicaid benefits because Medicaid is guaranteed to cover those benefits for dual-eligible individuals • State incentives, including implementing default enrollment or advantaging FIDE-SNPs in Medicaid managed care bid selection, could help with FIDE-SNP engagement
Providers	• Aligned benefit design may simplify billing and utilization management processes • May make it easier for Medicare providers, including primary care providers, to coordinate care and share data with behavioral health, LTSS or other traditional Medicaid providers

Strategy 2: Medicaid Rate Setting

Overview

This strategy encourages states to work with their actuaries to assess and incorporate expected savings to Medicaid, resulting from an aligned benefit design (described under Strategy 1 above) and integrated care more broadly, into their Medicaid capitation rates to managed care plans participating in FIDE-SNPs. Under the current statutory framework, the MA bid and Medicaid managed care capitation rates are often set in isolation, which may result in duplicative payments, cost-shifting across the two programs, and uncoordinated and inefficient benefit management. This approach directly promotes financial integration across Medicare and Medicaid, as it encourages state Medicaid agencies to consider MA spending and requirements in its Medicaid capitation determinations for FIDE-SNPs and the potential savings that could accrue from integration.

A handful of states are already incorporating savings resulting from an aligned and restructured benefit design to varying extents. For example:

- Florida has historically reduced its Medicaid capitation rates to D-SNPs to account for savings resulting from an integrated Medicare and Medicaid product in comparison with the capitation rate it pays for the Medicaid portion of services for dual-eligible individuals who are not enrolled in D-SNPs. The amount of savings that the state deducts from the D-SNP capitation rate varies by plan region.
- California incorporated Medicaid capitation rate increases for ECM that were discounted for dual-eligible individuals to account for the anticipated overlap of care coordination/care management functions between Medicare and Medicaid.

As described in further detail below, states are more easily able to adjust Medicaid rate-setting to promote financial integration than influence the MA rate-setting process, which is governed by federal statute and regulation and has been the subject of increasing attention from federal oversight agencies and regulators as MA profits continue to rise.

Implementation Considerations

Authority

State Medicaid agencies can implement this approach through their rate development processes. In its preamble to the CY 2023 Medicare Advantage and Part D Final Rule, CMS stated that Medicaid capitation rates can be actuarially sound if they consider:[28]

> The impact of MA supplemental benefits and any State-specific requirements for dual-eligible individuals on the projected costs and utilization of the Medicaid benefits covered by the Medicaid managed care capitation rates.

Medicaid managed care regulations require states to set actuarially sound capitation rates approved by CMS and certified by actuaries that **provide for all reasonable, appropriate and attainable costs required under the contract and for the operation of the managed care organization for the time period and the population covered**.[29] States must follow a CMS-prescribed process for setting actuarially sound rates that involves:[30]

- Identifying and developing base data
- Developing and applying trend factors
- Developing the non-benefit (e.g., administrative/operational) component of the rate
- Considering past and projected medical loss ratio (MLR)
- Making appropriate adjustments as necessary to develop actuarially sound rates

An actuary must certify the capitations as actuarially sound based on the federal requirements and the relevant standards of practice, which **may even require**—according to the American Academy of Actuaries—actuaries to consider Medicare-related costs in the capitation determination:[31]

> Medicaid capitation rates are "actuarially Sound" if, for business for which the certification is being prepared and for the period covered by the certification, projected capitation rates and **other revenue sources** provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental risk adjustment cash flows, and investment income. For purposes of this definition, costs include, but are not limited to, expected health benefits, health benefit settlement expenses, administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes.

The American Academy of Actuaries, in its comment letter to the proposed 2023 Medicare Advantage and Part D rule, continues that because Medicaid is a secondary payer to Medicare, Medicare benefits or requirements **that impact Medicaid cash flows would need to be considered in developing Medicaid capitation rates in order to comply with actuarial soundness requirements**.[32]

Despite CMS' general endorsement of this approach, stakeholders (particularly states and actuaries) strongly suggest that CMS provide specific guidance in its annual rate development guide on the guardrails that states and actuaries should follow that address the key implementation considerations described below, including required Medicare data and information and current Medicare and Medicaid rate-setting timing misalignment. Additionally, CMS could consider releasing a joint Medicaid and Medicare rate-setting regulation that reflects the unique nature of rate setting across these programs within FIDE-SNPs.

Timing Alignment

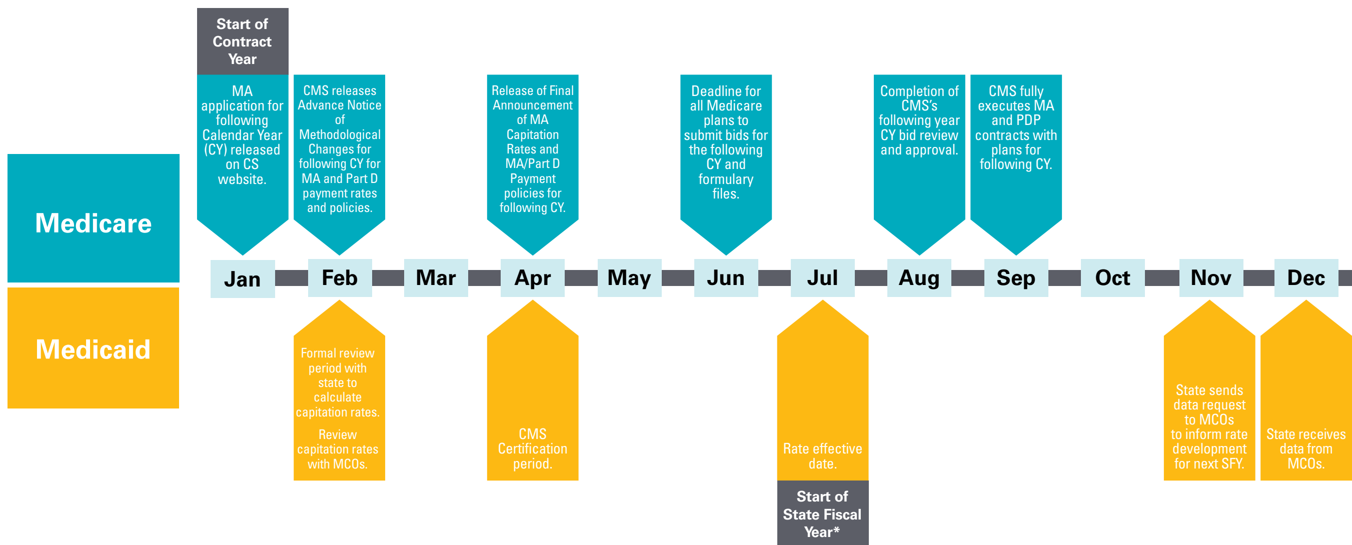
States may need to shift their Medicaid rate-setting timelines for FIDE-SNPs to align with the MA bid timelines to account for each MA's bid and benefit package within the current calendar year. Generally, MA bid and Medicaid rate development process timelines do not align, which can make it difficult for states to incorporate Medicare requirements and benefits into the Medicaid capitation rate (see Figure 7). As noted earlier, State Medicaid rate years commonly begin in July with the state fiscal year, while the MA bid and contract timelines are set according to the calendar year.

To align the timing, state Medicaid agencies can:

- Align the Medicaid rate year for FIDE-SNPs to the calendar year, which may increase the administrative burden for states and their actuaries as they could have multiple Medicaid rate years depending on the Medicaid product and population covered.
- Adjust the capitation rate for FIDE-SNPs mid-fiscal year to align with the Medicare calendar year, which could require the state to seek additional federal approval for the rate changes as actuarially sound.

Implementing this strategy in tandem with Strategy 1, where the FIDE-SNPs are required to provide a restructured, aligned benefit package, may also enhance the predictability of the FIDE-SNP benefit package and costs. In such a scenario, the state and its actuary would be able to anticipate its FIDE-SNPs' bids and benefit packages in advance of the formal bid submission and estimate the savings to the Medicaid capitation rates.

Figure 7: Sample Current MA Bid and Medicaid Rate-Setting Timelines



* Medicaid rate years vary by state. Most are aligned with state fiscal years which generally start in July. But some states start in October, January or April.

Sources: Milliman. Medicaid Rate Setting 101. Available at https://www.milliman.com/-/media/Milliman/importedfiles/uploadedFiles/insight/2018/01-intro-regulatory-oversight.ashx. Accessed July 7, 2022; Integrated Care Resource Center. Key 2022 Medicare Advantage Dates. Available at https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Key_2022_Medicare_Advantage_Dates_0.pdf. Accessed on July 7, 2022.

Required Medicare Information

States and their actuaries require Medicare-related claims and non-claims information in order to develop actuarially sound Medicaid rates that reflect relevant Medicare experience. While some states collect Medicare data as part of the required reporting from plans, there currently is limited, often summary-level, Medicare data available to states and their Medicaid actuaries.

Health plan-specific information that states could collect from FIDE-SNPs and other D-SNPs to inform rate development includes:[33]

- Base period benefit expenditures, non-benefit expenditures and enrollment
- Historical financial experience for the Medicare portion of the FIDE-SNP
- Descriptions of supplemental benefits offered under the Medicare program that may impact Medicaid-covered costs

New York, for example, requires its D-SNPs to share a copy of its annual MA bid filing submitted to CMS as well as CMS' approval of its bid filing final submission within ten business days.[34]

Stakeholders noted that Medicare data-sharing is a significant barrier for states seeking to promote financial and care integration for dual-eligible individuals. CMS, through the State Data Resource Center (SDRC), makes state-level Medicare data available to state Medicaid agencies upon request and offers technical advisors to provide assistance and guidance to states on how to use the Medicare data. Currently, 30 states are accessing Medicare data through the SDRC, which can include:

- Medicare Parts A and B claims and Part D prescription drug event data
- Medicare Parts A, B, C and D eligibility and enrollment data
- Assessments data (e.g., Minimum Data Set and Swing Bed)
- Provider data

Source: State Resource Data Center. Available at https://www.statedataresourcecenter.com/.

Sizing the Opportunity

The amount of savings that a state may realize depends on how aggressive it wishes to be on its savings adjustments and the level of state Medicaid investments that it can offset through an aligned benefit (e.g., Medicaid care management) designed as described in Strategy 1, if implemented together.

Stakeholder Perspectives

Figure 8 summarizes the impacts of this benefit design strategy on diverse stakeholders.

Figure 8: Stakeholder Perspectives on Medicaid Rate-Setting Strategy

Dual-Eligible Individuals	• Encourages states to pursue FIDE-SNPs, which can improve beneficiary outcomes and experiences. • Can advance health equity for dual-eligible individuals, particularly those with complex needs and social risk factors, who must navigate confusing and fragmented systems to access needed care, absent integrated models.
States	• Allows states to realize Medicaid savings that can be reinvested in other aspects of Medicaid programming. • May be administratively burdensome for states to implement, especially if they need to adjust their rate-setting processes and timelines and collect additional Medicare-related information from their FIDE-SNPs.
Federal Government	• CMS has already endorsed this approach in the CY 2023 Medicare Advantage and Part D Final Rule and approved state Medicaid capitation rates that incorporate Medicare-related costs as actuarially sound. • CMS has not yet provided explicit guidance to states, which can create some risk (or apprehension) for states as they implement this approach.
FIDE-SNPs	• May express concern depending on the extent of the state's savings adjustments and accompanying requirements that limit their flexibility on how to manage care for beneficiaries. • Where states have incorporated this approach, it does not appear to affect the D-SNP market offerings.
Providers	• Could face rate pressure from the FIDE-SNP if the Medicaid capitation rate were reduced to account for Medicare-related costs. • States can mitigate downstream impacts on providers through monitoring and enforcement of related contract requirements (e.g., network adequacy) and could build in additional rate protections (e.g., requiring a rate floor) for providers.

Other Rate-Setting Strategies for Promoting Financial Integration

In addition to incorporating Medicare-related costs into Medicaid capitation rates, states also could consider:

- Implementing an **integrated Medicare and MLR** for FIDE-SNPs. Currently, Medicare and Medicaid have separate MLR reporting and rebate requirements for FIDE-SNPs, and no standard calculation exists for calculating a combined MLR across Medicare and Medicaid. Combining an MLR for FIDE-SNPs and other highly integrated plans could better reflect a plan's total cost of care on Medicare and Medicaid services and furthers financial integration. However, the current statutory and regulatory frameworks for Medicare and Medicaid, respectively, do not allow for a fully integrated MLR. In the preamble to the CY 2023 Medicare Advantage and Part D Final Rule, CMS stated that it does not believe it has the statutory authority within Medicare to include Medicaid experience as part of the Medicare MLR. This likely reflects the statutory requirement that MA MLR penalties be assessed based on MA plan revenue. Regulatory updates to the Medicaid managed care rule would be required for states to incorporate Medicare spend in Medicaid managed care calculations. Increasingly, states are looking at reinvestment requirements as part of the Medicaid MLR test, and presumably, something similar could be developed for FIDE-SNPs as well.
- Requiring FIDE-SNPs to **share a percentage of MA profits**. States could require FIDE-SNPs to share a percentage of their MA profits, which the states could then reinvest in their Medicaid programs, including to improve the care available to dual-eligible individuals. This strategy is permissible within the current Medicare and Medicaid statutory and regulatory frameworks and could be implemented through their SMACs. FIDE-SNPs would need to include the share of their profits that would be shared with the state in their MA bids for CMS review. To soften FIDE-SNP opposition to a profit-sharing strategy, the state could implement default enrollment or other plan benefits. Stakeholders noted that the profit-sharing requirement could also help contract the FIDE-SNP market if FIDE-SNPs with lower quality scores that receive a smaller rebate are unable to fulfill the profit-sharing requirement.

Conclusion

Since the inception of Medicare and Medicaid in 1965, federal and state policymakers have recognized the need to better integrate administrative processes, financing, benefit coordination and care delivery for dual-eligible individuals enrolled in both programs. Efforts to date have resulted in several integrated care models, including PACE, the FAI and D-SNPs, that studies show experience high beneficiary satisfaction and help reduce unnecessary use of high-cost services, such as nursing facility care, hospitalization and emergency department use. However, only 10% percent of the over 12 million dual-eligible individuals are enrolled in these programs, as states experience numerous barriers to or limitations on expanding access to these programs.

One important barrier is the lack of financial incentive for states to pursue integrated care programs in the absence of a clear ability to 1) influence care delivery and service utilization for their dual-eligible beneficiaries enrolled in these MA products, and 2) share in any savings accruing from integrated care models. This report identifies two promising strategies for overcoming these barriers with the interrelated goals of improving financial integration of Medicare and Medicaid by aligning and better coordinating Medicare and Medicaid resources and benefits and encouraging more states to expand access to integrated care programs, with the ultimate goal of improving dual-eligible individuals' care experiences and outcomes.

Stakeholders engaged for this report identified and discussed a third strategy for promoting Medicare and Medicaid financial integration through leveraging Medicaid 1115 demonstration budget neutrality authority (see Figure 9). Using this strategy, states would be able to reflect in their 1115 demonstration waiver spending projections savings accruing to the Medicare program or other federal programs as a result of Medicaid investments in LTSS, behavioral health, social supports and other Medicaid benefits for dual-eligible individuals. This report does not focus in depth on that strategy for several reasons, including the fact that the strategy currently would only benefit a handful of states with 1115 demonstrations that cover these populations and services, and states must renegotiate budget neutrality with CMS every three to five years, which could impact the longer-term stability and success of integrated care models for dual-eligible individuals.

With the release of the CY 2023 Medicare Advantage and Part D Final Rule, CMS has signaled that FIDE-SNPs, which provide the highest level of integration under current Medicare and Medicaid rules, are the preferred chassis on which states should build their integrated care programs for dual-eligible individuals. As such, the strategies described in this report focus on improving financial integration through FIDE-SNP models, although these strategies also could be leveraged and adapted, as appropriate, in all D-SNP models to better integrate care for Medicare and Medicaid beneficiaries with complex care needs.

Figure 9: Medicaid 1115 Demonstration Budget Neutrality Strategy

Medicaid 1115 Demonstration Budget Neutrality

States can work with CMS to redefine Medicaid Section 1115 demonstration budget neutrality policy to recognize savings to the Medicare program resulting from state Medicaid investments for dual-eligible individuals covered through states' 1115 demonstration programs. Long-standing federal policy requires that Medicaid Section 1115 demonstrations be "budget neutral" and cost the federal government no more with the demonstration program than what it would have spent without the demonstration. State Medicaid agencies estimate the "without waiver" costs over a five-year period and are held by the federal government to keep the "with waiver" costs within that limit. States that spend less than their budget neutrality limits accumulate savings that they can reinvest in their Medicaid programs via 1115 demonstrations.

Current Medicaid budget neutrality calculations consider only demonstration-related Medicaid spending, including the federal share of Medicaid spending. Under this strategy, states would be able to consider savings accruing to Medicare or other federal programs (e.g., SNAP and WIC) as a result of Medicaid investments in LTSS, behavioral health, SDOH and other benefits authorized via a Section 1115 demonstration for dual-eligible individuals, including those enrolled in FIDE-SNPs.

This strategy could encourage states to increase Medicaid investments in LTSS, SDOH and other services tailored to improve beneficiary outcomes and experience, as well as advance health equity. Expanding budget neutrality policies to account for cross-program savings could enable states to address health disparities and direct funding for services (e.g., community-based LTSS) and populations (e.g., communities of color and disabled individuals) that have been targets of underinvestment. For example, states may be able to use 1115 savings to turbocharge their rebalancing efforts and expand their provision of community-based LTSS and supportive housing—expensive services—that enable high-need beneficiaries, including dual-eligible individuals, to live and participate meaningfully in their communities.

Implementation considerations associated with this approach include:

- **Timing Alignment**: Current budget neutrality policies require states to demonstrate savings within a five-year waiver period. States will be challenged to align the budget neutrality five-year window with the potentially longer window for realizing Medicare cost savings from Medicaid investments in LTSS and other services for dual-eligible individuals.
- **Medicare Savings Calculation**: As described above, it is very difficult for states to demonstrate that Medicaid investments resulted in Medicare cost savings. This strategy requires states to calculate and reach a consensus with CMS and the Office of Management and Budget regarding the projected Medicare savings. This process would likely need to include a mechanism to address projected and unrealized Medicare savings.
- **Limited Reach**: This strategy allows states to reinvest potentially significant savings into Medicaid programs. However, it requires states to pursue 1115 demonstrations that include dual-eligible individuals, LTSS and other Medicaid services it covers for dual-eligible individuals. While only a handful of states currently are positioned to pursue this strategy, including New Jersey, New York and Arizona, it may be the easiest strategy for states to implement.
- **Federal Cost Concerns**: The federal government may be concerned that this strategy could lead to increased federal spending through 1115 waivers. However, allowing for cross-program savings in the Medicaid budget neutrality determination would be unlikely to lead to unsustainable increases in federal Medicaid spending. States remain responsible for contributing the nonfederal share of Medicaid spending and are constrained by the amount of funding they have available to support programs.

Appendix A: CY 2023 Medicare Advantage and Part D Final Rule 2025 Changes for D-SNPs

In its CY 2023 Medicare Advantage and Part D Final Rule,[35] CMS signaled its intent to sunset the Financial Alignment Initiative (FAI) and the programs' Medicare-Medicaid Plans (MMPs), and preference for using FIDE-SNPs and HIDE-SNPs as the primary vehicle for integrating care for dual-eligible individuals. CMS intends to work with interested participating states to convert MMPs to integrated D-SNPs by 2025.

As part of the rule, CMS will apply select FAI/MMP features to D-SNPs with the goal of strengthening D-SNPs as an integrated care model, as follows:

MMP Characteristic	FIDE-SNP	HIDE-SNP	Coordination-only D-SNP
Enrollee advisory committee	Required		
Health risk assessment to include social risk factors	Required		
Exclusively aligned enrollment[36]	Required starting 2025	Not addressed in this rulemaking	
Capitation for LTSS **and** behavioral health in Medicaid, with limited exclusions	Required starting 2025	Not addressed in this rulemaking	
Capitation for Medicare cost-sharing	Required starting 2025	Not addressed in this rulemaking	
Unified appeals and grievances[37]	Required starting 2025 for all FIDE-SNPs	Not addressed in this rulemaking	Required for certain plans

Appendix B: Project Methodology and Acknowledgments

Manatt Health conducted this work through a comprehensive literature review, key informant interviews with national experts and thought leaders on issues related to dual-eligible individuals and integrated care models, and three stakeholder roundtables. The roundtables included consumers, consumer advocates and thought leaders; state and former federal officials; and providers and health plans. Several actuaries also participated in the roundtables. Arnold Ventures and Manatt Health would like to thank the diverse group of stakeholders listed below for their participation in this project and their thoughtful discussions and insights.

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Tom Betlach	Speire Healthcare Strategies
Sean Cavanaugh	Aledade
Amber Christ	Justice in Aging
Henry Claypool	Brandeis University
Will Dede	SNP Alliance
Camille Dobson	ADvancing States
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Merrill Friedman	Elevance Health
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Julian Harris	ConcertoCare

Jonathon Jaffery	UW Health Accountable Care Organization (currently with the Association of American Medical Colleges)
Nicholas Johnson	Milliman
Dr. Karen Joynt Maddox	Washington University School of Medicine in St. Louis
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Branch McNeal	Mercer
Michael Monson	Altarum
Corri Altman Moore	MassHealth
Ron Ogborne	Mercer
Pamela Parker	SNP Alliance
Frederic Riccardi	Medicare Rights Center
Allison Rizer	ATI Advisory
Mary Russell	Aurrera Health Group
Emma Sandoe	Division of Health Benefits, North Carolina Department of Health and Human Services
Dan Savitt	Visiting Nurse Service of New York
William Scanlon	West Health
Leena Sharma	Community Catalyst
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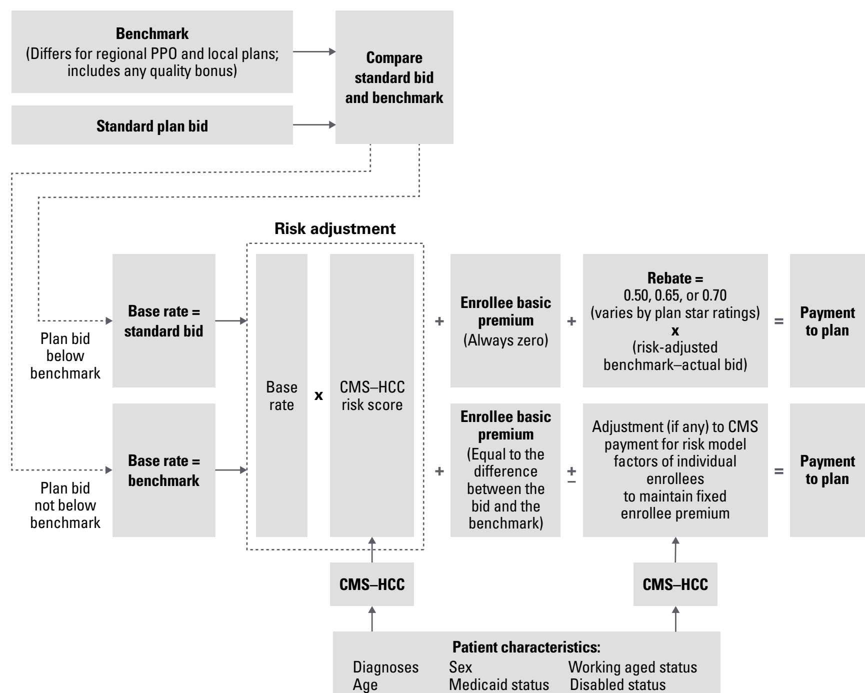
Mary Sowers	National Association of State Directors of Developmental Disabilities Services
Josh Trent	Leavitt Partners, an HMA Company
Pat Wang, Christine Logreira, Kristin Beach and Errol Pierre	Healthfirst
Lisa Watkins	Elevance Health

Appendix C: Medicare Advantage Payment System for Nondrug Benefits, 2023

Medicare Advantage premiums—including for D-SNPs—are set according to benchmarks, bids, adjustments and quality bonuses.

- Plans **bid** to offer Part A and Part B benefits; They are paid based on their bid's relationship to a **CMS benchmark**, which is determined based on a statutory formula that considers county/regional FFS spending.
- Higher ranked plans will have **bonus** amounts added to the benchmark.
- If the plan's bid is **above** the benchmark, the benchmark is the base rate and member premium's cover the shortfall.
- CMS **adjusts** the base rate using the CMS hierarchical condition category (CMS-HCCS) to account for each beneficiary's relative risk.
- If the plan's bid is **less than** the benchmark, they receive a **rebate** that is a fixed percentage (50, 65 and 70%) based on the plan's Star rating.
- Plans use their rebates to provide **supplemental benefits or lower cost sharing** for their members.



Notes: PPO (preferred provider organization), CMS–HCC (CMS–hierarchical condition category). If the plan bid equals the benchmark, there is no enrollee basic premium. Medicare payments also reflect an intra-service area adjustment based on the county of residence of the enrollee.

Source: MedPAC. "Medicare Advantage Program Payment System." October 2022. Available at: https://www.medpac.gov/wp-content/uploads/2021/11/MedPAC_Payment_Basics_22_MA_FINAL_SEC.pdf; Better Medicare Alliance. "Understanding Medicare Advantage Payment & Policy Recommendations." September 2018. Available at: https://bettermedicarealliance.org/wp-content/uploads/2020/03/BMA_WhitePaper_MA_Bidding_and_Payment_2018_09_19-1.pdf.

[1] Report to Congress on Medicaid and CHIP. Medicaid and CHIP Payment and Access Commission. June 2022. Available at https:/www.macpac.gov/wp-content/uploads/2022/06/MACPAC_June2022-WEB-Full-Booklet_FINAL-508-1.pdf.

[2] See https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and.

[3] People Dually Eligible for Medicare and Medicaid, CMS, March 2020; Data Book: Beneficiaries dually eligible for Medicare and Medicaid, MedPAC and MACPAC, February 2022.

[4] Data Book: Beneficiaries dually eligible for Medicare and Medicaid, MedPAC and MACPAC, February 2022.

[5] Ibid.

[6] See https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn.

[7] https://www.chcs.org/media/ADvancing-States-Value-of-Integration-Report-1119_4.pdf.

[8] https://www.macpac.gov/wp-content/uploads/2019/07/Evaluations-of-Integrated-Care-Models-for-Dually-Eligible-Beneficiaries-Key-Findings-and-Research-Gaps.pdf.

[9] Data Book: Beneficiaries dually eligible for Medicare and Medicaid, MedPAC and MACPAC, February 2022.

[10] CY 2023 Medicare Advantage and Part D Final Rule. Available at https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and.

[11] https://us.milliman.com/en/insight/key-insights-into-2022-medicare-advantage-d-snp-landscape#1.

[12] https://www.macpac.gov/wp-content/uploads/2022/03/Requiring-states-to-develop-an-integrated-care-strategy-for-dually-eligible-beneficiaries.pdf.

[13] 2022 Medicare Trustees Report (cms.gov). Available at https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf.

[14] S. 4635, The Comprehensive Care for Dual Eligible Individuals Act of 2022. 117th Congress (2021–2022). Available at https://www.congress.gov/bill/117th-congress/senate-bill/4635/text.

[15] Leavitt Partners: The Dual Eligible Coalition. Available at https://leavittpartners.com/dual-eligible-coalition/.

[16] Washington has coordination-only D-SNPs and HIDE-SNPs and will not be able to work with its MA plans to establish FIDE-SNPs after 2025, as LTSS is carved out of Medicaid managed care and reimbursed fee-for-service.

[17] Washington Health Care Authority. Amended and Restated State Medicaid Agency Contract, January 2023. Available at https://www.hca.wa.gov/assets/billers-and-providers/SMAC-Jan2023-model.pdf.

[18] MA premiums are set according to benchmarks, plan bids, adjustments to account for patient risk and quality bonuses; a plan that bids below the benchmark receives a rebate that is a fixed percentage based on its Star rating. See Appendix C for more detail.

[19] Friedman, J. M. and Yeh, M., Prevalence of Supplemental Benefits in the D-SNP Medicare Advantage Marketplace: 2018–2022, Milliman, April 1, 2022. Available at https://us.milliman.com/en/insight/prevalence-of-supplemental-benefits-in-the-d-snp-medicare-advantage-marketplace-2022.

[20] New York's FIDE-SNPs are referred to as Medicaid Advantage Plus (MAP) plans and cover behavioral health and LTSS.

[21] New York State Department of Health. State Medicaid Agency Contract for Calendar Year 2023. Available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/2022/docs/cy2023_state_med_agency_cont.pdf.

[22] 42 CFR § 422.107(c). Available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-422/subpart-C/section-422.107.

[23] All FIDE-SNPs will be required to have a unified appeals and grievances process as of 2025. The requirement for unified grievances and appeals in place for those FIDE-SNPs and HIDE-SNPs that meet the federal definition (42 CFR § 422.561, available at https://www.law.cornell.edu/cfr/text/42/422.561) for applicable integrated plans (AIP).

[24] https://www.integratedcareresourcecenter.com/sites/default/files/ICRC_Call_on_D-SNP_Performance_Monitoring_and_Oversight_for_508%20%282%29.pdf.

[25] Other reasons why MA plans must submit new MOCs include seeking to offer a new SNP, approval term ends or it is necessary to comply with CMS regulations (e.g., resulting from an audit or new regulation). Source: CMS, Model of Care, available at https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/SNP-MOC.

[26] MedPAC, Report to Congress Chapter 12: The Medicare Advantage Program: Status Report and Mandated Report on Dual-Eligible Special Needs Plans, March 2022. Available at https://www.medpac.gov/wp-content/uploads/2022/03/Mar22_MedPAC_ReportToCongress_Ch12_SEC.pdf.

[27] MedPAC, Report to Congress Chapter 12: Promoting Integration in Dual-Eligible Special Needs Plans, June 2019. Available at https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun19_ch12_medpac_reporttocongress_sec.pdf.

[28] CY 2023 Medicare Advantage and Part D Final Rule. Available at https://www.federalregister.gov/documents/2022/05/09/2022-09375/medicare-program-contract-year-2023-policy-and-technical-changes-to-the-medicare-advantage-and.

[29] 42 CFR § 438.4. Available at https://www.law.cornell.edu/cfr/text/42/438.4.

[30] 42 CFR § 438.5. Available at https://www.law.cornell.edu/cfr/text/42/438.5.

[31] American Academy of Actuaries. Re: Proposed Rule, Medicare Program; Contract Year 2023 Policy and Technical Changes to the Medicare Advantage and Medicare Prescription Drug Benefit Programs. March 7, 2022. Available at https://www.actuary.org/sites/default/files/2022-03/American_Academy_of_Actuaries_DSNP_Proposed_Rule_Comment_Letter_03072022.pdf.

[32] Ibid.

[33] Ibid.

[34] New York State Department of Health. State Medicaid Agency Contract CY2023. Available at https://www.health.ny.gov/health_care/medicaid/redesign/mrt90/2022/docs/cy2023_state_med_agency_cont.pdf.

[35] See https://www.govinfo.gov/content/pkg/FR-2022-05-09/pdf/2022-09375.pdf.

[36] Exclusively aligned enrollment is when a state limits D-SNP enrollment to only full-benefit, dual-eligible individuals who receive their Medicaid benefits through the D-SNP or through an affiliated Medicaid managed care plan offered by the same parent company as the D-SNP.

[37] The requirement for unified grievances and appeals was already in place for those FIDE-SNPs and HIDE-SNPs that meet the federal definition (42 CFR § 422.561, available at https://www.law.cornell.edu/cfr/text/42/422.561) for AIP.

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